

UNDERSTANDING AND CHALLENGING HIV AND KEY POPULATION STIGMA AND DISCRIMINATION

Caribbean Facilitator's Guide



Suggested citation: Health Policy Project. 2013. *Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide*. Washington, DC: Futures Group, Health Policy Project.

The Health Policy Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-10-00067, beginning September 30, 2010. The project's HIV-related activities are supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). It is implemented by Futures Group, in collaboration with CEDPA (part of Plan International USA), Futures Institute, Partners in Population and Development, Africa Regional Office (PPD ARO), Population Reference Bureau (PRB), RTI International, and the White Ribbon Alliance for Safe Motherhood (WRA).

Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide

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ACKNOWLEDGEMENTS

Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide is a facilitator's guide to be used in conducting training workshops and community meetings to raise awareness on stigma and discrimination, advocate for a more inclusive environment, and develop policies to reduce stigma and discrimination in the Caribbean.

The facilitator's guide contributes to the Health Policy Project (HPP) objectives of "Strengthening Capacities in a Caribbean Regional Response to HIV-related Stigma and Discrimination." The Health Policy Project is a five-year technical assistance mechanism funded by USAID under the President's Emergency Plan for AIDS Relief (PEPFAR). HPP Caribbean works in support of the Pan Caribbean Partnership against HIV and AIDS (PANCAP) in the development and rolling out of the *PANCAP Stigma Reduction Framework for HIV and AIDS*. The facilitator's guide is part of the rolling-out process of this framework. HPP also supports regional civil society networks to come together to share information and to develop a common regional advocacy agenda for addressing stigma and discrimination. HPP Caribbean is part of the five-year Partnership Framework between the Caribbean governments and the U.S. government to support the implementation of Caribbean regional and national efforts to combat HIV.

The guide was written by a team of persons, led by Ross Kidd and including Ayana Hypolite, Ken Morrison, Tamarah Moss-Knight, and Laura Nyblade, with additional assistance from:

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- PANCAP regional partners staff, including Rachel Charles, Teddy Leon, Donovan Emmanuel, and Mavis Tull (Caribbean HIV & AIDS Alliance)

The guide was developed for use in two Training of Facilitators (TOF) Workshops held in Dominica and St. Kitts and Nevis in April and May 2012, and in follow-up education, advocacy, and policy development programmes initiated by those trained in the workshops.

The guide draws on the experience, stories, and analysis of those who attended the TOF workshops. Their enthusiastic participation helped to provide a good test of the materials, and their responses to the exercises have become a major part of the facilitator's guide – a way of showing facilitators the kind of responses expected from each exercise.

The Fact Sheets are based on information from a number of sources and draw on fact sheets developed by Jonathan Boland.

The pictures in the guide were produced by Petra Rohr-Rouendaal.

The guide was developed in response to the situation of people living with HIV (PLHIV) and key populations in the Caribbean, including men who have sex with men (MSM), transgender people, sex workers, and people who inject drugs (PWID), and those who work with them. The guide is inspired by the ideas and experience of many organisations working in this field and draws on materials and ideas from other manuals, including:

- BONELA. 2010. *Human Rights and HIV: Trainer's Guide*. Gaborone: Botswana Network on Ethics, Law, and HIV/AIDS.
- BONELA. 2010. *Sexual Minorities, Human Rights, and HIV/AIDS: Trainer's Guide*. Gaborone: Botswana Network on Ethics, Law, and HIV/AIDS.

- Caribbean HIV/AIDS Regional Training Network. 2005. *HIV/AIDS Stigma & Discrimination in Caribbean Health Care Settings: Trigger Scenarios and Facilitator Guide*. International Training and Education Center on HIV (I-TECH), University of Washington.
- Engender Health, Global Network of People Living with HIV (GNP+), International Center for Research on Women, International HIV/AIDS Alliance, UNAIDS, UNDP, WHO, and ILO. 2011. *Draft Toolkit on HIV-related Stigma Reduction in Health Care Settings*.
- International Center for Research on Women (ICRW) and Bhoruka Public Welfare Trust. 2007. *Reducing HIV Stigma and Gender-based Violence: Toolkit for Health Care Providers in India*. Washington, DC: ICRW and Bhoruka Public Welfare Trust.
- International Center for Research on Women and Pact International. 2010. *Understanding and Challenging Stigma towards Men who have Sex with Men: Toolkit for Action (Cambodia)*. Phnom Penh, Cambodia: ICRW and Pact International.
- International HIV/AIDS Alliance, ICRW, and AED. 2007. *Understanding and Challenging HIV Stigma: Toolkit for Action*. Brighton, UK: International HIV/AIDS Alliance, International Center for Research on Women, and Academy for Educational Development.
- Nyblade, L., et al. 2006. *HIV/AIDS Stigma: Finding Solutions to Strengthen HIV/AIDS Programs*. Washington, DC: ICRW.
- PANCAP. 2009. *HIV Anti-Stigma Toolkits*. Separate toolkits for: educators, faith-based organisations, health workers, people living with HIV, the private sector, and the tourism sector.
- UNAIDS. 2003. UNAIDS Fact Sheet on Stigma and Discrimination. Geneva: UNAIDS.
- UNESCO. 2010. *“We Are All in the Same Boat”: Using Art and Creative Approaches with Young People to Tackle HIV-related Stigma*. Paris: UNESCO.

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ABBREVIATIONS AND ACRONYMS

ART	antiretroviral treatment (or therapy)
ARV	antiretroviral
LGBTI	lesbian, gay, bisexual, transgender, and intersex people
MSM	men who have sex with men
NGO	nongovernmental organisation
PLHIV	people living with HIV
PWID	people who inject drugs
QQR	quantity, quality, and route of transmission
STI	sexually transmitted infection
TOF	Training of Facilitators
VCT	voluntary counselling and testing

What Is the Facilitator's Guide?

What Is the Facilitator's Guide?

The facilitator's guide is a set of educational exercises to raise awareness on and promote advocacy and action to challenge HIV and key population stigma and discrimination. It will be used by facilitators to run training workshops and community meetings to teach people about the issues people living with HIV (PLHIV) and key populations are facing and what might be done to change this situation.



It uses a **participatory approach** – one based on discussion, small group activities, case studies, and other participatory methods (e.g., role playing, cardstorming) to make the learning lively and fun. The aim is to get participants actively involved in thinking about the issues affecting people living with HIV and key populations, rather than passively listening to a lecture. Participants learn through sharing ideas, discussing and analysing issues, relating new concepts to their own experience, trying to find solutions to problems, and planning what they can do to challenge stigma and discrimination. This approach fosters a sense of initiative and responsibility on the part of learners and reinforces their ability to think for themselves – a feature needed in building self-reliant action and advocacy.

The facilitator's guide is written for you—the facilitator. It provides detailed, step-by-step instructions on how you can plan and facilitate these sessions.

To use these exercises, you will need basic facilitation skills—the skills needed to facilitate large and small group sessions, use different participatory methods, summarise key points, manage conflict and challenging questions, and involve all participants. These skills and techniques are explained on pages 13–21 at the end of this chapter.

Who Is the Facilitator's Guide for?

The facilitator's guide is for individuals and organisations that are working to stop stigma and discrimination towards people living with HIV and key populations in the Caribbean. One of its aims is to help health workers, teachers, media workers, nongovernmental organisation (NGO) activists, and faith-based and community leaders to become more aware of stigma and discrimination towards people living with HIV and key populations, how it affects us, and what can be done to change it.

How Is the Facilitator's Guide Organised?

The facilitator's guide consists of seven chapters—this introductory chapter, plus six chapters, which include educational exercises on the following topics:

- Chapter A: Naming HIV and Key Population Stigma
- Chapter B: Sex, Morality, Shame, and Blame
- Chapter C: Understanding Key Populations and Stigma
- Chapter D: HIV Transmission and Fear-based Stigma
- Chapter E: Coping with Stigma and Discrimination
- Chapter F: Moving to Action

Chapters A, B, C, D, and F are written for mixed audiences, including people living with HIV, key populations, health workers, teachers, media workers, and faith-based and community leaders. **Chapter E** is written specifically for use by groups of people living with HIV or key populations, or people who work with these groups.

Why a Facilitator's Guide on HIV and Key Population Stigma and Discrimination?

HIV-related Stigma and Discrimination

HIV-related stigma is a powerful social process of devaluation of people or groups either living with or associated with HIV and AIDS. This stigma often stems from the pre-existing and intersecting stigmatisation of sex workers, people who inject drugs (PWID), and men who have sex with men (MSM).

Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Discrimination occurs when a distinction is made about a person that results in him or her being treated unfairly or unjustly on the basis of belonging to, or being perceived to belong to, a particular group (UNAIDS, 2003).

This definition is adapted from the International Center for Research on Women's *HIV/AIDS Stigma: Finding Solutions to Strengthen HIV/AIDS Programs* (Nyblade et al., 2006).

Key Populations

Groups who are more vulnerable to HIV infection are often called *key populations*; in the Caribbean, they include MSM, transgender people, sex workers, PWID, and migrants. Key populations are already stigmatised but if they are diagnosed with HIV, they can face additional stigma and discrimination. The existing negative attitudes that people have towards them is compounded by their association with HIV and AIDS. On top of this, countries have laws that criminalise their behaviour (e.g., sodomy laws and anti-sex work laws) and make it difficult for them to exercise their human rights, including accessing health services. Because of this, key populations face overt discrimination.

People living with HIV and key populations face many forms of stigma and discrimination—they are:

- Blamed and shamed at home, and in some cases forced to leave home
- Isolated and made fun of by their peers at school
- Subjected to verbal and physical abuse and social isolation in the community
- Denied work opportunities and access to accommodation
- Given poor treatment by health workers and find it difficult to access health services
- Subjected to discriminatory laws and unable to exercise their human rights

There are few places where people living with HIV and key populations feel completely safe. They often feel watched and face stigma and hostility in many places they go, and so many try to remain hidden.

Fear of being found out and stigmatised may inhibit people living with HIV and key populations from using public health services. Often they resort to using private doctors or health services in other islands, where they are more confident that they will not be exposed. As a result of the stigma, key populations may not be able to access information about HIV-related prevention and may be less able to take care of their sexual health. All of these factors increase the vulnerability of key populations to acquiring HIV.

The situation, however, is changing. Government and civil society are now working together to address this problem. They have initiated:

- Studies to measure stigma and document the situation facing key populations;
- The drafting of anti-discrimination policies and legislation; and
- Educational and media campaigns to make people aware of their rights and the effect of stigma and discrimination on us all.

The facilitator's guide is written to support these efforts – in particular to:

1. Help health workers, teachers, media workers, and faith-based and community leaders to overcome fears and prejudices towards PLHIV and key populations, and raise their understanding on how stigma and discrimination and lack of human rights damages people's lives and can reduce their participation in their communities and countries' development, fueling HIV transmission.
2. Build public recognition of the problem of HIV and key population stigma and discrimination, and public support and commitment to stop stigma and discrimination.
3. Get health workers, teachers, media workers, and other service providers to develop new codes of practice for how they work with and portray PLHIV and key populations.
4. Empower people living with HIV and key populations to support strengthening self-esteem and to develop assertiveness to demand rights and push for improved service provision.

A key aim of the facilitator's guide is to help people living with HIV and key populations break out of a life on the margins, build improved relations with their families and communities, reassert their rights, and get better access to health and other services.

Special Note on Stigma and Discrimination:

In the toolkit, we are going to use the word 'stigma' to indicate both stigma and discrimination because we think of discrimination as an end point of the process of stigma.

Stigma remains the single most important barrier to public action. It is the main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world.

Not only is it unethical not to protect [MARPs] groups, it makes no sense from a health perspective. It hurts us all!

—*Ban Ki Moon, Secretary-General of the United Nations, 2008*

How to Use the Facilitator's Guide

Use the Guide Selectively

The guide is a collection of individual training exercises, organised into different topics/chapters. It is not designed to be read like a novel, from cover to cover, or used as a complete package in a single course. You can select those topics and exercises which best suit your target groups/participants, your objectives, and the time you have for your training sessions or meetings. However, there are some core exercises that are recommended to be included in any session.

The guide provides detailed, step-by-step instructions on how you can plan and facilitate these exercises. The session plans provide a guide, but feel free to adapt and change exercises to suit your group, objectives, and context. For example, you may want to convert a case study exercise into role playing by asking participants to perform the case study – and then discuss it; or you may change a rotational brainstorm exercise (in which groups move round the room writing on flipcharts) into a topic group exercise. You know your audience and what will work best. The most important thing is the enthusiasm, energy, and creativity you bring to the training.

Examples of Workshop Plans

Annex C contains examples of training plans based on the exercises in the guide, covering different topics and designed for different target groups. Feel free to use and adapt these sample programmes to suit your situation and needs.

Case Studies

The case studies in the toolkit are based on real experiences of people facing stigma in the Caribbean. You will need to select those case studies which are relevant to your situation, e.g., case studies dealing with those key populations who are stigmatised in your country. You may also have to change the details in the case studies to suit your local context or, in some cases, you may need to write a new case study.

Handouts

The Annexes include Fact Sheets and pictures, which can be used to support your training. The Fact Sheets are designed as handouts and would be distributed at the end of sessions for reference after the training. The Fact Sheets are linked to specific exercises in the toolkit. All of this material needs to be photocopied in advance of the training session.

Use the Guide for Participatory and Collective Learning

The guide is designed for participatory learning, so it is not meant to be used for giving a lecture. Changing stigmatising attitudes cannot be achieved through treating participants as a passive audience for messages delivered by their facilitators. Participants will only become aware of their own attitudes and become less judgemental through an active and interactive process – one where they can talk and think and figure things out for themselves.

The idea is to create a safe space where participants can move beyond a purely intellectual look at stigma and begin to explore their own experiences of stigma; express their fears and concerns; discuss the values and beliefs that underlie stigma; look critically at their attitudes towards people living with HIV and key populations; take ownership of a new set of principles, values, and feelings; and work practically to challenge stigma and develop new codes of practice.

The guide is also designed for collective learning. Working with others makes it possible for people to learn together about stigma and discrimination, develop common ideas about what needs to be done, set group norms for new attitudes and behaviour, support each other in working for change, and monitor the results of change.

Some Participants May Be Living with HIV or from Other Key Populations

In planning your workshop, you should assume that some participants or co-facilitators may be HIV positive or a member of a key population. Participants or co-facilitators may or may not have disclosed this to other participants and may or may not choose to share this during the training.

For this reason, it is important to treat everyone the same and not make assumptions about individuals. Using the phrase “we” (rather than ‘us’ and ‘them’) when talking about stigmatised groups is one way to avoid further stigmatising people when carrying out the training.

Some participants may reveal their HIV status or status as a member of a stigmatised group during a training session – and you will need to know how to deal with it. See below.



Dealing with Disclosure

The first task is to create a safe and supportive environment within the workshop to enable participants to disclose if they wish to do so. Setting the climate and establishing ground rules play an important role, especially in establishing confidentiality and respect. As the facilitator, ensure the ground rules are followed.

Some participants may want support from the group. Disclosure is a way to break isolation and for participants to share their stories. Encourage group support and provide one-to-one support outside the session if appropriate.

Some participants may disclose because they are in a crisis and urgently need help. In this situation, you should assess how urgently help is needed and where the person might go to get it. It is really important that facilitators know about available support services in the local area.

Consideration about Literacy

In many settings, the facilitator will need to accommodate participants with various levels of literacy. Encourage participants to help each other and create an atmosphere where participants will feel free to ask for help if they need it. Use a mix of exercises—some exercises do not need any literacy skills; others will only need one person in a group to make notes.



PLHIV and Key Populations as Co-facilitators

One of the most successful strategies for stigma reduction is the meaningful involvement of stigmatised populations in decisions and programmes that affect them. This guide integrates this strategy through involving PLHIV and key populations in the planning and delivery of training.

PLHIV and key populations can be experts on stigma – they know how it feels to be stigmatised – and they can bring this experience to bear on the training, giving it a ‘human face.’ Involving those who are stigmatised in active roles in the training will help to change attitudes and at the same time provide members of marginalised groups with opportunities to teach others, thereby reducing their own self-stigma and building their capacity to take a positive role in the community.

People living with HIV and members of key populations should be invited to help plan the training programme, serve as co-facilitators, and help monitor and evaluate the training programme.

Approach support groups and networks for people living with HIV or key populations in your area to help identify individuals who could take part in the training. Look for people who:

1. Have some training experience in the HIV field
2. Are willing to disclose their HIV-positive status or identity as a member of a stigmatised group
3. Are confident and comfortable in talking about their experiences and the stigma they face

The co-facilitators can give testimonials about their experience, but their role in the training should not be limited to testimonials:

At the start of the training, the role of the two HIV positive co-trainers was limited to giving testimonials. Once the workshop started however, the two co-trainers made such a useful contribution to all sessions (not only the testimonial session) that their role was upgraded to full participation as co-facilitators throughout the training. Their participation had a huge impact on the change in health workers’ attitudes. For the health workers it was the first time for them to relate to people living with HIV as peers and as HIV experts, rather than as clients under their care.

—*Vietnam Safe and Friendly Health Facility Toolkit*

Caution: Some participants may hold negative attitudes about PLHIV and key populations, so it is important that the facilitators are able to handle the expression of these beliefs and opinions in a sensitive manner, making sure that any stigmatising beliefs are challenged in a way that participants do not get upset or defensive. Facilitators also need to be able to challenge any (hopefully rare) situation where anyone participating in the training – including a co-facilitator—is harassed or insulted by another participant. Take care that the co-facilitators do not feel that they are being interrogated or personally attacked in the process of answering the group’s queries.

Tips on handling harsh or negative responses to issues raised or opinions expressed:

- Don’t silence them. This will only re-confirm prejudice. Let them come out.
- Even the best exercises are unlikely to completely change people’s attitudes in a short period. However, you can offer alternative perspectives about these issues that will encourage people to think and question their own attitudes.
- Don’t let discussions get out of hand. Allow people to speak their minds, but do not allow them to reinforce themselves and each other negatively.

- Don't be afraid to say you do not know.
- Keep participants focused on every person's right to be treated with respect.

Session Plans

Each exercise in the facilitator's guide is written up as a session plan – a detailed, step-by-step description of how to facilitate the learning exercise. The session plans will help you run each session.

Each session plan is divided into the following parts:

Facilitator's Note

A brief note to the facilitators on the importance of the exercise and any extra advice on how to facilitate it.

Objectives

What participants will know or be able to do by the end of the session.

Time

Estimated amount of time needed for the session. This is a rough estimate; it will vary according to the size of the group. Larger groups will require more time (especially for report backs).

Target Group

Many of the exercises are suited to all groups, but some may be more appropriate for certain groups, e.g., health workers.

Materials

Pictures, case studies, role plays, etc. which are used in the session. We do not list basic materials, e.g., flipcharts, markers, masking tape.

Steps

The learning activities used in the exercise, described "step by step," and the learning content.

"Steps" are the core of each session plan. This section includes information on:

Methods

Discussion, rotational brainstorm, cardstorming, role plays, etc.

Groups

Buzz or small groups: suggestions on group size and tasks.

Questions

Specific questions used to guide discussion.

Example Responses

Examples of typical responses, presented in boxes. This helps you (the facilitator) understand the kind of responses expected from the discussion. They are only examples and are not meant to be read out as a lecture.

Report Back

Procedures for groups giving reports after discussion.

Processing

These are additional questions and discussion, conducted after the report back, to help deepen participants' learning and relate the new learning to participants' own context.

Summary

Points to be emphasised in a summary at the end of the session. The summary is very important, so allow enough time at the end of the session to do the summary. Start off by summarising participants' own ideas, then add the ones in this list if they have not already been mentioned.

Methods and Materials

The facilitator's guide uses a variety of participatory training methods and materials:

Discussion is the core method. Participants reflect on their own experiences, share with others, analyse issues, and plan for action together. All of the sessions are built around discussion.

Presentations are kept to a minimum and used only to summarise sessions or explain facts where participants are confused.

Small Groups are used to maximise participation in discussions. Some participants feel shy in a large group and are more comfortable speaking in a small group. Small groups also can be used to do "task group" work—different groups exploring different topics.

Buzz Groups—two people sitting beside each other—are a trainer's secret weapon! They help get instant participation. It is hard to remain silent in a group of two people.

Report Backs are used to bring ideas together after small or buzz groups. Often "round robin" reporting will be used – one new point from each group going around the circle. This ensures that all groups get a chance to contribute equally.

Cardstorming is a quick way to generate ideas and get everyone involved. Participants, working individually or in pairs, write words or short phrases on blank cards and tape them on the wall, creating a brainstorm of ideas. Once everyone is finished, the cards are organised into categories and discussed.

Rotational Brainstorming is another form of brainstorming done in small groups. Each group is given a topic and begins by recording ideas on a flipchart. After two or three minutes, each group rotates to a new topic and adds points to the existing list. During the exercise, each group contributes ideas to all topics.

Pictures: The guide includes pictures for use in different exercises. The main set of pictures is used to show various aspects of stigma. Another set shows different forms of casual contact – for an exercise on HIV transmission.

Case Studies offer a way to describe how stigma looks in a real situation and provide a focus for discussion. Some exercises include case studies or stories, while in others, participants are asked to write their own stories.

Role Plays can be used with stories. Participants act out the stories in the exercise or their own stories, or they act out their analysis of an issue as a way of reporting what they have discussed. Role playing helps to make things real.

Problem Trees help participants visualise the forms, effects, and causes of a problem by comparing them to the trunk, branches, and roots of a tree.

Warm Up Games and Songs: Trainers are encouraged to use their own games and songs to break the ice, build group spirit, and create energy for sessions.

Tips for Facilitating Participatory Learning

Part A: Planning

- The facilitator's guide is a set of **optional** exercises on different topics. It is designed to be used selectively, tailored for each group, rather than as a uniform training package.
- So select those exercises which suit your target group, your objectives, and the time you have for your sessions. Use a mixture of methods to keep interest levels high.
- Prior to the training, **meet with the managers** to discuss the benefits of the training, including any time and resource requirements. This will facilitate commitment from managers and ensure the success of the training and support for the implementation of the action plan following the training.

Planning for Action

- The guide is designed to encourage participants to put their new learning into action. So you should also work on solutions to problems and plans for action. The aim is to help participants agree on what needs to be done and support each other in working for change.
- Include in your plan what happens after each session. How will participants apply what they have learned? What follow-up support do they need? The aim is to make the process started by the sessions sustainable—participants doing relevant activities to make changes in their lives.

Part B: General Facilitation Tips

Work as a Team

- If possible, plan and run the sessions with another facilitator – and take turns in the lead role.
- One facilitator can lead the session, while the other facilitator records on a flipchart and helps with the preparation of materials.
- Plan the training sessions beforehand together—and decide on who will lead each session.
- Support each other—if one facilitator runs into trouble, the other can help him/her out.
- Meet at the end of each day to debrief and give feedback on performance and how the day went—and plan for the next day.

At the start of the training, do the following:

Prepare the room and materials

- The more preparation, the smoother the training sessions will go, and you will save time.
- Physical Preparations –
 - a) Remove tables to allow participants to move around and make the sessions less formal.
 - b) Set up the chairs in a circle or semi-circle so that everyone can see each other.
 - c) Set up a table for materials—handouts, markers, tape, flipchart paper, cards, etc.
 - d) Arrange the materials—put up blank flipchart sheets for recording, write up flipchart instructions for exercises, cut up paper for cardstorming, etc.

Break the ice and introduce the session

- Start with an ‘energiser’—a game or song to help participants relax and have some fun, and spark some energy.
- Then explain the objectives for the session.
- **Ground rules**—the rules for working together as a group. Agree on rules to ensure that everyone gets an equal chance to participate, and encourage those who are less confident to participate.

Examples of Ground Rules:

- We respect one another’s ideas.
- We treat one another in a positive way and are considerate of one another’s feelings.
- “What happens in de party, stays in de party!” We keep personal matters confidential.
- We do not interrupt one another.
- We do not put down or criticise each other.
- We have a right to pass if we do not want to answer a question.
- We can choose not to do an activity if we are uncomfortable with it.

Give Clear Instructions for Exercises

- Start off by telling participants what the exercise is – for example: “The first exercise is ‘Naming Stigma through Pictures.’ We will look at these pictures in pairs and discuss the kinds of stigma we see in these pictures.”
- Explain one step in an exercise at a time—and get participants to do it. For example, “Divide into pairs” – and then have them do it. Then explain the next step: “Each pair should select one of the pictures on the wall”—and get them to do it. If you take them through all the steps in the exercise before asking them to do any, they will just become confused, and it wastes time.
- Keep your instructions simple and clear and use examples to help with understanding.
- If participants have blank looks, check that they have understood. “What are you being asked to do—or discuss?”
- Write the instructions or discussion questions on a flipchart and use the same words that you plan to use in explaining the instructions or questions.
- After groups are formed, go around to each group to **check that they are clear about the task**. Ask them to explain what they are expected to do—to see if they understand.

Divide into Groups Quickly and Efficiently

- In dividing into groups, the aim is to mix participants up—to get them working with different people. Keep changing the members in a group for each exercise.
- To achieve this objective, select groups on a random basis. There are many ways you can use to divide people into groups. Be creative in dividing into groups and turn this process into an energiser if you need to get people moving.
- In deciding on the group size, you will need to think about the following:

- a) **Large groups** (e.g., 5–9)—less participation, but the report back takes less time.
 - b) **Small groups** (e.g., 2–4)—more participation, but more groups to report, so it takes longer.
- Some group work can be done in “**buzz groups**” (**pairs**)—everyone gets a chance to talk.

Organise Report Backs

After groups have done their work, they will report back. There are different ways of doing this:

- **Round robin reporting:** Each group presents only one point at a time, going round the circle until all the points are exhausted. The group reporter should give only new points. This method helps to equalise contributions by different groups—and avoids repetition.
- **One group—one topic:** Each group reports on a different topic or question.
- **Only one question:** Groups report on only one of the questions discussed—the key question.
- **Creative report:** Groups give their report in the form of a picture or role play.
- **Report back in paired groups:** Sometimes you can have two small groups meet and share what they have learned. The smaller numbers allow for a more intensive discussion.

Record Discussions on Flipchart

One facilitator should take notes on plenary discussion on the flipchart. This provides a permanent visual record, helping participants see what has been discussed and what needs to be added. Writing down points triggers other ideas and provides the basis for a summary of the discussion. Here are a few tips on recording:

- Write only the **main points or key words**, not everything that participants say.
- Use **participants’ own words** so that they recognise their own contributions.
- Write **big and clear** (ideally capital letters) so people at the back of the room can see.
- Use **different colors**, e.g., black for the main text and red for underlining key words.

Give Effective Summaries

At the end of each exercise, after participants have fully discussed the issue, you should give a brief summary of what participants have mentioned that they learned. The summary is important—this is the time you help participants consolidate what they have learned—so make sure you give yourself enough time to do it well.

Manage Energy

Check on energy level at regular points – and respond if energies are low.

- Observe their body language. Are they yawning? Do they look bored? Tired?
- Ask—“*How are you feeling? Is it time for an energiser or a break?*”
- When people are tired, change the activity to get more participation (e.g., break into buzz groups or do an activity standing up), do an energiser, or take a break.
- Use your own energy as a facilitator—communicated through a strong voice and active body language—to energise the group.

Manage Space

Change the space and the organisation of the chairs to suit your activity and provide variety:

- Start off with a circle or semi-circle so that everyone can see each other.
- For some activities, e.g., report backs, use a formation with participants sitting in rows close together—this adds energy and helps everyone hear better.
- Change the front of the room from time to time, suited to the activity. Where possible, organise some activities outside the training room in the open air.

Manage Time

- In a short training programme, there is not enough time to go into depth with all the issues. You will need to manage time carefully or your overall objective will be lost.
- Decide how much time you need for each session – and work to these time limits. Don't allow sessions to drag on too long! Tell participants in advance how long each session will be and explain your reasons if you subsequently decide to shorten or lengthen it.
- In establishing the ground rules, get the group to take co-responsibility for time management and the successful meeting of workshop aims.
- Remember—small group work takes more time than you expect. You will also need to allocate time for report backs.
- Don't go too fast. Let the group help you set an appropriate pace.
- Do small group work in the afternoon, when the energy levels drop.
- Give small groups enough time to do their work. Don't rush them.
- Close on time! Don't drag things on forever at the end of the day.

Evaluation

- Organise an evaluation at the end of each day.
- Hand out a one-page questionnaire (e.g., likes, dislikes, what was learned, issues needing more discussion) and ask participants to complete it. This helps to identify problems or issues which need to be addressed—and helps you improve the training sessions.
- Summarise the main points from the evaluation the following morning.
- Don't be defensive about the evaluation comments—try to learn from the feedback.
- Organise an evaluation at the end of the workshop.

Hold a Daily Review and Planning Meeting

- Hold a meeting of the facilitators at the end of each day to review the day's activities and plan for the following day.
- Start off with a quick go-around to get each person's views about the day. Then go through each of the activities and participants' evaluation forms, and ask for comments.

Action Planning

- At the end of each workshop, get participants to **develop an action plan** – to plan how they are to use what they have learned from the workshop.
- Get participants to think about **what they can do individually** (e.g., changes in their own lives) and **what they can do as a group** (e.g., things they can do to challenge stigma).

- Keep a **running list of critical issues** discussed throughout the workshop; then, on the final day, you can provide this list as the starting point for action planning.
- Action plans are often not implemented—they are shelved and not used to guide follow-up action. The reason is that **action planning is often left to the last session in the workshop**, when participants are focused on returning home, so the planning is rushed and done with little commitment. Another problem is that the **plans are too general** to be implemented, e.g., “Mobilise the community to raise awareness on the rights of people living with HIV.”

Part C: How to Facilitate Discussion

Discussion is the core activity. As a facilitator, you need to be good at facilitating discussion. Here are a few tips:

Open Questions and Probing

- One of your main tasks as a facilitator is to ask effective questions:
- Open questions encourage many different opinions and help get all participants talking and contributing.
- ‘Probing’ is asking more questions to encourage participants to give more information on an issue, find out the views of other people, find out how people feel about an issue, or look for solutions to the problem.



Active Listening

- After asking each question, listen carefully to what each person says. Give him/her your full attention and concentrate on what she/he is saying.
- If you listen actively, participants will know that they are being heard and understood. This encourages them to be more open about sharing their experiences, thoughts, and feelings.
- Active listening involves:
 - a) Eye contact – looking at the person most of the time to show interest and understanding.
 - b) Encouragers – Signals to the other person that you are listening, e.g., nodding your head, saying things like “Yes. ... Okay....I see....That’s interesting.....Tell me more....”
 - c) Rephrasing to check that you have understood what the person is saying.

Rephrasing

- Rephrasing is summarising what someone has said in your own words—for instance: *"What I heard you say is that you want to..."*
- The aim of rephrasing is to show the speaker you value what she/he has said, to help clarify it, and to help others add on their own ideas.
- Rephrasing helps to ensure that you and the group have heard correctly what the person said. It also helps the recorder—it gives him/her a clear summary of what was said in a few words.

Encouraging Participation

In some workshops, you will find a few participants dominating. Look for ways to get others involved and the talkers to talk less:

- Use the ground rules as the basis for encouraging everyone to contribute.
- Thank the big talker for his contribution and say, *"We would like to hear from everyone."*
- Ask questions to the silent and praise their responses. This will encourage them to talk.
- Divide into pairs (buzz groups) to get everyone talking.
- Go round the circle, getting one point from each person.

Handling Sensitive Issues

You have to be prepared to manage sensitive issues, e.g., talking about sex. Here are some tips:

- Get as much information as possible beforehand on what the potentially sensitive areas are going to be, so that you can work out strategies to bring them out and handle them.
- Start with yourself. Prepare yourself to discuss these issues without feeling uncomfortable.
- Build an open atmosphere in which participants feel comfortable talking about these issues. The body mapping exercise helps to get people talking about body parts and about sex.
- Challenge slogans and general statements but at the same time allow people to use the words they feel comfortable with, even if they are not politically correct. The aim is to get people to talk openly, rather than shutting them up.
- Usually participants will have more questions than you can answer. Be prepared for this and don't worry about having to admit that you don't have an answer to some questions. But show you are willing to find out the answers or refer people to other sources of information.

Managing Conflict

Participants may disagree on some issues, and these sessions may lead to conflict. This situation can be explosive, or you can turn it into an advantage—using the passion around the issues to understand them better. Your aim as a facilitator is to 'stop the fighting' and get participants to explore the issues.

- Restate the ground rules (e.g., active listening and respect) to create the right spirit.
- Ask the speakers to state their concerns and the reasons for them—to help everyone fully understand the issues and avoid making assumptions.
- Ask everyone to listen to the speakers—and rephrase what each has said to make sure everyone has heard the views clearly.
- Help participants identify common ground—things they agree on, and points of difference that need further discussion—or people can agree to disagree.

Part D: Specific Facilitation Techniques

Introduction

The exercises in the guide use five main techniques, along with discussion and small groups:



Technique	What happens?
Case Studies	Written descriptions of real situations facing men who have sex with men are used as the focus for discussion and problem solving.
Role Playing	Participants act out different situations or how they can solve a certain problem.
Cardstorm	Participants, working in pairs, write single points on cards. The cards are taped on the wall, creating a quick brainstorm of ideas. These are then clustered, prioritised, and discussed.
Rotational Brainstorm	Flipcharts are placed on different walls of the room with topics. Groups of participants move around the room, writing a few ideas on each topic and then moving to the next flipchart.
Individual Reflection	Participants sit by themselves and think about a situation in their lives when they were stigmatised—then they share.

Case Studies

- Hand out copies of the case study. In the exercises in the guide, there are enough case studies so that each group focuses on a different case study.
- Explain that the group task is to read the case study and analyse it. Usually the analysis of a case study involves:
 - a) Describing the problem and its root causes.
 - b) Deciding on ways to solve or avoid the problem.
- When groups have completed their work, ask each group to give its report. Then invite other participants to ask questions.

Role Playing

Role playing is improvised drama in which participants take on roles and act out a real-life situation. There is no written script; the drama is created spontaneously. Role playing is always followed by discussion—to draw out what was learned from the role play.

Role playing is used to increase communication skills and assertiveness, explore different situations and ways of dealing with them, express feelings openly, get inside other people's shoes and see how they feel, and try out different strategies for change.

Techniques for organising role plays are:

- Divide into groups and ask each group to make a role play based on the issue or problem.
- The group can also create a role play to show how the problem might be solved.
- After groups are ready, ask each group to perform their play for the other groups.
- At the end of each performance, ask questions to encourage the audience to analyse what happened—“*What happened? Why did it happen? Was it realistic? Would the solution work? What else might be done? What does it mean for us?*” etc.
- Sometimes the questions can be addressed to the actors to bring out their reaction to the situation they were in, e.g., “*How did you feel when your brother said*”

Paired Role Playing

Paired role playing is a specialised form of role playing which is designed to involve everyone. Participants pair off, and each pair performs a role play on a scenario described by the facilitator. The role plays are performed all at the same time, so participants do not feel self-conscious about their acting because no one is watching them—everyone is focused on her own pair’s role play.

- Ask participants to pair off and face the partner.
- Explain the roles; for example: “A is a health worker who stigmatises a male client who has sex with men, B is a health worker who challenges the stigmatiser.” Agree in each pair who is A and who is B.
- Explain the scenario; for example: “A makes an insulting remark about a male client who has sex with men, and B should challenge A in a strong and confident way.”
- Get them started by saying: “Start your role play!”
- After two to three minutes, shout “Stop!” and ask a few pairs to show their role plays, one at a time, in the center of the circle.
- After each role play, ask: “*How did B do? Was s/he convincing?*”
- If someone thinks s/he can do a better job, ask him/her to take over the role.
- Then ask, “*What did you learn from the role playing?*”

Cardstorm

- Prepare materials—cards (half sheets of paper), masking tape strips, cards, and markers. Make sure you have enough cards and markers and the markers are not going dry.
- Put up topic cards along the upper wall—categories/questions for the cardstorm.
- Put up a few example cards of what participants are expected to write.
- Divide into pairs and hand out cards and markers to each pair.
- Explain the task—“*Write points on xxxx—one point on each separate card. Check what others are writing so you don’t repeat points which are already on the wall.*”
- Encourage participants to start writing. As cards get written, tape them on the wall.
- After enough cards are on the wall, ask a few participants to eliminate repetition and cluster common points (put common points together) under different categories.
- Ask those who did the clustering to read out the points.

- Ask people to clarify points—“*What does this mean? Examples? Anything missing?*”
- Prioritise the points and then focus on the most important points (processing).
- Processing—“*What does it mean to you? What can we do to solve this problem?*”

Rotational Brainstorm

- Prepare by putting up topic headings on different flipchart sheets and tape these on different walls of the room. Make sure there is room between each sheet. Put markers at each flipchart.
- Give clear instructions about the task, such as what groups should discuss/write, the rotational system, and what direction to move in. Check that people understand the task.
- Divide into the number of groups for the number of topics and assign each group a topic.
- Ask groups to start discussing the topic and writing down their ideas immediately, rather than stand talking.
- Check on the output of each group. When every group has been able to write at least one or two points, ring a bell or start the song to get groups rotating.
- Remind participants of the direction to move and show them with your hands.
- Each group moves to a new sheet, reads what is already there, and then adds new points which are not already written.
- Continue the process until the groups have contributed to all flipchart sheets.
- Then organise a report back. Ask the group which started on the flipchart sheet to present points on its sheet.
- Clarify any confusing points and add points.
- Then ask extra questions to ‘process’ the output—“*What did we learn? What does this tell us? How does this relate to our own situation?*”

Individual Reflection

- Participants are asked to think and talk about experiences in their own lives. This may trigger strong emotions and you need to be ready to deal with them. The following tips may help:
- Establish a quiet, peaceful environment in which participants feel comfortable to reflect on their experience and share with others.
- Explain the ground rules:
 - a) No one is forced to share—the sharing is voluntary.
 - b) The information shared is confidential—it should not leave the room.
- Ask participants to take their chairs and find a space on their own.
- Ask them to close their eyes and reflect on a time in their life when they felt stigmatised.
- After three to four minutes of silence, ask them to open their eyes and find someone with whom they feel comfortable to share their experience.
- After 10–15 minutes, bring the whole group back together.
- Invite a few participants to give their experience. Remember, no one is forced to share.

- Then ask participants, “*What did you learn from this exercise?*”
- If it helps to get participants talking, share your own experience.
- Observe the mood and keep asking the group, “*How are you feeling?*”
- In some cases, a participant may talk about a personal crisis and break down or become too emotional to continue. If this happens, one facilitator can take the person aside while the other facilitator continues leading the discussion.
- If a person begins to cry, let him/her cry and reassure him/her that this is okay. If necessary, take a break.

Stop-Start Drama: A Special Technique

One of the techniques used in the toolkit is called “Stop-Start Drama.” This technique is new for many trainers, so it requires more explanation.

Stop-start drama uses role playing and discussion in a continuing rotation to look at problems and how to solve them. A few participants act out a short scene to show the problem, and then the facilitator shouts “*Stop*” and asks the group to discuss the problem, e.g., “*Is the problem real? Why is there a problem? How can we solve it?*” Ideas emerging from the discussion are then developed into new scenes performed by participants. Each new role play is stopped in turn for further discussion.

The role of the facilitator is to keep the drama making and discussion focused on the problem and how to solve it. She or he gets each scene going, stops the drama at appropriate points, asks questions, draws out ideas from participants, encourages them to act out their ideas, and then leads the discussion.



In summary, stop-start drama involves:

- Short improvised role plays performed by participants
- Discussion to analyse each of the role plays
- A facilitator who leads and shapes the whole process
- The aim of understanding issues, solving problems, or practising skills

In the toolkit, for example, stop-start drama is used to help health workers practise counselling skills. Two participants perform a drama to show how a health worker deals with a client who has HIV. Then the facilitator shouts “*Stop*” and asks the group, “*What happened? What approach was used? What was the impact of this approach?*” The facilitator might also ask the client, “*How did you feel when he used this approach?*” The facilitator then invites participants to suggest other approaches and asks the person who makes each suggestion to take over the health worker’s role and play out the scene again. At the end of this second role play, the facilitator leads a discussion on the approaches used and how the situation might be improved. The process continues until the group has agreed on and tried out (through role playing) a number of approaches health workers might use to treat people living with HIV.

Facilitation Techniques

- Ask a few participants to show the problem in a short, problem-posing drama.
- Stop the drama and get everyone’s attention. *“What do you think? Does this show the real problem? What is missing?”*
- Get responses and turn the most appropriate into another role play.
- Invite people who make suggestions to act them out.
- Give the actors enough time to develop the scene before ‘stopping’ it.
- Ask questions at the end of each scene—or when another problem arises.
- Use questions to:
 - a) Analyse the problem
 - b) Pull out solutions
 - c) Assess the realism and consequences of each solution tried
 - d) Get agreement on action
- Direct some questions to the actors, e.g., *“How are you feeling right now?”*
- Keep restating the focus to ensure the group is on track—*“We are trying to figure out how we can treat people living with HIV in the most caring and supportive way.”*
- Connect play acting with reality—*“This has been a fun drama, but what does it mean for us? What are we going to do in real life tomorrow?”*



CHAPTER A: NAMING HIV AND KEY POPULATION STIGMA



Introduction

This chapter gets participants to **name and own the problem**, to see that:

- Stigma exists and takes two major forms – isolating/avoiding and blaming/shaming;
- Stigma towards PLHIV has three major causes—a) fear and lack of understanding of how HIV is transmitted, b) judgemental attitudes, c) people’s lack of awareness that they stigmatise;
- Stigma towards other key populations has similar causes—lack of understanding of marginalised groups and moral judgement of their behaviour;
- Stigma has a number of effects, including self-stigma (PLHIV and key populations accepting the stigma, withdrawing from social contact, and not accessing health and other services);
- We are all involved in stigmatising, even if we are not aware that we do it;
- Stigma is harmful to our families, our communities, and our work as service providers;
- Stigma and the fear of being stigmatised results in PLHIV and key populations not getting full access to HIV-related health services and other forms of support; and
- We can make a difference by changing our own thinking and actions.

Exercises

- A1. Naming HIV and Key Population Stigma and Discrimination through Pictures
- A2. Naming HIV and Key Population Stigma in Different Contexts
- A3. Finding Solutions to Challenge HIV and Key Population Stigma and Discrimination
- A4. Naming HIV and Key Population Stigma through Case Studies
- A5. Our Own Experience of Being Stigmatised—Reflection Exercise
- A6. What Is the Meaning of Stigma?
- A7. Forms, Effects, and Causes of Stigma (Problem Tree—Method 1)
- A8. Forms, Effects, and Causes of Stigma (Problem Tree Analysis—Method 2)
- A9. How Key Population Stigma Fuels the HIV Epidemic
- A10. Naming Stigma and Discrimination towards Key Populations in the Health Facility

A1. Naming HIV and Key Population Stigma and Discrimination through Pictures

Special Note on Key Populations: Key populations are groups who have been identified as more vulnerable to HIV infection and, in the case of the Caribbean, include sex workers, MSM, transgender people, PWID, migrants, young people, and prisoners. Women are a special category of “key populations”—they are also vulnerable to HIV infection because of poverty and lack of power and control in their sexual lives.

For key populations, HIV stigma simply adds to the existing negative attitudes that people might have towards them. On top of this, many Caribbean countries have laws that criminalise the behaviours of sex workers and MSM, and this makes it difficult for them to exercise their human rights, including accessing health services. Because of this, key populations face overt discrimination.

These exercises **focus on the stigma and discrimination faced by MSM and sex workers**. But the same exercises could be adapted to look at and discuss the experience of other key populations—for example, by writing new case studies.

Special Note on Stigma and Discrimination: HIV-related stigma is a powerful social process of devaluation of people or groups either living with or associated with HIV and AIDS. This stigma often stems from the pre-existing and intersecting stigmatisation of sex workers, PWID, and MSM. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Discrimination occurs when a distinction is made about a person that results in him or her being treated unfairly or unjustly on the basis of belonging to, or being perceived to belong to, a particular group (UNAIDS, 2003).

We are going to use the word ‘stigma’ to indicate both stigma and discrimination because we think of discrimination as an end point of the process of stigma.

Facilitator’s Note: In this activity, participants look at pictures showing stigma and discuss what each picture means to them. This exercise helps participants to “name” stigma in an objective rather than personalised way. Participants identify different forms of stigma in different settings.

This is a good activity to ‘break the ice,’ get everyone interested in the issues around stigma and discrimination, and build a common vocabulary around stigma.

The pictures can also be used by participants to discuss stigma with their colleagues, families, and friends—a form of follow-up. So make photocopies and hand them out to your participants.

Objectives: By the end of this session, participants will be able to:

- Identify different forms of stigma in different contexts
- Identify how stigma affects individuals, families, and communities
- Explain why stigma happens
- Discuss examples of stigma from their own communities and work contexts

Target Group: All groups

Source: Understanding and Challenging HIV Stigma: Toolkit for Action (A1)

Time: 1 hour

Materials: Stigma Pictures, displayed on the wall

Handout: A-FS1: HIV STIGMA AND DISCRIMINATION

Steps:

Naming Stigma (Picture Discussion):

Divide into pairs. Ask each pair to walk around and look at as many pictures as possible. Then, when they have viewed all the pictures, ask each group to select one picture. Ask them to discuss:

What do you think is happening in the picture in relation to stigma?

- Why do you think it is happening?
- Does this happen in your own community/work setting? If so, discuss some examples.

Report Back:

Ask each pair to hold up their picture for everyone to see (or tape it on the wall) and explain its contents. Record points on flipchart.

EXAMPLE RESPONSES:

Picture—Community giving their backs to a woman seated on a bench.

- Woman sitting all alone—feeling sad and rejected. The whole community gives her their backs. They think she has done something wrong. Even a small child is rejecting her.
- Why? They do not approve of her behaviour or they fear they will get HIV through contact with her.

Does it happen? Yes—some people living with HIV or assumed to be HIV+ are totally isolated by the community. Some people refuse to go to the funeral of a PLHIV, thinking they can get HIV from an open coffin.

Picture—Man sitting all alone on the bus

- Other passengers are staring at him or gossiping about him. The man looks like he doesn't belong. He feels bad because he can see other passengers talking about him and making fun of him.
- Why? They think he has HIV. Fear of getting HIV from sitting beside someone assumed to be HIV positive.

Does it happen? One parent stopped her child from sitting next to a child whose mother had died of HIV.

Picture—Man leaving office carrying a dismissal note

- The man is leaving the office, having been fired for having HIV. Body language and face show he is demoralised—not sure what he will do next. "How will I take care of my wife, kids, bills, etc?"
- Why? People don't want to work with PLHIV, even though they know they cannot be infected through casual contact. Fear of losing business because of HIV+ employee—what people say may affect the business.

Does it happen? Yes—some PLHIV lose their jobs once their status is known.

Picture—Doctor talking to nurse beside patient’s bed

- The health workers are keeping a distance from the patient and gossiping about him. Nurse is overprotecting herself to treat the patient. Excessive use of gloves and mask makes the patient feel rejected.
- Why? Insufficient knowledge about how HIV is transmitted, or they may have the knowledge but not trust it.

Does it happen? Yes—some nurses use gloves when unnecessary. There is no need for gloves when taking patient’s temperature or blood pressure. PLHIV are put at the end of the waiting list for surgeries and refused the use of private rooms. One nurse asked the family of a PLHIV to “remove your guest” from the ward.

Picture—Father is kicking his gay son out of the house.

- The father is angry, disapproves and rejects his son for being gay. The mother is crying and saying, “He was not raised that way.” The son (who may be MSM) is upset and feels rejected. Stigma based on fear and shame.
- Why? Fear, shame, and embarrassment about what the neighbours will say.

Does it happen? Yes—some MSM are kicked out of the house and forced to live on their own. Some gay men get married to make their families happy.

Picture – MSM being examined by a disapproving nurse

- MSM patient shows he has a sexually transmitted infection (STI) in the butt. Nurse backs away from him in revulsion and shows through her body language that she disapproves—and refuses to provide the service. She scorns and condemns him for getting STI through immoral behaviour—thinks he deserves to get STI because of his “immoral” behaviour.
- Why? Morality and religion—MSM condemned for his lifestyle. Nurse has homophobic attitudes, which affect how she does her job. Nurse lacks the skills to do an anal examination.

Does it happen? Yes—some nurses refuse to serve MSM patients or show their disapproval openly.

Picture – A pastor preaching in church that people with HIV are sinners

- Pastor tells congregation that MSM are “sinners.” The congregations looks shocked, but some agree with him.
- Why? Views homosexuality as against the Bible or religion and those who practise it should be condemned.

Does it happen? Yes—some churches condemn the practice of homosexuality and eject gay men.

Picture—Nurse refuses to provide services to sex worker

- The nurse looks very angry and refuses to help the sex worker. The sex worker looks shocked and upset. She may be telling herself—“This woman is judging me. I will have to go to a private doctor.”

- Why? The view that sex work is immoral.

Does it happen? Yes—sex workers are discouraged from using public clinics, so they go to private doctors.

Processing:

Ask:

- What are the major forms of stigma?
- Why do we stigmatise people who are known to be or suspected to be HIV positive?
- Why do we stigmatise other key populations (e.g., MSM, sex workers, migrants, etc.)?

Summarise:

Draw out the main points from the discussion. Make some of the points below to add key things which may be missing:

- Sometimes we treat people badly. We isolate or reject them, e.g., refusing to sit beside someone who is assumed to have HIV; or we gossip about them and call them names. When we isolate or make fun of other people, this is called ‘STIGMA.’ Another word commonly used in the Caribbean for stigma is ‘prejudice.’
- Stigma is a process where we create a ‘spoiled identity’ for an individual or a group of individuals that attributes a lower value to the person or group. We identify a difference in a person or group—for example, a behavioural difference (e.g., same-sex relationships), physical difference (e.g., physical disfiguration), or social difference (e.g., poor or a migrant)—and then assign negative connotations to that difference, thereby marking that difference as something negative—a sign of disgrace. In identifying and marking differences as ‘bad,’ we create an ‘us’ and ‘them’ to distance ourselves from a person or group, and this allows and justifies our mistreatment and discrimination against the person or group. The end result is that stigmatised people often lose status and access to basic human rights, resources, and services because of these assigned ‘signs of shame,’ which other people view as showing they have done something wrong (sinful or immoral behaviour).
- When we stigmatise people, we *isolate them*, saying they are a danger/threat to us (because we think they might infect us with HIV or we might be negatively affected by their assumed behaviour), or we *judge* them, saying they have broken social norms and should be shamed or condemned.
- Stigma is a powerful social process of devaluing a person or group that often ends in the action of discrimination—unfair and unjust treatment, e.g., PLHIV or MSM not hired, a sex worker kicked out of the house, key populations refused treatment at the clinic, or their HIV status or sexual behaviour publicly revealed.
- Stigma hurts people. When we stigmatise, it makes people feel bad, lonely, ashamed, and rejected. They feel unwanted and lose confidence and, as a result, they may take less care in protecting their health (e.g., stop using health facilities and condoms). People who are stigmatised sometimes accept the negative image of themselves: this is sometimes called internal or self-stigma.
- People living with HIV and key populations are often stigmatised by their own families and the community. They often have to change their behaviour—to be accepted—or they are forced to leave home. Many people living with HIV or key populations are forced to lead a hidden, ‘underground’ existence and as a result they find it difficult to get work and housing, and access health services that could save their lives.

- There are different forms of stigma:
 - a) **Isolation and Rejection**—based on ignorance and fear about HIV transmission or about the behaviours of a marginalised group. The person stigmatised is forced to sit alone, eat alone, and live alone.
 - b) **Shaming and Blaming**—gossip, name calling, insulting, judging, shaming. Stigmatised people are “blamed and shamed” for assumed ‘bad behaviour,’ for breaking social norms.
 - c) **Discrimination (Enacted Stigma)**—unfair treatment, such as refusing to provide services, firing someone who is found to be HIV positive or MSM, or kicking someone out of housing.
 - d) **Self-Stigma**—PLHIV and key populations sometimes stigmatise themselves in reaction to stigmatisation from society. They accept the blame and rejection of society, and withdraw from social contact or exclude themselves from accessing health and other services out of fear of having their status revealed.
 - e) **Stigma by Association**—People associated with stigmatised groups often face stigma themselves. The family of a person living with HIV or of a person from a key population may be stigmatised because of the stigma faced by their family member—the reputation of the family is affected. People who work with PLHIV and key populations, such as health workers, are also often stigmatised by association.
 - f) **Layered Stigma**—Marginalised groups (e.g., MSM, sex workers, PWID, migrants, etc.) are already stigmatised. When they get HIV they are doubly stigmatised—getting another layer of stigma.

- Some of the effects of stigma are:
 - a) Feelings of sadness, loneliness, rejection, hopelessness, self-doubt
 - b) Shame and loss of confidence—feel they are no longer accepted by others
 - c) Discrimination—people kicked out of family, community, job, organisations, etc.
 - d) Denial—stops people disclosing status and seeking support

- **HIV stigma hurts everyone and drives the HIV epidemic underground.** People living with HIV or key populations may become silent out of fear of experiencing stigma and discrimination and may not get tested, seek health services, or disclose their status—and as a result, HIV may be more likely to be transmitted.

Action Ideas:

Take the pictures home and discuss them with family members and friends. Help others see what HIV stigma means in our lives—how it happens and how it hurts people.

A2. Naming HIV and Key Population Stigma in Different Contexts

Facilitator’s Note: In this exercise, participants describe stigma and discrimination towards PLHIV and key populations in specific contexts, e.g., home, community, faith-based setting, school, health facility, workplace, public spaces (e.g., bar, market, or bus).

The next exercise (A3) is a follow-on to this exercise—so make sure to save the outputs from this exercise to use in A3 and plan for enough time for both exercises to be completed in sequence.

Extra Tips for Facilitators:

- The number of flipchart stations/categories depends on the number of participants and the amount of time you have. With a large group, you will need many stations/categories so that the groups

are not too large. (For this activity, it is good to keep the group size to four or less. Example: 24 participants—eight groups of three people.)

- In introducing this exercise, tell groups which direction to move—so there is no confusion when you blow the whistle to ask groups to move to the next station.
- The rotational brainstorm is fun, but the real learning comes in the debriefing—so make sure you allow enough time/energy for this.

Objectives: By the end of this session, participants will be able to:

- Identify stigma and discrimination faced by PLHIV and key populations in different contexts
- Identify some of the effects of stigma

Target Group: All groups—works well in large community workshops

Source: BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer’s Guide (A4)

Time: 1 hour

Preparation:

Set up eight flipchart stations, depending on the number of participants. Tape blank sheets of flipchart paper on the walls of the room, with a topic on each sheet – home, community, school, health facility, church/mosque, workplace, bar, and media. (Select the contexts suited to your target group.)

Steps:

Setting Up Rotational Brainstorm:

Divide into groups of equal size and assign each group to one of the flipchart stations. Hand out markers and ask each group to write a list on the flipchart of specific forms of stigma or discrimination faced by people living with HIV and key populations in their particular context. Provide a few examples—write one example at the top of each flipchart. Explain that, after a few minutes, groups will be asked to rotate in a clockwise direction—to move to the next flipchart, read the points, and add new points. Then ask groups to start—and, after two minutes, shout “CHANGE” and ask them to rotate. Continue until groups have contributed to all flipcharts.

Report Back and Processing:

Ask each group to present the points on one flipchart (the one they started with). Then discuss some of the following questions:

- What are some of the common features across the different contexts?
- What are the attitudes/feelings in all contexts towards PLHIV and key populations?
- What are the effects on PLHIV and key populations who have been stigmatised?

Summarise:

Summarise the main points made by participants. You might include some of the following points:

- Stigma towards PLHIV and key populations takes place **everywhere**—homes, schools, communities, clinics, workplaces, churches, public places, and in the media.
- PLHIV and key populations are often shamed and rejected by families and forced to leave home; isolated and made fun of by their peers at school and in the media; mistreated at health facilities; harassed by the police; and banned from religious and social gatherings.

- There are few places where PLHIV and key populations feel completely safe. They often feel watched and face stigma and hostility in many places they go.
- **Stigma at home is particularly painful.** This is the place of last resort. If your own family stigmatises you, you may feel you have nowhere else to go. You are all alone.
- Stigma has a number of common features across these contexts:
- People make fun of or gossip about MSM or sex workers who dress or act differently from other people. Even if someone is not openly MSM, people will make assumptions on the basis of his clothing and body language and discriminate against him. The same is true for sex workers: people will abuse them if they dress ‘inappropriately.’
 - a) People ‘shame and blame’ sex workers, MSM, and PWID—condemning them for their sexual practices or use of drugs—practices viewed as breaking ‘traditional’ norms.
 - b) People may isolate or exclude people who are assumed to be HIV positive or from a key population, trying to keep them at a distance, e.g., not allowing them to attend social events.
 - c) Families and friends of PLHIV and key populations may also be stigmatised.
 - d) PLHIV and key populations face different forms of discrimination, e.g., health workers treat them unfairly, police officers harass them, and they are turned down for jobs.
 - e) MSM and sex workers also face violence—sex workers are attacked by clients and MSM may be attacked if people suspect they are MSM.
- **Stopping Stigma** will take a huge effort by everyone. **The starting point is to change ourselves**—the way we think, talk, and act towards PLHIV and key populations. We have to personalise the issue for ourselves, to see that we have to do something to change things. We first need to change our attitudes—the way we feel towards PLHIV and key populations
- After we have changed ourselves, **we can start to educate and challenge others.** It takes courage to stand up and challenge others when they are stigmatising PLHIV or key populations—but this is one of the ways to stop stigma. Breaking the silence and getting people talking openly is the first big step.
- **Talk with your family and friends, and get community leaders** to speak out against stigma and discrimination. Help everyone make these problems visible and unacceptable.
- **Reach out to and support PLHIV and key populations.** Once PLHIV and key populations feel accepted, they will be more open to discussing their situation with others, seeking support, and accessing services.

Example Responses:

Home

- Name calling, scolding, belittling, and shaming – “*Why have you brought shame on the family?*”
- Shunned, isolated, and neglected. Forced to stay alone. Not sharing utensils, food, or clothing.
- Some PLHIV or key populations are kicked out of the home and forced to move to another place. Exclusion from family activities. Disowned—no longer can access family property.

- Parents try to hide the behaviour of their gay children, fearing what the neighbours will say.

Community

- Name calling, finger pointing, whispering, and gossip. Isolation and rejection.
- Angry looks. Dissing. Verbal and physical violence towards key populations.
- Disclosure of HIV status to others. Refusal to shop at a store where owner/family is HIV positive.
- Non-acceptance in groups or clubs. Discrimination on public transport.
- The community says they will not attend a funeral of a PLHIV or person from a key population.

Health Facility

- PLHIV and key population patients are kept waiting, told to come another day, or treated last.
- Unfriendly treatment. Harsh/scolding language. Negative body language and facial expressions.
- Blaming and shaming—“You deserve to get this, because of your disgusting behaviour.”
- Medication in paper bags. Extra mask and gloves. Treatment in a back room.
- Cleaning the back room with extra sanitary measures. Disposing of bed linens instead of washing them.
- Exposing records, e.g., person’s HIV status, on a lab request. Using red ink to designate HIV+ status. Breaking confidentiality. Informing PLHIV’s partner or parents. Gossip and labelling.
- Invasive questioning about MSM patients’ behaviour, e.g., “*What kind of sex are you doing?*”
- Some patients go to other islands to avoid being seen by neighbours, but this is expensive.

School

- Stigma towards children of HIV-positive parents. Placing child at back of classroom. Not allowing child to play or eat with other children. Refusing to teach them or sending them home.
- Calling children derogatory names. Writing insulting notes on chalkboard. Teasing and bullying.
- Disclosure of child’s or parent’s HIV status. Low grades (harsh grading).
- Students make fun of and isolate MSM students. They insult them and imitate their body language.
- Some MSM students accept the shame (self-stigma) and drop out of school because of stigma.

Workplace

- Fired from job. Anyone assumed to be HIV+ or a key population is not hired. Mandatory testing.
- Denied promotion or educational opportunities. Breach of confidentiality. Harassment.
- Gossip and isolation towards anyone suspected to be HIV positive or from a key population.
- Coworkers refuse to socialise, do not share utensils, washrooms, seats, or dining area.
- Supervisors don't allow time off for medical treatment/appointments.

Church

- Isolation and rejection—segregation in seating. Shaming, blaming, and gossip. Labelled “sinners.”
- Preaching—sermons—Sodom and Gomorrah—“*We don't want Sodom & Gomorrah here.*”
- Kicked out of the church membership for being a ‘sinner’ and refusing to ‘repent.’
- No home visits. Isolation on church bus. Refusal to greet someone with HIV. Stopped from accessing baptism. Treated as modern-day lepers (unclean). Family gets treated differently.
- Stigma related to the use of the communion cup. Pastors refuse to marry HIV-affected couples.

A3. Finding Solutions to Challenge HIV and Key Population Stigma and Discrimination

Facilitator's Note: This exercise is an add-on to the previous exercise (A2). We recommend you do this exercise immediately after doing A2. The aim of Exercise A3 is to get participants to start thinking about how to solve or challenge stigma and discrimination. Participants work in small groups, developing solutions for each of the contexts discussed in A2.

Objectives: By the end of this session, participants will be able to identify possible solutions to challenge the stigma and discrimination in specific contexts.

Target Group: All groups

Source: BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer's Guide (A5)

Time: 1 hour

Materials: Outputs from A2



Steps:

Task Groups:

Divide into small groups and give each group one of the flipchart outputs from A2. Ask them to read the flipchart and do the following:

- What are the **causes** of HIV and key population stigma and discrimination in your context?
- What can we do to **solve or challenge** these forms of stigma and discrimination?

When they are finished, ask them to prepare a **short role play** to show the stigma and discrimination in their context.

Report Back:

Ask each group to:

- Present their drama showing the forms of stigma and discrimination
- Present their ideas on: i) causes and ii) solutions

Example Responses

Family

- Help families overcome shame by providing more information on PLHIV and key populations.
- Help them understand that PLHIV and key populations are not criminals; they are like anyone else—they just want to be respected, loved, and treated as part of the family.
- Help families understand that stigmatising members of the family who are seen as different (e.g., MSM, sex workers, PWID) makes them hide their sexual activities—this may result in their not using health facilities and safe sex practices, and getting HIV.
- Help PLHIV and key populations overcome self-stigma and build confidence and self-esteem.

Health Facility

- Get health workers to treat all patients with respect—to follow their code of practice.
- Get health workers to talk openly about their concerns about patients who are HIV positive or members of key populations and correct misconceptions.
- Encourage health workers to stop gossiping and name calling and protect confidentiality.
- Train health workers on basic skills in the management of STIs in MSM and sex workers.
- Train health workers on how to counsel key populations – nonjudgemental, neutral language.

Community

- Help community leaders become more informed—so they can speak out on behalf of PLHIV and key populations.
- Teach the community to treat PLHIV and key populations like other members of the community.

- Empower PLHIV and key populations to participate in community activities.

Workplace

- Build on existing HIV workplace policies—aim to build an accepting atmosphere.
- Workplace approach: Because someone is HIV positive does not mean s/he can no longer make a significant contribution as a worker. The same is true for MSM or sex workers—they have lots to contribute, so they should be accepted. One's sexual orientation or sexual behaviour is only a small part of one's identity.

School

- Incorporate education on sexual minorities within the curriculum in schools.
- Involve school clubs which focus on life skills. Provide training on this issue for teachers.

Church

- Help leaders and members understand the issues of PLHIV and key populations.
- Use religious texts which talk about inclusiveness and accepting people who are different.
- Help the churches be less judgemental—*“He who casts the first stone”*



A4. Naming HIV and Key Population Stigma through Case Studies

Facilitator's Note: These case studies are based on real experiences of PLHIV and key populations. They can be used to help participants develop a better understanding of the lives of PLHIV and key populations.

To prepare for the exercise, review the case studies and make changes necessary to adapt to the local context. If these case studies are not applicable, you should create new ones more relevant to the reality and experiences of participants.

Objectives: By the end of this session, participants will be able to:

- Understand stigma and discrimination towards PLHIV and key populations in more depth
- Discuss real-life stories and look at ways of challenging stigma

Target Group: All groups

Source: BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer's Guide (A6)

Time: 1 hour

Materials: Copies of the case studies for participants

Steps:

Case Study Analysis:

Divide into small groups of three to four people. Assign each group one of the case studies, but give each group the whole set of case studies so they can have a look at the others. Ask them to read the case study and discuss the following questions:

- What happened? Why?
- What do you think about the situation?
- What could help to change things for the main character?

Report Back:

Ask each group to report back on the things that they have learned from discussing the case study.

Case Study of a Health Worker Living with HIV

Martha is a 45-year-old nurse who works in a hospital. Her husband died in 2002. She has two children. When she applied for a new job at another hospital in 1995, she was turned down on medical grounds, but didn't understand this response because she felt well. Later she realised she was turned down because of testing HIV positive.

Martha's husband found out he had HIV when he was chosen for a work assignment overseas in 1999. He was tested for HIV and when they found out he was HIV positive, they told him he could not go. By 2001, he was extremely sick and was admitted into hospital. When Martha saw his medical records, she found out he was HIV positive and decided that she should test herself. She took the test where she was not known, and found out she too had HIV. Depressed and confused, she tested twice more at other places to confirm she was HIV positive. Then her husband died.

Martha moved to a one-room house, was unable to send her children to school, and sold off assets to buy herself antiretroviral treatment (ART), getting prescriptions from a doctor she knew at a private clinic. At times she could not afford ART and had to stop treatment.

At work, she told the matron she was HIV positive when work assignments were making her vulnerable to pneumonia. The matron told other nurses—and this led to stigma from some nurses. For example, if Martha took her turn to prepare tea, some nurses would refuse to drink the tea. So now Martha doesn't drink tea at work. Some nurses make fun of her by saying in her presence that people living with HIV must be sex workers.

After five years working in the hospital Martha started working within a prevention of mother-to-child transmission (PMTCT) programme. She met a nurse there who had a big influence on her life. This nurse confided in Martha that she was HIV positive. "*Are you? I am also HIV positive!*" Martha exclaimed. They began to share their feelings about their status with each other. Having a confidant gave Martha the courage to start telling her children. Her children initially found it hard to believe her, since she was looking so well, but eventually they accepted she was telling them the truth and have been very supportive.

MSM Case Studies

Case Study A: Home

David is 12 years old. He loves his mother and spends a lot of time with her, helping with kitchen tasks. He also spends a lot of time playing games with his sisters. One day his auntie visits. She observes him helping out in the kitchen and complains to David's mother: *"What are you doing to David? You've turned him into a sissy—a mother's boy! Get him involved in activities where he will learn to be a man. He is spending too much time doing housework and playing girls' games. Get him out of here or you will be in trouble!"*

Case Study B: School

Joe is 30, married, a father, and a teacher. Although he is married, Joe sometimes has sex with men. His family does not know about this, but some teachers suspect that he is MSM. They tell the principal that he is "gay" and, even though there is no evidence, they say that Joe is having sex with boys in his class. Based on this information, the principal asks Joe to resign, saying he will corrupt his students with his "disgusting behaviour". When this information is announced at a staff meeting, one of the teachers says, *"Does this mean you will also fire those teachers who are sleeping with their female students?"*

Case Study C: Clinic

Greg is 19 years old, single, and lives with his parents. He has a girlfriend but he also has sex with men. One day he went to the clinic because he had a rash around his anus. When he explained this problem to the doctor, the doctor started to give him funny looks. Instead of doing a proper examination, he began to ask him many questions, such as *"How did you get this STI? What kind of sex are you having?"* He looked at Greg as if he was no longer a human being. Greg had trusted this doctor and believed he was tolerant and understanding, but he now felt humiliated. He says he would never go back to that clinic again.

Case Study D: Workplace

Tim has been working in an office for the last three years. He is single and often gets offers from female staff to go out on dates. However, Tim is gay and, although he keeps this a secret at work, he is open in his life outside and has several gay friends. One night, as he is meeting with a gay friend in a bar, he sees two staff members from work staring at him. The next day, his colleagues seem to be avoiding him and he worries about what might happen.

Case Study E: Church

Joe is 25, single, and lives in a house near his parents. He has been going through a hard time, trying to understand why he is different from other men, why he has feelings for men. At first he tries to hide or deny it. Eventually he realises that this is his nature—that he loves men—and he begins to respond to other men. After a while, his mother begins to suspect that he is gay. His mother keeps asking, *"Where is your girlfriend? When are we going to see the woman you want to marry?"* Joe keeps saying that his girlfriend is studying overseas and when she comes back, they will get married.

His mother has stopped believing his stories and starts to take Joe to church each Sunday. After a few Sundays, his mother arranges a special visit to see the minister. When they go there, the minister says, *"Look, your mother tells me you are bewitched and have become a gay man. This is wrong, against the will of God, but this sinful behaviour can be cured. All it takes is prayer—now I will pray for you, but you must take this prayer seriously and try to change."*

Sex Worker Case Studies

Case Study A: Stigma from family and neighbors

Lorraine grew up in a small village. She enjoyed going to school, was doing very well, and hoped to go to university. When she was 17, her mother died and her father got married again. When his new wife moved in, her father stopped caring for Lorraine. She was forced to drop out of school and look for work.

She couldn't find office work, so she started to sell sex. Her father asked her what she was doing, and she told him she was working in a company. Later, he found out what she was actually doing, and he stopped talking to her. She had few friends. In her home area, she was treated like an outcast; neighbours would avoid her when she walked by. She used to buy many things for the house, but this didn't make any difference. Family members shunned her and hardly talked to her. One day, her father shouted at her, saying: *"No one in our family has ever worked as a sex worker like you. Why are you killing our family honor?"* He told her to leave and find a place of her own.

Case Study B: Stigma from clients

Kate didn't want to be a sex worker when she grew up, but her parents were poor and this seemed the only job available when she came to the city. A friend found her a job in a bar and she started work as a waitress. The owner told her she had to please the clients, but no one told her this included having sex. On the first day, a client tried to touch her breasts and said he wanted to have sex with her. She refused and he got very angry, insulted her, and threatened to beat her. She told him, *"I'm only here as a waitress,"* but he said, *"Who are you kidding! Stop pretending you are a good woman. You are bad woman, a whore. That's why you are working here. You must give me sex!"* He complained to the manager, and the manager came and told her to *"please the client."* Kate felt humiliated. She wanted to keep the job so she went out with the customer. He was very rough and the sex was very painful. Afterwards, he beat her, saying, *"Don't do that again!"*

Case Study C: Stigma at the health facility

Mary is a sex worker. She insists on condoms when having sex with clients, but sometimes they give her extra money to have sex without a condom. She also has a boyfriend. She doesn't use condoms with him; if she did, this would imply she doesn't trust him. One day she started to have painful symptoms in her vagina. She went to the clinic to get tested and treated. The doctor who examined her looked at her as if she were nothing, and said, *"You sleep with your clients, don't you?"* Mary didn't like his tone of voice, so she said, *"I don't sleep with men. It must be my boyfriend."* The doctor said, *"Why do you bore me and have your blood tested? If you don't sleep with your clients, why do you waste my time getting your blood tested?"* Mary had trusted this doctor and believed he was tolerant and understanding, but she now felt humiliated. She said she would never go back to that clinic again.

Case Study E: Stigma and discrimination from the police

Ruth was going home one day after her work at the bar. A policeman stopped her and told her she was beautiful and that he wanted to sleep with her. Ruth told him that she was late for an appointment with her husband. He told her, *"Don't fool with me, little girl. I know who you are. You're not married. You work in that bar and you have sex with tons of clients, so you have to sleep with me too!"* She became afraid and said, *"Look, I just want to go home. Leave me alone."* He said, *"I'm tired of your excuses. If you refuse to sleep with me, I'll arrest you, so you'd better come with me."* He grabbed her and forced her to have sex without a condom.

Summarise:

- Stigma towards PLHIV and key populations takes place **everywhere**—homes, schools, clinics, bars, workplaces, churches, on the street, and in the market. There are **very few places where PLHIV and key populations feel safe**. They face stigma and hostility most places they go.
- PLHIV and key populations are often shamed and rejected by their families and forced to leave home, kicked out of jobs, given poor treatment at the clinic and forced to go to private clinics, and heckled and attacked in public spaces.
- Stigma has a number of common features across these contexts:

- a) MSM and sex workers are stigmatised for looking and dressing differently from others.
 - b) People condemn MSM and sex workers for their sexual practices—practices viewed as immoral, as breaking ‘traditional’ sexual norms.
 - c) MSM and sex workers also face verbal and physical violence.
- Sex between men and sex work are illegal in many countries and, as a result, MSM and sex workers are forced to live in a climate of secrecy. This leaves them open to being exploited, stigmatised, and subject to violence.
 - You may believe that men having sex with men or women (or men) doing sex work is wrong (against culture, religion, the law), but this does not justify stigmatising MSM and sex workers. It is important to separate your values about certain behaviours, from the way to you treat a person you assume engages in that behaviour—it is not about judging but about accepting everyone as human.
 - Stigma towards PLHIV and key populations defeats our mandate as health workers and service providers, as it may cause PLHIV and key populations to stop using our services. If so, we are failing in our role as service providers.

Example Responses:

MSM Case Study A: Home (David)

David loves to help his mother with housework and plays games with girls. His auntie assumes that he will become gay—and tries to change him. She assumes he has become ‘gay’ because of staying under his mother’s skirts. She tells David’s mother to involve him in activities to become a real man.

MSM Case Study B: School (Joe)

The principal accepted rumours, without any evidence, that Joe was having sex with his students.

The principal did not give Joe a chance to explain or defend himself. He made lots of assumptions and kicked him out without any discussion. Joe was told to resign on the basis of insufficient information. The principal can discipline Joe if Joe is molesting students, but there was no sign of this.

SW Case Study A: Home (Lorraine)

Lorraine was shunned by family members once they discovered she was a sex worker. Even if she provided things for the home, this did not change family members’ attitude towards her. Eventually her father kicked her out of the house.

SW Case Study B: Kate (Stigma from Clients)

Kate was insulted and abused by a customer in the bar where she worked. He assumed that if she worked there, she sold sex. Finally she agreed to have sex with the customer to keep her job.



A5. Our Own Experience of Being Stigmatised (Reflection Exercise)

Facilitator's Note: This is one of the most important exercises in the guide because it draws on personal experiences of stigma. Participants reflect on their own experience of being stigmatised and how it felt. These feelings help participants get an insider's view of stigma—how it hurts and how powerful those feelings are. The idea is to use this experience to help participants to empathise with stigmatised groups.

This exercise requires a lot of trust and openness within the group, so it should not be used at the start of stigma education. It should be used after participants are beginning to open up with each other and are ready to share some of their own experiences and feelings.

The exercise looks at stigma in general, not stigma towards people living with HIV or stigma towards key populations. This is why the instructions for the exercise are to: *“Think of a time in your life when you felt isolated or rejected for being seen as different from other people.”*

Introduce the exercise carefully to help participants overcome their initial discomfort about sitting and reflecting on their own and sharing their own experiences with others.

Emphasise that the sharing is voluntary—no one is forced to give their story—and emphasise the importance of confidentiality. Remind participants about the ground rules—*“What is shared should stay in the room.”* Encourage group members to listen carefully to each other's stories.

This exercise can trigger painful memories for some participants. Participants are being asked to think and talk about strong feelings. You should be ready to deal with the emotions raised. (See the introductory chapter for suggestions on how to do this.)

“This exercise helped me understand how it feels to be stigmatised and discriminated against. I reflected on my experience of being stigmatised as a left-handed person when I was very young. I remembered how it felt to be teased by other children and forced to write with my right hand—it was very painful to me at the time.”

Objectives: By the end of this session, participants will be able to:

- Describe some of their own personal experiences of being stigmatised
- Identify some of the feelings involved in being stigmatised

Target Groups: All groups

Source: Understanding and Challenging HIV Stigma: Toolkit for Action (A2 and A3)

Time: 1 hour

Steps:

Individual Reflection:

Ask participants to sit on their own. Then say: *“Think about a time in your life when you felt lonely or rejected for being seen to be different from others.”* Explain that these do not need to be examples of stigma towards people living with HIV or other key populations; it could be any form of stigmatisation for being seen to be different. Ask them to think about what happened, and how it felt.

Sharing in Pairs:

Say, *“Share your experience with someone with whom you feel comfortable.”* Give the pairs a few minutes to share their stories with each other.

Sharing in Plenary:

Invite participants to share their stories in the large group. This is voluntary; no one should be forced to give his/her story. People will share if they feel comfortable. If it helps, give your own story to get things started. As the stories are presented, ask, *“How did you feel? How did this affect your life?”*

Then ask—“What did you learn from this exercise?”

EXAMPLE RESPONSES:

How did you feel when you were stigmatised?

Angry. Ashamed. Misunderstood. Depressed. Rejected. Pitying myself—feeling miserable. Resentful. Doubting myself. Useless. Failure. Hated. Despised.

What did you learn from this exercise?

- We stigmatise for many reasons—nationality, gender, ethnicity, language, religion, physical or mental abilities or challenges, etc.
- We all stigmatise—it is a part of life. Some people stigmatise without realising it.
- When we stigmatise, we create separation—‘us’ and ‘them.’
- We need to recognise the damage we can do to others by stigmatising and judging them.
- The experience of being stigmatised is very painful. It really hurts. It can last for a lifetime.
- Once we have been stigmatised, we know how it feels for key populations to be stigmatised.
- Facing stigma has taught me to empathise and embrace people from different churches.

SUMMARISE:

Summarise the main points which participants have made during the exercise. In giving your summary, you may use some of the following points if they have not already been mentioned by participants.

- This exercise helps us get an inside understanding of how it feels to be stigmatised—shamed or rejected. It helps put us into the shoes of people living with HIV or key populations. It helps us understand how painful it is to be stigmatised.

- Stigma destroys our self-esteem. It makes us doubt ourselves and our self-worth.
- Everybody has felt ostracised or been treated like a minority at different times in their lives. And it is okay to feel like that, because you are not alone. We have all experienced this sense of social exclusion.

EXAMPLE STORIES OF BEING STIGMATISED

- I was born into a poor family. We lived in two rooms in a small house. The neighbors despised us for being poor. We used to go to our friends' houses to watch TV, but their parents often chased us away, saying we were dirty and making fun of us. When our friends visited us, my mother fed them, but when we went to their houses, we were never invited to eat. Eventually our economic status improved and we were able to build a bigger house, but the neighbors resented this, saying that our new house was "*taking up too much land*". They could not accept our improved status and continued to make fun of us. I still feel the pain of being treated as 'second/poor class.' I felt rejected, despised—we were nothing, no matter what we did.
- When I was 16, I had a serious case of acne—a big breakout. I looked in the mirror and felt really bad. For three weeks I didn't go out of the house. I hid myself, feeling a sense of shame. I felt different from others. My big brother laughed at me. People looked at me as if they wanted to run away from me. It was very painful, but I had a few supportive friends.
- When I was younger and going to secondary school, people called me names because I was darker than them. These insults have continued my whole life. In fact, some of those who insulted me have been served by me—as a nurse, counsellor. I've delivered their babies and they have forgotten how they insulted me.
- I have been stigmatised and discriminated against my whole life as an indigenous person. Some boys used to call us names, and my sisters used to throw insults back at them, but I didn't like this way of handling the problem. These insults bothered me, but as I grew older, I learned how to handle these slurs. I still face stigma every day of my life.
- I joined the church after coming to live and work here as a health worker. I come from another country. One day at a church function, someone made fun of me because of my 'strange accent.' People started to laugh, and I asked, "*Why are you laughing?*" Someone responded, "*Is this English you are speaking?*" and continued to laugh. This discriminatory treatment made me feel very bad, and I have not taken an active role in the church ever since.
- I became pregnant. At the time, I was not married. A church member used to be very good friends with me, but when my belly started showing, he avoided me. He would cross the street and try to pretend he didn't see me. When I got married, however, his whole attitude changed, and he became my friend again.
- When I was small, my brother and I used to play with two poor children who lived in our area. One day, my father came home and found us playing with them. He shouted at them and kicked them out of our house. This made me cry. I felt very bitter, I was so ashamed. This girl was my best friend. My brother and I did not accept this treatment. When my father was not around, we would still go and play with them.
- People have always stigmatised me as a woman. They underrate me, never listen to my ideas, and think my opinions are useless. When I was young, I wanted to study, but my parents kept saying, "*No, you are a girl. Your work is in the house, not in the classroom.*"

When I completed primary school and was about to start secondary school, they tried to block me, saying I would get pregnant and drop out. But I never gave up, and completed my secondary and university studies. Eventually they began to see that girls can also do well. Now they listen to me and accept that I have something to contribute.

A6. What Is the Meaning of ‘Stigma’?

Facilitator’s Note: Discussions on the definition of stigma should occur only after participants have developed a better understanding of stigma on an experiential basis through participating in some of the previous exercises.

Objectives: By the end of this session, participants will be able to describe what stigma means and give examples.

Time: 20 minutes

Steps:

Participants’ Ideas about Stigma? (Brainstorm): Ask, “What do you think is the meaning of ‘stigma’?” Record participants’ responses in a circle diagram. Below is an example of what this diagram might look like.



Presentation:

Next, explain and discuss the following:

- Stigma is a process where we create a ‘spoiled identity’ for an individual or a group of individuals that attributes a lower value to the person or group. We identify a difference in a person or group—for example a behavioural (e.g., same-sex relationships), physical (e.g., physical disfiguration), or social difference (e.g., poor or a migrant) and then assign negative connotations to that difference, thereby marking it as something negative—as a sign of

disgrace. In identifying and marking differences as ‘bad,’ we create an ‘us’ and ‘them’ to distance ourselves from a person or group, and this allows and justifies our mistreatment of and discrimination against the person or group. The end result is that stigmatised people often lose status and access to basic human rights, resources, and services because of these assigned ‘signs of shame,’ which other people view as showing they have done something wrong (sinful or immoral behaviour).

- To stigmatise is to believe that people are different from us in a negative way, to assume that they have done something bad or wrong. When we stigmatise, we judge people, saying they have broken social norms and should be shamed or condemned, or we isolate people, saying they are dangerous or a threat to us.
- Stigma is a powerful social process of devaluing a person or group that often ends in the action of discrimination—unfair and unjust treatment, e.g., PLHIV or MSM not being hired, a sex worker kicked out of the house, key populations refused treatment at the clinic, or their HIV status or sexual behaviour being publicly revealed.
- Stigma and discrimination result in great suffering. People get hurt.
- Applying these terms to HIV:
 - d) HIV stigma takes two major forms: isolation or rejection, and shaming and blaming
 - e) HIV stigma has three major causes:
 - Lack of awareness about stigma—what it looks like, what it does—and lack of awareness that we are stigmatising others;
 - Fear and ignorance: People do not know how HIV is or is not transmitted, so, fearing they might get infected through contact with persons living with HIV, they isolate them; and
 - Moral judgements: People know that HIV is transmitted mainly through sex or injecting drugs, so they assume that people living with HIV got HIV through these activities. Therefore, they condemn people living with HIV for immoral behaviour.
- Stigmatisation is a process:
 - f) We identify and name the differences in someone suspected to have HIV.
 - g) We make negative judgements about the person (e.g., promiscuity).
 - h) We isolate or judge/ridicule the person, thereby separating ‘her/him’ from ‘us.’
 - i) The person who is stigmatised (isolated and judged) loses status and faces discrimination.
- Stigma is often viewed as something right, as a tool to ‘control’ behaviour and people. People think that it is acceptable to isolate and shame people. People are not aware of how stigma affects people living with HIV and how it affects the HIV epidemic.
- HIV stigma is wrong and unacceptable! HIV stigma hurts people living with HIV and drives the HIV epidemic underground. Those stigmatised may become silent and, out of fear of stigma and discrimination, not disclose their status to their sexual partners, which may lead to an increased risk for HIV transmission.
- People living with HIV have the right to be protected from stigma and discrimination.

- We need to support people living with HIV, not blame them.

A7. Forms, Effects, and Causes of Stigma (Problem Tree—Method 1)

Facilitator’s Note: This is a good exercise to review all the things learned in the earlier exercises. It uses a Problem Tree method to make a list of forms, effects, and causes. Then the group can do further analysis on causes and start looking at solutions.

When doing this exercise, you cannot assume that all participants have ‘de-stigmatised.’ Some may say that the cause of stigma is “*the behaviour of PLHIV or key populations—they are bad people so they deserve to be stigmatised.*” You (the facilitator) should flag these views and the stigmatising language and raise them for discussion. You could, for example, place these cards into a separate cluster of cards—and then find time to discuss them.

Objectives: By the end of this session, participants will be able to:

- Identify different forms of stigma towards PLHIV and key populations and how stigma affects PLHIV, key populations, families, and communities, and fuels the transmission of HIV
- Identify some of the root causes of stigma towards PLHIV and key populations, and possible solutions

Target Groups: All groups

Source: Understanding and Challenging HIV Stigma: Toolkit for Action (A8)

Time: 1–2 hours

Preparation: Using cards, set up the structure for the problem tree on the wall.

Location	Feature	Question
Top	EFFECTS	How does this affect the person stigmatised (e.g., isolation)
Middle	FORMS	What do people do when they stigmatise? (e.g., name calling)
Bottom	CAUSES	Why do people stigmatise? (e.g., lack of knowledge)

Write an example card for each category and tape it on the wall. See examples on the following page.

Steps:

Problem Tree:

In pairs, participants write points on cards and tape them on a combined wall diagram to make a ‘problem tree,’ showing forms of stigma (main trunk), effects (branches), and causes (roots). Then points are reviewed—and more analysis is done on the causes.

Cardstorming (Pairs):

Divide into pairs. Hand out cards and markers. Ask pairs to write points on cards corresponding to effects, forms, and causes—one point per card. Then tape their cards under the correct category (effects, forms, causes).

Clustering:

Ask a few pairs to come up to the wall and organise the cards for each category –eliminate repetition and put similar points together. Then ask these participants to present the cards they have organised.

Debriefing (Plenary):

Review one category at a time and clarify any points which are unclear. Then look at the links between the different levels. For example, identify one form of stigma (e.g., shaming and blaming) and show its root causes (e.g., moral judgements) and some of its effects (e.g., shame, feeling excluded).

Analysing Causes and Developing Solutions (Task Groups):

By this stage, you will have a big list of points or ‘trees,’ but it needs further analysis to be able to ‘see the forest’ to make things more meaningful.

- Get agreement on the major causes. Then **assign each cause to a task group.**
- Ask each group to **analyse its cause**—“*Why is this a root cause? How does this lead to stigma? Give examples.*”
- Then ask the group to **develop solutions**—“*What can we do to challenge these causes?*”

EXAMPLE RESPONSES

Effects

PERSONAL—Shame. Loneliness. Feeling excluded. Loss of status and self-esteem. Loss of rights. Loss of hope. Self-blame. Stress. Anger. Poor health. Alcoholism. Depression. Suicide.

FAMILY—Family conflicts. Forced to leave home. Breakdown in communication with parents.

COMMUNITY—Forced to leave community. Difficulty getting jobs or joining clubs.

HIV EPIDEMIC—Loss of confidence—less ability to protect one’s health. Avoid using health services. Not getting STIs treated. Not using condoms. Not getting tested for HIV. Result: increased risk of HIV transmission to both male and female partners. Result: HIV transmission.

Forms

SHAMING & BLAMING—Bad words. Condemning. Judging. Scolding. Insulting. Gossip.

ISOLATION—Rejection. Refuse to sit beside them. Excluded from activities. No one talks to them.

DISCRIMINATION—Poor treatment at clinic. Harassed by police. Not hired by some employers.

SELF-STIGMA—Blaming and isolating oneself. Accepting shame. Withdrawal from activities.

STIGMA BY ASSOCIATION—Family, partners, and friends are also stigmatised.

LAYERED STIGMA—MSM, sex workers, prisoners, and migrants are already stigmatised, so when they get HIV, this adds another layer of stigma.

Causes

MORAL JUDGEMENTS—View that PLHIV and key populations have broken social norms.

IGNORANCE, UNFAMILIARITY, & UNWILLINGNESS TO ACCEPT DIFFERENCE—People know little about key populations, so out of ignorance they judge them unfairly or reject them out of fear. They are prejudiced towards people who are seen as looking and behaving differently.

GENDER EXPRESSION—MSM who do not look or act ‘like real men’ are judged harshly because their clothing and appearance differs from the norm.

POWER AND GENDER NORMS—stigma is rooted in power and gender norms. Moral rules are often based on unequal power relations—a way of punishing those who challenge gender norms, e.g., “not behaving like a real man.”

A8. Forms, Effects, & Causes of Stigma (Problem Tree Analysis—Method 2)

Facilitator’s Note: This is an optional way of doing the problem tree analysis. In this exercise, participants divide into groups, and each group analyses the stigma facing a different category, using the problem tree methodology (effects, forms, and causes), and then looks at what they can do to solve these problems. This provides a more integrated methodology than in A7.

Objectives: By the end of this session, participants will be able to identify:

- Different aspects of stigma and how it affects different people
- Some of the root causes of stigma
- Practical things they can do to stop or reduce stigma

Sources: Draft Toolkit on Stigma Reduction in Health Care Settings

Time: 1 hour

Handout: A-FS2: EFFECTS OF STIGMA ON THE HIV EPIDEMIC

Steps:

Analysing Different Forms of Stigma (Task Groups):

Write the different types of stigma which may occur in your context on cards. (Select those which apply.)

- A. STIGMA TOWARDS HIV-POSITIVE CLIENTS BY HEALTH WORKERS**
- B. STIGMA TOWARDS MSM BY THE COMMUNITY**
- C. STIGMA TOWARDS SEX WORKERS BY HEALTH WORKERS**
- D. STIGMA TOWARDS ADOLESCENTS LIVING WITH HIV BY SERVICE PROVIDERS**
- E. STIGMA TOWARDS HIV-POSITIVE WOMEN WHO GET PREGNANT**
- F. BREAKING THE CONFIDENTIALITY OF HIV-POSITIVE CLIENTS**

Then divide into groups and assign one topic to each group. Ask each group to do a **PROBLEM TREE** analysis of their problem, using the following steps:

- Draw a picture of a tree on a flipchart paper.
- On the trunk, write the problem—e.g., ‘Stigma towards HIV+ clients by health workers.’
- Then, on the trunk, using cards, add more details on **FORMS** of stigma, e.g., ‘shouting and scolding the client, making the client wait, using gloves to do non-invasive tasks, etc.’
- Then, at the roots at the bottom of the picture, write **CAUSES** on cards, e.g., ‘fear of getting HIV through casual contact, judgemental attitudes, heavy workloads and stress, etc.’ Ask participants to ‘dig deeper’—to look for the causes of some of the causes they list.
- Then, on the branches of the tree, write the **EFFECTS** on cards, e.g., ‘feeling isolated and ashamed, feeling angry and depressed, self-blame, wanting to leave the health facility, etc.’

- Then, underneath the flipchart paper, write POSSIBLE SOLUTIONS on cards, e.g., ‘remind health workers of their code of conduct, improve health workers’ knowledge about HIV transmission so they no longer fear getting HIV through contact with HIV-positive clients.’

Hand out flipchart paper, cards, markers, and tape to each group and ask them to prepare their analysis as a problem tree on the wall.

Report Back (Gallery Walk):

Organise a gallery walk, moving around the room and having each group present its report. Other groups can make additions.

A: STIGMA TOWARDS HIV-POSITIVE CLIENTS BY HEALTH WORKERS

Forms: Shaming and blaming clients for getting HIV. Making HIV-positive clients wait. Using gloves for non-invasive tasks. Moving away from clients assumed to be HIV positive.

Causes: Fear of getting HIV through casual contact. Judgemental, moralising attitudes. Heavy workloads and stress.

Effects: Feeling isolated, ashamed, angry, and depressed. Self-blame. May go to another health facility, go to another island for treatment, or stop treatment. Failure to adhere to anti-retroviral (ARV) medication.

Solutions: Remind health workers of their code of conduct. Improve health workers’ knowledge about HIV transmission so they no longer fear getting HIV through casual contact with clients. Orient new health staff on how to treat/interact with all clients.

B: STIGMA TOWARDS MSM BY THE COMMUNITY

Forms: Isolation and minimal contact. Gossip, whispering, and finger-pointing. Violence.

Causes: Moral and religious views about MSM—viewed as breaking social norms. People know little about MSM—so out of ignorance, they judge them unfairly or reject them out of fear. They are prejudiced towards people who look and behave differently.

Effects: Feel rejected and all alone. Stress, depression, and alcohol abuse.

Solutions: Help community leaders become more informed—so they can speak out on behalf of MSM. Teach community to treat MSM like other members of the community. Empower MSM to speak out and participate in community activities.

C: STIGMA TOWARDS SEX WORKERS BY HEALTH WORKERS

Forms: Scolding, shaming, and blaming sex workers for their sex work. Using insulting words. Revealing the occupation of sex worker patients to other health workers and clients.

Causes: Moral and religious views about sex workers. Judgemental, moralising attitudes. Feeling of superiority. Heavy workloads and stress.

Effects: Feeling isolated, ashamed, and angry. Sex workers may stop using health facilities and not get their STIs treated.

Solutions: Remind health workers of their code of conduct – treating all patients equally and with respect. Train health workers on how to interact with all patients in a non-judgemental way.

D: STIGMA TOWARDS ADOLESCENTS LIVING WITH HIV BY SERVICE PROVIDERS

Forms: Keeping adolescents waiting and treating them last. Blaming adolescents for being sexually active and getting HIV. Blaming their parents for not raising them properly.

Causes: Judgemental, moralising attitudes. Heavy workloads and stress. Fear of getting HIV through casual contact. Lack of experience in dealing with young people.

Effects: Feeling ashamed and angry. Self-blame. Becoming suicidal. May go to another health facility or stop going to health facilities. Do not adhere to treatment.

Solutions: Train health workers on how to interact with adolescent PLHIV. Remind service providers of their code of conduct.

E: STIGMA TOWARDS HIV-POSITIVE WOMEN WHO GET PREGNANT

Forms: Scolding by health workers—*“You should have used a condom and prevented the pregnancy.”* Some pregnant women who are HIV positive are forced to have an abortion.

Causes: View that mother will transmit HIV to baby, creating a new problem. View that when a woman becomes HIV positive, she no longer has a life or the right to make her own decisions.

Effects: Women feel condemned for their behaviour and discouraged about giving birth.

Solutions: Advocate for women’s right to have children. Ensure that all health workers know how to prevent mother-to-child transmission and can counsel an HIV-positive pregnant woman about safe pregnancy and childbirth.

F: BREAKING THE CONFIDENTIALITY OF HIV-POSITIVE CLIENTS

Forms: Telling other health workers and family members the status of HIV-positive clients. Being careless with charts. Talking about a patient’s status in public spaces where others can overhear the conversation.

Causes: View that health workers should know who has HIV so they can protect themselves, and families should know so they can provide support. Lack of awareness and training in how to properly maintain confidentiality.

Effects: HIV-positive clients may stop using health facilities and stop adherence to ARVs.

Solutions: Stop practice of informing health workers and family about the status of HIV clients. Develop a health facility-wide policy around confidentiality and enforce it.

SUMMARISE:

Summarise the main points which participants have made during the exercise. In giving your summary, you may use some of the following points if they have not already been mentioned by participants.

- The three main causes or drivers of HIV-related stigma are: a) lack of awareness that they are stigmatising; b) inadequate knowledge on HIV transmission and fear of getting HIV through casual contact; and c) judgemental attitudes.
- Judgemental attitudes towards key populations bring up issues of:
 - a) **Gender** (e.g., the common perception that *“MSM are not real men”*)
 - b) **Culture** (e.g., the perception that *“homosexuality, sex work, or use of drugs is ‘abnormal,’ breaking social norms”*)
 - c) **Religion** (e.g., the perception that *“MSM relationships, sex work, and use of drugs are immoral, against the teachings of our faith”*)

- Service providers on their own cannot solve many of the root causes of stigma. However, general awareness of the root causes will help service providers better understand the needs and concerns of PLHIV and key populations so they can provide better services and refer them to other appropriate services.
- Stigma leads to low uptake of health services by PLHIV and key populations. Reducing stigma is key to increasing the uptake of HIV prevention and services; improving HIV disclosure; and improving client follow-up to treatment, care, and support services.

A9. How HIV and Key Population Stigma Fuels the HIV Epidemic

Facilitator’s Note: This exercise helps participants understand how stigma towards PLHIV and key populations fuels the HIV epidemic.

Objectives: By the end of this exercise, participants will be able to see how stigma or the fear of being stigmatised stops PLHIV and key populations from getting health services and practising safe sex, which increases their risk of getting HIV and passing HIV to their partners.

Time: 1 hour

Materials: Copies of the case studies for participants

Steps:

Story and Discussion:

Ask the group to read the following stories.

Story 1 (MSM): John is 30, single, and lives with his parents. He started to have sex with men when he was a teenager. He knew that being gay was natural for him, but he was worried his family would find out and make his life miserable. Other gay friends of his had been ‘discovered’ by their parents and their lives had become hell—and he wanted to avoid this.

He used to invite men to the house. One day John’s sister became suspicious about his male visitors. She looked into his room and found John having sex with a man. She reported this to her uncle. The uncle wanted to stop this behaviour, so he forced John to get married and arranged a wife. John agreed to the marriage to get them off his back.

For one year, John stayed with his wife, without seeing other men. He wanted his sister to forget what had happened—he was afraid she would tell his wife that he was gay. After one year, he felt he could no longer wait, so he started having sex with one of his former lovers. Even when he was with his wife, he was thinking about having sex with this man.

In the marriage, he insisted on the use of condoms, but in his sexual relations with his male lover, he found it more difficult to negotiate safe sex.

After two years of married life, John learned that one of his previous male partners had tested HIV positive, so he started to worry about his own status. What would people think if he was HIV positive? Would they find out that he was gay? How would he be treated?

For a while, he avoided getting tested because he was afraid he would be exposed as gay. But he was confused and worried that he might have HIV.

Eventually he went to get tested, but the voluntary testing and counselling (VCT) counsellor made him feel very uncomfortable. She asked lots of questions about John’s sex life—and when John mentioned

having had sex with men, the counsellor said, “*No, you are not one of those! You seem different!*” John left the VCT without taking the test—and told himself he would never go back.

He started to worry about infecting his wife and his male lover. He insisted on using condoms with his wife, but she got angry and said he must be having an affair. He was so worried about losing his male lover that he agreed to have sex without a condom—to please his partner. He became very depressed and worried about what he would do next.

Story 2 (Sex Worker): Dora came from a poor family, and was given little support when she was growing up. When she became 16, she left school and went to town looking for work. She had very little education, so she found it hard to find an office job. She tried looking for work for six months and found nothing. Out of frustration, she got pulled into sex work—a way of getting regular money. But she kept this information from her parents. She told them she was working as a secretary and sent money home regularly to her parents, so they were proud of her.

She learned to cope with her job as a sex worker and discovered how to please men, but she protected her health carefully and insisted on condoms with all clients, even those who offered to pay her more money to have sex without condoms.

In her second year, she met a man from her own village who was working in the same town. They became lovers and she moved in with him. When she had sex with him, they didn’t use condoms. Three months after moving in with him, she started to get a burning sensation in her vagina, so she started to get worried. How did this happen? Was he having sex with other girls? What would happen if her parents discovered she had HIV?

She went to the government clinic to take an STI and HIV test, but the counsellor made her feel very uncomfortable. He asked lots of questions about her sex life—and even asked if he could come visit her at the bar. These questions upset Dora and she left the clinic without taking the test—and told herself she would never go back.

She started to worry about getting HIV and how this would affect their lives. She told her partner that they should use condoms, but he got angry and said she didn’t trust him. She was so worried about losing him that she kept quiet and agreed to have sex with him without a condom—in order to please him. She became very depressed and this affected her work at the bar. She no longer insisted on using condoms with the clients who offered her more money. She felt her life was falling apart, so why should she worry?

Plenary Discussion:

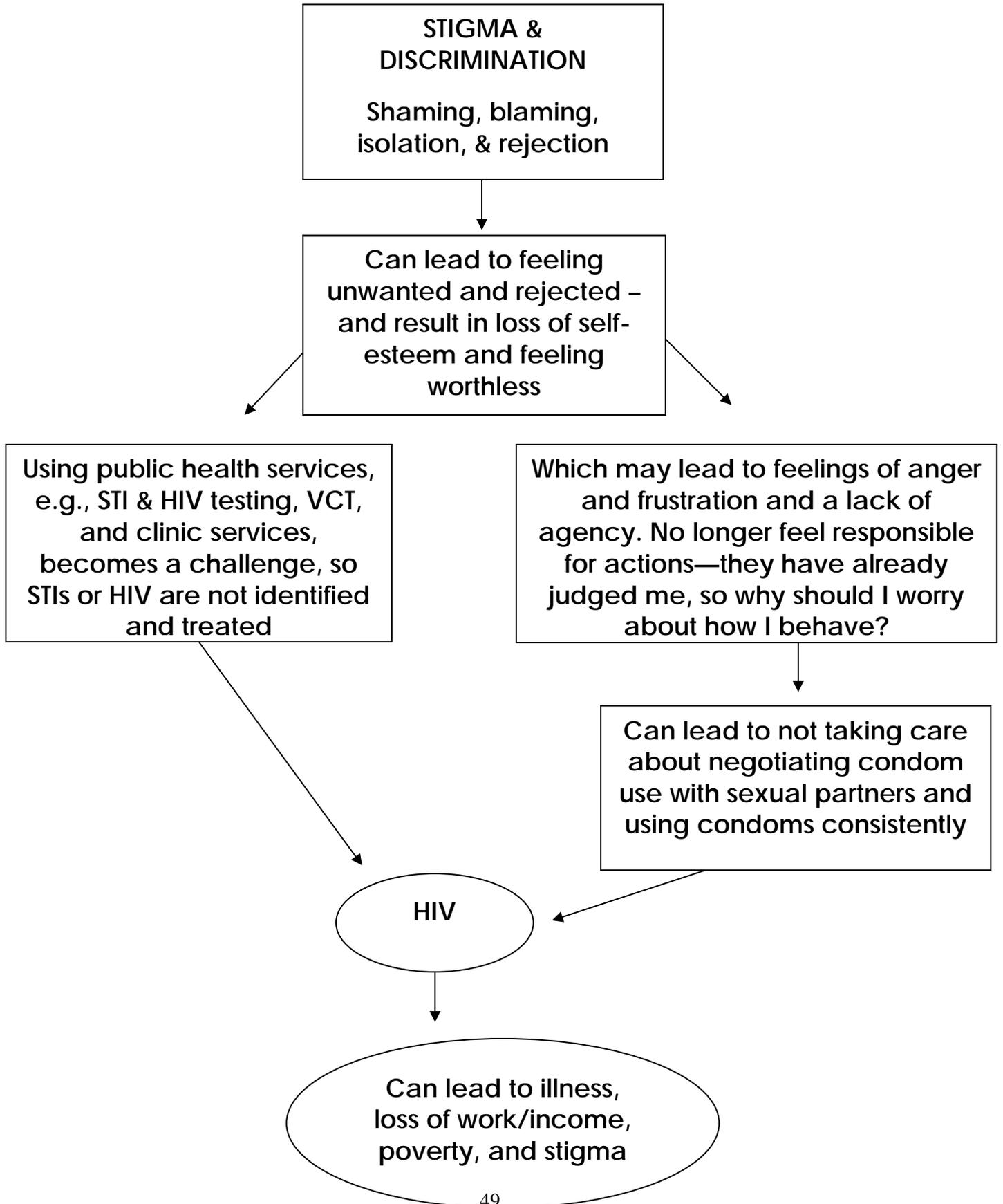
- What happened in the story? Why are John and Dora behaving the way they are?
- How does stigma affect disclosure to partners—and use of health services?
- How does stigma towards key populations increase the risk of HIV transmission?

Summarise:

- Stigma or the fear of stigma stops PLHIV and key populations MSM from:
- **Accessing health services**—getting tested for HIV and STIs, getting information on how to avoid HIV transmission, and getting condoms and lubricant;
- **Openly discussing their sexual behaviour with health workers** and providing complete information about their sexual practices, which is necessary to receive appropriate screening and care;

- **Accessing treatment** (ARV therapy or treatment of opportunistic infections);
- **Protecting their own health and the health of their sexual partners by insisting on safe sex with their sexual partners.** For example, often gay men and sex workers feel so stigmatised that when they find a partner who loves them, they may avoid insisting on condoms because they want to hang on to this new relationship. This makes them and their partners vulnerable to getting HIV; and
- **Disclosing their HIV status and getting counselling, care, and support.** Because of stigma, people living with HIV and key populations are afraid to tell others about their HIV status. As a result, they may have difficulty negotiating condom use and accessing HIV services, and therefore the risk of transmitting HIV increases.

How Stigma Affects PLHIV and Key Populations



A10. Naming Stigma and Discrimination towards Key Populations in the Health Facility

Facilitator's Notes: This exercise looks at the experience of key populations in accessing health facilities—how key populations are treated, the specific forms of stigma and discrimination they face, how it makes them feel, and the effect of stigma on their health-seeking behaviour.

Use this exercise only after a general exercise to introduce the idea of stigma and discrimination (e.g., A1, A2, A3, A4, or A5). This exercise will help to prepare health workers to name stigma and discrimination in their own work setting. The aim is to help health workers make a frank and open assessment about stigma in their own workplace.

Use one of the case studies to start the process of naming stigma in the health facility—and then get health workers to add other examples of stigma they have observed in their own facility.

Objectives: By the end of this session, participants will have:

- Identified forms of stigma which prevent key populations from accessing services
- Started to think about how to improve the way they handle PLHIV and key populations in their health facility

Target Group: Health workers

Source: Draft Toolkit on Stigma Reduction in Health Care Settings

Time: 1 hour

Materials: Case studies

Handout: A-FS3: STIGMA IN HEALTH FACILITIES—FORMS, CAUSES, AND SOLUTIONS

Steps:

Case Studies:

Divide into six groups and hand out the case studies below. Ask three groups to read Case Study A and three groups to read Case Study B, then discuss the questions below:

- What happened in the case study? Is the situation realistic?
- What other forms of stigma have you seen in health facilities towards key populations?
- What are effects of stigma and discrimination on key populations—and on the spread of HIV?
- Why is stigma and discrimination towards key populations happening in the health facility?
- What can we do to make our health facilities more friendly/accessible and challenge stigma?

Case Study A: Stigma and discrimination towards MSM in the health facility

One day, I started to get painful sores around my anus. I went to the clinic to get tested and obtain possible treatment, but I was worried about how I would be treated by the clinic staff. So I told the nurse that I was constipated, and that it was very painful. The nurse didn't say anything, but she left the room and a few minutes later returned with two other nurses. The nurses looked at me, whispered to each other, and then left.

When the first nurse returned, I challenged her and said, "*I've been waiting a long time. Could you examine me and give me some treatment.*" She laughed and said, "*Who are you to tell me what I should*

do? You'll just have to wait. We know you people!" She said this in the presence of the other patients and then left. I was told that she and the other nurses had gone off for tea break. I could imagine them gossiping about me over their tea. I wondered who they would tell about me.

After a long break, a doctor entered and, without even examining me, said, *"What have you been doing? How did you get this STI?"* I explained that I had a sore in my anus. He said, *"What did you expect to get from this unusual sexual behaviour? I normally treat STIs in the front, not the back. Why are you making my life difficult?"* Then he told me to take off my pants. I did so, and he looked at my bum from a long distance away, and said, *"Why do you have STIs in your anus? What have you been doing?"*

He then began to ask me a lot of questions about my sex life—*"What kind of sex have you been having? When was the last time you had sex with a woman? Do you have a girlfriend? How do you have sex with a man?"* I told him I just wanted to be tested and given treatment, not asked about my sex life. He responded that *"the clinic only did testing for real men, not men pretending to be women."*

As soon as the doctor went to the next room, I put my pants on and left the clinic. It was humiliating! I will never go back there again. I went to the clinic with a medical problem to get help from the doctor, but I didn't receive any treatment—all I got was insults and blame!

Case Study B: Stigma and discrimination towards sex workers in the health facility

One day, I started to get painful sores and a burning sensation in my vagina. Even though I was worried about how I would be treated by the clinic staff, I still went to the clinic to seek out testing and, if needed, treatment.

When I arrived at the clinic, I waited a long time. The nurse kept calling patients who had arrived after me. Eventually, I challenged her and said, *"I arrived before her. Why can't you treat me now?"* She laughed and said, *"Who are you to tell me what I should do? You'll just have to wait. We know you, ladies of the night! You wait all night for men, so why can't you wait a few more minutes."* She said this in the presence of all the other patients, and I felt humiliated. She then left and had a long talk with three other nurses, and I could see them looking in my direction.

Eventually, I was called in to see the doctor. Before I went into his room, the nurse had been talking to him, so I suspected she had told him that I was a sex worker. The doctor gave me a funny look and asked, *"What is your problem?"* I explained that I had sores and a burning sensation in my vagina. He said, *"I don't know why we are wasting our time on you. You are just a virus collector. I don't care if you die. You deserve to get this infection because of your disgusting behaviour. It's your own fault sleeping with all these men."* Then he told me to take off my dress. I did so, and he looked at my sexual parts from a long distance away.

He then began to ask me a lot of questions about my sex life: *"How often do you have sex? What kind of sex do you enjoy the most? Can I see you some time?"* I told him I just wanted to be tested and treated, not asked about my sex life. He responded that the clinic only did testing for normal women, not sex workers!

As soon as he left, I put my dress on and left the clinic. It was humiliating! I will never go back to that clinic again. I went to the clinic with a medical problem to get help from the doctor, but I didn't receive any treatment. All I got were bad words and blame!

EXAMPLE RESPONSES—MSM CASE STUDY

Forms of stigma in the health facility:

- The MSM client is kept waiting a long time. Other clients are served first.

- Bureaucratic and unfriendly treatment and insulting language.
- Clinic staff gossip about the MSM client and show their disapproval/judging—body language.
- Break confidentiality—one nurse tells the other nurses and other clients about him.
- Blaming and shaming - *“You deserve to get this because of your disgusting behaviour.”*
- Poorly done, rushed examination—doctor inspects client’s bum from a long distance.
- Invasive questioning, e.g., *“Where did you get this STI? What kind of sex do you do?”*
- Doctor is more concerned about the client’s sexual orientation than dealing with the illness.
- No information is provided on safe sex for MSM.
- Some MSM are afraid to access health services because they do not want to reveal their sexuality, for fear they will be discriminated against and others will be told.

Effects

- The man comes out of the clinic feeling insulted, humiliated, and angry, and finds no solution to his problem, i.e., medicine to treat the problem.
- He will stop using the clinic and may resort to other forms of treatment, e.g., private doctors who treat them with more confidentiality and less stigma, or self-treatment.
- If the STI is not treated, then the STI spreads.
- Stigma may affect the self-esteem/self-confidence of clients and they may deny their sexual risk and take more risks in their sexual behaviour (e.g., not using condoms).

Why are these problems happening?

- Symptoms (e.g., sores in the anus or ulcers in the throat) are themselves a trigger for stigma—suspicion towards a man who has these symptoms.
- Stigma towards MSM—based on views about sexual orientation.
- Lack of confidentiality—share information among other staff and clients.
- Health workers not trained on how to diagnose, interact with, and counsel MSM clients.
- Doctor sidetracked—can’t get past the client’s sexual orientation in order to focus on the STI.

Solutions

- Educate service providers on PLHIV and MSM issues and how to deal with PLHIV and MSM.
- Change the attitudes of service providers—more caring and less judgemental.
- Re-establish the code of practice, i.e., treating all clients equally.
- Train all staff on basic skills in the management of STIs in MSM.
- Train staff on how to counsel MSM clients, i.e. not judgemental, neutral or supportive language, and appropriate body language.

Discuss:

- What happens if we stigmatise key populations who are using the health facility?
- Why is stigmatising clients wrong?

What happens if we stigmatise key population clients?

- Key population clients may stop using the clinic and not have their STIs treated.
- Fear of stigma might prevent MSM or sex workers from giving us information about their sexual behaviour so we can help them prevent STIs and HIV.
- Stigma may affect the self-confidence of key populations and, as a result, they may take less care in using condoms with partners and negotiating safe sex.

Why is stigmatising clients wrong?

- Our role as health workers is to care for people, not hurt them.
- Our code of practice tells us to treat all clients equally.
- If we stigmatise key population clients, this will undermine their ability to manage their sexual health and may result in more HIV transmission.

Summarise:

Because of your religion or upbringing, you may believe that people having sex with the same sex or sex work is wrong—but it is not okay to stigmatise MSM and sex workers—to treat them as immoral or evil.

Stigmatising MSM and sex workers fuels the HIV epidemic—it makes MSM or sex workers hide their sexual behaviour and, as a result, they may take less care about their sexual health, increasing the risk of HIV exposure.

Stigmatising MSM and sex workers defeats your own mandate as a health worker. If you stigmatise MSM and sex workers, they will stop using the clinic and their health will be negatively affected. If so, you are failing in your role as a health worker.

Health workers' code of conduct requires us to treat all clients without exception.

We are not saying that the moral values are wrong— we are saying that health workers' judging of MSM and sex workers is wrong. This form of stigma has to be stopped, i.e., condemning MSM and sex workers as 'bad people' who don't deserve our support.

Stigmatising MSM and sex workers results in their feeling cut off from the family, community, and health services. **This lowers self-esteem and undermines their ability to take positive action to manage their health.** As a result, MSM and sex workers may take less care about their use of condoms and put themselves at risk of getting HIV. Once they get HIV, MSM and sex workers are doubly stigmatised (for being both MSM/sex workers and HIV positive), and this affects their ability to care for their own health and others' health. Fearing stigma and discrimination, MSM and sex workers may hide their status from their partners and continue having unprotected sex, and this allows HIV to continue to spread.

If we are to fight HIV, we have to stop calling MSM and sex workers 'bad people.' MSM and sex workers are not bad people. In many parts of the world, MSM and sex workers are accepted as part of the community. This removes the moral condemnation and the source of the stigma that is so damaging.

Stigmatising MSM and sex workers does not help us to fight HIV. Instead of stigmatising MSM and sex workers, **we need to show care, compassion, and acceptance**—so that MSM and sex workers can lead a healthy life and act in their own and other people’s interest.

If we can stop blaming and shaming, and instead accept MSM and sex workers, we can make a difference!

ADDITIONAL CASE STUDIES

Case Study A: Stigma towards HIV-positive patients

Victor is a 40-year-old man. He started to have rashes and diarrhea, which did not respond well to treatment. The health staff bullied him into taking an HIV test and he was diagnosed as HIV positive. He was admitted to the health facility and his health got worse. He stayed in the health facility for four days without being given any treatment. During the ward rounds, he complained to the doctor, but the nurses told the doctor to pay him no attention, saying that he was confused. Victor’s condition became so bad that he could no longer get himself to the toilet and started to soil his bed. The nurses would not give him a bed pan no matter how often he requested one, and they scolded him for spoiling the bed. Finally, he asked to be discharged so that he could go home and die peacefully.

Case Study B: Stigma towards young MSM

Terry is an 18-year-old boy. Since graduating from high school, he has been dating his boyfriend David, who is 20 years old. All through high school, Terry was called a ‘batty boy.’ Terry has not ‘come out’ to his family because of the shame he thinks they will feel because he is ‘gay.’ His other gay friends told him that there is a clinic near his house. They caution him that the clinic is new and they are not sure how the staff will act towards him, but thought it would be convenient. Terry went to the clinic to get free condoms. As soon as he arrived, he noticed the whispering from the staff. One nurse asked him why he needed condoms, and told him he was too young to be having sex! Terry was so shocked by the experience that he never returned to the clinic.

CHAPTER B: SEX, MORALITY, SHAME AND BLAME

Introduction

In the Caribbean, HIV is primarily transmitted through sex, so many people assume that people get HIV through having “immoral sexual encounters.” People often think that getting HIV means a person has sinned—gone against social norms or religious teachings. So they shame and blame PLHIV and key populations who are viewed as engaging in sex outside marital boundaries and breaking religious or moral codes.

The link in people’s minds between HIV and immoral behaviour means that PLHIV, MSM, and sex workers are judged or “shamed and blamed” by others for their “bad behaviour.” This judging is perceived to be legitimate or reasonable, and a way of shaming people into stopping their involvement in sex with the same sex or sex work. But it represents a major form of stigma. It makes people living with HIV and key populations feel ashamed, and it often makes them hide, which helps to drive the epidemic underground.

This module aims to tackle the difficult subjects of sex, morality, and religion, and explores these issues in relation to HIV-related stigma. Many of the exercises are optional. Choose the ones that suit your target group.



EXERCISES

- B1. We Are All in the Same Boat
- B2. The Blame Game—Things People Say about PLHIV and Key Populations
- B3. What People SAY, FEAR, and DO about Key Populations
- B4. Breaking the Sex Ice
- B5. Body Mapping for Understanding LGBTI
- B6. Tradition, Morality, and Religion
- B7. Beliefs about PLHIV and Key Populations (Value Clarification)

B1. We Are All in the Same Boat

Facilitator's Note: This is a warm-up exercise to introduce the idea that we are all affected by HIV. It can be based on any competitive game that eliminates players when a person makes a mistake (e.g., 'Simon Says' or 'Tides In/Tides Out'). This form of exclusion is a metaphor for stigma and will be used to trigger discussion on how it feels to be excluded from the group. At the end of the game, ask those who were eliminated, "How did you feel when you were eliminated and left sitting watching the other players?"

Objective: By the end of this session, participants will recognise that everyone is at risk of getting HIV.

Target Groups: All groups

Source: Understanding and Challenging HIV Stigma: Toolkit for Action (C1)

Time: 15 minutes

Steps:

WE ARE ALL IN THE SAME BOAT (Game + Discussion):

Facilitate the elimination game (example described below). Then discuss "What does the game mean?"

GAME—'IN the water, ON the shore' (or 'In the River, On the Bank')

Ask players to stand in a line, all facing the same direction. Then explain:

You are standing ON the shore. When I say, "IN the water," you should take one step forward. If, however, I say "ON the water," you should not move. When I say, "ON the shore," you should take one step back to our starting point here "on the shore." If, however, I say "IN the shore," you should not move. If anyone makes a mistake, she/he will be asked to leave the game.

Then start the game. Give the commands quickly. If anyone makes a mistake, ask him/her to leave the game. After a few minutes, stop and debrief.

DEBRIEFING:

Ask—

- Those who were kicked out of the game—how did you feel?
- Those who remained in the game—how did you feel?
- What happened when someone made a mistake?
- What can we learn from the game about stigma?

EXAMPLE RESPONSES

Those kicked out of game—how did you feel?

Why me? Anger. Confusion. Embarrassment. I felt I had made a little mistake—didn't know why I was being kicked out. Why can't you give me another chance? Others were laughing at me. I felt all alone. I felt good when others were eliminated—and then I was not alone. I wanted others to fail—then they would feel the same and join me in the 'loser' category.

Those who remained in the game—how did you feel?

I felt very nervous. I wanted to avoid being singled out so I was very careful. Yes, I did laugh at others, but it was a natural response. It was a very competitive situation and when someone makes a mistake, you laugh to relieve the tension. I kept watching others to see if they would make a mistake.

What happened when someone made a mistake?

People laughed, pointed fingers, mocked, insisted they leave the game.

What can we learn from the game?

- People laugh when others make a mistake—this is a form of exclusion, and makes the person eliminated (stigmatised) feel bad.
- Laughing at others making mistakes can be interpreted as a form of blaming.
- Laughing at others happens naturally or unconsciously—it just comes out.
- Stigma is like this—often we are unaware that we are doing it. We are only acting out the way we have been socialised.
- It is easy to make a mistake in the game and in real life, e.g., not using a condom or taking risks in our sexual behaviour.
- Those who were still in the game were watching and judging other people's behaviour—this is just like the way we stigmatise.
- When you get HIV, it is final. You do not get 'another chance,' although effective treatment is available once you know you have HIV.

SUMMARISE:

This game shows us that **'We are all in the same boat.'** There is no separation between US and THEM. We are all facing and living with this epidemic together. We are all affected. We have all taken risks at one time in our lives and many of us still do.

All of us are at risk of getting HIV so there is no point stigmatising or blaming those who are already affected. We could join them any day!

Lots of people like to laugh at and make fun of others, but one day they may also 'fall into the water'—and others will laugh at them. Remember, HIV affects everyone.

Stigmatising others **makes us feel superior to others.** It makes us feel that WE are right and THEY are wrong. Yet we may be in the same boat.

Don't point fingers at anyone. **As you point one finger towards others, four fingers are pointing back towards you—you are blaming yourself.**

Whatever misfortune befalls me, tomorrow it may be you! Your friend's misfortune can become your misfortune.

Every dog has his day. Today fuh me, tomorrow fuh you!

B2. The Blame Game—Things People Say About PLHIV, MSM, Sex Workers, Drug Users, etc.

Facilitator's Note: This exercise is not designed for those who are stigmatised; it is designed for those whose attitudes we are trying to change—service providers, teachers, community and political leaders, media workers, and others. This exercise helps participants verbalise stigma towards different types of people. The language can be very strong, so people need to understand why they are being asked to make lists of stigmatising words for different marginalised groups.

The title of this exercise – “Things **People** say about PLHIV, MSM, sex workers, etc.” – allows participants to express their own stigmatising labels for other groups under the cover of attributing them to “the people.” So while some words are those commonly used by the community, other words are those actually used by participants themselves.

In doing this exercise, we should make it clear that we are using these words not to insult people, but to show how these stigmatising words hurt.

In debriefing this exercise, it is important to focus on ‘how participants feel about these names,’ rather than focusing on the words themselves. This helps to avoid the embarrassed laughter. The whole point of this exercise is to help participants recognise how these words can hurt.

Objectives: By the end of this session, participants will be able to:

- Identify labels used by people to stigmatise PLHIV and key populations
- See that these words make people feel bad about themselves
- Recognise why they should stop using these stigmatising words

Target Groups: All groups

Source: Understanding and Challenging HIV Stigma: Toolkit for Action (C2)

Time: 1 hour

Handout: B-FS1: BLAMING AND SHAMING

Preparation:

Make a list of groups that might experience stigma in your context or community—PLHIV, MSM, sex workers, PWID, migrants, poor people, indigenous persons, Rastafarians, etc. Then using this list, prepare the flipchart stations—blank sheets of flipchart paper on different walls of the room, with the name of one of these groups written at the top of each sheet. You do not need to use all categories.

Steps:

Warmup: Switching Chairs Game

Set up the chairs beforehand in a circle. Allocate roles to each person going round the circle, based on the groups listed on the flipcharts – “*PLHIV, MSM, sex worker, PWID, migrant, poor person, indigenous person, Rastafarian, ...*” Continue until everyone has been assigned a role. Then explain how the game works—

I am the caller and I do not have a chair. When I call out two roles—e.g., “PLHIV” and “MSM,” all the “PLHIV” and “MSM” have to stand up and run to find a new chair. I will try to grab a chair. The person left without a chair becomes the new caller—and the game continues. The caller may also shout “REVOLUTION”—and when this happens, **everyone** has to stand up and run to find a new chair.

Then shout – “*PLHIV and MSM*”—and get the “PLHIV” and “MSM” to run to a new chair—and this starts the game.

Debriefing:

Ask—“How did it feel to be called a PLHIV, MSM, or sex worker?”

Things People Say About _____ (Rotational Brainstorm):

Divide into the groups based on the roles used in the game, e.g., all PLHIV in one group, all MSM in one group, etc. Ask each group to go to its flipchart station. Hand out markers and ask each group to write on the flipchart all the things people say about people in that group. After two minutes, shout “CHANGE” and ask groups to rotate in a clockwise direction and add points to the next sheet. Continue until groups have contributed to all flipcharts and end up back at their original list.

EXAMPLE RESPONSES

PLHIV: Nasty. Immoral. Promiscuous. Sinners. Whores. Disgusting. Abomination. Loose. Paying for their sins. They deserve it. Sex crazy. Irresponsible. Careless. Unhappy. Unlucky. Disease carriers. Have de plague. Outcasts. Lepers. Dead man/woman walking. Cursed. Should be quarantined. Should be sent to a special place.

MSM: Batty man. Anti-man. Dirty boy. Nasty. Babylon. Abomination. Sodomites. Homo. Faggot. Buggerman. Dirty. Maco. Sick. Promiscuous. Sinners. Disgusting. Sex for money. Perverts. Pedophoiles. Dogs. Immoral. Cursed. Dead. Unnatural. Spread diseases. Cursed. Shit truck. Pit toilet. Stool pusher. Back door keeper. Fire bun dem. Kill dem.

Sex Workers: Nasty. No good. Whores. Sluts. Bitches. Sinners. Loose women. Skank. Husband stealers. Home wreckers. Man eaters. Sex maniacs. Money grabbers. Cheap girls. Bus stop girls. Top up girls. Night nurse. Culvert. Irresponsible. Disease spreaders. Vermin.

PWID or People Who Use Drugs: Druggies. Crack heads. Junkies. Drug pushers. Dirty. Thieves. Criminals. Homeless. Orphans. Vagrants. Beggars. Stupid. Lazy. Useless. Lost cause. Parasites. Do anything for drugs. Good for nothing. Sex for drugs/money. Outcasts. Deserve to die.

Migrants: Outsiders. Bang-water. Alien. Deportees. Passport scammers. Opportunists. Thieves. Disease carriers. Prostitutes. Taking away jobs. Taking up space. Cats and dogs. Run-aways. Beggy-beggy people. Tricky. Ambulances (want want).

Report Back:

Bring everyone together into a large circle. Ask one person from each group to stand in the middle of the circle and read out the names on their flipchart, starting with “*I am a [MSM] and this is what you say about me*” [Add the name of the stigmatised group.]

After all lists have been read out, ask the following questions:

- Choose a word that really affects you from one of the names. How would you feel if you were called this name?
- How would you feel if your sister or brother were called these names?
- Why do we use such hurtful language?
- What are the assumptions behind some of these labels?

How would you feel if you were called these names?

- Sad. Hurt. Angry. Ashamed. Embarrassed. Unfairly treated. Discredited. Rejected.
- Their words are insulting. It makes me sad and ashamed. I wish I could die.
- It makes me feel unfairly treated. It’s no fault of mine I got HIV but I am blamed.
- I’m going to hide my identity from others so I won’t be stigmatised.
- I feel hopeless. All my confidence is gone. I don’t know how I will survive.
- I have teenage daughters and it makes me angry to hear these names.

Summarise:

The summary in this case is very important, so allow enough time to do it.

- We are socialised or conditioned to judge other people. We judge people based on **assumptions about their sexual and other behaviour, country of origin, or other features which are different.**
- **Sex is a taboo**—something shameful that we should not talk about. So we often shame and blame people whose sexual behaviour is different from ours.
- **PLHIV, MSM, and sex workers** were all labeled as sexually immoral on the flipcharts. They were called “sex crazy,” “irresponsible,” and “disease carriers.” The judgements in this case are based on sexual morality.
- These are disadvantaged/vulnerable groups who are lacking in power—they are stigmatised partly because they have limited power to resist these labels. They are often isolated and try to hide from being open in society.
- These labels show that when we stigmatise, we stop dealing with people as human beings—we forget their humanity (by using mocking or belittling words) and this gives us a feeling of power and superiority over them.
- These labels are based on assumptions in which we have insufficient information. They are based on generalisations which have no validity—we simply assume that “the other people” are “dirty, disgusting, sex crazy, etc.”
- Stigmatising words can be very strong and insulting—they have tremendous power to hurt, to humiliate, and to destroy people’s self-esteem. When we “shame and blame” PLHIV and key populations, it is like stabbing them with a knife—it hurts! And the shaming has consequences in the way people lead their lives.
- We often attribute characteristics to a group and to everyone who belongs to that group. We assume that all members of that group have the same characteristics—e.g., all PLHIV are promiscuous, all MSM are mentally sick.
- So how should we treat PLHIV and key populations? We should give them a) respect and affection; b) support and encouragement; c) space, place, and recognition. If we treat PLHIV and key populations well—giving them love and respect, they will keep their self-esteem, feel empowered, and take charge of their lives, including being more able to access health services and take care of their sexual health. But if we treat PLHIV and key populations badly, because of the feelings of hurt, shame, and rejection, they may hide from society, avoid using clinics, and may not protect themselves during sex. All of which puts them at higher risk of getting HIV – and this may result in HIV being passed to others.
- Why do we condemn some groups and accept others? We are not saying that PLHIV and key populations are right or wrong. Whether or not you agree with someone, you don’t have the right to belittle him. You must look at a human being as a human being and empathise as though the person is your son or daughter. Try to put yourself in the shoes of the other person—how would you feel if you were called these names? Even if you don’t like the person, understand him or her.

B3. What People SAY, FEAR, and DO About Key Populations (Cardstorm)

Facilitator’s Note: This is an optional exercise to help participants identify how they talk about key populations, their fears towards them, and what they do. This helps to name the problem of stigma and discrimination faced by key populations—and the root causes.

This exercise overlaps with exercise B2—so only use one of these exercises.

Objectives: By the end of this session, participants will be able to:

- Describe the stigma and discrimination faced by key populations
- Analyse the root causes of the stigma and discrimination

Target Groups: All groups

Sources: BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer’s Guide (A2)
Cambodia Toolkit on Stigma Reduction towards Men who have Sex with Men

Time: 1 hour

Handout: B-FS1: BLAMING AND SHAMING

Preparation: Put up three cards along the top of the wall: “SAY,” “FEAR,” and “DO.”

- What people **SAY** about key populations (e.g., names people call members of key populations, comments community members may make when gossiping about key populations, etc...)
- What people **FEAR** about key populations (e.g., concerns the community may have about key populations that lead them to isolate and discriminate against key populations)
- What people **DO** to key populations (e.g., the kinds of actions people take towards key populations, based on their stigmatising attitudes)

Steps:

WHAT PEOPLE SAY, FEAR, AND DO ABOUT KEY POPULATIONS (Cardstorm):

Divide into pairs and hand out cards and markers. Ask pairs to write points on each of the three topics— one point per card. Emphasise that pairs should write only one point per card; and should avoid repeating points which other participants put on the wall. Tape the cards on the wall under the correct topic. Then eliminate repetition and cluster common points.

EXAMPLE RESPONSES: From a Workshop

What people SAY about key populations:

Nasty. Dirty. Disgusting. Immoral. Irresponsible. Batty boy. Anti-man. Whores. AIDS carriers. Wicked. Promiscuous. Abomination. Selling their body. Lazy. Buggerman. Lovers of money. Husband stealers. Cursed. Outcasts. Bun them. Punish them. They reap what they sow.

What people FEAR about key populations:

Don’t want to have anything to do with them. They will infect us with HIV or STIs. They will destroy family values and bring shame to the family and community. They will teach our children bad things. Our children will become confused. They will steal our husbands/wives, and this will result in family breakdown.

What do people DO to key populations?

Harass and bash them. Kick them out of the house. Disown them. Beat them. Stone them. Point fingers and make fun of them. Laugh at them. Insult/curse them. Gossip about them. Not hired for jobs. Unfriendly treatment in clinics. Not allowed to join community activities.

Ask participants to read out each of the lists of cards.

Then review the list of cards on the wall and ask:

- If you were called these names, how would you feel?
- What are the effects of these names and discriminatory acts on key populations?
- What is the thinking behind these fears? Are these fears justified?
- What can we learn from these labels, behaviours, and fears towards key populations?

Record their responses on the flipchart.

EXAMPLE RESPONSES

How would you feel?

- Sad. Hurt. Angry. Ashamed. Depressed. Unfairly treated. Rejected. Miserable.
- These words are insulting—It would make me feel sad and ashamed. I wish I could die.
- I would hide my sexual orientation/activity from others so I would not be stigmatised.

What would be the effect of stigma on key populations?

- These words make key populations feel despised and rejected by family and community. Stigma destroys their self-esteem—they feel ashamed and as a result they may take less care about their health. They may stop accessing health services and practise unsafe sex.

Are these fears justified?

- A member of a key population could transmit HIV if they do not know they have HIV and are practising unprotected penetrative sex.
- We are often socialised to fear MSM. Fear sometimes results in insecurity.
- You may identify someone who is different, e.g., fellow passenger on a bus. Will you get HIV on a bus? No. It is not an airborne virus. There is no risk involved, so there should be no fear. The problem is ignorance—lack of information on how HIV is transmitted.

What can we learn from the labels and fears?

- The stigma towards MSM is based on two things—their sexual behaviour (having sex with the same sex) and their gender expression (their appearance, body language, and voice).
- Many fears are myths or misconceptions. It shows that people know little about key populations—we often stigmatise people on the basis of things we know little about.

SUMMARISE:

Summarise the main points made by participants. You might include some of the following points:

- The stigma towards MSM is based on two things—their sexual behaviour (having sex with the same sex) and gender expression (their appearance, body language, and voice).
- People make assumptions about sexual orientation based on gender expression. They assume, for example, that if a man behaves in an effeminate way, he must be gay.

- Stigma towards MSM is called ‘**homophobia**’—hatred, disapproval, and violence towards MSM. Homophobia refers to social disapproval, rejection, and exclusion of people based on their actual or perceived homosexuality, homosexual behaviour, and/or variance from local social conventions of sexuality and sexual behaviour (UNDP).
- Many of these fears are expressed as **myths or misconceptions**—e.g., ‘key populations are mentally ill, sex crazy, etc.’ These are **stereotypes**—things we say about other people that we know little about—we believe these things are true, but they are false.
- People have lots of **questions about key populations**—this shows they would like to understand more about key populations.
- Stigma makes key populations **lose their self-esteem**, and it affects how they manage their health.
- As a result, key populations may avoid using health services and may take less care about their sexual health, e.g., not being able to access condoms and not using them regularly and consistently with all sexual partners. This may put them at higher risk of getting HIV and as a result, they may pass HIV to their partners. In this way, stigma towards key populations helps to fuel the general HIV epidemic.
- The change has to start with ourselves. Who rejects and curses and beats MSM and makes them feel humiliated—it is WE! We are change agents and we can stop the hate and the violence towards MSM and make a difference!



B4. Breaking the Sex Ice

Facilitator's Note: Sexuality is a taboo subject—in particular talking about sex that is viewed as ‘immoral’ or ‘abnormal’ and breaking social norms. Our views about what is ‘appropriate’ sex leads to a lack of acceptance of people who do not conform to our own, or society’s, views about what is proper sexual behaviour, and this fuels stigma against MSM and sex workers. Sex, our beliefs about sex, and how they lead to stigma against MSM and sex workers, is a major topic in this chapter, so we need to help participants talk openly about sex. These exercises help to achieve this objective.

One of the barriers is the embarrassment we feel when discussing sex. Through the following activities, we hope to build some comfort and develop a common vocabulary for talking about sex.

Don't use these activities at the start of a training programme. Wait a few days until participants are comfortable with each other and feel free to talk together.

When introducing this topic, remind people that we are not just talking about “socially acceptable” sex, we are talking about all types of sex—sex between men and women, sex between people of the same sex, vaginal sex, anal sex, oral sex, masturbation, etc.

Objectives: By the end of this session, participants will be able to:

- Talk more openly about sex and their feelings about ‘proper’ and ‘improper or immoral’ sex
- Recognise that our beliefs about what is ‘acceptable’ or ‘proper’ sex is one of the root causes of stigma towards key populations

Target Groups: All groups

Source: Understanding and Challenging HIV Stigma: Toolkit for Action (C7)

Time: Depends on the number of activities selected

ACTIVITIES TO TALK ABOUT SEX: In this exercise, we provide 5 **OPTIONAL** activities to get participants talking about sex + a review activity (F). Choose the activities which suit your group:

- **ACTIVITY A: FIRST THOUGHTS ABOUT SEX**
- **ACTIVITY B: SECRET VOTE: ANONYMOUS PARTICIPATORY SEX SURVEY**
- **ACTIVITY C: WHY DO PEOPLE HAVE SEX?**
- **ACTIVITY D: BUILDING A COMMON VOCABULARY FOR SEX**
- **ACTIVITY E: INDIVIDUAL QUESTIONNAIRE**
- **ACTIVITY F: BREAKING THE SEX TABOO (All groups should do this review activity).**

ACTIVITY A: FIRST THOUGHTS ABOUT SEX

Cardstorm: Write the word ‘sex’ on a title card and tape the card on the front wall. Divide into pairs, hand out cards and markers, and ask, “*What are your first thoughts when you hear the word ‘sex’?*” Ask pairs to write down the first things they think about on the cards—and then tape them on the wall around the title card ‘sex.’

Then divide into four groups and ask groups to discuss:

- Why is it difficult to talk about sex?
- What are the social norms around sex?

What are your first thoughts when you hear the word 'sex'?

- Sin. Sweet. Hot. Pleasure. Fun. Oo la la! Yes, please. Yum yum! Bring it on. Passion. Hot. Kissing. Love. Intimacy. Orgasm. Climax. Explosion. Coming. Calm and storm.

Why is it difficult to talk about sex?

- Sex is a secret, a taboo subject. We are shy to talk about sex because we normally don't talk about it in public—religious norms don't allow people to talk about sex in public.
- Christianity affected attitudes to sex—it emphasised sex as reproduction in the hope of preventing young girls from getting pregnant.
- We learn about sex as a taboo subject from our parents. These messages become internalised and shape how we think about sex (e.g., shame, embarrassment).

Social norms around sex

- Sex is only acceptable between a man and a woman—sex between two men is 'wrong.'
- The man decides when and how to have sex. The woman doesn't have a choice; she must have sex. If she says no, this might lead to violence. The woman does not initiate sex.

ACTIVITY B: ANONYMOUS PARTICIPATORY SEX SURVEY

- At least two facilitators are needed to run this exercise: one facilitator at the front of the room to read the questions, the other facilitator at the back of the room to collect the answer slips and quickly record the results on a flipchart.
- Explain that the survey is anonymous—“*No one will know how you respond.*”
- Hand out 12 slips of paper to each participant.
- Read out each question below and tell participants to record one answer per slip of paper, then fold it up. Collect the slips after each question and record the results on a flipchart. Do not present these results until all the questions have been done.
- After people have answered all 12 questions, present and discuss the results. Then ask:
- How did you feel answering the questions?
- What did you learn from the exercise?”

EXAMPLE QUESTIONS AND RESULTS

No.	Example Questions and Example Results	Yes	No	Total
1	Can you talk openly about sex to close friends?	16	8	24
2	Do you enjoy sex?	20	4	24
3	Have you ever masturbated?	22	2	24
4	Have you ever participated in vaginal sex?	22	2	24
5	Have you ever participated in oral sex?	14	10	24

6	Have you ever participated in anal sex?	4	20	24
7	Have you ever had a sexually transmitted infection (STI)?	12	12	24
8	Have you ever taken a HIV test?	12	12	24
9	Did you use a condom the last time you had sex?	18	6	24
10	Have you ever paid for sex?	8	16	24
11	Have you ever been paid for sex?	3	21	24
12	Have you ever been attracted to someone of the same sex?	5	19	24

What did you learn from the exercise?

- The survey helped us reveal our own sexual experience without embarrassment
- It was easier because it was anonymous. People were laughing—so it loosened people up.
- It forced us to reveal what we don't want to talk about in public.
- We were able to bring out our own sexual experience without feeling embarrassed.
- We often feel uncomfortable talking about sex, so this may block our communication with groups such as MSM and sex workers.

ACTIVITY C: WHY DO PEOPLE HAVE SEX?

Put up three or four flipcharts on the wall:

- Why do MEN have sex with WOMEN?
- Why do WOMEN have sex with MEN?
- Why do MSM have sex?
- Why do SEX WORKERS have sex?

Ask participants to decide which flipchart to write on. They should only write on the flipchart where they have personal knowledge. It's ok if some flipcharts have no participants.

Once the groups have finished, ask one person from each group to read the points.

Then compare and discuss the three flipchart products:

- What are the similarities and differences between the lists?
- What did we learn from this exercise?

EXAMPLE RESPONSES

Why MEN have sex with WOMEN

Fun/pleasure. Have orgasm. Human nature. Have children. Prove he is a man. Love. Exercise. Make partner happy. Explore woman's body. Relieve stress. Relieve boredom.

Why WOMEN have sex with MEN

Pleasure. Have orgasm. Human nature. Have children. Love. Find and keep partner. Relieve stress. Keep relationship. For sake of family. Give comfort to partner. Make money. Forced to have sex.

Why MSM have sex

- Love. Fun/pleasure. Have orgasm. Human nature. Love. Find and keep partner. Give comfort to partner. Relieve stress. Make money. Forced to have sex.
- Similarities: Fun/pleasure. Have orgasm. Human nature. Love. Relieve stress.
- Differences: MSM and women—Give comfort to partner. Find/keep partner. Forced to have sex.

What did we learn from this exercise?

- There are differences, but there are many common reasons for having sex.
- Sexual minorities have many of the same reasons for having sex as heterosexuals.
- Women often have sex to get something (e.g., money, partner), men to show their power.
- Poverty and economic hardship may force some of us to sell sex to make money.
- In some cultures, we pretend that the main reason for having sex is to have children, but in fact many people have sex to have pleasure and to give pleasure to others.

ACTIVITY D: BUILDING A COMMON VOCABULARY FOR SEX

Cardstorm: Divide into pairs and hand out cards and markers. Ask pairs to write **words related to sex and sexual body parts**. They should write as many words as they can—one word per card. Tape the cards on the wall—and eliminate repetition. (Avoid repeating words which are already on the wall.)

EXAMPLE RESPONSES

Sex. Love. Romance. Feelings. Desire. Lust. Pleasure. Passion. Sin. Hot. Sweet. Kissing. Caressing. Hugging. Penetration. Dogstyle. Ejaculation. Orgasm. Semen. Masturbation. Oral sex. Anal sex. Foreplay. Penis. Vagina. Clitoris. Breasts. Thighs. STI. Condoms. Stress. Pain. Pregnancy. Sexual harassment. Rape.

Then ask each participant to select one word on the wall and talk about—“*What thoughts, feelings, or associations do you have about this word?*”

Examples:

Sex—dirty, sin, enjoyable, excitement, passion, having children, tiring, intimacy

Lust—strong desire, not thinking—just responding to one’s attraction to another person

Masturbation—perceived as dirty, hidden, or secret, not talked about, anti-social

Orgasm—feeling so good, sweet, intense pleasure, my whole body is on fire

Then ask:

- How did it feel to use these words?
- Which words are easy to say? Which words are hard to say? Why?

- Why do we have different responses to some words?
- What are the cultural and sexual attitudes behind these words

Optional Activity—Rotational Brainstorm: Put up six flipchart sheets on the walls, each with a key word – MALE SEXUAL ORGANS, FEMALE SEXUAL ORGANS, VAGINAL FLUIDS, SEMEN, ORGASM, MASTURBATION. Divide into six groups and assign each group one of the flipcharts. Hand out markers and ask each group to write on the flipchart all the words they can think of which are related to the key word. The words should be different words to describe the topic and will include formal words and slang terms. After two minutes, shout “CHANGE” and ask groups to rotate in a clockwise direction and add points to the next flipchart sheet. Continue until groups have contributed to all flipcharts and end up back at their original list.

Give all participants stickers—two colors. Ask them to place a blue sticker on words that they feel comfortable using and a red sticker on words they feel uncomfortable using.

Then discuss:

- How did it feel to use these words?
- Why are some words labeled as ‘bad words’ and other words as ‘good words’?
- Why do we have different responses to some words?
- What are the cultural and sexual attitudes behind these words?
- Which words are you unfamiliar with?
- What did you learn from this exercise? How could it be applied in your work?

Many of the words we use to talk about sex are nicknames for different activities or body parts. This comes from a lack of comfort in talking about sex.

ACTIVITY E: INDIVIDUAL QUESTIONNAIRE

Steps:

Print this questionnaire with spaces after each question for individual answers.

This questionnaire is for your eyes only – you will not need to show it to anyone. Take a few minutes for each question and answer the questions as honestly as possible.

1. Think back to when you were growing up. How did you find out about sex? Where did you get your information from? Who did you talk to?
2. Is there anyone you can talk to now about sex in an open way? If the answer is yes, think about what makes it comfortable to talk to that person?
3. Which phrases best describe your own views and experience about sex and sexuality?
 - I think I am well informed about most things to do with sex
 - There are some areas I would like to know more about
 - My own sexual experience is quite wide
 - I feel confident talking openly about sex
 - I have a very open mind and avoid judging people on issues about sex
 - I hold strong views about certain issues related to sex
 - There are some subjects I would find difficult to discuss
 - I know quite a lot but I am open to learning more

4. How do your religious and cultural beliefs affect your views about sex and sexuality?
5. How does your family background affect how you think/feel/talk about sex?
6. How does your gender affect how you can think/feel/talk to others about sex?
7. Which of the following issues would you find it difficult to discuss if you are asked a question about it in your work as a service provider?

HIV and AIDS	Homosexuality	Vaginal sex
STIs	Bisexuality	Oral sex
Orgasm	Transgender	Anal sex
Abortion	Intersex	Masturbation
Pregnancy	Circumcision	Commercial sex

After everyone has filled out the questionnaire, go through each question one by one and ask volunteers to share their responses with the group. Utilise the questionnaire as a launching pad into a discussion about sex.

Ask participants: *What does this conversation teach us about our comfort levels with talking about sex? What makes us uncomfortable? Why?*

Activity F: Breaking the Sex Taboo

Note: This activity should be done as a follow-up to one or more of the previous exercises.

Discuss as a large group:

- What is the link between sex and stigma?
- Why is it difficult to talk about sex?
- Why is it important to talk about sex?

What is the link between sex and stigma?

- We judge/stigmatise others on the basis of the type of sex we assume they are having.
- People who do not follow the sexual norms will be stigmatised.
- MSM and sex workers are stigmatised for having 'immoral sex' (e.g., sex with the same sex, oral sex, anal sex, commercial sex)—for breaking the moral code.

Why is it difficult to talk about sex?

- We never talk about sex publicly—unless we are making a joke about it.
- Parents (or teachers) find it hard to talk about sex with their children (or students).
- Service providers are not trained in sexuality and find it difficult to talk about sex with clients.
- Sexual partners (including married couples) often don't talk about sex.
- Partners who have not disclosed to each other may find it difficult to talk about safe sex.
- Sex is something positive, not negative, yet we use it to stigmatise others.
- We judge others on the basis of how much sex we assume they are having.

- We stigmatise PLHIV or key populations—we assume they are doing immoral sex.
- Religion plays a big barrier. Churches often say that sex = sin.
- Why is it important to be able to talk about sex?
- HIV (and STIs) can be transmitted sexually, so if we are to control this epidemic, we have to become better at talking about sex and learn to talk about sex in a non-judgemental way.
- It's common for people to be uncomfortable with something they are not familiar with. The more we talk about these issues, the more comfortable we will become and the more accurate information we will have.

SUMMARISE:

- Talking about sex or certain types of sex is a taboo. We have been socialised not to talk about sex, especially in our families, between generations, or even between married couples. Parents find it hard to talk about sex with their children, teachers with their students, and health workers with their clients. Sexual partners often don't talk about sex.
- We learn about sex at an early age from parents, siblings, friends, etc. Often we don't question these messages because they come from parents or we are too young to fully understand them. These messages become internalised and shape how we think about sex (e.g., embarrassment).
- It is important to challenge and change these messages. Sex is not something dirty or secret—it is something beautiful. We need to get over this idea that sex is taboo and not to be discussed if we are going to learn more about sexuality.
- HIV can be transmitted sexually, so if we are to control this epidemic, we have to become better at talking about sex and learn to talk about sex in a non-judgemental way.
- The more we talk about sex, the more comfortable we will become in talking about it, educating our clients about it, and providing appropriate sexual and reproductive health services.
- Our views about the sexual practices of key populations is a major factor in stigma. We judge or stigmatise key populations for having 'immoral' or 'abnormal' sex (male-to-male sex, oral sex, anal sex, sex for money). However, we have seen that they have the same reasons for having sex as heterosexuals—to have pleasure, express love, and to give others pleasure. Any sexual activity which aims at obtaining happiness and expressing love on the basis of mutual consent and causes no harm to one's health, economic condition, and dignity, should be respected, be it heterosexual, homosexual, or bisexual.

B5. Body Mapping for Understanding LGBTI

Facilitator's Note: This exercise and **Exercise D2** can be combined. Develop the body map, label the body parts and sexual activities, and then put up three categories (High Risk, Low Risk, and No Risk) and ask participants to put the sexual activity cards under the right category—then discuss and explain why each activity is high, low, or no risk.

This exercise uses a technique called 'Body Mapping.' Participants work in separate gender groups—the men making a map of a man's body and the women making a map of a woman's body. One person lies down on top of flipchart sheets taped together and another participant draws around him/her. The resulting life-size picture of a man's body and a woman's body becomes a focus for discussion on sexual body parts and sexual activities. Later, it can be used to talk about HIV transmission (**D2**). All of this extra information is recorded on cards and added to the body map.

Body mapping is a good activity to get people talking about sex because it shifts control away from the facilitators to the participants, who take the lead in making the body map and adding the body parts and sexual activities. Participants have fun and at the same time have a serious discussion about sex and sexuality issues triggered by the drawings.

Body mapping is done in separate gender groupings, which allows women and men to talk freely. The drawings provide a non-threatening way to start an open discussion about sensitive topics. The discussion helps reveal what people know about their bodies and different sexual activities.

Things to Guard Against:

During this exercise, let participants take control. Give them the markers and let them do the recording on the body map. They will show and explain how they view sexual body parts and sexual activities. If you try to control this activity too much, you will stop them from giving their own views. If one person is dominating, stop and ask him/her to hand the marker over to other participants.

At the start, participants may be shy about naming sexual body parts. However, it is important that participants name the body parts themselves, not the facilitator. This might take a lot of prompting and encouragement by you, even to the point of putting your finger on the relevant parts and asking, “*What do we have here?*” Once participants have gotten over any embarrassment about naming sexual body parts, the process usually goes smoothly.

Objectives: By the end of the exercise, participants will be able to:

- Identify sexual body parts and name sexual activities
- Describe their feelings in relation to sexual body parts and sexual activities
- Talk about sex and sexuality issues comfortably

Target Groups: All groups

Source: BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer’s Guide (B4)

Time: 1 hour

Preparation: Tape six flipchart sheets together to make a large sheet of paper.

Steps:

DRAWING THE BODY:

Put the large sheet on the floor and ask one volunteer to lie down on the sheet. Ask another participant to draw an outline of his/her body, using a marker.

BODY PARTS:

Ask participants to mark parts of the body. Use local names for each part.

Men’s Body Map: Head. Hair. Eyes. Ears. Nose. Mouth. Neck. Shoulders. Chest. Breasts. Arms. Hands. Fingers. Stomach. Penis. Testicles. Anus. Legs. Thighs. Knees. Foot.

Women’s Body Map: Head. Hair. Eyes. Ears. Nose. Mouth. Neck. Shoulder. Arms. Breasts. Tummy. Hip. Thigh. Vagina. Clitoris. Anus.

SEXUAL BODY PARTS:

Ask participants to label sexual body parts. Push them to use local words for each body part

Men: Penis (dick, cock, shaft, joystick, coco, rod of Moses, rod of correct, bamboo, wood). Testicles (balls, boom boom). Anus (pit toilet, shit street, backpussy). Mouth. Breasts.

Women: Vagina (coco, twat, mush mush, hairy, bank, nunooks, saltfish, tun tun, cat, seekey). Clitoris (cacayot). Labia. Vulva (coco). Womb (soosoon). Uterus. Ovaries. Anus. Breasts.

SEXUAL ACTIVITIES:

Ask participants to write on cards different sexual activities (including local names) and tape these on the body map.

Examples: Vaginal sex. Oral sex (blow job, going down on someone, cunnilingus). Anal sex (going to pit toilet). Mutual masturbation. Masturbation. Massage. Hugging. Fingering or fisting. Licking anus (rimming). Licking testicles. Kissing (including deep kissing). Sex between the breasts. Sex between the thighs.

Check that everyone is familiar with each of these types of sexual activities.

DIFFERENCES—TRANSGENDER AND INTERSEX PEOPLE: Ask:

- “Do all male bodies look like this? How might the male body look different for some people?” Then do the same for the female body.
- “What about transgender people?”

Intersex people: Have sexual body parts that do not fit typical descriptions of female or male. Example: a) they may appear to be female on the outside but have male typical anatomy on the inside or b) they may have genitals that seem to be ‘in between.’

Transgender person: When a person feels that their personality, their inner self is different from their biological sex, we say that the person is ‘transgender.’

- Does it matter what is underneath someone’s clothes? Why? Do we treat people different based on what their genitalia look like? If their genitals don’t match their gender expression?

SUMMARISE:

- Our bodies are different. We are all unique, and there is more to what makes up a man or a woman than just a penis or a vagina.
- What someone’s genitals look like or how they match with one’s gender expression does not affect one’s character.
- We all should be treated with dignity and respect, regardless of what our bodies look like.

B6. Tradition, Morality, and Religion

Facilitator’s Note: This exercise looks at one of the root causes of stigma towards key populations—the views of traditional morality and religion. It uses a technique called ‘Dramatic Monologue’ in which actors read out statements in a dramatic way. Select participants beforehand and ask them to prepare (e.g., during the coffee break).

Objectives: By the end of this session, participants will be able to:

- Describe some of the social attitudes which underpin homophobia
- Find ways to challenge the cultural and religious views which underpin homophobia

Target Groups: All groups

Source: BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer's Guide (A10)

Time: 1 hour

Materials: Copies of the Dramatic Monologues

Preparation: Select actors to read out the different statements—and prepare themselves.

Steps:

Dramatic Monologues:

Explain that this session will focus on culture, morality, and religion. Then set the scene for the dramatic monologue. Ask each actor to stand at the front and read his/her statement in a dramatic way.

Then divide into groups and hand out copies of the dramatic monologues. Ask groups to discuss—“*Do you agree or disagree with the statements presented?*”

DRAMATIC MONOLOGUES

Community Leader:

I am concerned about this new practice of men sleeping with men and women sleeping with women. This practice is a foreign culture and bodes ill for our future as a nation.

According to tradition, men are expected to have sex with women and produce children. There is nothing in our tradition which talks about men having sex with men. It is a sacrilege. If this happens, it is a waste of manhood.

This new practice comes with the white men's influence. It is taboo. It is a bad influence which will destroy our culture.

If we allow men to have relationships with men, and women with women, what will happen to the next generation? There will be no procreation, so our society will eventually collapse.

Church Minister:

I am a minister, an interpreter of God's teachings, and a defender of the faith. In my pastoral role I must ensure that evil does not enter the house of God. This new thing which is called homosexuality' is an abomination—a blot against the teachings of God. God has warned us against these sinners in the Bible—he called it 'Sodom and Gomorrah.'

Homosexual practices are unnatural. God created man and woman—Adam and Eve, not Adam and Steve. Man was created to have sex with women and for one purpose—for procreation. Sex between two men or between two women is wrong—this is a curse against God.

Why do you think God put our sexual body parts in a hidden place? His aim was to ensure the dignity and sacredness of sex—and this means he only sanctioned sex between a man and a woman with the purpose of creating children.

Female Elder:

I am an older woman who has grown up in the traditions of the community. I am married and have five children, so I am also concerned about what is happening to our community through this new thing where

men have sex with men and women have sex with women. I have never heard of this before and think it will be the undoing of our culture.

What will happen if the man does not play his role as the husband and household head? Who will become the household head? Who will represent the family at funerals?

I am concerned about the erosion of our roles and responsibilities as men and women. In the past we all knew our roles—what men had to do, what women had to do—so, for example, when a funeral occurred, everyone knew what his role was—and he went and did it.

This new thing called homosexuality will confuse things. People will no longer know their roles. Now anyone can do anything—sleep with someone of the same sex. Next thing we'll be saying it is okay to sleep with a dog!

We have been too lax, allowing everyone to choose who they want to be with. In the past, there was no choice—the roles were clearly defined, a man was a man, and a woman was a woman, and everyone knew what they had to do—there was no choice involved.

If a man is not married, he will be regarded as a boy—so who will lead the family?

If a woman refuses to get married and has sex with another woman, then who will bring children into the family?

These men and woman are a threat to our society.

Male Elder:

I am one of the elders in our village. This new foreign influence called 'homosexuality' is dangerous and should be rooted out.

The problem started with the way we have been running our families. There are now many families where there is no male head. Women run the family and they don't teach the boys how to be boys. As a result, the boys grow up as sissies—mummy's boys, always sheltering under their mother's skirts. Without a male influence in their lives, they grow up as women—and they are confused. It's no wonder they end up having relations with other men.

This thing is happening because most boys grow up not knowing their fathers—this is why they end up having sex with men.

Examples of Group Analysis

Community Leader

- Assumes there is no procreation if there are only homosexuals
- Uses his position as community leader to oppress others

Church Minister

- Uses his position as Minister to push his interpretation of the Bible
- Very judgemental—says that the only proper sex is sex between a man and a woman

Female Elder

- She is living in the past—not willing to accept change—fear of change
- She says that if you allow homosexuality, you will kill tradition/culture

Male Elder

- Believes that single parenthood has encouraged homosexuality
- Promotes male perspective—society treats men better than women

Summarise:

- When we talk about homosexuality, we often turn to the Bible or culture to condemn MSM. We say that homosexuality is against religion and tradition.
- This view is rooted in views about sex; that the only proper sex is between a man and a woman for the purpose of having children. Sex between two men is viewed as wrong because it does not produce children and it breaks social and religious norms. Anal sex is condemned as ‘immoral,’ as outside the traditional and religious norms.
- Religions have varying views and interpretations of homosexuality. Islam and some Christian churches consider homosexuality a sin, other religions consider it a weakness which can be cured, and some feel it is an acceptable and normal sexual orientation.
- In all religions, there is a difference between the texts and daily practice. Some people read the holy books literally, and use these texts to condemn MSM. Others use the texts as a source of inspiration, but in daily life they accept MSM as human beings.
- Others emphasise that religious teachings mention compassion and tolerance of other people. For example, Jesus advocates that we should be non-judgemental—‘Let he who is without sin cast the first stone’ or ‘Love thy neighbour as thyself.’ Jesus also says that all of us are made in the image of God, so there should be no discrimination—we should respect everyone, whatever their views. Jesus also taught us that the church (the house of God) should be a place for the outcasts of society.
- Many people believe that homosexuality is not indigenous to the Caribbean, that it is only a form of western contamination. Some even believe that MSM only exist in Europe and America. But historical research has shown that homosexuality existed in Africa and the Caribbean long before Europeans came to Africa. In many African countries, for example, there are vernacular names used to describe people who are gay. Research has shown that 5–10% of people in every community in the world—including the Caribbean—are attracted in different ways to the same sex. In the Caribbean, there are lesbian, gay, bisexual, transgender, and intersex people living in every community, although because of stigma and discrimination, the majority are in hiding.

B7. Beliefs about PLHIV and Key Populations (Value Clarification)

Facilitator’s Note: This exercise explores the beliefs and attitudes which result in stigmatising judgements towards people living with HIV and key populations. Often we are not aware that we are judging. These exercises help participants think about the judgements they make and why they make them, and the impact they have on people living with HIV and key populations.

This is a value clarification exercise—participants review a number of statements about people living with HIV and key populations and decide if they agree or disagree.

Value clarification exercises can be organised in different ways. A quick method—the one described in this exercise – is to use topic groups. Each group is given three to four value statements and asked to discuss if they agree or disagree, and why. Then groups report and others comment.

A more time-consuming method is to put up the statements one at a time and get participants to respond to each statement by ‘voting with their feet’—each person walks to a point in a continuum drawn down the centre of the room—‘Agree’ on one end, ‘Disagree’ on the other, ‘Unsure’ in the middle. Then the group can discuss their views—e.g., one participant standing under ‘Agree’ can give his/her views, and one participant standing under ‘Disagree’ can give his/her views.

This exercise generates lots of discussion and needs a good facilitator to allow everyone a chance to give his/her opinion while achieving a meaningful result. As the facilitator you should:

- Remain neutral throughout the exercise. You may, however, provide factual information to clarify matters, as needed.
- If a participant expresses extreme views which reinforce stigma, allow other participants to challenge these statements, or if no one responds, do it yourself.
- Emphasise that there are no ‘right’ or ‘wrong’ answers. The aim of the exercise is not to ‘win’ or ‘lose’ but to explore different views where they exist.

Objectives: By the end of this session, participants will have explored their attitudes and values about PLHIV and key populations.

Target Groups: All groups

Source: Draft Toolkit on Stigma Reduction in Health Care Settings

Time: 1 hour

Materials: Statements written on cards. Examples are given at the end of this exercise. Select those statements which are suited to your context or participants.

Steps:

Divide Into Groups:

Give each group 3–4 statement cards and ask them to discuss—“*Do you agree or disagree, and why?*” Explain to the groups that there are no “right” or “wrong” answers. We all respond to the statements based on our beliefs and values, and the purpose of this activity is to explore these differences where they exist.

Report Back:

Then ask each group to report and ask other participants to comment.

Processing:

Ask:

- Which statements were the most controversial and why?
- How do our attitudes towards people living with HIV and key populations affect the way we behave towards these people?
- How can we keep our own values from influencing our behaviour towards PLHIV and key populations in a negative way?

Summarise:

Summarise the main points which participants have made during the exercise. In giving your summary, you may use some of the following points:

- Some of the statements are **stereotypes**, negative things we say and believe about PLHIV and key populations. Often we believe these misconceptions are facts, when in fact they are false. The belief or assumption leads to stigma and discrimination towards PLHIV and key populations. Being a minority, key populations are particularly vulnerable to being stereotyped.
- We are **socialised to judge** other people based on assumptions about their behaviour. PLHIV, MSM, and sex workers are regarded as breaking social norms—so some people think that they deserve to be condemned and punished.
- The truth is that key populations:
 - a) Are found in all nationalities, races, classes, and professions
 - b) Can lead normal and settled lives like everyone else when permitted to do so
 - c) Experience the same feelings and emotions as heterosexuals
 - d) Are equally capable of deep, long-term, loving relationships
 - e) Have to survive in a very hostile environment due to stigma and discrimination
 - f) Are denied basic human rights and are powerless to demand fair treatment.
- The concept of human rights requires that we try to **understand and respect** other people as human beings. MSM, sex workers, and other key populations are as fully human as anyone else and are entitled to be treated in the same way.
- We have no right to judge others. We should **treat every person as a human being** and empathise with all people as though they are our sons or daughters. To stigmatise is to wipe out a person's humanity and treat them as having no value. Try to put yourself in the other person's shoes—how would you feel if you were 'blamed and shamed'? Even if we don't like a person, we need to understand and respect him/her.
- We are not saying that the moral values are wrong, we are saying that the 'judging' is wrong. We have no right to judge others—and the judging ends up hurting people.
- We need to be aware that our opinions and actions have negative effects on other people. Some of these opinions are very judgemental towards PLHIV and key populations. As a result, they may feel hurt, humiliated, and depressed, and this in turn can affect their access to health services and how they protect their sexual health.

STATEMENTS FOR VALUE CLARIFICATION EXERCISE

Select the statements suited to your context and training group.

Statements on People Living with HIV

- People who get HIV through sex deserve it because of their bad behaviour.
- People living with HIV should be forced into a health care system and registered so their health can be closely monitored by health workers.
- All health workers have a right to know which of their clients are HIV positive.
- Health workers have a duty to inform the spouse and family of a PLHIV about the person's positive HIV status.
- Women living with HIV should not be allowed to have babies.

Statements on Men who have Sex with Men

- MSM deserve to get HIV because of their immoral behaviour.
- MSM are mentally sick, so they should be given treatment and cured.
- MSM cause harm to society and to families, so they should all be locked up in prison.
- Men don't decide they want to love men. It just happens to them.
- Preventing an HIV epidemic is more important than condemning MSM.
- If you hang around with MSM as friends, you will easily become MSM.
- MSM are all the same. You can identify them by the way they dress and behave.
- Young people become MSM because parents did not educate them properly.
- Men who have sex with men are the result of child abuse.

Statements on Sex Workers

- Sex workers deserve to get HIV because of their immoral behaviour.
- Sex workers love money and are lazy to work. They could easily get other jobs.
- Sex workers are like other people—they have long-term, loving relationships with their regular partners.
- Sex workers have a right to say 'No' to sex. No one can force them to have sex, even a client who has already paid.
- Sex workers are sex maniacs—they love to have sex with anyone.

Statements on People Who Use Drugs

- People who use drugs deserve to get HIV because of their immoral behaviour.
- Drug addiction should be considered a disease, not a crime.
- People who use drugs cause harm to society, so they should all be locked up.
- People who use drugs should be registered so that their use of drugs can be closely monitored by health workers.
- People living with HIV who use drugs are unreliable and won't adhere to ARVs, so don't give them ARVs.

Mixed Statements

- I believe that having sex without love is wrong.
- I believe that sex between two men is wrong.
- I believe that girls should not have sex before getting married.
- I believe that young people are all promiscuous.
- I believe that sex workers can continue to work and be married.
- I believe that PWID do not deserve health services.
- I believe that 16-year-old youth who are sexually active and unmarried should have access to condoms and other contraceptives.

CHAPTER C: UNDERSTANDING KEY POPULATIONS AND STIGMA

Groups who are more vulnerable to HIV infection are often called *key populations*, and in the Caribbean, they include men who have sex with men (MSM), transgender people, sex workers, PWID, and migrants.

For key populations, HIV stigma adds a second layer of stigma. The existing negative attitudes that people have towards them are compounded by their association with HIV and AIDS. On top of this, countries have laws that criminalise their behaviour (e.g., sodomy laws and anti-sex work laws) and make it difficult for them to exercise their human rights, including accessing health services. Because of this, key populations face overt discrimination.

This chapter also refers to LGBTI—an inclusive acronym used to talk about the entire Lesbian, Gay, Bisexual, Transgender, and Intersex population. Transgender and intersex people are often included in this grouping because they face similar struggles in being harassed or discriminated against due to their gender expression and not conforming to traditional gender roles. However, transgender and intersex people may be gay, straight, or bisexual.



Objectives

This chapter has three objectives:

- To provide participants with more information on key populations
- To identify how key populations may be stigmatised in different contexts, and the impact of this stigma on their access to health and other services

- To develop strategies to break the stigma and improve interaction with key populations

Participants may lack information about key populations—for example, how they live, why they have sex with men, why they sell sex, etc. Some people may not even understand the link between the behaviours of key populations and their vulnerability to HIV.

This lack of information can result in people creating barriers to services, such as:

- Fear of working with certain groups
- Judging and blaming attitudes
- Belief in myths and misconceptions about certain groups or practices
- Lack of friendly, informed, and caring services and the existence of discriminatory practices

This chapter will help teach some of the basics so that participants have the right information and understanding needed to overcome fears and myths about key populations.

Exercises

- C1. Understanding Key Populations—Individual Quiz and Panel Discussion
- C2. Our Multiple Social Identities—The Power Flower
- C3. What Is Sex? What Is Gender?
- C4. Understanding the Identities of LGBTI
- C5. Stigma towards Sex Workers

Annex: What Do You Know about Key Populations? (True/False Questionnaire)

C1. Understanding Key Populations—Individual Quiz and Panel Discussion

Facilitator’s Notes: This exercise consists of two activities—1) a quiz about key populations; and 2) personal stories and information provided by resource persons from key population groups.

Participants complete the quiz individually as a form of homework. The next day, they listen to resource persons drawn from different key populations who:

- Help to answer some of the questions on the quiz and other questions asked by participants
- Talk about their experience of being stigmatised

The quiz, which is given at the end of this chapter, consists of 15 questions on each of the different key populations—MSM, sex workers, and PWID. It helps participants assess what they know about each key population, clarify things they don’t know, and trigger other questions. Select the quiz suited to your context or target group. You might, for example, ask the group—“*Which key populations would you like to know more about?*” Then hand out the quiz for those key populations.

The next day, organise a panel discussion with the resource persons from key populations as the guest speakers. The resource persons help to answer any questions sparked by the quiz and other questions asked by participants. The resource persons also talk about their own experience of using health and other services and how they were treated. Your job as facilitator is to guide this panel discussion, asking questions and ensuring that everyone on the panel gets a chance to talk.

The personal stories have a powerful impact—often the first time that participants have listened to key populations talk about their lives and their experiences of being stigmatised.

"The panel discussion was the high point of the whole workshop. Panelists from the MSM and sex worker communities shared a lot of personal stories—some very emotional. Participants listened with rapt attention for two hours without getting bored. This really made us change our attitudes. It helped us see we should stop judging other people and to respect everyone, regardless of their sexual orientation or sexual practices." (Participant)

You will need to provide accurate information to respond to all of the questions, so make sure that the resource persons are well prepared. Give them copies of the quiz and the answer key beforehand, along with questions raised by participants. You can also hand out the answer key to participants at the end of the session.

Objectives: By the end of this session, participants will be able to:

- Explain some of the basic facts and issues affecting key populations
- Describe how stigma and discrimination affects key populations

Source: Draft Toolkit for Stigma Reduction in Health Work Settings

Time: Part A (Quiz)—Homework. Part B (panel discussion)—2 hours

Handout: C-FS1: TRUE/FALSE QUESTIONS RE: KEY POPULATIONS

Preparation: Ask key population support groups to provide people who are willing to talk about their lives. You may need to provide financial support for travel and other costs.

Given the high level of homophobia in the Caribbean, very few MSM activists are open about their sexual orientation within their own communities, so you may need to invite resource persons from neighbouring islands—and ensure that they are in safe, secure surroundings..

Ask the resource persons to respond to participants' questions and give examples drawn from their own lives—what happened and how it made them feel.

Steps:

Quiz:

Hand out the quiz (adapted to suit your context and group) given at the end of this chapter and ask participants to complete it, writing 'True' or 'False' beside each statement. You can hand out the quiz at the end of the day as a form of homework.

Setting the Agenda:

At the start of the following day ask participants:

- Which of the questions on the quiz would you like to know more about?
- What other questions would you like to ask the resource persons?

Write down the questions (see examples at the end of this exercise). You might rephrase any questions that could be offensive or judgemental. Use this set of questions to guide the panel discussion.

Panel Discussion:

Ask resource persons to respond to each question. At the end of the session, hand out the Answer Sheet to the True/False Questions.

Summarise:

- Some people know little about key populations, so with little understanding and knowledge, they judge key populations unfairly or isolate/reject them out of fear of the unknown.
- When we know little about others, we often make assumptions or accept stereotypes about them. We attribute characteristics to a group and everyone belonging to that group. We assume that all members of the group have the same characteristics, e.g., that all MSM want to destroy family structures, all sex workers are sex crazy, etc.
- These assumptions are stereotypes—things we say about other people that we know little about. Often we believe these assumptions are facts, when in fact, they are false. This belief leads to prejudice, which can result in stigma and discrimination.
- Each of these groups is unique and includes people with diverse knowledge, attitudes, and practices. We often think we know more about these groups than we actually do or generalise when we should not. We still have a lot to learn!
- By learning more about key populations, we will begin to overcome some of our doubts or prejudice about key populations and be less fearful or condemning towards them.
- We need to understand and respect key populations as human beings. MSM, transgender people, sex workers, PWID, migrants, and prisoners are as fully human as anyone else and entitled to be treated in the same way.

EXAMPLES OF QUESTIONS FROM OTHER WORKSHOPS

Questions to MSM

- How did you become gay? When did you first know you were gay?
- How do you feel being gay? Why do you like having sex with a person from the same sex?
- What word do you use to describe yourself—gay? Homosexual? MSM?
- Does a gay man have the feelings of a woman?
- How do MSM have sex? Who is on top? Is anal sex comfortable?
- How do you identify other gay men—can you tell by looking?
- Do your family and friends know you are MSM? How did they react when they found out?
- How easy is it to tell others you are gay? How do you feel society looks at you being gay?
- How does the community treat you if they know you are gay?
- If you openly identify yourself as MSM at a health facility, what response do you get?
- Do gay men want to have children?

Questions to sex workers

- How and why did you become a sex worker?
- How do you get your clients as a sex worker?
- How do sex workers negotiate rates for sex work?
- Why don't sex workers quit sex work and get a job?
- Do you think that what you do is wrong?
- Does your work affect how you enjoy sex?
- If you fall sick as a sex worker, where do you usually go for help—and why?
- How would a health worker identify you as a sex worker?
- If you openly identify yourself as a sex worker at a health facility, what response do you get?
- If you don't use condoms with a client, what are your options?



- How can you protect yourself from violence?
- What do you tell your family about your work?

C2. Our Multiple Social Identities—The Power Flower

Facilitator's Notes: This exercise helps participants recognise that we all have many identities, e.g., nationality, race, ethnicity, gender, etc.—and often these identities are used as a focus for stigma.

Objectives: By the end of this session, participants will be able to:

- Recognise that humans have many social identities
- See that stigma and discrimination are part of a process of imposing dominant identities

Target Groups: All groups

Sources:

- BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer's Guide (A15)
- Educating for a Change (Arnold, Burke, James, Martin, and Thomas, 1991)

Time: 1 hour

Handout: C-FS4: OUR MULTIPLE SOCIAL IDENTITIES

Preparation:

- Draw the Power Flower on a flipchart sheet and tape it on the wall
- Hand out copies of the Power Flower

Steps:

POWER FLOWER (Introduction):

Ask—“*What are some of our different social identities as human beings?*” As participants respond, record the identities on the inner circle of the flower and ask participants to do this too. (See the picture for an example).

Nationality. Male/female. Age. Race. Class. Ethnicity. Marital status. Religion. Occupation. Employed or unemployed. Education. Language. Birth position. Socioeconomic status. Income (rich or poor). Ability/disability. Physical features. Having children (or not). Political affiliation. Health status. HIV status. Sexual orientation. Sexual experience. Rural/urban.

WHAT IS OUR OWN SOCIAL IDENTITY? (Individual Work):

Ask each person to record his/her identities in relation to each factor in the flower. This is an individual task—no one is forced to share this product.

WHO DO WE STIGMATISE? (Cardstorm):

Then divide into pairs, hand out markers, and ask—“*Who do we stigmatise?*” Ask participants to write single points on cards and tape them on the wall. Then ask a few pairs to eliminate any repetition.

EXAMPLE RESPONSES

PLHIV. MSM. Sex workers. PWID. Migrants. Prisoners. Indigenous people. Street children. Homeless people. Poor people. Illiterate people. People of different colour. People with disabilities. Young people. Old people. Pregnant teenagers. Women who have children from different fathers. Women without children. HIV+ pregnant women.

PROCESSING:

- Why do we stigmatise these groups?
- What is the effect of a person having more than one stigmatised identity?

Why do we stigmatise?

- Tradition/culture/religion—we have been socialised to stigmatise
- Fear of people we know little about—we stigmatise those with different identities than ours
- We like to judge others—we reject anything that seems different or not normal
- Control/power—stigma allows us to stay in power over others
- Superiority complex—we like to feel we are superior
- Judging others for immorality—people who break the social norms

What is the effect of a person having more than one stigmatised identity, e.g., MSM who is HIV positive?

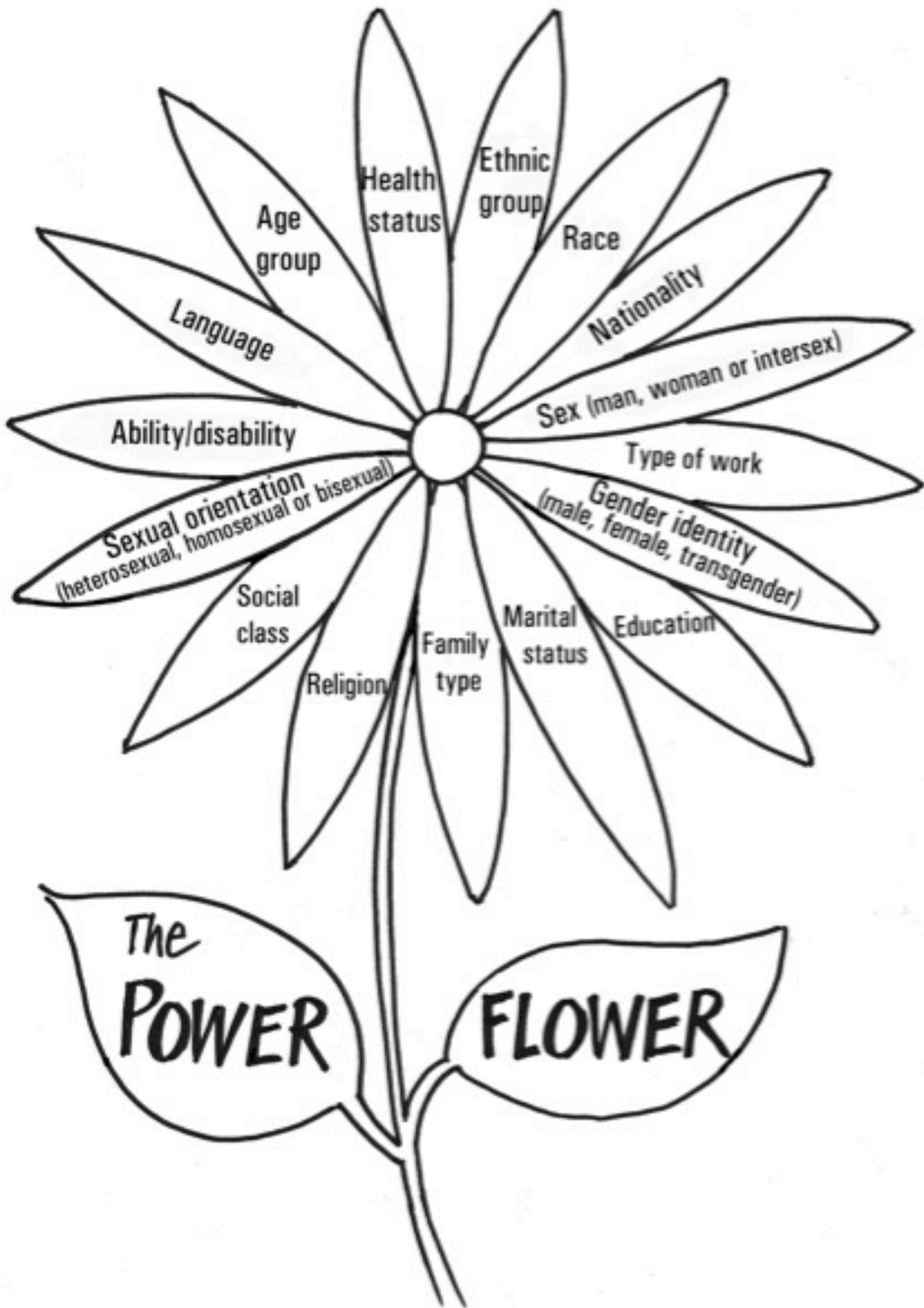
- Increases the level of stigma
- Forces the person to hide all of their stigmatised identities or selectively hide identities

SUMMARISE:

Include some of the following points in your summary:

- All of us have many social identities—nationality, race, class, ethnicity, biological sex, age, marital status, gender identity, gender expression, sexual orientation, language, religion, education, occupation, children or no children, ability/disability, or health status.

- Key populations are marginalised and stigmatised on the basis of some of these identities or characteristics. They are forced to live within a world dominated by identities which exclude them. As marginalised groups, they are expected to conform to those identities, and when they don't, they become targets for stigma and discrimination.
- In thinking about key populations, we often limit ourselves to thinking about one of their characteristics, e.g., sexual orientation, occupation (in the case of sex workers), disability, etc. In other words, we don't treat them as whole people, with a full set of identities. We treat them as having only one identity—their stigmatised identity. We make this single feature the basis for their entire identity.
- In focusing on this single identity, we **stop treating key populations as human beings**—we forget their humanity, and this gives us a feeling of power and superiority over them. We focus on one aspect of a person's identity and we become blinded and rob ourselves of the entire rich package of a human being.
- So we need to change our ways of thinking about key populations as having a single identity and **look at them as people with a full set of identities**—they are our children, our brothers or sisters, our friends, workmates, church members, and community members, and not just MSM or sex workers or PWID. We need to respect members of key populations by treating them like anyone else.
- There are also layers of stigma. People who experience HIV stigma may also be stigmatised on the basis of other stigmatised identities. For example, a woman could be stigmatised as a woman, a sex worker, a PWID, a person living with HIV, a woman without children, a mother who has children from different fathers, or an HIV-positive woman who is pregnant. Each layer of stigma magnifies the level of stigma. This makes it even more difficult for a woman to access health and other services and to get out of an often hidden, marginalised existence.



C3. What Is Sex? What Is Gender?

Facilitator’s Notes: This is a short exercise to explore gender roles and how they affect our views about gender identity and gender roles/expression.

This exercise is preparation for the first part of Exercise C4—which explains terms such as biological sex, gender identity, gender roles/expression, and sexual orientation.

The facilitator may also refer to the definitions of transgender given in the glossary in Annex A.

Objectives: By the end of this session, participants will be able to:

- Explain the roles that society expects us to play as males and females
- Analyse how our views about gender roles affect how we think about men who have sex with men and transgender people

Target Group: All groups

Sources: BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer’s Guide (B7)

Time: 30 minutes

Handout: C-FS5: WHAT IS SEX? WHAT IS GENDER?

Steps:

Gender vs. Sex:

Divide the flipchart into two equal halves. On one side, write down ‘males’ and on the other side ‘females.’ Ask participants to brainstorm the differences between males and females—and record their answers.

Then ask—“Which of the answers refer to biological features (*SEX*) and which refer to the roles that males and females have been assigned by culture (*GENDER*)?”

	Females	Males
Sex	Large Breasts. Hips. Vagina. Produce eggs to make babies. High voice.	Penis. Testicles. Beard. Deep Voice. Produce sperm.
Gender	Sweep. Cook. Wash clothes. Care for children. Provide comfort.	Head of household. Breadwinner. Decisionmaker.

Based on their answers, explain the difference between gender and sex, using some of the points from the Summary (given below).

Gender, Sex, and LGBTI: Discuss:

In terms of sex (biological characteristics), is there any difference between gay people, transgender people, and heterosexuals?

EXAMPLE RESPONSES
There are no biological differences—they may have the same biological characteristics, e.g., having a penis and testicles. However, gay men are sexually attracted to men, whereas transwomen (transgender people who are born with male biological characteristics) do not regard themselves as men.

SUMMARISE:

- **Sex** describes the *biological and physiological characteristics that define men and women*. Men have a penis and testicles and produce sperm to make babies. Women have a vulva, vagina, and ovaries, and produce eggs to make babies.
- **Gender** refers to the *socially constructed roles, behaviours, activities, and characteristics that a given society considers appropriate for men and women*. People are expected to perform ascribed gender roles and have certain characteristics. Men are expected to be strong, play the role of breadwinner, marry, and have sex with women. Women are expected to be gentle, hard-working, marry, and have sex with men.
- **Sex** is *physical*, while **gender** is *social or cultural*, e.g., a woman can give birth to children but a man cannot (sex); women can raise children and so can men (gender). Sex is fixed or inborn, but gender can change—it is socially constructed. Note that these socially constructed roles can change over time.
- Boys and girls are taught how they should behave to become ideal men and women according to the culture. From an early age, children are taught that boys and girls have **different roles** and should behave differently, e.g., girls work in the home; boys do physical work outside the house. Girls and boys are expected to respond differently to the same experience. These different expectations are expressed in slogans such as “*Act like a real man,*” “*Boys should never cry,*” and “*Girls should behave properly*” (e.g., girls should never initiate sex or talk about sex).
- LGBTI who behave differently from these expectations are often stigmatised and harassed. For example, gay boys are often forced by their parents to change the way they dress or act, or the roles they play in the family—to become a ‘real man.’
- Perceptions of gender roles strongly influence how society views LGBTI. For example, gay men or MSM have the same biological characteristics (sex) as men who are not gay/MSM. However, they often challenge traditional perceptions of gender roles—for example, they may refuse to get married to a woman and want to get married to a man, or marry a woman as part of their ‘hiding.’ They may also conform to traditional stereotypes of what is considered to be masculine (e.g., not expressing emotion, not doing housework, etc.)
- MSM also challenge heterosexual norms of sexual practice (penis-anus instead of penis-vagina), and as a result are stigmatised. In most of the Caribbean, sex between men is considered illegal and men found having sex with other men can be severely punished or be subject to extortion or violence.
- Transgender people who have not adopted the gender ascribed to them and/or consider themselves as a member of the opposite gender are severely stigmatised. In the eyes of other people, they do not behave appropriately to their gender characteristics and roles. Transwomen, for example, who have a man’s body but do not consider themselves as men but as women, dress and behave like women and want people to treat and view them as women. Because their behaviours are seen as inappropriate and not masculine, they are often mocked, humiliated, and subjected to violence.
- Growing up in the same society, LGBTI have often internalised the same set of gender roles and stereotypes—‘Be a real man,’ ‘don’t cry,’ etc. When LGBTI are shamed by their families for not following these gender roles and expectations, it makes them feel abnormal, they begin to stigmatise themselves, and become confused about their own identity and behaviour.

C4. Understanding the Identities of LGBTI

Facilitator's Notes: This exercise looks at the different identities within the LGBTI community and how they are treated by the larger community.

The first half of this exercise will help to build understanding about different terminologies that are used in relation to sexuality, including biological sex, gender identity, gender roles/expression, sexual orientation, and sexual behaviour. It is important to recognise that these identities are held by everyone, not just sexual minorities. A heterosexual man, for example, may not be attracted to other heterosexual men but have female gender expression, acting in a feminine way.

You will need to provide accurate information to respond to all the questions which might come up in this exercise. So arrange for LGBTI representatives to attend this session to help explain these issues if possible, and use the Fact Sheets as an extra resource. Make sure that the resource persons are fully briefed beforehand and aware of what is being asked of them.

Objectives:

By the end of the activity, participants will be able to:

- Explain the meaning of biological sex, gender identity, gender roles, and sexual orientation
- Use these concepts to explain the different identities within the LGBTI community
- Examine how different identities are stigmatised by the larger community

Target Groups: All groups

Sources: Engaging Boys and Men in Gender Transformation (Engender Health)
Cambodia MSM Stigma Toolkit (Exercise B5)

Time: 1.5 hours—Part A (30 minutes) and Part B (1 hour)

Handouts: C-FS2: GLOSSARY FOR SEXUAL MINORITIES
C-FS3: LGBTI—FREQUENTLY ASKED QUESTIONS

Steps:

Introduction:

Explain that many people think that gay men, bisexuals, and transgender people all look, dress, and behave in a similar fashion. This is not true. MSM and transgender people have many different identities, and we need to be able to understand the differences if we are to respond to their needs effectively. This exercise will help to explain the different identities.

Acknowledge that some participants might have very strong views about this topic. Explain that you will respect every person's right to his or her opinion, but emphasise that this topic is important to discuss because it is a human rights issue and an important part of every individual's sexuality. Invite participants to ask questions as you explain and discuss the following information. Sexual health is a vital part of a response to HIV, and understanding sexuality is an important step in building a more effective response.

PART A: INTRODUCTION TO CONCEPTS (30 minutes)

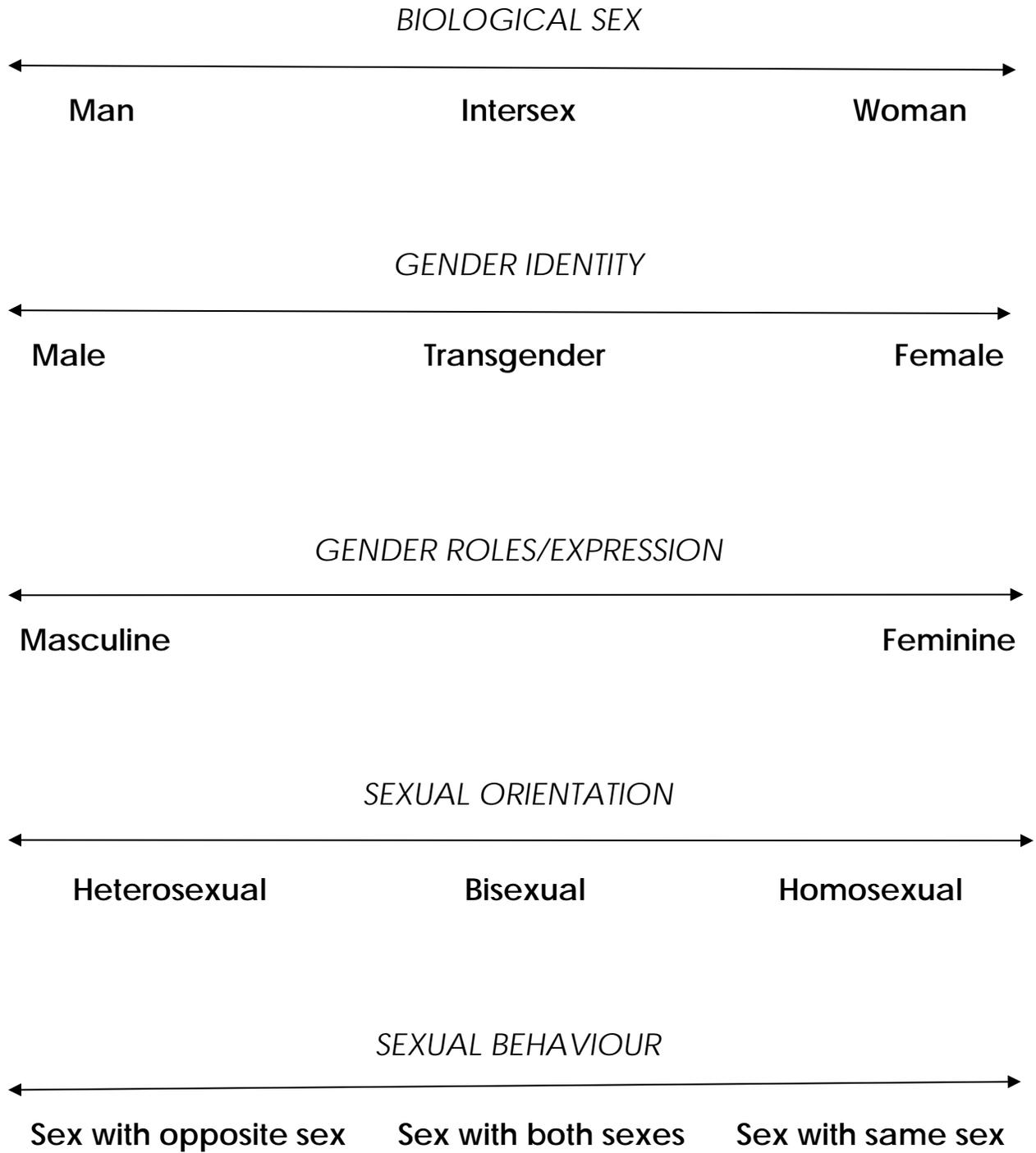
Use the diagram on the following page to explain these concepts.

- Write 'BIOLOGICAL SEX' at the top of a flipchart sheet and draw a line immediately below it. Label one side of the line 'Man,' the other side 'Woman,' and place 'Intersex' in the middle. (See diagram on next page.) Then explain: Most children are born male or female, but some people are

born with full or partial genitalia of both sexes, underdeveloped genitalia, or unusual hormone combinations. We say these people are ‘intersex.’

- Draw a second line and title it ‘GENDER IDENTITY.’ Label one side ‘Male’ the other side ‘Female,’ and the midpoint ‘Transgender.’ Explain that a person’s GENDER IDENTITY is not always the same as their biological sex. When a person feels that their personality, their inner self, is different from their biological sex, we say that the person is ‘transgender.’ A transgender person may decide to wear clothing of another gender, decide to change his or her biological sex (called ‘gender reassignment surgery’), or do nothing at all. Explain that a ‘transwoman’ is a person whose biological sex is male, but identifies as a woman; a ‘transman’ is a person whose biological sex is female, but identifies as a man.
- Draw a third line and title it ‘GENDER ROLES/EXPRESSION.’ Label one side ‘Masculine’ and the other ‘Feminine.’ Explain that gender roles are society’s expectations of how men and women should act. Often, when a man acts in a feminine manner, he is assumed to be homosexual, but this may not be true, because gender roles and sexual orientation are different. Explain that a person’s gender roles can also move across the continuum over time or can change in a given situation.
- Draw a fourth line and title it ‘SEXUAL ORIENTATION.’ Label one side ‘Homosexual,’ the other side ‘Heterosexual,’ and the mid-point ‘Bisexual.’ Explain that sexual orientation can be seen as a continuum, from homosexuality to heterosexuality, and that most individuals’ sexual orientation falls somewhere along this continuum. While individuals cannot change their sexual orientation at will, the expression of one’s sexual orientation might change throughout a person’s lifetime. So an individual’s orientation can move along the continuum as time passes. Most people, however, do not change much during their life.
- Draw a fifth line and title it ‘SEXUAL BEHAVIOUR.’ Label one side ‘Sex with Men’ and the other side ‘Sex with Women.’ Explain that a person’s sexual behaviour does not always indicate his or her sexual orientation. Not all individuals who have had sexual experiences with members of their own sex define themselves as homosexual. For example, some men who have sex with other men in isolated settings, e.g., prisons, do not consider themselves to be homosexual. In addition, individuals who engage in same-sex sexual activity might not be exclusively attracted to members of their own sex and might not wish to engage in sex only with members of their own sex. Some married persons, for example, engage in same-sex sexual activity outside of marriage and still consider themselves to be heterosexual. People who have sex with both men and women might consider themselves to be bisexual, homosexual, or heterosexual.
- In summary, our human sexuality and gender identity include five elements:
 - a) **Biological Sex:** Based on our physical status of being either male or female
 - b) **Gender Identity:** How we feel about being male or female
 - c) **Gender Roles:** Society’s expectations of us based on our sex
 - d) **Sexual Orientation:** The sex to which we are attracted to sexually
 - e) **Sexual Behaviour:** The sexual experiences we have

SEXUALITY CONTINUUM DIAGRAM



PART B: PRACTISE USING THE CONCEPTS (1 hour)

Group Work: Divide into small groups and hand out the following character descriptions to each group. Ask groups to think about and discuss each individual in relation to the diagram on the wall, and decide where that character falls on each one of the lines/continuums.

Case Profiles

Makara is a young gay man who works as a computer expert. He first discovered that he was attracted to men in his teens, but didn't start having sex with men until he finished his studies and started work. One day at work, his colleagues teased him that he was holding a tea cup "like a gay man," but he kept quiet and no one bothered him. When he started work, he had lots of short-term relationships with other men until he met **Issa**, whom he has been seeing for two years. Issa is a gay man who works as a mechanic. He loves to play football and drink with the boys, and no one has ever suspected that he is gay or MSM.

Sam is a 25-year-old transman. He was born in a woman's body, but from an early age began to think of himself as a male, and used to dress in boy's clothing. After trying to change Sam, his parents gave up and kicked him out of the house. Sam moved to the city where he met a 28-year old, gay man, **Bob**, a taxi driver. They fell in love, developed a strong sexual relationship, and moved in together.

Sulley is a married businessman of 40 years. He has a few effeminate gestures, but everyone sees him as a happily married man. But he loves to have sex with men and arranges this with male sex workers. One of the sex workers is **Peter**, a poor, uneducated young man who makes his living as a sex worker. Peter only has sex with men for money. He is sexually attracted to women and, in the future, when his finances allow it, hopes to get married to his girlfriend.

Joseph is a 30-year-old policeman. Men in the community make fun of him because of his walk, and this makes him less confident in his job. He has a male lover but also a girlfriend, to keep the appearance that he is not gay. He is struggling with leading this double life and wishes he could be more comfortable with himself as a gay man.

Tom is a 25-year-old person who uses drugs. He grew up in a middle-class family and started to feel sexual feelings towards men in his teens. His parents scolded him and tried to change him and, in desperation, he turned to friends who use drugs. He became addicted and dropped out of school. He hangs out with two other MSM who also use drugs.

MSM	Example Analysis
Makara	Biological sex—man. Gender identity—male. Gender expression—primarily male, but some effeminate gestures. Sexual orientation—gay (sexually attracted to men).
Issa	Biological sex—man. Gender identity—male. Gender expression—totally male. Sexual orientation—gay (sexually attracted to men).
Sam	Biological sex—woman. Gender identity—male. Gender expression: masculine. Sexual orientation: gay (sexually attracted to men).
Bob	Biological sex—man. Gender identity—male. Gender expression—masculine; no feminine characteristics. Sexual orientation—gay (sexually attracted to men).
Sulley	Biological sex—man. Gender identity—male. Gender expression—slightly effeminate. Sexual orientation—bisexual (sex with his wife and with men).
Peter	Biological sex—man. Gender identity—male. Gender expression—masculine. Sexual orientation—heterosexual (sexually attracted to women). Sexual behaviour—he has sex with women (love) and men (money). He identifies as heterosexual.

Joseph	Biological sex—man. Gender identity—male. Gender expression—slightly effeminate. Sexual orientation—bisexual/not sure (sex with men + one woman).
Tom	Biological sex—man. Gender identity—male. Gender expression—totally male. Sexual orientation—gay (sexually attracted to men).

Report Back:

Ask each group to report on one of the eight characters. In giving their report, they should show or plot on the diagram the position of each character for each of the dimensions (sex, gender identity, gender roles, gender expression, and sexual orientation).

Then Discuss:

“Which of the characters is more stigmatised, and why?”

Summarise:

- Society tells us that the Sexuality Continuum Diagram should be one straight line, i.e., a man has a male gender identity and a masculine gender expression and is totally heterosexual (i.e., sex with women only). **The reality is totally different—there is lots of diversity.** One man may have male gender identity but have feminine gender expression and be attracted to both men and women (bisexual). Another might have male gender identity and gender expression (muscles and male body language) but be solely attracted to men. The examples given in the exercise show the diversity.
- A person’s gender identity and gender expression do not always match his/her sexual orientation and sexual behaviour. A man may have sex with other men but identify as a man and look, talk, and dress like a man; another man may look feminine but only be attracted to women, i.e., heterosexual; another man may be masculine and heterosexual but for economic reasons engage in commercial sex with men.
- Many gay men and MSM consider themselves to be men and have no interest in changing. They dress and act no differently than men who do not have sex with men.
- Sexual identity is strongly influenced by society and culture. Whether we call ourselves gay, bisexual, or heterosexual depends on the culture we grow up in, the place we live, and the social groups we identify with. Some men, for example, get married only because of family and social pressure, not because they want to get married. Some men may adopt the practice of having sex with men when they are in prison, because this is the norm.
- The exercise shows us that **people get stigmatised and harassed for ‘stepping outside of the box,’** i.e., having gender identity, gender expression, and sexual orientation which is outside the gender norms (opposite to their biological sex.)
- MSM who exhibit masculine gender expression are often able to hide their sexual orientation and, on the whole, avoid stigma. They only face stigma at the clinic when health workers find out they are having sex with men (e.g., through anal STI). More effeminate MSM, on the other hand, are heavily stigmatised and harassed for their overtly feminine gender expression and the assumption that this means they are having sex with men. They have no place to hide—because of their feminine looks and behaviour, they are a target for the strongest stigma. Stepping outside of the ‘gender box’ puts them at risk of stigma.
- So while MSM is a term developed by health workers to describe sexual behaviour, rather than gender identity and gender expression, the reality is that **MSM are often stigmatised not only for having sex with men but also for their gender expression.**

- In summary, the term ‘MSM’ describes a **wide variety of sexual practices and identities**, including gay men; bisexuals; married men who have sex with men; prisoners who self- identify as heterosexual, but have sex with men while they are in prison; and male sex workers who see themselves as heterosexual ‘real men’ but sell their bodies for sex with men. It is very important to understand these different identities and realities if we are going to provide effective services to these different types of MSM.

C5. Stigma towards Sex Workers

Facilitator’s Notes: This exercise helps participants name the problem of stigma towards sex workers. It includes case studies based on the real experiences of sex workers.

Sex workers live on the margins as outcasts from the community. They are the targets for stigma and discrimination; live under the threat of being arrested by the police; are treated as powerless and without rights; find it difficult to negotiate fair wages and safe sex; have limited access to health services; and, because of their marginalised situation, are vulnerable to HIV and other STIs.

Objectives: By the end of this session, participants will be able to:

- Identify stigmatising practices towards sex workers
- Identify practical things they can do to change the way they relate to sex workers

Time: 1 hour

Materials: Copies of case studies for participants

Handout: C-FS9: SEX WORKERS AND STIGMA

Steps:

Case Study:

Divide into groups and hand out copies of the case studies. Ask groups to read both case studies and discuss the following questions:

- What happened in case study A, and why?
- What are the effects of stigma on sex workers?
- What can we do to make our health facilities more client friendly and challenge stigma?
- What happened in Case Study B, and why?
- What can be done to make sex workers’ lives safer?

Case Study A: Sara, a sex worker, went to the clinic for an STI check and a supply of condoms. When she arrived at the clinic, she was kept waiting a long time. Clients who arrived after her were treated before her. When she asked one nurse for help, the nurse said, *“You’ll just have to wait. We know your dirty habits!”* The nurse said this in the presence of the other nurses and patients, and Sara felt humiliated. Eventually Sara was called in to see the doctor. The doctor gave her a funny look and said, *“What is your problem?”* She explained the symptoms and the doctor said, *“You deserve to get this STI for your shameful behaviour. I don’t know why we waste our time on you. You are just a virus collector. I don’t care if you get sick. It’s your own fault sleeping with all these men!”* When Sara left the doctor’s office, she felt upset—and wanted to leave the clinic. One nurse grabbed her arm as she was going out the door, pushed some condoms into her hand, and said, in front of everybody—*“You better use these condoms or you’ll die!”*

Case Study B: One day I was approached by a client at a bar. He said he would pay \$20 for my services, but he wanted to have sex in the bush. I was scared of that place—another woman had been raped there,

but I needed the money for the rent, so I agreed. I told him I wanted to be paid in advance—he said, no problem, and gave me the money. But he said, “*Now I have paid you, I can do anything I want with you.*” This scared me, but I left with him and we went into the bush outside the bar. The next minute, there were four other men there, grabbing me and holding me down. When I tried to say something, one man slapped me and said, “*Shut up, you’ve already been paid!*” Each man took his turn. I wanted to shout for help, but I told myself, “*Who am I? I’ve been paid, let them do what they want and leave me in peace.*” When it was over, the men just disappeared. I felt like death. My friend Mary found me. When I told her I had been raped, she told me to go to the police. I said, “*What can I say? They will just arrest me. They never listen to sex workers!*”

EXAMPLE RESPONSES

Case Study A

Forms of stigma and discrimination towards sex workers in the health facility

- Kept waiting a long time. Other clients are served first.
- Name calling. Abusive language. Gossip. Disapproval. Stared at by other clients.
- Blamed – “immoral,” “virus collectors,” “you deserve to get an STI.”
- Health workers feel that they are wasting their time treating sex workers because sex workers will continue doing sex work and getting STIs or HIV.
- Break confidentiality – tell other health workers that the client is a sex worker.
- Poorly done, rushed, low-quality examinations and treatment.

Effects of stigma on sex workers

- Feel isolated, humiliated, and demoralised—lose self-esteem.
- Stop using health facilities and try to treat themselves.
- May be prevented from getting access to ARVs or opportunistic infection (OI) treatment—health suffers.
- Do not access information and services needed for HIV prevention and treatment.
- Take more risks (e.g., not using condoms).

What can we do to make health facilities more client friendly and challenge stigma?

- Ensure that sex workers receive the same standard of health care.
- Provide a friendly, welcoming environment—friendly face, body language, and voices.
- Ensure that the security and confidentiality of sex workers’ medical information is guaranteed, and that their HIV status is not disclosed.
- Train health workers on the right of sex workers to equal care and confidentiality.
- Train health workers how to provide counselling and services to sex worker clients, using non-judgemental and supportive language.
- Speak up and challenge in a polite but firm way those health workers who are stigmatising.

Case Study B – What happened?

- The sex worker was gang raped by four men, who thought that if they paid her, they could do anything to her, including rape. Payment does not justify abusive treatment. The sex worker deserves respect and fair treatment, like anybody else.
- The sex worker thought she has no rights, so she felt she could not go to the police.
- No one has the right to rape someone. Sex workers have rights like anyone else.
- Sex workers, like any persons, should have the right to look to the police for protection.

SUMMARISE:

Summarise the main points which participants have made during the exercise. In giving your summary, you may use some of the following points, if they have not already been mentioned by participants.

- Sex workers have to survive in a very dangerous environment—they are vulnerable to being raped, robbed, beaten, and exploited by their clients, and arrested by the police. Sex workers feel they lack rights and are powerless to assert their rights and demand fair treatment, i.e., safe sex with a fair payment and no violence.
- In many parts of the Caribbean, sex work is illegal; as a result, sex workers are forced to operate in a climate of secrecy. This often leaves sex workers open to being exploited, extorted, stigmatised, and subject to violence.
- Many people believe that sex workers lose their rights when they start selling sex. But sex workers have rights like other people, e.g., the right to healthcare, freedom from inhumane treatment, etc.—and they should be able to access those rights.
- Payment by a client does not give him the license to abuse the sex worker—she (or he) is deserving of respect and fair treatment like anybody else. Men should be responsible for their behaviour. No one has the right to rape or abuse anyone.
- Sex workers have a right to be free from inhumane and degrading treatment, and the right to be recognised as a person by the law. So police officers need to deal with their complaints when they make charges against clients.
- Sex workers have a right to health, so they deserve fair and equal treatment when they go to the clinic. Health workers should not stigmatise or discriminate against them. This can serve to put them and their clients at higher vulnerability for HIV or other health issues.
- The fear of being arrested prevents sex workers from asserting their rights. As a result, they find it difficult to challenge stigma and discrimination.
- Sex workers are more at risk of HIV infection because of their limited access to human rights. Because they have limited power to demand their rights, it is difficult for them to negotiate safer sex with clients and partners. This makes them vulnerable to getting HIV.
- Many sex workers do this job only for survival purposes. Most sex workers have few other income sources, often because their education and skills are limited. Many sex workers are poor, have difficulty finding other work, have little education, and are the sole breadwinner or have children to support.
- Some sex workers would like to leave sex work if they could get a decent job and a fair wage. Many feel they have no alternative. Many sex workers were drawn into sex work because of poverty. The primary reason they continue as sex workers is the money they can earn. The concept of human rights demands that we try to understand and respect other people as human

beings. Sex workers are as fully human as anyone else and entitled to be treated in the same way.

- Stigmatising sex workers does not help us to fight HIV. Instead of stigmatising sex workers, we need to show care and compassion—so that they can lead a healthy life and act in their own and other people’s interest.

Annex for Chapter C: What Do You Know about Key Populations? (True/False Questionnaire)

Annex A: What Do You Know about MSM? 15 True or False Questions

QUESTIONS

1. Becoming MSM does not just happen. Men decide that they want to be MSM.
2. If you hang around with and become friends with MSM, you will also become MSM.
3. MSM are mentally ill, but they can be cured.
4. Sex between two men is against religion.
5. Sex between two men is a product of Western influences.
6. Sex between two men is motivated by love, sexual pleasure, and/or economic exchange.
7. MSM are all the same. You can identify them by the way they dress and behave.
8. In many countries, it is illegal for men to have sex with men.
9. MSM have an increased risk of getting HIV and other STIs because of having unprotected anal sex.
10. MSM engage in the same sexual practices as other couples.
11. MSM do not want long-term partners; they only want casual sex.
12. MSM may also have sex with women.
13. Safe sex for MSM is different from safe sex between a man and a woman.
14. MSM are not at risk of getting HIV, so they do not have to practise safe sex.
15. There is no stigma against MSM; they stigmatise themselves.

ANSWERS

1. Becoming MSM does not just happen. Men decide that they want to be MSM.

FALSE. Wanting to have sex with other men is part of some men’s nature. Some men are born gay—this is just the way they are. They are ‘wired’ from birth to be attracted to the same sex. It is like being right handed or left handed. It is inborn and cannot be explained or predicted. It is not known what makes some men desire men while other men desire women. Some studies suggest there are genetic influences, while other people believe it is a mixture of genetics and social influences. A man who has sex with men cannot simply be taught to be sexually attracted to women. There is no scientific evidence to prove that people can change their sexual orientation through exerting their will.

Men have sex with men for many different reasons. Some men, who may call themselves homosexual or gay, are attracted to other men and enjoy having sex with these men. Other men have sex with men in all-male environments, like prisons, where there are no women available and they want to release sexual tension. Some men have sex with other men because they need money and can earn money that way. Some men are married to women and have sex with them, but they also have sex with men out of desire.

2. If you hang around with and become friends with MSM, you will also become MSM.

FALSE. Simply spending time with or being close to MSM will not change you to become MSM. Being MSM does not pass from person to person like a disease, nor can people be talked into a sexual orientation that is not their own.

3. MSM are mentally ill, but they can be cured.
FALSE. Being MSM is not a mental illness. In the past, psychiatrists tried to show that men wanting to have sex with other men was a mental illness, but they failed. Starting in 1973, the medical profession in most Western countries no longer treated being gay as an illness. However, some parents still wrongly send their sons who are gay to clinics or psychologists to be 'cured.' If being MSM was accepted by everyone, no one would feel the need to 'cure' it.
4. Sex between two men is against religion.
TRUE/FALSE. Religions have different views and interpretations of men having sex with men. Some Islamic and Christian churches consider men having sex with men a sin, other religions consider it a weakness which can be cured, and some feel it is an acceptable and normal sexual orientation. Some churches condemn homosexuality but have tolerance for the gay person.

In all religions, there is a difference between the texts and daily practice. Interpretation of ancient texts written in another language is difficult, but some fundamentalists try to interpret texts literally to use these texts to condemn MSM. Others use the texts as a source of inspiration, but in daily life they accept MSM as human beings. Still others emphasise that religious teachings mention compassion and tolerance of other people. There are many religious people who are faithful to their religions and accepting of MSM.
5. Sex between two men is a product of Western influences.
FALSE. Historical research shows that homosexuality existed in Asia and Africa long before Europeans arrived in these regions. Research has shown that 5–10 percent of people in every community in the world are attracted to the same sex. In all countries of the world, men having sex with men existed in the past – it was secret, but it existed. Today, it is relatively more open, and it is estimated that there are MSM living in every community, although because of stigma and discrimination, the majority are in hiding.
6. Sex between two men is motivated by love, sexual pleasure, and/or economic exchange.
TRUE. The same things that motivate sex between a man and a woman motivate men to have sex with other men. The reasons may include love and companionship, sexual pleasure, and as a way of earning money in exchange for sex. In effect, there is diversity among MSM and a diversity of reasons for being in a sexual relationship with another person.
7. MSM are all the same. You can identify them by the way they dress and behave.
FALSE. As with all people, MSM are individuals who look and behave in different ways. Some MSM wear their hair longer and dress in a feminine way, while others may have short hair and dress and act in a way that is stereotypically male. In some cases, MSM are married and have families or act one way in public and another way in private. Many MSM dress and act no differently from men who do not have sex with men. It is impossible to tell whether someone is a man who has sex with men just by the way they look and behave.
8. In many countries, it is illegal for men to have sex with men.
TRUE. In many countries the penal code prohibits men from having sex with other men.
9. MSM have an increased risk of getting HIV and other STIs because of having unprotected anal sex.
TRUE. At least 5–10 percent of all HIV infections worldwide are due to anal intercourse between men. Unprotected anal intercourse carries a higher risk for contracting STIs, including HIV, than vaginal intercourse. This is because the rectum tears very easily, leaving openings for HIV to be transmitted. Anal sex also requires a condom and lubrication to be practised safely. Water-based lubricant, which is safe to use with condoms, is often not accessible. Oil-based lubricant, e.g., Vaseline, will cause the condom to deteriorate and break. However, MSM can reduce the risk of contracting HIV by practicing safe sex.

10. MSM engage in the same sexual practices as other couples.

TRUE. MSM use many of the same sexual practices as heterosexual couples, including: kissing, masturbation, touching, anal sex, and oral sex. These activities are not restricted to sex between a man and woman or sex between two men, but are commonly practised by both groups. Some of us, for example, assume that all MSM practise anal sex, but in fact, many do not and there are many heterosexual couples who practise anal sex.

11. MSM do not want long-term partners; they only want casual sex.

FALSE. Many people think that MSM are only interested in sex—that their relationships are shallow and only based on physical attraction, not love. In fact, MSM are equally capable of deep, long-term, loving relationships, as non-MSM are with women. Some MSM may have lots of sexual partners and some MSM may have only a single partner in a permanent relationship.

12. MSM may also have sex with women.

TRUE. Some MSM enjoy sex with both men and women. Other MSM may prefer sex with other men, but have sex with women to hide their MSM status. In many cases, MSM are married and have sex with their wives in addition to having sex with other men.

13. Safe sex for MSM is different from safe sex between a man and a woman.

FALSE. The concept of safe sex for MSM is no different from the concept of safe sex for sex between a man and a woman. In both cases, the aim is to prevent the exchange of body fluids and blood through using barrier methods, such as condoms, dental dams, etc.

It is recommended that strong/reinforced condoms and water-soluble lubricant be used for anal sex to prevent the condoms breaking. (The same technologies are recommended for heterosexuals practising anal sex.) Condoms should also be used for oral sex practised on a man.

14. MSM are not at risk of getting HIV, so they do not have to practise safe sex.

FALSE. HIV or STIs can be transmitted from one man to another man or woman through unprotected anal or vaginal sex, so MSM should use protection. Oral sex has shown the possibility of transmission although it is considered of lower risk.

See: <http://www.countdownaids2012.org/victory-cdc-quietly-releases-per-act-probability-of-acquiring-hiv-by-exposure-act/>

15. There is no stigma against MSM; they stigmatise themselves.

FALSE. Stigma towards MSM does exist in society and it may include discrimination in hiring practices, arbitrary harassment by police, or being excluded from family decisions and activities. The stigma and discrimination experienced by MSM may lead to self-stigma. Living in a society where MSM are often condemned, rejected, and isolated, MSM may internalise some of the negative attitudes from the community and develop feelings of shame about who they are. Self-stigma is induced by stigma that exists in the larger society and can lead to social withdrawal, subterfuge, search for easy escape, and lowered health-seeking behaviour. Self-stigma leads to 'unsocial' behaviour (drugs, danger, sexual violence, etc.), which results in more vulnerability, and further exacerbates social stigma.

Annex B: What Do You Know about Sex Workers? 15 True/False Questions

QUESTIONS

1. Sex workers love money and are too lazy to work. They could easily get other jobs.
2. Sex workers all provide the same services.
3. Sex work is the quickest way for poor women to make money.

4. HIV is the only serious problem sex workers face.
5. Sex workers are sex maniacs; they love sex with anyone.
6. Sex workers show off and sell their bodies, so they deserve to be raped.
7. Some sex workers hide their work to avoid being stigmatised by families and the community.
8. Sex workers' relationships with men never last.
9. Sex workers are highly vulnerable to HIV because they often find it difficult to negotiate for safe sex with clients and their full-time partners.
10. When sex workers come to a health facility, they receive the same treatment as everyone else.
11. Programmes to reduce HIV among sex workers should be done without involving sex workers.
12. In many countries, sex work is illegal.
13. Laws that criminalise sex work stop sex workers from selling sex.
14. Sex workers are afraid to report to the police in cases where they have been beaten or raped by their clients because they have limited rights or think that they have no rights.
15. Arresting and imprisoning sex workers are the best methods to stop sex work.

ANSWERS

1. Sex workers love money and are too lazy to work. They could easily get other jobs.

FALSE. Many sex workers have taken up this work because they are poor, have difficulty finding other work, have little education, or are the sole breadwinner and/or have children to support. Often sex workers have taken up this work because they are providing financial support for several family members. They like money for the same reasons as anyone else: They need money to live. Many sex workers are not happy with sex work and would like to get out, but feel they have no alternative.
2. Sex workers all provide the same services

FALSE. There are several different categories of sex workers. Some operate on the street, others work in bars or hotels, and others operate from designated homes. Some are stationary, some are mobile. Some target truck drivers, and others focus on tourists or visitors in hotels. Some work on a full-time basis, others on a part-time basis. Some have other jobs and do sex work in the evenings. Some do survival or transactional sex (occasional sex in exchange for services or gifts—could be as simple as a roof for the night).
3. Sex work is the quickest way for poor women to make money.

TRUE. Sex workers can make money quickly through this work. Earnings from sex work help women to pay the rent or build a house, put food on the table, send their children to school, support other family members, and buy new clothes. Many sex workers want to remain in this work because of the financial benefits. They can often make considerably more money as a sex worker than in unskilled labor, e.g., as a day laborer. Many sex workers would leave this work if they could find other work with similar pay.
4. HIV is the only serious problem sex workers face.

FALSE. Sex workers have many problems, and their job is often very dangerous. Clients exploit and abuse them because they think they can do anything to them once they have paid them. They regard sex workers as women without rights. As a result, some clients refuse to pay them the agreed amount, beat them, and rape them—in some cases, involving gang rape. They are also abused by pimps and the police. They may also face harassment and violence at the hands of their long-term partners.

5. Sex workers are sex maniacs; they love sex with anyone.

FALSE. Most sex workers do not get pleasure out of sex with clients; it is just a way of making money. When they are with a client, they want him to do it quickly and leave. In fact, having sex with a stranger can be very painful due to the lack of sexual arousal, which is needed for vaginal lubrication. Sex work often results in medical problems, such as acute and chronic pelvic pain, pathological vaginal discharge, genital ulcers, skin disease, pain during urination, bladder and kidney infections, and STIs.

6. Sex workers show off and sell their bodies, so they deserve to be raped.

FALSE. While sex workers do show off their bodies to attract men to hire their services, this is no justification for rape. Sex workers are not ‘asking to be raped.’ The way someone dresses does not give anyone the right to rape them. No one deserves to get raped. The payment by a client does not give him the license to exploit or abuse the sex worker. She is deserving of respect and fair treatment like anyone else.

7. Some sex workers hide their work to avoid being stigmatised by families and community.

TRUE. Sex workers often do everything possible to ensure that, while they are working, family members or family friends do not find out what they are doing. While family members may know that they are supported by money from sex work, it is still heavily stigmatised by the family and the community. Sometimes the community stigmatises the entire family if one member is known to be a sex worker. The stigma associated with this work is so painful that it forces the women to carry the burden of their secret life alone, and usually away from home.

8. Sex workers’ relationships with men never last.

FALSE. Sex workers have sex with many men – this is the nature of their work – but most do have lasting relationships with their regular partners or husbands. Sex workers can also be men in long-term relationships with other men or women, as they can be fathers and sons.

9. Sex workers are highly vulnerable to HIV because they often find it difficult to negotiate for safe sex with clients and their full-time partners.

TRUE. Sex workers are relatively powerless and often don’t feel they have the strength to insist that their clients use condoms. Some clients offer to pay more for sex without a condom. Because sex workers are often poor and supporting many family members, they feel inclined to accept, even though they know this puts them at risk. Some sex workers, however, are very adept at negotiating.

10. When sex workers come to a health facility, they receive the same treatment as everyone else.

FALSE. Sex workers are sometimes stigmatised by health workers because of their work. Sex workers often wait longer, even when they arrive at the health facility early, and they may receive an incomplete diagnosis, inadequate counselling, or inappropriate medication for their health problems.

11. Programmes to reduce HIV among sex workers should be done without involving sex workers.

FALSE. There is a need to involve sex workers in planning and implementing HIV prevention programmes. Sex workers have much more knowledge of the sex work culture and what is involved in changing peer norms, getting messages across in ways men enjoy, and have the contacts with the largely hidden and marginalised sex worker population. Getting them actively involved is crucial to the process of stopping HIV transmission.

12. In many countries, sex work is illegal.

TRUE. The penal code in many countries prohibits the selling of sex. Sex workers can be arrested for charging for sex. In some countries, selling sex itself is not criminalised, but some other aspects of sex work, such as “pimping” and running a brothel, may be criminalised. In addition, in some

countries, sex workers may be arrested for other offences, e.g., loitering, public nuisance, offences against public morality, etc.

13. Laws that criminalise sex work stop sex workers from selling sex.

FALSE. Rather than stopping sex workers from selling sex, laws that criminalise the sale of sex often make sex workers go underground, hiding their activity from the police. In going underground, sex workers are sometimes less able to practise safe sex. Because they feel under threat, they may be less able to negotiate safe sex with clients, making them and their clients more vulnerable to HIV.

14. Sex workers are afraid to report to the police in cases where they have been beaten or raped by their clients because they have limited rights or think that they have no rights.

TRUE. Most sex workers do not report to the police cases of rape, physical violence, or theft by their clients because of this fear of being arrested. In some cases, sex workers are harassed by the police, who demand that sex workers give them free sex or money.

15. Arresting and imprisoning sex workers are the best methods to stop sex work.

FALSE. International experience in dealing with sex work has shown that severe punishment does not change behaviour. The minute the women are released from prison, they go straight back to sex work.

Annex C: What Do You Know about People Who Use or Inject Drugs? 15 True or False Questions

QUESTIONS

1. The main reason people start using drugs is simply that they are bad people.
2. Not everyone who starts using illegal drugs, such as heroin, becomes addicted.
3. Cigarettes and alcohol are also addictive like heroin, but they are legal substances.
4. Once people who use drugs become addicted, their main motivation for continuing to take drugs is to get that feeling of pleasure induced by the drug.
5. People who are addicted to drugs just love their drugs and don't want to quit. They could stop any time.
6. People who are addicted to drugs and want to give up drugs are able to do so the first time they try.
7. People who have quit drugs for prolonged periods of time often start using drugs again, for a number of reasons.
8. The only reason why PWID prefer to use injections is that injecting produces a strong and immediate effect.
9. It is not drug use or injecting drugs which is the major cause of HIV transmission, but the practice of sharing needles and syringes among people who use drugs.
10. HIV is the only health problem faced by PWID.
11. Using harsh punishment, including locking people up, is the best method to treat people who are addicted to drugs.
12. Needle and syringe programmes (NSPs), which provide sterile needles and syringes to PWID, result in more drug use and more people who use drugs.
13. The discarding of used syringes is a potential source of HIV transmission.
14. Laws which criminalise possession of injecting equipment stop PWID from injecting.
15. Drug addiction creates a huge burden on the family.

ANSWERS

1. The main reason people start using drugs is simply that they are bad people.
FALSE. People don't take drugs simply because they are bad people. Different people have different motivations for starting to use drugs, including the following: to make use of leisure time as a form of recreation, experiment, respond to peer pressure, relieve pain or depression, or forget poverty and misery. The reasons are complex and multiple, and often have to do with social or economic factors, such as unemployment, poverty, or rapid social and economic change.
2. Not everyone who starts using illegal drugs, such as heroin, becomes addicted.
TRUE. Many people use drugs without being addicted. They take drugs on an occasional, experimental basis. People who use drugs normally become addicted when they take drugs on a regular basis over a period of time, varying from a few weeks to many years. Drug use becomes habitual and the person who uses drugs becomes dependent on the drugs. So drug use and drug addiction are two different things. In the United States, for example, out of 25 million people who use drugs, it is estimated that only 1–2 million (8%) people become addicted.
3. Cigarettes and alcohol are also addictive like heroin, but they are legal substances.
TRUE. Cigarettes also produce an addictive effect on the body. Nicotine is one of the most addictive substances known—smokers develop a dependence on nicotine quickly. Many people want to stop this habit, but they find it very difficult to stop. If they stop, they feel very uncomfortable. Tobacco prices are often low, so many people become addicted. Smoking has serious effects on the body – prolonged use can cause lung, heart, blood vessel damage, and cancer. The World Health Organisation (WHO) estimates that smoking is responsible for one out of five deaths, or 3 million people per year; more than 50 percent of smokers will die prematurely as a direct result of tobacco-induced illnesses. In spite of these adverse consequences, it is a legal substance. And alcohol can have long-term health effects as well as short-term health effects like drunk driving accidents, etc.
4. Once people who use drugs become addicted, their main motivation for taking drugs is to get that feeling of pleasure induced by the drug.
FALSE. People start taking drugs to get a pleasurable feeling, but once they are addicted, their main motivation for taking drugs is to overcome the feelings of withdrawal. The initial attraction to drugs is the feeling of happiness that the drugs induce in the body. These pleasurable feelings produce strong memories, which are stored in the brain and create a desire to take more drugs – to bring back those pleasurable feelings. But once people become addicted, they have withdrawal or painful symptoms when the drug wears off, including fast heartbeat, anxiousness, increased blood pressure, perspiration, and pains in the body. At this stage, their main motivation in taking the drugs is to deal with these symptoms of withdrawal, i.e., to get back to 'normal.' Their main focus is to feel normal—not to feel happy, but to feel 'normal.'
5. People who are addicted to drugs love their drugs and don't want to quit. They could stop any time.
FALSE. Many people don't understand the nature of addiction. They assume that it is easy for people who are addicted to drugs to stop—that it is only a matter of will. They assume that people who are addicted to drugs 'just don't want to quit their bad habits,' that they are 'weak people.' They don't see that drug addiction is beyond the control of the drug users—the craving for drugs makes it difficult for them to break the addiction. Not because they don't want to, or are weak, lazy, or don't try, but because of the power of the addiction. Drugs create a strong physical dependency, which forces the person who uses drugs to continue taking them. Once addicted, drug users have very painful withdrawal symptoms when the drugs wear off. These feelings have such a powerful effect on the body that people who are addicted to drugs would do anything to get drugs to overcome the painful withdrawal feelings and get back to normal.

6. People who are addicted to drugs and want to give up drugs are able to do so the first time they try.
- FALSE. Most people who are addicted to drugs and try to give up drugs may make several attempts before they succeed. It would be unusual for a person to succeed the first time. They may want to quit drugs, but the physical pain of withdrawing is too much; before they know it, they are out looking for drugs again. They may recover from drug use and then relapse several times, particularly in the early stages of treatment. It is quite real—some people have no social support system and fall back into living with other drug users. Even when they break free, they are still vulnerable to addiction, and might return to drugs 5 or 10 years later.
7. People who have quit drugs for prolonged periods of time often start again, for a number of reasons.
- TRUE. It is hard to break the drug habit. Many people quit for a short or long time, and then start using drugs again. The reasons for this include such things as a) they were forced to quit by others—it was not their decision; b) they start feeling better and tell themselves that taking drugs will cause no harm; c) they are persuaded by other users to take drugs again.
8. The only reason why PWID prefer to use injections is that injecting produces a strong and immediate effect.
- FALSE. This is only one of the reasons why PWID prefer to use injections. There are a number of others. Most people who use drugs are poor and want to get more out of the drugs they buy. Injecting is an effective way of getting the drug into the body, since all of the drug is used. If you inhale the drug, much of it is lost in smoke. In addition, injecting can be done much more quickly than smoking, so users are less exposed to police action. Injecting takes little time, can be done almost anywhere, and needle and syringes are easily disposed of.
9. It is not drug use or injecting drugs which is the major cause of HIV transmission, but the practice of sharing needles and syringes among people who use drugs.
- TRUE. Drug use itself does not transmit HIV (e.g., inhaling drugs does not transmit HIV), nor does injecting drugs, if you are using your own sterile equipment. The problem is the sharing of needles and syringes, especially with several other people. HIV spreads among PWID mainly because of the sharing or reuse of needles and syringes which have become contaminated with HIV-infected blood. Small amounts of blood, which are not necessarily visible, can remain in the needle and syringes after they have been used. HIV could survive up to one week in the blood left in the syringe or needle. If the equipment is reused, this blood will be directly injected into the bloodstream of the next person who uses the equipment. If the blood is infected with HIV, then HIV can be passed on to that person.
10. HIV is the only health problem faced by PWID.
- FALSE. Injecting can also lead to drug overdose, abscesses, septicaemia, thrombosis, scarring, circulatory problems, collapsed veins, and poor healing of wounds. Also, it can damage the immune system, which can make other infections, including HIV, worse.
11. Using harsh punishment, including locking people up, is the best method to treat people who are addicted to drugs.
- FALSE. International experience of dealing with drug addiction over the years has shown that severe punishment does not often result in long-lasting behaviour change. If anything, it just makes the situation worse.
12. NSPs, which provide sterile needles and syringes to PWID, result in more drug use and more people who use drugs
- FALSE. Studies of NSPs have shown that these programmes do not lead to more use of drugs by current drug users, nor do they encourage other people to start taking drugs. NSPs encourage safe use of drugs and personal responsibility by PWID, and through this, slow or stop HIV transmission.

Using sterile needles and syringes to inject drugs without any sharing is the most effective approach for limiting HIV transmission.

13. The discarding of used syringes is a potential source of HIV transmission

TRUE. The discarding of used syringes around places of injection can be a danger to local communities—creating a risk of needle stick injuries or the reuse of contaminated needles. Public health authorities should arrange for the safe retrieval and disposal of used needles.

14. Laws which criminalise possession of injecting equipment stop PWID from injecting.

FALSE. Laws which criminalise possession of injecting equipment discourage people who use drugs from acquiring and using their own injection equipment (a safer way of injecting) and push PWID into sharing injection equipment, which increases their vulnerability to HIV. Abolishing such laws would not increase the number of people who use drugs—it would remove a barrier to safer use of injection equipment.

15. Drug addiction creates a huge burden on the family.

TRUE. There are huge financial pressures on a family who is supporting a drug addict—the cost of paying for daily fixes and detoxification or other forms of treatment and the lost earnings because the addict cannot hold down a job. In addition to this huge financial burden, there is the psychological cost of worrying about the theft of family property, the loss of family status, stigma from the community, etc.

CHAPTER D: HIV TRANSMISSION AND FEAR-BASED STIGMA

"One day I went to visit a family with my sister. While we were there, I asked for water. The father gave me a glass of water, but my sister stopped me from drinking it. This confused me and really upset the man. We said nothing about it, but when we left, my sister told me that people suspected he had AIDS, and touching the glass might have given me AIDS."

This story is an example of fear-based stigma. The man offered some water, but it was rejected out of fear of getting HIV. This rejection was a form of stigma.

This chapter focuses on the fear of getting HIV through casual contact with PLHIV—sharing the same space, dishes, towels, and toilets with a PLHIV. This fear of getting HIV through casual contact leads to stigma—minimising contact with PLHIV to avoid getting HIV. This response has no medical justification and makes PLHIV feel like outcasts in their own homes, and a threat to those around them. This chapter will help teach the basics on HIV transmission so that people have the information and understanding needed to overcome fears about getting HIV through casual contact. At the same time, it will help them see that keeping PLHIV at a distance and restricting social contact is stigmatising.

This chapter also looks at HIV transmission in relation to MSM. Many MSM in the Caribbean lack the knowledge about HIV transmission and prevention needed to save their lives. Health workers also lack information about these topics. They may have general knowledge about HIV transmission but lack the specifics of how HIV is transmitted—for example, through anal sex—or the ability or comfort in talking about it.

The third topic in this chapter is Universal Precautions—a set of skills and procedures used by health workers to protect themselves and their patients from infection in the health facility. The exercise on this topic:

- Helps health workers look at their fears of getting HIV through work in the health facility;
- Shows that certain practices used by health workers (e.g., using double gloves for routine tasks, forcing clients to take the HIV test) are stigmatising—and fail to provide real protection;
- Helps health workers recognise the importance of replacing these stigmatising practices with Universal Precautions, which will improve their safety and the safety of their patients.

EXERCISES

- D1. Fears about Getting HIV through Non-sexual Casual Contact
- D2. HIV Transmission and MSM
- D3. HIV Transmission and Sex Workers
- D4. Health Worker Fears of Infection, Universal Precautions, and Stigma

D1. Fears about Getting HIV through Non-sexual Casual Contact

Facilitator's Note: In this exercise, participants identify specific forms of contact with people living with HIV that they fear might result in their becoming infected with HIV. Then they explain the reasons behind their fear, and the trainer provides information to counter these fears.

This exercise brings out common misconceptions about how HIV is transmitted. Then these misconceptions are challenged with a simple, three-point theory (QQR) on how HIV is transmitted (or not

transmitted). Then participants practise using this information to challenge misconceptions, using the Margolis Wheel method.

Fear of HIV transmission is one of the main drivers of stigma, and it is important to allow participants time to explore how HIV is—and is not—transmitted. Being able to give clear information about HIV transmission is an important tool in eradicating stigma.

If you are short on time, display the pictures on the wall at the start and ask the group to prioritise the fears—what forms of contact with a person living with HIV are they the most afraid of.

Objectives: By the end of this session, participants will be able to:

- Name common fears about getting HIV through non-sexual contact with PLHIV
- Explain how HIV is, and is not, transmitted
- Explain why HIV cannot be transmitted through non-sexual casual contact

Target Group: All groups

Sources: Understanding and Challenging HIV Stigma: Toolkit for Action (B4);
UNESCO Youth Stigma Toolkit (#18)

Time: 1 hour

Materials: FEARS PICTURE CARDS
QQR Fact Sheet—copy for each participant

Handouts: D-FS1: HIV AND AIDS: THE BASICS
D-FS2: QQR—QUANTITY, QUALITY, AND ROUTE OF TRANSMISSION

Steps:

PART A: NAMING AND ANALYSING FEARS AND PROVIDING CORRECT INFORMATION

1. **NAMING THE FEARS (Picture Cards):** Display the picture cards on the wall. Divide into pairs and ask each pair to select one picture which represents one of their fears (in relation to getting HIV). Ask each pair to discuss the form of casual contact shown in the picture and how this form of contact could lead to getting HIV.
2. **ANALYSING THE FEAR:** Ask each pair to present their picture and to explain how they think HIV might be transmitted. Ask probing questions to get people to explain what is really behind each fear—“Why do people think this form of contact will lead to HIV infection?”

SAMPLE RESPONSES

Contact through food: A woman living with HIV cooks food for her family. While cooking, she cuts her finger. They fear that blood gets into the food and, through the food, into the mouths of her family, who then get HIV.

Sharing cups or utensils: Fear that saliva left on the cup will carry HIV into the mouth.

Sharing clothes or blankets: Think virus in sweat gets into clothing and is transmitted.

Toilet: A man living with HIV sits on a toilet, his sweat gets onto the seat, and the next person who sits on the seat touches the sweat—and there is a fear that through this, this person gets HIV.

Needle prick: If a health worker or client is pricked with a needle which has already been used with a client, there is a fear that HIV can go directly into the bloodstream.

3. **PROVIDING CORRECT INFORMATION:** Then respond to each of these statements, using information from the QQR Fact Sheet. Hand out and discuss the Fact Sheet.

Example of Responses by the Trainer:

Contact through food: HIV cannot survive outside the body, so even if the blood gets into the food, the HIV would die as soon as it is exposed to air. In addition, the heat of the cooking would kill the HIV.

Sharing cups, utensils, clothes, or blankets: There is no HIV found in sweat and there is no route of transmission into the bloodstream—so no possible transmission.

Toilet: There is no HIV in sweat, so one cannot get HIV by touching sweat. There are only small quantities of HIV in urine or faeces, and HIV does not survive once it is outside the body.

Needle prick in healthcare setting: This is a possible way in which HIV might be transmitted. A needle prick would allow HIV to go directly into one's body and into one's bloodstream.

4. **HOW DO FEARS AFFECT OUR BEHAVIOUR TOWARDS PEOPLE LIVING WITH HIV? (Buzz Groups):** Divide participants into pairs. Ask pairs to discuss: "How do people's fears affect the way they treat people living with HIV?" Then organise a report back.

EXAMPLE RESPONSES

They minimise contact and stay at a distance. Separate out towels and bed sheets. Ask a person living with HIV to stop preparing the meals.

Explain that some people believe that limiting contact with PLHIV helps to protect them against HIV. This practice is not a form of protection, since HIV is not transmitted in this way. This practice is stigmatising—it makes the PLHIV feel like an outcast.

5. **SUMMARISE: Explain QQR—**There are three conditions, all of which need to be satisfied for HIV to be transmitted:
- There must be enough **QUANTITY** of the virus in body fluids. HIV is found in large quantities in blood, semen, vaginal fluids, and breast milk—so in these fluids, there is a risk of transmission. HIV is found in small quantities in saliva, vomit, faeces, and urine, and not at all in sweat or tears—so in these cases, there is no risk. HIV is only transmitted through infected blood, sexual fluid, or breast milk getting into the body.
 - There must be enough **QUALITY**—the virus must be **STRONG ENOUGH**. HIV does not live on the surface of the skin, it lives inside the body. HIV is a fragile organism and does not survive for long outside the body. It starts to die as soon as it is exposed to air.
 - HIV must have a **ROUTE OF ENTRY** through the skin into the bloodstream of the uninfected person:
 - a) Through a vein (e.g., a needle injection, which puts infected blood directly into the blood of the uninfected person);
 - b) Through the lining of the anus or vagina, or through sores on the penis, anus, or vagina;
 - c) Through open cuts in the skin, although HIV cannot pass through these very easily; and
 - d) Mother-to-child transmission—HIV can pass to a baby during pregnancy or birth (through blood), or after birth through breast milk.

- Our body is a closed system. Healthy skin is an excellent barrier against HIV. HIV cannot pass through unbroken skin.
- To become infected with HIV, the virus has to get inside your body. When we have sex, sexual fluid can get into the bloodstream through small cuts on the penis, vagina, or anus. When we inject drugs, the infected blood on needles or syringes can go directly into the bloodstream.
- **It is natural to fear HIV because there is no cure.** This is a human reaction to a disease, which can lead to people dying. Now that ARVs are available, however, HIV should be treated as a **manageable disease, like cancer or hepatitis.**
- **Some fears are rooted in lack of knowledge** about how HIV is transmitted—some people still believe they can get HIV through casual contact with a PLHIV. As a result of this fear, they try to protect themselves by minimising contact with people who have HIV or are suspected to have HIV. These practices are stigmatising—they make the person feel unwanted, despised, and rejected.

PART B: PRACTISING THE NEW INFORMATION (MARGOLIS WHEEL)

When participants have learned the basic facts on HIV transmission (QQR), allow them to practise using this information—to convince someone they should not fear certain forms of contact with a person living with HIV. Use the Margolis Wheel technique, which is described below:

1. Set up the Margolis Wheel—two concentric circles of chairs—an inner circle and an outer circle, with the two circles facing each other so that each person has a partner. Ask the more confident participants to sit in the inner row. Assign one question, e.g., *“Tell me why there is no risk of getting HIV if a person living with HIV prepares the food and cuts himself.”* Ask the consultants to ‘convince’ their partners. They should try to give clear information and reasons to explain the transmission.
2. Then ring a bell, ask the outside row to rotate, ask the second question, and so on.
3. After four questions, ask the two circles to change places—and continue with the second question sheet, so that both sets of participants have a chance to practise.

Questions for the Margolis Wheel:

- a) Can you tell me why you cannot get HIV from shaking hands?
- b) Can you tell me why there is no risk of getting HIV from a mosquito bite?
- c) Can you tell me why you cannot get HIV from a person living with HIV who is cooking?
- d) Can you tell me why there is no risk of getting HIV from sharing utensils or blankets with a person living with HIV?
- e) Can you tell me why you cannot get HIV from sharing a toilet?
- f) Can you tell me why there is no risk of getting HIV from a barber’s equipment?
- g) Can you tell me how a health worker might get HIV from health work?
- h) Can you tell me why there is no risk of getting HIV from a pedicure or manicure?



QQR – Tool for Understanding HIV Transmission

For HIV transmission to take place, the **QUALITY** of the virus must be strong, a large **QUANTITY** must be present, and there must be a **ROUTE OF TRANSMISSION**.

QUALITY: For transmission to take place, the *quality* of the virus must be strong.

- HIV cannot survive outside the human body. It starts to die the moment it is exposed to the air.
- HIV is not an airborne virus. This is why there is no risk of transmission in sitting close to or sharing the same room with someone living with HIV.
- HIV does not live on the surface of the skin; it lives inside the body. There is no risk from shaking hands or hugging someone. The only place the virus can survive outside the body is in a vacuum (like a syringe), where it is not exposed to air.
- HIV will die if it is exposed to heat (e.g., if someone bleeds into a cooking pot).

QUANTITY: For transmission to take place, there must be *enough quantity* of HIV to pose any risk.

- HIV is found in large quantities in blood, semen, vaginal fluids, and breast milk.
- HIV is not found in sweat or tears.
- HIV can be found in very tiny amounts in urine, faeces, and saliva, but the quantity of HIV is not enough for there to be any risk of transmission.
- Cleaning or bathing a patient is quite safe, provided all wounds are covered.
- Kissing, even deep kissing, poses no risks.

Is deep kissing a route of HIV transmission?

Deep or open-mouthed kissing is a very low-risk activity in terms of HIV transmission. HIV is only present in saliva in very minute amounts, insufficient to cause infection with HIV.

ROUTE OF TRANSMISSION: For HIV transmission to take place, the virus must get *inside* your bloodstream.

- Our body is a closed system—and HIV cannot pass through skin.
- HIV can pass through the skin on the genitals—penis, vagina, or anus – during sex, because the skin there is much thinner and has small openings where HIV can pass.
- Even if you have cuts or sores on the skin, there is a very low risk of transmission for the following reasons:
 - a) If you have cut yourself, the blood flows outwards, away from the bloodstream, and it is impossible for anything to swim into your body against that flow; cuts do not suck things in. Example: If you have a plastic bag of water and you hit it with a sharp knife, water flows out, not in.
 - b) If you touch someone else’s cut, their blood will not *swim* into your bloodstream (and your blood will not swim into theirs).

Common sense and everyday hygiene mean that many concerns that people worry about would not really happen in everyday life. For example, you wouldn’t share a toothbrush if it was covered in blood; you would wash if you cut yourself; you would wear gloves or cover your hands if you are cleaning up someone’s diarrhoea.

Using QQR, you can see why HIV CANNOT be transmitted by: kissing; hugging; mosquitoes; sharing food, cups, plates, sheets, or clothes; shaking hands or hugging; sharing toilets; using the same washing water; or sneezing or coughing.

D2. HIV Transmission and MSM

Facilitator’s Notes: This exercise is designed to review and update participants’ understanding of HIV transmission as it applies to MSM.

Ideally, this exercise should be done with the involvement of a resource person who is openly MSM and skilled in explaining these basic facts.

It starts off with a technique called ‘BODY MAPPING.’ A man lies down on top of flipchart sheets taped together and another man draws around him, making an outline of a man’s body. A woman lies down on top of flipchart sheets taped together and a woman draws around her, making an outline of a woman’s body. The resulting life-size pictures of a man’s body and woman’s body become a focus for discussion on sexual body parts, sexual activities, and HIV transmission. All of this extra information is recorded on cards and added to the body map.

The drawing provides a fun, nonthreatening way to get people talking about sexual body parts, sexual activities, and HIV transmission. Using two body maps—a man and a woman—helps to make it easier to talk about all forms of sexual activity and sex between people of the same sex. Participants have fun and have a serious discussion about sex and sexually related issues.

Preparing the body map is only the first step. The important part is using the body map as a focus for discussion on sexual body parts, sexual activities, and HIV transmission.

Body mapping is also used in **Exercise B5**, so you could use the body map produced during that exercise as the focus for discussion.

Participants may be shy at first about naming the sexual body parts. As the facilitator, you should let them do it, rather than doing it for them. Encourage them, even to the point of pointing a finger to a sexual body part and asking, “*What do we have here?*” Once people have got over the initial embarrassment of naming the body parts, the process usually goes smoothly.

Objectives: By the end of this session, participants will be able to identify the risks of getting HIV through different forms of sex involving sexual minorities.

Target Group: All groups

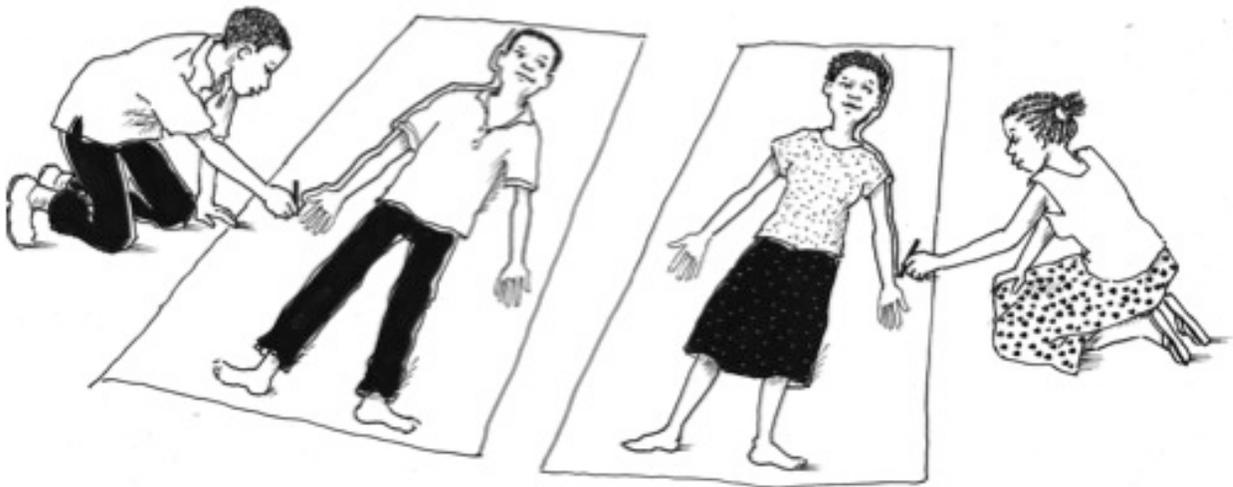
Source: Cambodia MSM Stigma Toolkit (D4)

Time: 1 hour

Handout: D-FS5: HIV TRANSMISSION AND MSM—RISK CONTINUUM

Preparation: Before the session, ask a few participants to help you draw the outline of a male body and a female body on flipchart sheets:

- Tape four sheets of flipchart paper together to form a large sheet.
- Put the taped sheets on the floor and ask one male volunteer to lie down on it.
- Another male participant then draws around the volunteer, making an outline body shape.
- Then use a similar process to prepare a female body map.
- Then tape the two body maps on the wall.



Steps:

SEXUAL BODY PARTS:

Ask participants to write on the sheet the sexual body parts for the male and female bodies, using local names for each part. This could be done in a mixed group or in single-sex groups. In single-sex groups, participants may talk more freely.

EXAMPLE RESPONSES

Male: penis, testicles, buttocks, anus, breasts, nipples, mouth, neck, etc.

Female: vagina, clitoris, breasts, nipples, belly, buttocks, anus, mouth, neck

SEXUAL ACTIVITIES:

Ask participants to write on cards the names of sexual activities—sexual activities between man and woman, between man and man, and between woman and woman – and tape this on the body map. Help the group produce a complete list of sexual activities. Ask probing questions to make sure participants understand each sexual activity.

EXAMPLE RESPONSES

Vaginal sex. Oral sex. Anal sex. Kissing. Mutual masturbation. Massage. Fingering. Fisting. Thigh sex. Licking the anus. Licking the testicles. Other activities.

Discuss the sexual activities practised by MSM, making some of the following points:

- Oral sex and anal sex are practised by heterosexuals and homosexuals.
- Not all men who have sex with men engage in anal sex.

RISK CONTINUUM:

Then put up three topic cards along the wall: high risk, medium/low risk, or no risk. Ask participants to place the MSM sexual activity cards (from the body map) underneath the appropriate category. Involve all participants in doing this activity.

Sample Responses:

Risk Level	Ways in Which HIV May Be Transmitted
High Risk	Receptive anal sex. Insertive anal sex without condom.
Medium/Low Risk	Oral sex (receptive and oral). Fingering or fisting.
No Risk	Mutual masturbation. Thigh sex (pushing penis between the thighs). Massage. Using condoms and lubricant for anal sex.

Take each of the HIGH-RISK activities and ask, “Why is this form of sex a high-risk activity?” Take a few of the MEDIUM-/LOW-RISK activities and ask, “Why is this form of sex a medium- or low-risk activity?” Take a few of the “NO-RISK” activities and ask, “Why is this form of sex a ‘no-risk’ activity?” Record responses on a flipchart.

EXAMPLE RESPONSES

The information below is technically correct information about HIV transmission within an MSM context. Use this information to help participants understand each of these risk situations. Start off by getting participants to explain what they know about each risk situation and how HIV is transmitted. Then provide some of this factual information, when needed, to help fill the gaps in understanding.

- **Receptive anal intercourse: Highest risk.** The rectum is lined with a mucous membrane, a very sensitive part of the body which tears very easily, especially if the insertive partner is not using lubricant. Once the lining of the rectum gets cut, HIV in the sperm or in blood from cuts on the penis of the insertive partner can get easily into the body and

bloodstream of the receptive partner.

- **Insertive anal intercourse: High risk.** This is also risky for HIV transmission, but not as risky as *receptive* anal sex. HIV is contained in blood and rectal fluids that can pass through the urethra of the penis or under the foreskin of someone who is uncircumcised.
- **Oral sex (receptive): Low risk.** Receptive oral sex is more risky than insertive oral sex. The person sucking is more at risk than the person whose penis is sucked. Why? Sperm gets into the mouth of the person sucking and can penetrate the skin around the teeth, which can easily get cut. The skin is strong in most parts of the mouth except around the teeth (the gums), so there is a potential for HIV entering the body through cuts or bleeding in the gums.
- **Oral sex (insertive): Low risk.** The skin on the penis, especially if circumcised, is strong and less vulnerable to cuts. The person sucking may have cuts in the mouth which produce blood, but saliva in the person's mouth protects the penis—there is HIV in saliva, but in such small quantities that it is not risky. Acid in the saliva neutralises the blood from the gums.
- **Extra Note—Oral Sex and STIs:** Oral sex is low risk for transmitting HIV, but it is high risk for transmitting STIs (e.g., chlamydia, gonorrhea, herpes, and syphilis).
- **Fingering or fisting:** Low or medium risk. The risk is low, provided that basic hygiene is ensured and if there are no cuts or broken skin on the hands and no contact with semen or blood. Fisting, however, can tear rectal tissues.
- **Thigh sex: No risk.** Sperm does not get into the anus or mouth, where it could get into the body and the bloodstream.
- **Mutual masturbation:** When MSM masturbate each other, the hands may come into contact with sperm, but the sperm remains outside the body, where it is exposed to air and dies. There is no risk if there are no cuts or broken skin on the hands and no contact with semen.
- **Kissing:** As long as there are no cuts or sores in the mouth, kissing is completely safe. The saliva of the infected person may get into the mouth, but saliva has very low quantities of HIV.

Hand out **HIV Transmission and MSM—Risk Continuum fact sheet (D-FS5)** and discuss. Then ask pairs to talk about what information in the Fact Sheet would help them challenge misconceptions about HIV transmission.

- **HIV has to get inside your body—to become infected by HIV.** This is why sex and injecting drug use help to get HIV into the body. When a person has anal sex without a condom, sexual fluid can get into the body through small cuts in the rectum or penis. When a person injects drugs, the infected blood can go directly into the bloodstream.
- **Receptive anal sex is more risky than insertive anal sex.** The rectum has a large surface area, and the skin in the rectum is very susceptible to tears during anal sex, especially if the insertive partner is not using lubricant. Once the skin gets broken, HIV in the semen or in blood from cuts on the penis of the insertive partner can get easily into the body and the bloodstream of the receptive partner, if they are not using a condom.
- **Insertive anal intercourse is, however, high risk.** Why? HIV contained in blood and rectal fluids can pass through the urethra of the penis or under the foreskin of someone who is uncircumcised during anal intercourse.

- Adolescent boys whose skin in the rectum is not fully mature are more likely to develop lesions or cuts during unprotected anal sex and are therefore at higher risk of getting HIV or STIs.
- Men who are uncircumcised are more likely to become infected with HIV if exposed during unprotected anal (or vaginal) sex than men who are circumcised. How does circumcision prevent HIV? There are several ways in which the foreskin acts as HIV's main 'entry point' during penetrative sex between an uninfected man and an HIV-infected person. The inner surface of the foreskin contains a higher proportion of the cells that HIV targets, such as T-cells. Conversely, the inner foreskin has less keratin, a protein found in the skin, which has a protective effect. Circumcision can reduce the likelihood of genital ulcers, which increase HIV risk. In addition, any small tears in the foreskin that occur during sex make it much easier for the virus to enter the body. See <http://www.avert.org/circumcision-hiv.htm>.
- Water-based or silicone-based lubrication is a must for anal sex. With a condom and lubricant, anal sex can be practised and enjoyed safely.
- **Receptive oral sex is more risky than insertive oral sex.** The person sucking is more at risk than the person whose penis is sucked. Why? Sperm gets into the mouth of the person sucking and can penetrate the skin around the teeth, which can easily get cut. The skin is strong in most parts of the mouth except around the teeth (the gums), so there is a potential for HIV entering the body through cuts in the gums.
- **Insertive oral sex is low risk.** The skin on the penis, especially if circumcised, is strong and less vulnerable to cuts. The person sucking may have cuts in the mouth which produce blood, but saliva in the person's mouth protects the penis—there are very small amounts of HIV in saliva. Acid in the saliva neutralises the blood from the gums.
- Oral sex is low risk for HIV but high risk for other STIs, e.g., orally transmitted gonorrhoea and herpes.
- **Untreated STIs greatly increase one's risk of getting HIV.** Many STIs cause sores, which make it easier for HIV to enter the body. Having a discharge, as with STIs like gonorrhoea, chlamydia, herpes, and syphilis, means that more white blood cells are present. Since white blood cells are hosts for HIV, it means that more HIV can be transmitted or received when the discharge is present. MSM may not have symptoms of STIs or cannot see the sores because they are inside the anus or mouth, which puts them at greater risk.

D3. HIV Transmission and Sex Workers

Facilitator's Note: This exercise is designed to help participants understand HIV transmission as it applies to sex workers.

Preparation:

BODY MAP

Ask a few participants to prepare a body map before the session:

- Tape four sheets of flipchart paper together to form a large sheet.
- Put it on the floor and ask one volunteer to lie down on it.
- Other participants draw around the volunteer, making a body shape.
- Then ask participants to write on the sheet the names of female sexual body parts, e.g., vagina, clitoris, breasts, nipples, anus, mouth, neck, etc.

- Then add sex workers’ sexual activities, e.g., vaginal sex, oral sex, anal sex, masturbation, massage, etc.—each activity written on a card and taped on the diagram.

Steps:

REVIEW OF BODY MAP:

Ask the participants who prepared the body map to present it—sexual body parts and sexual activities. Invite questions to clarify.

RISK CONTINUUM:

Then put up three topic cards along the wall—high risk, low risk, and no risk—and ask participants to place the sex worker sexual activity cards (from the body map) underneath the appropriate category.

Sample Responses:

Risk Level	Ways in Which HIV May Be Transmitted
High Risk	Vaginal sex. Receptive anal intercourse.
Low Risk	Oral sex (receptive).
No Risk	Masturbation. Kissing.

Take each of the HIGH-RISK activities and ask, “*Why is this form of sex a high-risk activity?*” Take a few of the LOW-RISK activities and ask, “*Why is this form of sex a low-risk activity?*”

Take a few of the ‘NO-RISK’ activities and ask, “*Why is this form of sex a ‘no-risk’ activity?*”

EXAMPLE RESPONSES

- **Vaginal intercourse: High risk.** The vagina is lined with a mucous membrane, a very *sensitive part of the body*, which tears very easily, especially if the man is very rough. Once the lining of the vagina gets cut, HIV in the sperm or in blood from cuts on the man’s penis can get into the woman’s body and bloodstream.
- **Receptive anal intercourse: Highest risk.** The rectum is lined with a mucous membrane, a very *sensitive part of the body*, which tears very easily, especially if the insertive partner is not using lubricant. Once the lining of the rectum gets cut, HIV in the sperm or in blood from cuts on the penis can get easily into the woman’s body and bloodstream.
- **Oral sex (receptive): Low risk. Providing oral sex is more risky than receiving oral sex.** The woman sucking is more at risk than the man. Why? Sperm gets into the woman’s mouth and can penetrate the skin around the teeth, which can easily get cut. The skin is strong in most parts of the mouth except around the teeth (the gums), so there is a potential for HIV entering the body through cuts or bleeding in the gums.
- **Masturbation:** When the sex worker is masturbating the client or her sweetheart, her hands may come into contact with sperm, but the sperm remains outside the body, where it is exposed to air and dies. There is no risk of HIV transmission if there are no cuts on the hands.
- **Kissing:** as long as there are no cuts or sores in the mouth, kissing is completely safe. The saliva of the infected person may get into the mouth, but saliva has very low quantities of HIV.

SUMMARISE:

- You can only get HIV through:
 - c) Having vaginal or anal sex without condoms with an HIV-infected person
 - d) Sharing needles or syringes with a PWID who is HIV positive
 - e) HIV-positive mothers passing HIV to their babies before or during birth (through blood) or after birth through breast milk
- **HIV has to get inside your body** to become infected by HIV. When we have vaginal sex, sperm can get into the body through small cuts in the vagina. When we have oral sex, sperm and blood from the man's penis can get into cuts in the gums of the woman. When we inject drugs, the infected blood can go directly into the bloodstream.
- **Providing oral sex is more risky than receiving oral sex.** The woman sucking is more at risk than the man whose penis is sucked. Why? Sperm gets into the woman's mouth and can penetrate the skin around the teeth, which can easily get cut. The skin is strong in most parts of the mouth except around the teeth (the gums), so there is a potential for HIV entering the body through cuts in the gums.
- Oral sex is low risk for HIV but high risk for other STIs, e.g., orally transmitted gonorrhoea and herpes.
- **Untreated STIs greatly increase one's risk of getting HIV.** Many STIs cause sores, which make it easier for HIV to enter the body. Women may not be aware that they have an STI, and the STI sore provides another route for HIV to get into the body.

D4. Health Worker Fears of Infection, Universal Precautions, and Stigma

Facilitator's Note: This exercise is designed for health workers—to help them look at the risks of occupational exposure to HIV within the healthcare setting and how fears about occupational exposure underpin HIV stigma. The aim is to help them understand which healthcare activities are a potential risk, which are not risky, and why Universal Precautions are needed.

Objectives: By the end of this session, health workers will be able to:

- Explain what 'Universal Precautions' means
- Describe what Universal Precautions have been adopted in their own health facility
- Describe healthcare-associated infections and occupational exposure to HIV
- Analyse risk factors and causes of occupational exposure to health workers

Target Group: Health workers

Source: Draft Toolkit on Stigma Reduction in Health Care Settings

Time: 2 hours

Materials: FEARS PICTURE CARDS—see Annexes

Handout: D-FS6: INTRODUCTION TO UNIVERSAL PRECAUTIONS
D-FS7: FEARS OF GETTING HIV IN HEALTH FACILITIES AND HOW TO OVERCOME FEAR THROUGH UNIVERSAL PRECAUTIONS

Steps:

UNIVERSAL PRECAUTIONS PRACTISED IN HEALTH FACILITIES (Group work):

Divide into small groups and ask:

- What do you understand by the term ‘Universal Precautions’?
- What are some Universal Precautions used in your health facility?
- What are the barriers to using Universal Precautions?

EXAMPLE RESPONSES

What do you understand by the term ‘Universal Precautions’?

- Things you do on a daily basis to prevent contact with body fluids
- Use of masks, gloves, gowns, and other protective equipment to protect yourself and others

What Universal Precautions do you use in your health facility?

- Hand washing. Masks. Gloves. Goggles. Gowns/aprons. Caps. Shoe covers.
- Isolation/bags. Sterilising equipment. Good ventilation. Sharps bins. No recapping of needles.

What are the barriers to using Universal Precautions?

- Some materials/equipment (e.g., gloves) are not available to support Universal Precautions.
- Allergic reactions to the use of gloves.
- We want to do things in a hurry—so we don’t give them enough attention.
- Water is not available or water is located a long distance away from the work area.
- Stress and burn-out by staff.

SUMMARISE:

- ‘Universal Precautions’ refers to practices performed to protect health workers from exposure to blood-borne micro-organisms. ‘Universal’ means that these precautions should be applied to all clients, regardless of whether health workers know their status or not.
- Universal Precautions is a system for infection control used to make health facilities safe for health workers and clients. It involves the use of precautions, which are designed to help minimise the risk of HIV exposure by health workers and clients.
- The first principle of Universal Precautions is that health workers apply the precautions to ALL clients, regardless of whether or not they think the client may be HIV positive or have any other infectious disease. It is important to emphasise, however, that Universal Precautions deal with all healthcare-associated infections, not just HIV.
- It is safer to act as if every client is infected, rather than to apply Universal Precautions to some clients and not to others. This is important because it is impossible to tell who is HIV positive based on appearance. Most blood-borne diseases that pose a risk to health workers and clients cannot easily be detected and could be present in the blood of ALL persons, including health workers themselves.
- The general topic areas of Universal Precautions include:
 - a) Hand hygiene
 - b) Using barriers (gloves, masks, gowns, goggles, etc.)
 - c) Aseptic techniques

- d) Use and disposal of sharps
- e) Instrument processing
- f) Housekeeping and waste disposal
- g) Respiratory hygiene and cough etiquette

RISK-CLARIFICATION EXERCISE (Individual Exercise):

Hand out the risk-clarification exercise below and ask participants to complete it individually. (5 minutes)

Please tick (x) in the appropriate column your response to the following statements.

Code: 1 = Strongly agree 2 = Agree 3 = Don't agree 4 = Strongly disagree

Statement	1	2	3	4
Clients who are HIV positive should be placed in a separate room.				
The linens of HIV-positive clients should be separated from the linens of other clients and washed separately.				
All clients prior to surgery should be given a HIV test.				
Appropriate protective barriers, e.g., wearing gloves, are needed when coming into contact with the blood of HIV-positive clients.				
Special care should be taken in cleaning up the blood spills of HIV- positive clients.				
After giving an injection to HIV-positive clients, the needle should be separated and treated differently than needles used for other clients.				
Gloves must be used at all times when touching HIV-positive clients.				
The risk of getting HIV in the healthcare setting is the biggest occupational risk facing health workers.				
Health workers should treat the blood of all clients as having the potential of transmitting HIV and Hepatitis B and C (HBV and HCV).				

Review the responses for each statement and make the following points:

Statement 1: FALSE. There is no need to isolate HIV-positive clients in a separate room because HIV is not transmitted through casual contact.

Statement 2: FALSE. Linen used by clients with HIV does not need to be treated separately from the linen of other clients.

Statement 3: FALSE. There is no need to test all clients prior to a surgery, because surgeons and their teams should apply Universal Precautions in dealing with blood and bodily fluids from all clients. During surgery, they would put on gloves and masks to protect themselves.

Statements 4 & 5: FALSE. Health workers should always wear appropriate protective barriers whenever they come into contact with the blood or bodily fluids of ALL CLIENTS.

Statement 6: FALSE. Health workers should treat ALL NEEDLES in the same way. All used needles should be discarded.

Statement 7: FALSE. When coming into contact with the skin of all clients, a health worker needs to wear gloves only if the client’s or health worker’s skin is not intact. There is no need, however, to use gloves when feeding a client or taking his/her temperature.

Statement 8: FALSE. Contact with HIV-positive clients is NOT the biggest occupational risk facing health workers. The biggest occupational risk will depend on the context.

Statement 9: TRUE. Health worker should regard the blood of every client as a potential source for transmission of Hepatitis B, Hepatitis C, and HIV because it is impossible to test every client; and even if it can be done, a negative test result does not guarantee the HIV-free status of the client (some clients may be in the window period).

HOW IS HIV TRANSMITTED AND NOT TRANSMITTED? (Cardstorm):

Divide participants into groups of three people and provide them with cards and markers. Ask the groups to brainstorm examples of the following and write each point on a separate card:

- What are the ways in which HIV is possibly transmitted in a healthcare setting?
- What are the ways in which HIV IS NOT transmitted in a healthcare setting?

Put up two title cards—“REAL or POTENTIAL RISK OF EXPOSURE” and “NO RISK OF EXPOSURE.” Ask participants to stick cards under the title card which represents the level of risk involved.

Sample answers:

Real/Potential Risk of Exposure	No Risk of Exposure
Needle-stick injury Surgery, e.g., splashing of blood or bodily fluids from a client to a health worker’s eyes, nose, or mouth during a procedure Pelvic examination without gloves Blood transfusion with blood that has not been screened for HIV Delivering a baby without gloves	Taking a client’s blood pressure Taking a client’s temperature Eye examination Feeding the client Consulting with the client

PROCESSING (Plenary):

Discuss the answers, and where answers are under the wrong title card, move to the right column.

DISEASE TRANSMISSION (Buzz Groups):

Divide into pairs and ask:

- What are the possible causes of infections in the health facility?

EXAMPLE RESPONSES
<p>What are the possible causes of infections in the health facility?</p> <ul style="list-style-type: none"> • Poor environmental hygiene. Poor handling of contaminated needles, sharps, and waste. • Poor handling of blood and bodily fluids. Poor hand-washing practices.

MAPPING INFECTION IN THE HEALTH FACILITY (Group Work):

Divide into four groups. Ask each group to make a map of the health facility—and show what forms of infection or health hazards might be found in each section. Then ask them to discuss:

- Who is at risk of being infected with HIV in the health facility?
- How could each group of people contract HIV in the health facility?

EXAMPLE RESPONSES

Who is at risk of getting HIV and how could they get it?

- Nurses and doctors – during surgery and when giving injections
- Lab technicians – when drawing blood
- Cleaners – when cleaning and disposing of medical waste, including sharps
- Clients—through contact with health workers which involves blood or bodily fluids

STIGMATISING PRACTICES WHICH DO NOT PROTECT THE HEALTH WORKER: Discuss:

- What are some unnecessary safety practices performed by health workers?
- Which of these practices may be perceived by clients living with HIV as stigmatising?
- Why are these practices used?
- What can be done to ensure that people are adequately protected from infection, as well as feel less stigmatised?

EXAMPLE RESPONSES

Unnecessary safety practices:

- Using gloves to serve food to a client, take a client's temperature, or do a physical examination when a client has no open sores or injuries;
- Wearing masks to talk to a client with HIV when the client does not have an airborne disease like TB;
- Staying at a distance when attending to an HIV-positive client; and
- Focusing your medical attention on those you suspect are not HIV positive.
- Unnecessary but stigmatising practices
- All of the above

Why are these practices used?

- To make health workers feel safer.
- Some health workers fear getting HIV through contact with HIV-positive clients. They have incomplete knowledge about how HIV is transmitted.
- Some health workers are judgemental towards people living with HIV.

What can be done to ensure that people are adequately protected from infection, as well as feel less stigmatised?

- Train all health workers (including cleaners and guards) on Universal Precautions so they know how to protect themselves and their clients from infection.
- Explain to clients about Universal Precautions so they know why certain precautionary practices are needed—this will make them feel less stigmatised.

SUMMARISE: Present and discuss the following points:

- Some health workers insist that it is their right to be told who is HIV positive so they can protect themselves against HIV. They claim that not knowing who has HIV puts them at risk. They identify who has HIV by isolating HIV clients in separate rooms, marking HIV clients' files, or simply telling other health workers. Or they use double gloves when they are with clients assumed to be HIV positive. These practices are wrong—they stigmatise HIV-positive clients and create a climate of fear around them, and they do not decrease the risk of HIV transmission in the health facility.
- There is no medical justification for the above practices – they do not protect the health worker because HIV is not contagious; it is not spread through casual contact. Trying to put clients into two groups – those who are HIV positive and those who are negative – can be counterproductive. Health workers may be more cautious with HIV-positive clients and less cautious with HIV-negative clients, even though some of the negative clients may be in the window period, when people are at their most infectious or have other blood-borne infections, such as hepatitis.
- Universal Precautions provide a better, non-stigmatising method for protecting health workers and their clients. Universal Precautions are based on the assumption that all blood and bodily fluids are potentially infectious, whether they are from a client or health worker, regardless of their known HIV status, and should be applied to all clients. Universal Precautions give health workers more control over ensuring their own safety within the health setting, while ensuring the safety of their clients.
- We often assume that we as health workers are the ones who are getting infections but, in some cases, we may be the ones who are passing the infections. So Universal Precautions protect both health workers and clients—and health workers should realise that they can potentially pass on infections to clients.
- Everyone in a health facility is at potential risk of contracting HIV – nurses, doctors, non-clinical health workers, clients, and visitors are all at risk in different ways. For example, medical staff are at risk during clinical procedures, while members of the cleaning staff are at risk of infection while cleaning instruments or disposing of waste.
- Knowing how HIV is actually transmitted is an important first step in preventing HIV infection in the health facility. It is equally important to learn how HIV is NOT transmitted, so that health workers know how to properly protect themselves and others.
- Practising correct precautionary measures and explaining why these precautionary measures are taken are two good ways to ensure that people in the health facility are adequately protected and clients feel less stigmatised by the necessary precautions.
- Infection in the health facility may occur through contact with blood or other body fluids, which in turn may occur through broken skin, injuries with contaminated needles and/or sharp

instruments, transfusion of infected blood or blood products, splashing of contaminated body fluid into the mucous membranes, or the use of contaminated razors.

- There is no evidence of transmission through other modes. Transmission does not occur through:
 - a) Casual social contact such as talking, hugging, or sitting next to someone with HIV
 - b) Working together with someone with HIV
 - c) Feeding clients or taking their temperature with a thermometer

CHAPTER E: COPING WITH STIGMA AND DISCRIMINATION

The exercises in this chapter are designed to be used **only with PLHIV and key populations**—or with people who are working with PLHIV and key populations, e.g., health workers, social workers, or other service providers. In the latter case, the aim would be to help service providers get a better understanding about what PLHIV and key populations are going through so they can provide better support.

The aim of this chapter is to help PLHIV and key populations think through their own experiences—how they have been stigmatised, how it has affected their lives, and to help strengthen key populations as individuals to cope more effectively with stigma. The activities allow PLHIV and key population support groups to share experiences and strategies, develop communication and assertiveness skills, and build self-esteem.

Exercises E1, E2, and E3 work well as a package and should be done together—one after the other.

Most of the exercises have been borrowed from:

- BONELA Sexual Minorities, Human Rights, and HIV: Trainer’s Guide
- Cambodia Toolkit on Understanding and Challenging Stigma towards MSM

EXERCISES

- E1. Personal Experiences of Stigma (Reflection)
- E2. Strategies for Coping with Stigma
- E3. Keeping Quiet (Staying in the Closet)
- E4. How to Challenge Stigma in an Assertive Way
- E5. Coming Out of the Closet
- E6. Disclosing to the Family
- E7. Paranoia and Hypersensitivity
- E8. Coping with Stress
- E9. Relations within the PLHIV and LGBTI Community
- E10. Domestic Violence within LGBTI Relationships

E1. Personal Experiences of Stigma (Reflection)

Facilitator’s Note: This exercise is similar to A5. A5 is designed for service providers, community leaders, and the general community. It asks them to think about any experiences they have faced of being stigmatised. E1 is designed for PLHIV and key populations and asks them to think about their experience of being stigmatised as PLHIV or key populations.

If you have a workshop for service providers, use A5. If you have a workshop for PLHIV or key populations, use E1. If you have a combined workshop, use a combination, i.e., the service providers will think about their own experience of being stigmatised, and PLHIV or key populations will think about how they have been stigmatised as PLHIV or key populations.

This exercise requires a lot of **trust, mutual support, and openness** within the group, so it should not be used as the first exercise. It works better if it is used after two to three exercises selected from A1 to A4, where participants identify stigma faced by key populations in different contexts. Then E1 can be used to get a personalised understanding of stigma. By this point, participants are beginning to open up with each other and are now ready to share some of *their own* experiences of being stigmatised as a person living with HIV or member of a key population.

This exercise needs a **good introduction**—to help participants break out of their initial discomfort about sitting and reflecting on their own and sharing their own experiences with others.

Emphasise that **sharing is voluntary**—no one is forced to share, and remind people about the ground rules—that members are protected, and what is shared should stay in the room.

This exercise can trigger painful memories or experiences for some participants. As the facilitator, you should be **ready to deal with the emotions raised**. Some suggestions on this are given in the note on Individual Reflection in the introduction to the facilitator’s guide.

I don’t care what people say. I’ve stopped worrying about what people say about me. We should no longer live in fear of what people are saying. We need to be strong. If you get upset when they insult you, then you are playing into their hands. It gives them more power over you, that they can control your feelings. So don’t let them push your button. Don’t show emotion or you are allowing them to defeat you.

—MSM, Dominica

Objectives: By the end of this session, participants will be able to:

- Describe how they have been stigmatised as PLHIV and/or key populations
- Recognise some of the feelings in being stigmatised and how they have been affected

Target Groups: PLHIV and key populations

Source: Understanding & Challenging HIV Stigma: Toolkit for Action
BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer’s Guide
Cambodia Toolkit on Understanding and Challenging Stigma towards MSM

Time: 1 hour

Steps:

Individual Reflection:

Ask participants to sit on their own. Then say: “*Think about a time in your life when you **felt stigmatised** for being seen as PLHIV, MSM, or a sex worker.*” Give them a few examples—being teased at school for being seen to be different, or being poorly treated in a clinic once staff found out that you were PLHIV, MSM, or a sex worker. Ask them to think about – “*What happened? How did it feel? What impact did it have on you?*”

Sharing in Pairs:

Say – “*Share with someone with whom you feel comfortable.*” Give the pairs a few minutes to share their stories with each other.

Sharing in the large group:

Invite participants to share their stories in the large group. This is voluntary—no one should be forced to give his/her story. People will share if they feel comfortable. If it helps, give your own story to get things started. As the stories are presented, ask—“*How did you feel? How have you reacted to or coped with stigma?*”

EXAMPLE RESPONSES

Personal Experiences of Being Stigmatised

- Stigma and discrimination—at home, community, school, workplace, in the street.
- Standing in line in a public clinic and being ignored or neglected, and being served last.
- Being beaten up in the street for being seen as different.
- Being abused verbally in homophobic songs played over the radio.
- When we walk down the road, people gossip about us, and sometimes they say insulting words, such as “bogra” or “buggerman”—and you know they are talking about you.

How did you feel when you were stigmatised?

- Terrible. Angry. Ashamed. Worthless. Misunderstood. Depressed. Rejected. Judged. Nothing. Powerless. Second-class citizen. Pushed down. Useless. Failure. Hated. Despised.

How have you reacted to or coped with stigma?

- I talk to other MSM and tell them how I am feeling. I ignore the insults and shut my ears. I no longer use the public clinic; I now go to a private doctor. I keep things hidden—I don't tell anyone I am a sex worker. I disguise my behaviour so I don't get harassed.

PROCESSING:

Ask—“What did you learn from this exercise?”

SUMMARISE:

- The feelings of being stigmatised—of being mocked, despised, and rejected – can be very painful, and they last a long time. Everybody has felt stigmatised at different times in their lives. It is okay to have these feelings of shame and isolation – you are not alone.
- Stigma destroys our self-esteem—we begin to doubt and hate ourselves – even in subtle ways. We feel very alone at a time when we really need the support and company of other people.
- The hardest stigma we face is the blaming and shaming from our families. We are forced to change our behaviour to be accepted. Once we lose the love of our families, we feel very alone.
- PLHIV, MSM, and sex workers have rights like other people. We are human beings and deserve to be treated like anyone else.

EXAMPLE STORIES—Stories from key populations at a previous workshop

- I've been told my whole life that I am an 'anti-man,' but this insult still hurts, although I don't let it show. It still bothers me when I hear people saying things about me behind my back. It makes me angry when they taunt me with these words. I can't change – I can't make myself a 'real man.' So it is really hard to be MSM in this country. The starting point is to acknowledge ourselves.
- My sister found out I was gay and told my father that I had invited a boy home to have sex. But we were not doing anything, just talking. My father came home when he heard this and beat me severely. I felt betrayed by my sister—she was the one I used to share everything with. Now there was no one to talk to. I left home and never went back.
- When I go to the clinic, the nurse says in a loud voice, so everyone can hear, "Oh, the 'shim' is here again." The doctor tells me to come back at 2, but when I return at 2, the doctor has already gone. When I finally get to see him, he says, "I don't know how to examine you—you're not normal—you're neither man nor woman." People just don't understand transgender people, so they try to ignore us.

E2. Strategies for Coping with Stigma

Facilitator's Notes: This exercise builds on exercise E1. Participants review the different forms of stigma they are facing—and develop strategies for confronting stigma.

Objectives: By the end of this session, participants will be able to work out personal strategies for confronting stigma and discrimination.

Target Groups: PLHIV and key populations

Source: Understanding & Challenging HIV Stigma: Toolkit for Action
 BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer's Guide
 Cambodia Toolkit on Understanding and Challenging Stigma towards MSM

Time: 1 hour

Steps:

1. With participants' help, **make a list of common experiences** of stigma and discrimination, building on the first exercise (E1).

EXAMPLE RESPONSES: Here are some examples of different forms of stigma and discrimination—identified by key populations at a workshop.

Context	Stigma and Discrimination
Home	Forced to dress and behave like a 'real man.' Scolded for bringing shame to the family. Beating. Forced to do men's tasks. Isolation and exclusion within the family. Forced to get married. Kicked out of the house.
Clinic	Clinic staff are insulting, show their disapproval, and keep their distance out of fear. Gossip about us. Break confidentiality—tell other clinic staff and patients. Invasive questioning—"What kind of sex do you do? Are you man or woman?" Fail to provide appropriate diagnosis, treatment, and care. Fail to provide condoms and lubricant because they are viewed as "immoral."

Public Spaces	Finger pointing, gossip, name calling, and harassment by the public. Not allowed to enter bars and buses, or kicked out of venues.
Community	Name calling, gossip, and isolation towards key populations and their families. Kicked out of housing.
Workplace	Blocked from getting employment or promotion. Name calling and exclusion. Fellow workers avoid talking to you—and whisper behind your back.
LGBTI	There is some stigma within the LGBTI community. Some LGBTI people try to avoid other LGBTI so they are not identified and stigmatised as key populations. For example, some straight-looking MSM discriminate against feminine-looking MSM because they are afraid that if the latter come to meetings, they will be exposed to stigma from the general population.

2. In pairs, **discuss**—“*What strategies do you use to cope with stigma and discrimination? How do you protect yourselves against the effects of stigma and discrimination?*”

<p>Possible Strategies</p> <ul style="list-style-type: none"> • Love yourself—accept who you are. If you accept the stigma and discrimination, you will be weak. So tell yourself—I am gay and I am proud. • Understand who you are. Don’t live your life trying to please other people—if you do, you will end up trying to be many persons. Instead, be yourself. • Ignore stigmatisers and their remarks—and continue on as if nothing has happened. • Try to fit in and avoid drawing attention to yourself, e.g., dress, walk, and behave in ways that help you avoid being stigmatised. • Be assertive and courageous and tell people we have the right to be treated fairly. • Show we are as productive and valuable as any other family or community member. • Find jobs and environments where we won’t get stigmatised. • Educate people about key populations so they know more and are less stigmatising. • Educate service providers so they can speak out and advocate on our behalf. • Find persons in similar situations and form support groups and work together with other key populations. • Challenge people about their stigmatising attitudes in an assertive way. • Fight back when we are seriously being abused. • Demand rights from law enforcement officers.
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3. **Report Back and Processing:** Organise a report back. Then discuss:
- Which of these strategies are the most realistic and doable?
 - Which can we start to implement right away?
 - How can we support each other in coping with stigma as LGBTI people?

4. **SUMMARISE:** Key populations often have a sense of isolation that can cause depression and may lead to alcohol abuse, avoiding loved ones, or risky behaviour. Below are some common coping mechanisms:
- **Ignore stigmatisers**—and continue on as if nothing has happened.
 - Avoid situations which cause stress.
 - **Try to fit in** and avoid drawing attention to yourself as much as possible, e.g., dress, walk, and behave in ways that avoid your being stigmatised.
 - **Be courageous**—challenge people about their stigmatising attitudes in an assertive way. Tell people you have a right to be different.
 - **Challenge the stigma** by showing we are as productive and valuable as any other family or community member.
 - **Educate people about key populations** so they know more and are less stigmatising.
 - **Educate service providers** so they can speak out and advocate on our behalf.
 - **Form support groups** and work together with other key populations.
 - Find jobs and environments where we won't get stigmatised.
 - Challenge people about their stigmatising attitudes in an assertive way.
 - Fight back when we are being seriously abused.
 - Demand rights from law enforcement officers.

E3. Keeping Quiet (Staying in the Closet)

Facilitator's Note: Some people think this is a controversial strategy, but keeping quiet is one of the coping strategies identified by PLHIV and key populations to cope with stigma. It means that in some situations, we might choose to remain quiet and not reveal our HIV status or being a key population member, as a way of protecting ourselves against stigma and discrimination.

Objectives: By the end of this session, participants will be able to:

- Recognise that keeping quiet is a coping mechanism for dealing with stigma in some situations
- Understand how to choose who and when to disclose

Target Group: PLHIV and key populations

Source: Understanding & Challenging HIV Stigma: Toolkit for Action
BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer's Guide
Cambodia Toolkit on Understanding and Challenging Stigma towards MSM

Time: 30 minutes

Steps:

WHEN SILENCE PROTECTS US:

Ask—*“In what situations would you keep quiet about your HIV status, sexual orientation, or sex work?”*
Record responses on different A4 sheets of paper taped on the wall. (In the next step, each sheet will be used by one group.)

EXAMPLE RESPONSES—WHEN WOULD YOU KEEP QUIET?

- At home, wanting to avoid rejection and loss of economic support from parents
- At work, wanting to hold onto your job
- In a public place, wanting to avoid drawing attention to yourself
- Wanting to avoid being stigmatised in front of many people
- In bars, wanting to avoid violence – it may be dangerous—could get attacked
- Choosing carefully who you want to talk to
- Waiting for the right moment to tell someone that you trust

CHALLENGING THE STIGMA (Stop-Start Drama):

Divide into small groups. Ask each group to select one of the situations listed in Step 1—and prepare a role play to show someone being quiet in the situation. (10 minutes)

Report Back:

Ask each group to perform their role play. After each role play, invite other participants to make up another role play, showing the person challenging the situation.

Discuss: in large group

- What happened in the role plays?
- How did the strategy of keeping quiet work?
- How did the strategy of speaking out work?
- How did the characters feel?
- Are there any other strategies you could use in this situation?

E4. How to Challenge Stigma Assertively

Facilitator's Notes: This exercise helps PLHIV and key populations learn how to challenge stigma and discrimination in an assertive way—saying what they think, feel, and want in a clear, forceful, and confident way. Participants practise this skill through a series of paired role plays.

Objectives: By the end of this session, participants will be able to challenge stigma and discrimination in an assertive way.

Target Groups: PLHIV and key populations

Source: Understanding & Challenging HIV Stigma: Toolkit for Action
BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer's Guide
Cambodia Toolkit on Understanding and Challenging Stigma towards MSM

Time: 1 hour

Steps:

Introduction:

Explain that the session is aimed at practising how to challenge stigma in an assertive way, i.e., looking the stigmatiser in the eye and saying what we think, feel, and want in a clear, forceful, and confident way—without being aggressive or showing anger.

Ask participants—in the large group – to brainstorm a list of specific situations in which key populations are stigmatised. Record the list of stigmatising situations on the flipchart.

EXAMPLE RESPONSES

Stigmatising situations faced by key populations:

- Family tells you that you have to be a 'real man'
- Health workers make fun of MSM or sex workers at the clinic
- Family tries to force a gay man to marry a woman

Paired role playing:

Explain that we will now practise how to challenge these forms of stigma and discrimination—taking one issue at a time. Then give the following instructions:

“Everyone stand up and find a partner. Face your partner. A is the father and B is the gay son. In each pair, agree on who is A and who is B. (Wait until they decide.) The situation is: The father tells the son that he should be a ‘real man.’ The son should respond in a strong and confident way. Act out the situation—PLAY!” (Ask pairs to start their role plays.)

EXAMPLE ROLE PLAY

This is an example of what the role play might look like –

Father: “You should change—I want you to be a real man!”

Son: “I am a real man. I’m just attracted to other men. This is who I am. I can’t change.”

Father: “Don’t you care about your future?”

Son: “I do care. If you want me to get married to a woman, that’s impossible. I don’t have feelings for women.”

Father: “If you don’t have interest in women, who is going to marry you?”

Son: “Maybe no one will marry me, but this is the way I am, and I’m proud of it.”

After two minutes, ask a few pairs to show their role plays (one at a time) in the centre of the circle. After each role play, ask: “*How did the gay boy do? Was he convincing and effective? What made a difference in the way he challenged his father?*”

Examples of types of comments on this role play from participants:

- Good eye contact—looked directly at his father. Strong voice. Spoke with confidence.
- Didn’t criticise the stigmatiser—simply asserted his rights clearly and simply.
- Good arguments—“I like myself the way I am.” “I can’t change.”
- Did not apologise for his behaviour. Did not allow his father to dominate or bully him.
- Was not afraid to disagree with his father. Did not give up—insisted on being treated fairly.
- Helped his father (stigmatiser) get a sense of how it feels to be treated like this.

After a few pairs perform, ask other participants if they have a better way of challenging the stigmatiser—and let them take over the role of the gay boy in the play and show their approach. After each new play,

ask – “*What made a difference?*” [Examples—good arguments, strong voice level, body language, confidence, etc.].

Then repeat the same process for other stigmatising situations raised in the Step 1 brainstorm.

PROCESSING:

Ask—“*What have you learned from the practice role plays?*”

EXAMPLE RESPONSES: *What did you learn?*

- I now see that I can do something. I never realised I could challenge the stigmatiser.
- It’s difficult at first. I felt shy. But after a while I began to feel confident.
- The best approach is to say it honestly and simply—“I love men” – it works.
- When I challenged him politely but firmly, he denied that he was stigmatising.
- Don’t be afraid to disagree with the person—to say “No.”

SUMMARISE:

Explain and discuss the following list of assertiveness techniques:

- Tell people what you think, feel, and want clearly and forcefully.
- Say ‘I’ feel, think, or would like.
- Don’t apologise for saying what you think, or put yourself down.
- Stand or sit straight in a relaxed way.
- Hold your head up and look the other person in the eye.
- Speak so that people can hear you clearly.
- Stick with your own ideas and stand up for yourself.
- Don’t be afraid to disagree with people.
- Accept other people’s right to say ‘No’ and learn how to say ‘No’ yourself.
- Some people are full of prejudice—don’t let them make their problems yours.

E5. Coming Out of the Closet

Facilitator’s Note: This session is designed to help MSM (and other LGBTI people) think about what is involved in coming out of the closet. This information could also be used by counsellors in helping LGBTI people prepare themselves for coming out.

Objectives: By the end of this session, participants will have:

- Decided when it is appropriate to come out of the closet, and to whom
- Practised the skills involved in coming out

Target Group: LGBTI

Source: BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer’s Guide
Cambodia Toolkit on Understanding and Challenging Stigma towards MSM

Time: 1 hour

Handouts: E-FS1: COMING OUT OF THE CLOSET

Steps:

EXISTING EXPERIENCE:

Ask the following question and record responses on flipchart—*“Coming out is not easy. Who have you already come out to—and how was it?”*

FEELINGS:

Ask—*“What feelings come up when you think of coming out to a new person? How does that make you feel?”* Record responses on a flipchart.

EXAMPLE RESPONSES

Nervous. Scared. Confused. Excited. Numb. Vulnerable. Empowered. Exhilarated. Relieved. Proud. Uncertain. Ashamed. Affirmed. Brave.

Explain that all of these emotions and feelings are completely normal.

IMPORTANCE AND ADVANTAGES (Buzz Groups):

Divide into pairs and ask:

- Why is it important to come out to others?
- What are the benefits/advantages of coming out?
- What are the risks or disadvantages?

EXAMPLE RESPONSES

Why is it important?

- Can't stand hiding anymore. Don't like lying to my friends and family.
- Keeping my relationship a secret is becoming stressful.
- I don't want to carry this burden alone any more.
- It's hard feeling like I can't trust people.
- I want people I care about to know who I am—all of me.
- It allows me to meet and get support from other MSM.
- I want to accept myself and let others accept me as I am.

What are the benefits or advantages?

- Living openly and no longer having to hide this secret from everyone.
- Building closer and more genuine relationships.
- Getting acceptance and support from the family and others.
- Building self-esteem and empowerment.
- Reducing the stress of secrecy.
- Connecting with other LGBTI who are going through the same situation.

What are the risks?

- People may judge me or not be understanding or reject me.
- I no longer have control over who knows about my sexual orientation.
- Once I am out of the closet, it may be difficult to go back into the closet.
- Friends may be shocked and stop talking to me.
- Loss of economic support, kicked out of the house or a job, blackmail.

Explain that coming out can often contain both advantages and disadvantages when we are trying to decide who to come out to, and when.

WHEN IS THE RIGHT TIME? (Topic Groups):

Divide into four groups and assign each group one of the following topics to discuss. Ask—“When would you feel comfortable in coming out to... a) another MSM? b) family members? c) close friends? d) co-workers? e) health worker?”

Report Back:

Ask each group to give a report.

EXAMPLE RESPONSES

- When I hear them say something supportive of gay or LGBTI people
- When I feel strong enough to tell them
- After I've come out to other MSM (or LGBTI)
- Once I have a supportive group of people to rely on
- When I feel empowered and proud
- I would never feel comfortable coming out to these people
- It's not worth coming out to them
- My privacy should be respected and I don't need to tell them

MAKING A PLAN TO COME OUT (Individual Work):

Ask each participant to make a list of people who they want to come out to. This list is for their eyes only. Then ask a few volunteers to share some of the people they want to come out to. After each report, ask—“*Why do you want to come out to that person? How difficult will it be, and why?*”

- I want to come out to my best friend because I think he is also gay. It will be easy and this wall between us will be lifted.
- My mother already suspects that I'm gay, so I don't want to hide any more. I'm afraid of being kicked out of the house, but I can't lie anymore.
- I want to come out to my ex-girlfriend. We are still friends, but she still doesn't know or understand the real reason our relationship had to end.
- I don't want to lie to my wife any more. We love each other very much, but our relationship can't continue as it is.
- My friend has a gay friend who she talks about all the time, so I might come out to her.

PRACTISING HOW TO COME OUT (Paired Role Playing):

Divide into pairs – ask participants to pair up with someone they don't know or don't know very well.

- Step 1: Ask everyone to pick one person on their list (whom they want to come out to). Then each partner takes a turn doing a role play to show how to come out to this person.
- Step 2: Role Play A: Partner A plays how to come out to partner B, who is playing the role of the person selected in Step 1.
- Step 3: Role Play B: Partner B plays how to come out to partner A, who is playing the role of the person selected in Step 1.
- Step 4: Ask a few of the pairs to volunteer to show their role plays to the whole group.

Debrief:

- How did you feel about disclosing your identity?
- What words or arguments did you use?
- What techniques did you use to tell your story?
- What do we learn from this?

EXAMPLE RESPONSES

- I was so nervous! But now I know I can do this. I will do this!
- I feel so supported and empowered being in this room. It's great to be with people who don't judge me and understand what I'm going through.
- It was so much easier than I thought it would be. I just need to practise saying the words more often.
- I thought even the people in this room would think I was a freak. I was so wrong, and it's good to be supported.
- I couldn't do it. I just couldn't do it. I need more time.
- I feel liberated. I love this feeling.

Statements from MSM in another workshop:

- It's those first five minutes coming out to your friends that are really the hardest. But after that, things get better, because there's nothing standing in between you anymore.
- Admitting I was gay to myself took a long time. Once I was past that step, I realised that not everyone would accept me. But it's not about them. It's about me, living my life as the person I really am.
- There was a wide spectrum of reactions – from warm and accepting to cold and judgemental. But mostly, I was just projecting my own insecurities onto others.
- Everyone needs to make their own decision about when to come out. For me, it's important that people I'm close to know about this important piece of me.
- Most people don't know about gay people. I thought my friend would stop talking to me. He was a bit confused at first, but he accepted me.
- I came to understand that one of the biggest hang-ups was me. I was convinced everybody would have a horrible reaction to my coming out. But my parents were wonderful – as were many others.
- I was really frustrated with people I was coming out to until I realised how long it took for me to accept myself. This process taught me to be more patient with people I love.

SUMMARISE:

Give a summary, using some of the following points:

- Opening up to the possibility that you may be gay is opening up to the idea that you're on a path that's your own. It's also why coming out can be a liberating experience. In the end, and at the beginning, the first person you have to be open with is yourself.

- Coming out and living openly is an act of bravery and authenticity. Whether it's for the first time ever, or for the first time today—coming out may be one of the most important things you will do in your entire life. Being brave doesn't mean that you're not scared. It means that if you are scared, you do the thing you're afraid of anyway.
- There is no one right or wrong way to come out. It's a lifelong process of being ever more open and true with yourself and others—done in your own way and in your own time.
- When you weigh the benefits and risks of being open about who you are, it's important to remember that the person in charge of your coming out journey is you. You decide who to confide in, when to do it, and how. You also decide when coming out just may not be right or necessary.
- Your sexual orientation is an important piece of you, but it does not define you. Living openly doesn't change all the many unique things that make you who you are.
- Don't assume prejudice and project your negative assumptions onto others.
- In coming out, we meet a challenge that was handed to each of us at birth: to be honest about this aspect of our lives, even when it's hard; to talk with the people we care about, even when we don't know all the words.
- Each of us meets this challenge in our own way and in our own time. Throughout the process of coming out and living ever more openly, you should always be in the driver's seat about how, where, when, and with whom you choose to be open.
- When you're ready to tell that first person—or even those first few people—give yourself time to prepare. Think through your options and make a deliberate plan of who to approach, when, and how.
- You can get a sense of how accepting people will be by the things they say—or don't say—when gay issues come up. Try to bring them up yourself by talking about a gay-related news story or something someone else said about gay people.
- The reactions of others will most likely be based on a lifetime of misinformation and, in some cases, even negative portrayals of gay people. If you've done some reading on the subject, you'll be prepared to answer their concerns and questions with reliable and accurate information.
- You don't have to do this alone. A support system is an invaluable place to turn to for reassurance.
- Some people will need time to deal with this new information, just as it took time for many of us to come to terms with being gay. When you come out to others, be prepared to give them the time they need to adjust to what you've said. Rather than expect immediate understanding, try to establish an ongoing, caring dialogue.

E6. Disclosing to the Family

Facilitator's Note: Many LGBTI people are not open with their families about their lives and have difficult relationships with their families. Our families are often the last people to come out to—and the most difficult. Many LGBTI people are willing to take the risk of losing friends or other relationships when they come out, but we only have one family. LGBTI people need skills to be able to tell their families that they are LGBTI. This exercise helps LGBTI explore how they might tell their families and learn techniques for doing this.

One day, my mother told me that I must get married and that she would arrange a wife for me. I refused and found the courage to tell her—“Look, I don’t want a wife. I have feelings for men.”

Objectives: By the end of this session, participants will have:

- Decided when it is appropriate to tell their families that they are LGBTI
- Practised techniques for telling their families that they are LGBTI

Target Groups: PLHIV and key populations

Source: BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer’s Guide
Cambodia Toolkit on Understanding and Challenging Stigma towards MSM

Time: 1 hour

Steps:

INTRODUCTION:

Tell the following story as an introduction to this topic.

“After years of being in the closet, I decided to tell my sister Rosa about being gay. I chose her because I trust her and she is a good listener. We went for a long walk and I poured my heart out to her. I was really nervous about her reaction, but she was great. She said she always suspected that I was gay and would support me. She asked me lots of questions, such as how many partners I’d had. I was a bit shy talking about those kinds of things to my sister. But I was very relieved to at last be telling someone the real truth. Since then, our relationship has got really strong. We now tell each other all sorts of things, not just about our love lives. I don’t feel ready yet, but I hope that one day she’ll help me to ‘come out’ to the rest of the family.”



EXPERIENCE OF DISCLOSING:

Discuss in pairs—*“Have you told anyone in your family about being LGBTI? If so, how did you do it? What happened?”*

PREPARING FOR DISCLOSURE (Pairs):

Discuss in pairs: Think about your relationship to your family and how you feel about telling them that you are LGBTI:

- What are the **advantages** of telling your family that you are LGBTI?
- What are your **fears** about telling your family that you are LGBTI?
- What **methods** would you use (have you used) in telling your family that you are LGBTI?

EXAMPLE RESPONSES

Advantages of telling the family that you are LGBTI:

- Relief – no longer need to hide my identity and have to tell lies to fit in.
- No longer need to live a double life—things would be in the open.
- An opportunity to tell my family who I am and how I feel.
- This would help me ensure that people really understand who I am.
- Enjoy more support from the family once they know what I have been going through.
- Less stigma and harassment from the family.
- No more pressure from the family to get married.

Fears and concerns about telling family members

- Possible rejection. Insults. Shaming and blaming. Name calling. Embarrassment.
- Biggest fear—not to have love and acceptance.
- Relations with others would change completely—loss of love and support.
- Losing economic support from parents.
- Violent reaction—being beaten and kicked out of the family. End of relationship.
- Blackmail—people might use this information against me.
- Not letting my friends come to visit me—watching me all the time.

Methods for telling your family

- Prepare yourself. Are you ready to cope with strongly negative responses?
- Make sure you can take care of yourself financially before disclosing to the family.
- I told one person at a time. When I got a supportive response from the first person, then I tried a second; if the response had been poor, I would have delayed telling others.
- Start with someone you can trust—someone whom you expect will be understanding and compassionate. Convince him/her and then get his/her help in telling other family members, and helping you deal with potential denial and rejection.
- Find a time and place where it is easy for people to concentrate without interruptions.
- Establish a good relationship and trust. Start off by saying—*“The reason I wanted to talk to you is because I know you can support me.”*
- Explain that disclosing this information is very stressful for you.
- Be assertive. Look the person in the eye, tell him clearly and simply that you are attracted to men (or women) and want the person to know this; and want his/her support.

- I told my history, including incidents in my life which showed that I had been gay for a long time. I kept saying, “Do you remember when I was like this?”
- In coming out do it early—don’t wait—the earlier the better. Then you are not waiting your whole life to really live fully.
- Tell your family member that you are not the only LGBTI—that there are other families with LGBTI children.
- Say that your being an LGBTI person is natural. It just happens.
- Explain that you cannot change your sexual orientation, that you cannot stop loving men.
- I poured my heart out and expected them to give me immediate acceptance—this did not happen and I got hurt. We need to be more patient with those around us.
- If someone rejects you, you need to understand that this person has not been to a workshop. Give your family some time to realise and accept that you are LGBTI and eventually they will accept you. This process may take a long time.
- Make sure that your family members know that it is not their fault—it is nobody’s fault.

PRACTISING DISCLOSURE (Role playing in pairs):

Divide into pairs and agree in each pair who will be the first person to practise disclosure. The other partner will be the ‘listener.’

- Do the first role play—and debrief in pairs. Then swap roles and repeat the process.
- After 10 minutes, ask one or two pairs to volunteer to show their role plays to the whole group.

EXAMPLE ROLE PLAY: This is an example of what the role play might look like—

Son: I would like to tell you a personal story—and explain why I refuse to get married.

Mother: You are old now and should have a wife and produce babies for our family.

Son: I know you want me to get married so you can have grandchildren, but I need you to understand my feelings. I cannot get married—I have feelings for men, not women.

Mother: I don’t understand, you look like a real man. Your friends are influencing you.

Son: No – this is my nature, these are my true feelings. This is why I am still single.

PROCESSING:

Discuss with the whole group:

- How did you feel about disclosing your sexual orientation?
- What words or arguments did you use?
- What techniques did you use to tell your story?
- What do we learn from this?

EXAMPLE RESPONSES

How did you feel about talking to your mother?

- I felt both frightened and shy to talk to her about my sexual orientation.
- I was so nervous, but now I know I can do this, I will talk to her.
- I love my family and want their continuing love and respect and acceptance.

- Once I got started to tell my mother, it was easier.
- It was easier than I thought it might be. I just need to practise saying these words.

What words did you use?

- I told her that I want her understanding and support.
- I simply told her that I don't want a wife, I have feelings for men.
- I simply told her that I date men, that I like men.
- I told her that she is not the only mother of an LGBTI, that other parents have LGBTI children.
- I told her that being LGBTI was natural. It's just who I am, like having brown skin.
- I told her that that I cannot change my behaviour, that I cannot stop loving men.

SUMMARISE:

Summarise the main points made by participants. You might include some of the following points:

- Many families find it difficult to cope with the idea that their children are LGBTI—they feel embarrassed, that this will bring shame to the family, and that their children won't get married and give them grandchildren.
- Many LGBTI people are close to their families and want their continuing love, respect, understanding, and acceptance. Families are a very important part of our lives, so telling their families is a big and fearful step. They worry about a negative reaction—shaming and blaming, and violence.
- Many LGBTI have disclosed to friends, but they are still in the closet in relation to their families. Coming out to the family is challenging—in the Caribbean, the family often is the last group LGBTI people come out to.
- LGBTI people who disclose to their families are often those who are financially independent. Those who are financially dependent on their parents may find it to be more difficult to come out of the closet.
- Sometimes the family response might be positive—“We are so happy to know. We knew it already, but waited for you to tell us.” But the response might also be highly negative—some parents kick their LGBTI children out of the house, fearing the shame and loss of status. They also might take the LGBTI child to the church to be prayed for.
- So making the decision to tell your family—who and how and when and where to tell – is a personal decision. You decide when you are ready. No one should force you to disclose before you are ready.
- Practising telling someone can be a useful way to develop personal strategies for disclosure.
- Don't rush—take it slowly and give your parents time to absorb the new information. Because of homophobia, it will take time. Don't expect them to love you in the same way without any change. It takes time for them to understand. It took you time to understand yourself.
- Parents have high expectations and goals for their children, and when you arrive with this 'bomb,' it can shatter all their dreams. They were hoping you were going to give them lots of grandchildren. So take it slowly!
- Your parents are also concerned about what others are saying, and how it will affect the family's reputation. Parents feel partly responsible for how their children are raised. If they discover you are gay, they may think that this reflects on how they raised you. They feel they are being blamed for producing a gay son or daughter.

E7. Paranoia and Hypersensitivity

Facilitator's Note: This exercise aims to explore how self-stigma can develop. It is important to explain that identifying self-stigma is not a reason to blame someone for feeling self-conscious or isolating themselves. Self-stigma happens because of the climate of stigma—it is a reaction to being stigmatised by the community, or the fear of being stigmatised.

Paranoia is defined as an unreasonable belief that you cannot trust other people, or that they are trying to harm you or have bad opinions about you. 'Hypersensitivity' is being easily offended or upset by criticism or implied criticism.

When I go to the hospital, I know that most people don't mind, but I am always thinking about it and worrying. I'm wondering if they know, if they are thinking, 'Why does he always come to the hospital on Mondays.' People treat you differently once they know you are HIV positive or MSM.

Objectives: By the end of this session, participants will be able to:

- Identify the symptoms and causes of paranoia and hypersensitivity rooted in stigma
- Understand how to respond to people who are stigmatising them.

Target Groups: PLHIV and key populations

Source: Understanding & Challenging HIV Stigma: Toolkit for Action
BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer's Guide
Cambodia Toolkit on Understanding and Challenging Stigma towards MSM

Time: 1 hour

Materials: Story (below)

Steps:

PARANOIA (Story-Role Play):

Ask a participant to read the story below or prepare beforehand for some participants to act out the story as it is read aloud. One of the trainers can be 'Tom.' Stop at intervals to listen in on some of Tom's thoughts (say them out loud).

Story

Tom has just started a new job. In his last job, his supervisor found out that he was gay and he was forced to resign. He has moved to a new town and found a new job, but is now worried that his 'reputation' has followed him and his new employers will find out—and he might have to move again.

As soon as he starts the new job, he feels that everyone is watching him and talking about him. They are friendly, but he can see they think him 'different.' When he goes to the toilet, he thinks he can hear them talking about him.

On his way by bus to work, he hears someone in the back, whispering, "gay"—and then a bunch of giggles. He doesn't dare turn around, but he becomes so upset that he gets off at the next stop and walks to the office, even though it is a 20-minute walk.

At work he notices that someone has taped a poster on the wall about monogamy, showing a picture of a man and a woman getting married. Tom has kept to himself at work, but he

thinks that someone has already guessed that he is gay, and the picture is a way of telling him he should marry a woman.

When his boss asks him how he is feeling, he thinks she is asking him indirectly about his sexual orientation. He starts to sweat and feels the beginning of a headache. He thinks that he should have stayed at home today. His boss tells him that he will be working on a new program from next week and, although this is an opportunity he has looked forward to, now he thinks she is trying to get rid of him from her department.

The final straw comes when he sees a male co-worker gesturing and flailing his arms in an effeminate manner, as if he is making fun of someone. Everyone on the other side of the office is laughing. Now he is sure everyone is talking about the fact that he is gay.

Discuss:

- What happened in the story?
- Have you had similar experiences?
- What can we do to reduce these feelings of always being looked at or judged?

EXAMPLE RESPONSES—STRATEGIES FOR COPING WITH FEELINGS OF PARANOIA

- Learn to recognise that we will face stigma in society, but if you are prepared, you won't let it destroy you.
- Don't always assume that you are stigmatised in every situation. Ask why.
- Discuss your experiences of being stigmatised with other LGBTI—and try to distinguish between stigmatising behaviours and those which are simply normal/human reactions.
- Encourage friends who know your sexual orientation to stop 'killing you with kindness'—help them see that over-sympathy also hurts.
- Gain control over your feelings and emotions.
- Use humour as a way to cope with stigma, especially among others in the same situation.



E8. Coping with Stress

Facilitator's Note: LGBTI people face a lot of stigma in their lives, and this leads to stress. This exercise looks at how key populations can cope with stress.

Objectives: By the end of this session, participants will be able to:

- Recognise some of the factors that cause stress in their lives
- Develop skills and strategies for dealing with stress

Target Group: PLHIV and key populations

Source: Understanding & Challenging HIV Stigma: Toolkit for Action
BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer's Guide
Cambodia Toolkit on Understanding and Challenging Stigma towards MSM

Time: 1 hour

Steps:

Discuss:

- What things cause us stress?
- How do we react to stress?

EXAMPLE RESPONSES

What Things Cause Us Stress?

- Finding it difficult to accept or acknowledge myself as a LGBTI person.
- Failing to understand why I am different from straight people.
- Fear of people finding out that I am gay.
- Worrying about how I will disclose that I am gay to my parents.
- Being rejected and disowned by my family and losing their love and recognition.
- Poor relationship between my partner and my family.
- Being unemployed and depending on my partner for survival needs.
- Being in a relationship with a partner who is 'out' but I am not.
- Worrying about where I am going to find a partner.
- Isolation as a transgender person—longing for people to make friends with me.
- Stigma and discrimination at the workplace and people not talking to me.
- Finding work when people know that I am gay.
- Being abused by my partner but finding it difficult to leave the relationship.
- Being blackmailed by my partner, who threatens that if I leave him he will tell my boss.

How do we react to stress?

Feel depressed. Exhausted. Feel irritable. Can't concentrate. Feel negative about myself. Cry very easily. Loss of appetite. Hate waking up in the morning. Can't talk to people about my problems. Drink or smoke too much. No longer enjoy my work.

PROCESSING:

Discuss the following questions:

- Which of these things can we do something about and which are too difficult to deal with?
- What practical things can we do to reduce stress?

EXAMPLE RESPONSES

Which things can we do something about?

- We can do something about problems at the workplace and relationships with friends.
- We should acknowledge ourselves as the first step—to avoid stress.

Which things are too difficult to deal with?

- Poor relationship with my family.
- Being unemployed and depending on my partner for survival needs.

What practical things can we do to reduce stress?

- Acknowledge ourselves—being open to ourselves will help to relieve stress.
- Tell our families and friends that we are LGBTI. Some people will support us.
- Find friends who understand our feelings so they can share them and support and encourage us.
- Being open helps to overcome stress. If you don't, one day you will explode.
- Give ourselves positive messages to build self-esteem.

SUMMARISE:

Summarise the main points made by participants. You might add some of the following ideas on ways to reduce stress:

- Stress is our mental or physical response to problems we are facing. In our lives, as key populations, we are constantly exposed to stress. If we don't do something about the stress, this can lead to illness.
- Stress can be negative or positive—it can break us, or it can be positive.
- One way of dealing with stress is to deal with some of the problems we are facing—those we can do something about. Put your problems in order and set goals to solve one or two of the most important problems.
- Break key problems into small manageable problems which we can solve. Recognise what you can change, and accept what you cannot change—or the things that will take time to change.
- Don't carry all your problems on your shoulders. Maybe friends or family can help you with some of your problems. If your friends and neighbours have similar problems, meet together and share worries and feelings. Look for solutions which you can do together.
- As you learn to accept yourself as a LGBTI person, you will begin to feel better.
- Remove yourself from the source of stress. Use relaxation techniques. Relaxation helps to reduce stress. Play some music that makes you feel relaxed. Have a good cry—it can relieve stress and sadness. Dance!

- Gain control over your feelings and emotions and use humour as a way to cope with stress.

E9. Relations within the PLHIV & LGBTI Community

Facilitator’s Note: One of the biggest problems facing PLHIV and LGBTI people in the Caribbean is the lack of trust within their community. There are examples of PLHIV or LGBTI people disclosing the HIV status or sexual orientation of other people. As a result, there is very little trust among PLHIV or LGBTI people.

There are also examples of divisions and tensions between different types of LGBTI people—some transgender people or MSM who are effeminate are shunned by other MSM, for fear of being exposed themselves.

Objectives: By the end of this session, participants will be able to:

- Recognise the factors, including stigma and lack of confidentiality, which create tensions within the PLHIV and LGBTI communities
- Develop strategies to strengthen relationships within the PLHIV and LGBTI communities

Target Groups: PLHIV and key populations

Source: BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer’s Guide

Time: 1 hour

Steps:

RELATIONS WITHIN THE PLHIV AND LGBTI COMMUNITIES? (Plenary Discussion):

Ask: “*What are the relationships within the PLHIV and LGBTI communities?*” Record the responses on the flipchart.

EXAMPLE RESPONSES

- This is a small country, lots of gossip, and everyone knows what others are doing. Sometimes one PLHIV will reveal the status of another PLHIV. As a result, there is very little trust among PLHIV. They won’t share their secret with anyone.
- Everyone is scared of their secret leaking out—and sometimes it is another PLHIV who reveals this information. So disclosure among PLHIV is a huge issue.
- If I tell anyone, 10 other people will know within a short time. This is why we go to other islands for testing services and medical treatment.
- I don’t discriminate against transgender people, but when I walk with one, I feel ashamed and am afraid people might see us together and mock me for being with them.
- Some gay men stigmatise transgender people—they want to hide their identity and be seen as ‘real men,’ so they avoid contact with transgender people, who are more exposed to stigma.
- Some gay men want to hide their sexual orientation, so they won’t be seen with other gay men who are more effeminate. They are still in the closet or have difficult issues. Everyone has to find his or her own process.
- We have a strong confidentiality rule within our group that members have to agree to.

- Our support group members are comfortable with each other but they are afraid to let new members join the group. It's a matter of trust.

STRATEGIES TO STRENGTHEN RELATIONSHIPS

Ask—“What can we do to strengthen relationships within the PLHIV and LGBTI communities, so together we can fight for our rights?” Record responses on flipchart.

EXAMPLE RESPONSES

- More joint workshops like this one, where we can work together to analyse stigma and discrimination and develop joint strategies for fighting it.
- Learn more about each other by spending more time together and asking questions openly.
- Educate and learn about the diversity within our own community.
- Learn the terminology for all of the different identities and different types of gender expression and sexualities that exist.
- Don't stigmatise each other and don't be ashamed of spending time with other LGBTI people.
- With rights come responsibility—we have a right to identify as we choose, but we have to respect others in our community.
- Service providers should encourage all LGBTI people to work together.

Then agree on one or two things that the group can put into action immediately.



SUMMARISE:

- Some LGBTI people stigmatise other LGBTI people—they avoid contact with them and even join in calling them names and keeping them from attending social events.
- This is a coping strategy by some LGBTI people—to avoid being stigmatised themselves through association with the others, they avoid them and join in stigma and discrimination towards the more exposed LGBTI people.
- In doing this, these LGBTI individuals have accepted the stigmatising practices of the community.
- We need to work together if we are going to break the stigma and discrimination towards our community.

E10. Domestic Violence within LGBTI Relationships

Facilitator’s Note: This issue looks at the issue of domestic violence within LGBTI relationships—something which is often misunderstood or ignored.

Objectives: By the end of this session, participants will be able to:

- Identify different forms of domestic violence within LGBTI relationships
- Identify how violence affects LGBTI people and their partners
- Recognise that domestic violence within LGBTI relationships is wrong and should be stopped

Target Groups: PLHIV and key populations

Source: BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer’s Guide

Time: 1 hour

Materials: Copies of the Case Studies

Steps:

CASE STUDY AND DISCUSSION (Small Groups):

Divide into small groups and hand out copies of the case study. Ask groups to discuss the following questions:

- Make a list of the different forms of domestic violence, with examples.
- What are the effects of the violence on Leo?

Case Study

Martin, a gay man of 35 years, is living with and supporting a 25-year-old gay man called Leo. The relationship works okay at first, but after a while, Martin becomes very controlling.

Leo belonged to a LGBTI support group, but after a while Martin became jealous and told Leo to stop going. He said the group was a waste of time—and threatened to stop supporting Leo financially. He keeps reminding Leo that he pays for his clothes and food and other things.

Martin provides for every need, but he also abuses Leo verbally, saying that Leo is smelly and needs to wash more. He stops having sex with Leo, saying he won’t sleep with him until Leo washes more. Martin starts to beat Leo on a regular basis—when Leo challenges him, Martin says he is doing it because he loves Leo.

Eventually Leo becomes tired of all the violence and emotional stress. He decides to end the relationship. When he tells Martin, Martin says he will tell Leo's family if Leo ends the relationship.

Discussion:

- What happened in the story?
- What other forms of domestic violence happen in LGBTI relationships?
- How can we control and minimise domestic violence within LGBTI relationships?

REPORT BACK:

Organise a round-robin report back.

EXAMPLE RESPONSES

What happened in the story?

- Different types of violence—physical, emotional, and economic violence.
- There is also a form of sexual violence, in the sense that Martin refuses to have sex with Leo on the pretext that Leo is smelly.
- The emotional violence includes blackmail—a) Martin refuses to have sex unless Leo washes more; b) he threatens to tell Leo's parents if Leo ends the relationship.
- There is a continuum of violence—Martin starts off using emotional violence and later begins to use physical violence.
- Leo accepts the violence (physical, emotional, and economic) for a long time before he decides to do something.

How can we control and minimise domestic violence within LGBTI relationships?

- Discuss this issue within the LGBTI community.
- Brief LGBTI – especially young LGBTI—on their rights.

DIFFERENT TYPES OF DOMESTIC VIOLENCE (Topic Groups):

Divide into groups and give each group one of the following case studies. Ask them to read the case study and discuss: “*What happened?*”

Case Study 1: James was raped by his boyfriend and he doesn't know what to do. They have had a great relationship up until recently and have lived together for five years. They got into a heated argument one evening and his boyfriend wanted to have sex, kiss, and make up. But James was still upset with him and certainly not in the mood to have sex. His boyfriend is stronger than him so he overpowered and raped him. James wants to get out of the relationship and report this incident to the police. He's afraid of how he'll be treated by the police. Will they make fun of him? Will they question his manhood? Will they say he deserved it for being in a relationship with a man?

Case Study 2: Godfrey is a well-respected, successful banker. He is known as a “ladies man,” but nobody knows that he is gay, even though he has been living with his boyfriend for two years now. The first time he showed up to work with bruises all over the right side of his face, he told everyone he fell down some stairs. The time he showed up limping, he told his co-workers he got injured playing soccer. He doesn't know how much longer he can cover up his boyfriend's physical abuse. His boyfriend threatens him and says if he tells anyone about the beatings, he will out him to the community. Godfrey doesn't want to lose the respect of others in the town. He wants to seek help but doesn't know where to go. Will the police press charges on both of them for being in a gay relationship? Will the police criticise him? Will they say “*Aren't you a man? Can't you defend yourself?*”

Organise a report back.

EXAMPLE RESPONSES

Case Study 1:

- This case study involves rape within a relationship between two MSM.
- The law says that MSM is illegal, so the victim in this case is worried that if he reports that his boyfriend raped him, he will be arrested as a gay man.
- Instead of prosecuting the rape and collecting evidence, the police will make fun of him, saying things like, *"How could you be raped – you're gay, aren't you? Didn't you like it?"*

Case Study 2:

- This case involves physical violence by one of the gay partners.
- The violence is continuing, not a one-off thing.
- The perpetrator uses blackmail, threatening to out Godfrey if he reports the violence.

PROCESSING:

- What are the causes of domestic violence within LGBTI relationships?
- Why do LGBTI partners not report cases of violence?
- How do the police deal with domestic violence involving LGBTI people?

EXAMPLE RESPONSES

Causes of domestic violence:

- Unequal power within the relationship. One partner wants to use violence to assert control.
- There is very little understanding about violence within LGBTI relationships, so there are few sanctions against this form of violence.

Why do LGBTI partners not report cases of violence?

- They fear further violence, blackmail, and loss of economic support if they report.
- LGBTI partners are not aware of their rights and have accepted domestic violence as a norm, something to be accepted rather than challenged.
- They fear losing face/respect/honour within the community—they have been taught to bottle up the problems and protect the secrets of the relationship.

How do the police deal with domestic violence involving LGBTI people?

- Often there is no serious response from the police. Instead of investigating the case and collecting evidence, some police officers focus on the LGBTI relationship.
- Invasive questioning—Example: *"How could you be raped – you're gay, aren't you? Didn't you like it?" "You deserved it because of having sex with the same sex."*

SUMMARISE:

- Domestic violence does happen in LGBTI relationships and takes **four forms**—physical, emotional, economic, and sexual. It involves **the abuse of power**—one partner takes advantage of the other because s/he is stronger or economically more powerful.
- Domestic violence has a devastating impact on LGBTI partners:
 - a) They get badly hurt **physically** – injuries, disfigurement, miscarriage, STI infections, trauma, and death.
 - b) They get hurt **emotionally**—they feel belittled/worthless, become fearful and anxious, and lose self-esteem and a sense of control over their lives.
 - c) They also lose out **economically**—e.g., loss of their income.
- Domestic violence **destroys relationships, productivity, and health**, and the health of the family and community.
- Domestic violence often takes the form of a **continuum of violence**, with one partner starting off by abusing their partner verbally, later starting to slap them, and then moving to severe forms of battering. Many LGBTI partners suffer through a long-term, violent relationship and, in spite of severe, regular beatings, are often reluctant to get out of the relationship.
- Domestic violence is often viewed by society as something normal—as something not to be taken seriously, so it rarely gets reported to the police. When violence cases are taken to doctors, they are reported as ‘accidents’ rather than as a form of violence.
- Domestic violence is **WRONG**—it is against the law! There is no acceptable form of violence—even a slap is violence!
- LGBTI people have the right to be safe from violence, just like anyone else.
- Domestic violence within LGBTI relationships has to stop. The LGBTI community should break the silence, name domestic violence as a problem, and speak out against it.

CHAPTER F: MOVING TO ACTION

In this chapter, participants plan how they are to take action to reduce stigma and discrimination towards people living with HIV and other key populations.

Thinking about solutions to stigma should not be left to the end of the workshop. It should start from the beginning of the process, so earlier exercises have included problem solving, e.g., exercises in Chapter A: A3, A6, A7, and A9.

This chapter is intended to:

- **Bring together all the things we have learned about stigma towards PLHIV and key populations**—including what can be done practically to change attitudes and behaviour
- **Build up our commitment to change things**—to stop stigma and discrimination towards PLHIV and key populations
- **Focus on what we can do to change things**—as individuals, as communities, and in our workplaces
- **Agree on goals and how to achieve them**—as individuals, as organisations, and as part of a collaborative participatory approach or initiative

Objectives: By the end of this chapter, all participants should be expected to:

- Develop a specific plan of action for challenging stigma towards PLHIV and key populations in their homes, workplaces, and communities, and
- Make a public commitment to work individually and collectively to identify, understand, and challenge stigma and discrimination towards PLHIV and key populations

KEY MESSAGES

- **We are all responsible for challenging stigma, not just PLHIV and key populations.** We can all play a role in educating others and advocating for new attitudes and practices.
- **Be a role model.** Apply what you have learned in your own lives. Think about the words you use about PLHIV and key populations, and try to change how you think, speak, and act.
- **Encourage political leaders and senior managers to speak out**—to talk to others about PLHIV and key populations and condemn stigma and discrimination.
- **Encourage PLHIV and key populations to speak out**—to help people understand how it feels to be the object of stigma and discrimination—and make sure that PLHIV and key populations are listened to.
- **Share what you have learned.** After the training, tell others what you have learned and get others talking about stigma and discrimination, and how to change it.
- **Talk openly about HIV and key population stigma.** Show you are not afraid to talk about this issue. This will help people see that it is not a shameful thing that has to be hidden. Talking openly will also empower PLHIV and key populations and help relieve self-stigma.
- **Discuss stigma with family, colleagues, and friends.** What are the most common forms of stigma in your family, community, or workplace? What can be done to change things?

- **Avoid using stigmatising words.** Instead of saying “these sick people,” use positive words, such as “men who have sex with men” or “brothers and sisters.”
- **Challenge stigma when you see it in your home, workplace, and community.** Speak out, name the problem, and let people know that stigma and discrimination towards PLHIV and key populations hurts them, makes them hide, and helps to fuel the HIV epidemic.
- **Act against stigma as a community.** Each community can look at stigma in their own situation and agree on practical things they can do to do to bring about change.
- **Saying “stigma is wrong” is not enough.** Help people move to action—agree on what needs to be done, develop a plan, and then do it.
- **Think big! Start small! Act now! Have a big vision—but start with something small. And don’t wait – act now!**

Things You Can Do Yourself as Individuals

- Making a change has to start with YOU! Don’t tolerate stigma towards key populations—challenge it whenever you see it, e.g., in the home, school, clinic, workplace, everywhere!
- Watch your own language and avoid stigmatising words.
- Provide a caring ear and support to people living with HIV and key populations.
- Encourage PLHIV and key populations to use health facilities, VCT, and other services.
- Encourage people living with HIV and key populations to join support groups.
- Challenge stigma and discrimination when you see it happen.

Things You Can Do to Involve Others

- Use informal conversations as opportunities to raise and talk about stigma.
- Help normalise PLHIV and key populations. Help people understand that MSM are not ‘sick or morally bad people,’ but people like anyone else, who have a different sexual orientation, not through choice, but through nature.
- Encourage people to talk openly about their fears about PLHIV and key populations and correct myths and misperceptions about them.
- Form local support groups to provide mutual support for key populations.

Things to Get the Community Acting against Stigma

- Activities which get people to identify and analyse stigma towards PLHIV and key populations in the community:
 - a) Testimonies by PLHIV and key populations about their lives.
 - b) Language watch—school children or youth groups can make a ‘listening survey’ to identify stigmatising words used in the community, media, or popular songs.
 - c) Drama performance by a youth group based on real examples—as a trigger for discussion.
- Community meetings to discuss what has been learned from the above methods and make decisions about what the community wants to do to reduce HIV and key population stigma.

- Training workshops on HIV and key population stigma for service providers, NGOs, community-based and faith-based organisations (CBOs and FBOs), and community leaders.

Things You Can Do at School

- Assign students to do mini-research projects on HIV and key population issues.
- Integrate study of HIV and key population stigma into the life skills programme and other school subjects, e.g., getting students to read a story on the life of an HIV-positive or gay boy.
- Put on picture-drawing competitions and drama performances about these issues.
- Publish articles on HIV and key population stigma in the school newspaper.
- Get existing school clubs to discuss HIV and key population stigma.
- Invite PLHIV and key population resource persons to give testimonies on their experiences.

Things You Can Do in the Workplace

- Watch our language, remove stigmatising words, and challenge statements which make fun of people who are different.
- Challenge cases of homophobia in the workplace.
- Incorporate learning about HIV and key population stigma within workplace policies.

Things You Can Do in the Police Force

- Incorporate training on key populations into the training curriculum for police officers.
- Encourage all police officers to address cases of violence towards and victimisation of key populations seriously, focusing on the violence, not the sexual orientation of the victims.
- Work with human rights organisations to advocate for law reform related to key populations.
- Document the obstacles which block officers from serving the public in a stigma-free way.

EXERCISES

- F1. Start with a Vision – “A World without Stigma”
- F2. Problem Analysis and Problem Solving
- F3. Problem Solving in Stakeholder Groups
- F4. Human Rights – PLHIV and Key Populations
- F5. How Inequality Leads to Denial of Human Rights and Vulnerability to HIV
- F6. Challenge the Stigma—and Be the Change!
- F7. Confidentiality
- F8. Counselling Skills and Value Judgements
- F9. Writing a Code of Conduct for a “Stigma and Discrimination-free Health Facility”
- F10. Ten Steps for Moving to Action

F1. Start with a Vision—“A World without Stigma”

Facilitator’s Note: This exercise helps to develop a vision of the kind of world we want to build—a world without stigma—and then use this vision to decide on the steps to reach it.

If you are running a workshop that includes many different groups, divide into the different groupings to conduct this exercise (e.g., health workers, community workers, teachers, etc.). The aim is to have stakeholders working in the same field (e.g., health workers) do this exercise as a group and agree on the changes needed within their own contexts (e.g., a health facility).

Objectives: By the end of this session, participants will be able to:

Describe the existing world, with stigma, and the future desired world, without stigma.

Identify specific actions which need to be taken to challenge and uproot stigma.

Target Groups: All groups

Source: Cambodia Toolkit on Understanding and Challenging Stigma towards MSM

Time: 1 hour

Steps:

PICTURE DRAWING (Groups):

Divide into groups and hand out paper and markers.

- Work as a group to draw pictures and write words on sheets of paper to show different scenarios and tape the sheets on the wall as a group drawing. The first drawing will be a **BEFORE** picture—the world as it is now, a world with HIV and key population stigma. The pictures could show different scenes of PLHIV and key populations being stigmatised.
- Make a second drawing of the **AFTER** picture—a world without stigma.
- Make a list of actions to be done to change things—to create a world without stigma.

Report back:

Ask each group to present its picture. As each presentation is made, ask questions to help clarify the drawing—and invite others to comment.

Individual Actions:

After the groups have reported, ask each person to write down on a sheet of paper what s/he can do individually to make a change. Then go round the circle, asking each person to state what s/he plans to do to make a change.

EXAMPLE: HEALTH FACILITIES

Picture 1 – World with stigma: MSM sitting alone on a bench at a clinic. Other patients staying at a distance from him. Clinic staff serving other patients first and the MSM last. Health workers showing disgust and fear in examining MSM—making negative comments.

Picture 2 – World without stigma: MSM sitting with other patients who are friendly to him. Health workers providing counselling, information, and condoms and lubricant.

Action Plan

- Train health workers about: 1) key populations—their lives and challenges; 2) patients’

rights, including the right of HIV+ and key population patients to equal care and confidentiality; 3) how to provide counselling in a nonjudgemental way

- Train health workers in the skills to diagnose and treat STIs in MSM and talk with comfort about different sexual practices without judgement.
- Invite PLHIV and key populations to attend the stigma-reduction training workshops for health workers so that health workers learn directly from them how they feel about the way they are treated in health facilities.
- Implement a new code of conduct—treat all patients equally, with confidentiality and non-stigmatising attitudes.
- Build working relations between health workers and PLHIV and key population support groups, and invite the support groups to advise health workers on services provided to these patients.
- Provide information on HIV transmission within same-sex relationships and through anal or oral sex.
- Speak up and challenge other health workers when they stigmatise or discriminate against PLHIV and key populations.
- Get all health workers to stop using insulting words towards PLHIV and key populations.
- Teach everyone that PLHIV and key populations are like anyone else—deserving of respect, acceptance, confidentiality, and equal treatment.

EXAMPLE: POLICE SETTING

Picture 1 – World with Stigma: MSM makes complaint at police station about being raped, but police refuse to deal with it.

Picture 2 – World without Stigma: MSM reports case to police and police take action.

Action Plan:

- Hold meetings with key population organisations to develop a collaborative plan to protect key populations when they have problems and ensure they are safe.
- Train police officers on: 1) sexuality and sexual orientation; 2) the rights of PLHIV and key populations to equal treatment by the police; 3) how to deal with PLHIV and key populations in a sensitive and nonjudgemental way.
- Speak up and confront other police officers who stigmatise PLHIV and key populations.
- Get all police officers to stop using insulting words towards PLHIV and key populations.
- Teach the police that PLHIV and key populations have rights like anyone else.
- Teach everyone that PLHIV and key populations are human beings, so we should treat PLHIV and key populations the same way as other members of the public.

F2. Problem Analysis and Problem Solving

Facilitator's Note: This exercise asks participants to analyse the root causes of HIV and key population stigma—and then to work on solutions.

See also problem solving exercises in Chapter A—exercises A3, A6, and A7.

Objectives: By the end of this session, participants will be able to:

- Define the root causes of HIV and key population stigma
- Identify specific actions which need to be taken to overcome stigma

Target Groups: All groups

Source: BONELA LGBTI, Human Rights, and HIV/AIDS

Time: 1 hour

Steps:

SMALL GROUP WORK:

Divide into groups and ask each group to define the root causes of HIV and key population stigma in their country.

Organise a report back.

Example of output from workshop

Problems and Root Causes

- Lack of information about PLHIV and key populations
- Attitude of individual service providers towards PLHIV and key populations
- Legal context—penal code which criminalises homosexuality and sex work
- Cultural and social conditioning which makes people reject PLHIV and key populations
- Religion—churches label key populations as sinners (but in the New Testament, Jesus asked: “Who shall cast the first stone?”)
- Political, community, and religious leaders opposed to changes on this issue
- PLHIV and key populations afraid of a strong response if they are found out—so they remain in hiding
- Lack of trust and conflicts within the PLHIV and key population communities
- Health workers and other service providers afraid to work with key populations, thinking that they will be viewed as breaking the law
- Lack of information on safe sex practices to be used by PLHIV and key populations

Ask each group to work on **SOLUTIONS** to the above problems—short-term and long-term solutions. Ask them to be as specific as possible.

Example of output from workshop

- Provide education in the schools and the community on PLHIV and key populations
- Encourage PLHIV and key populations to come out and let people know about their rights
- Encourage PLHIV and key populations to form support groups to make their voices heard and become more visible – so they can talk and advocate on these issues

- Educate political, religious, and community leaders and senior managers on these issues, because they are the change makers and set policy
- Educate community and church leaders so that they can speak out and say that PLHIV and key populations exist and should be accepted—people will listen to them
- Educate everyone to see that key populations exist, that they are part of the HIV solution, and should not be left out
- Educate faith-based leaders—emphasise the necessity of acknowledging key populations and challenge resistance because of deeply rooted beliefs in the Bible and culture
- Emphasise that culture should be dynamic enough to be open to change—to ensure that key population issues are accepted and incorporated into our culture
- Educate families and challenge the practice of families disowning and abandoning their LGBTI sons and daughters
- Educate employers so that they stop firing LGBTI employees
- Use the media for public education on these issues; weave these issues and PLHIV and key population characters into radio drama; use radio phone-in programmes in which PLHIV and key populations are given an opportunity to answer questions
- Law reform—change the law (penal code)
- Lobby for the inclusiveness of policies related to service provision, e.g., PLHIV and key populations should be able to access health and other services without difficulty
- Use the argument that you need to protect PLHIV and key populations because, in the long run, HIV will come back and infect you



F3. Problem Solving in Stakeholder Groups

Facilitator's Note: In this exercise, participants work in stakeholder groups (e.g., PLHIV support groups, key population support groups, health workers, teachers, community leaders, faith-based leaders, media workers, etc.) to analyse problems in their own context and look for solutions. It can be used in large workshops where there are participants from different stakeholder groups. This exercise can support the development of anti-stigma policies and practice.

Objectives: By the end of the session, participants will have developed practical strategies for challenging and uprooting stigma in their own contexts.

Target Groups: All groups

Source: Understanding and Challenging HIV Stigma: Toolkit for Action

Time: 2 hours

Preparation: Put up signs for meeting spaces for different task groups—a) PLHIV support groups, b) key population support groups, c) health workers, d) youth workers, e) faith-based groups, f) teachers, and g) media workers.

Steps:

1. Ask participants to “vote with their feet”—to join the group of their own choice. You should monitor this process so there is a good mix of people in each group.
2. Ask groups to develop concrete action plans by discussing the following questions:
 - What forms of HIV and key population stigma do you see in your organisation or community?
 - Prioritise – What is the biggest stigma problem in your organisation or community?
 - What is the source of this problem?
 - What are some possible solutions to this problem?
 - What are two or three specific new things you would like to do to stamp out stigma in this context?
3. Push groups to make concrete suggestions—“Think big. Start small. Act now!”
4. **Report Back:** Ask each group to give a report.



EXAMPLE RESPONSES

HEALTH WORKERS

Forms of Stigma: Poor handling of confidentiality. Files carelessly handled; some health workers gossip about patients. For this reason, many HIV-positive and key population patients have stopped going to the clinic. Nurses pass remarks about patient’s sexual history—‘having had many partners’ or ‘selling her body.’ Health workers avoid doing anal examinations of MSM patients.

Strategies to Combat Stigma: Allow health workers to talk about their own attitudes, feelings, fears, and behaviour. Help them deal with fears about their own HIV status and burn-out. Teach skills in sensitively handling HIV-positive and key population patients. Develop codes of practice. Update health workers on HIV and stigma, including HIV contracted through anal sex.

COMMUNITY

Forms of Stigma: PLHIV and key populations face isolation, insults, and discrimination. In some cases, they are kicked out of accommodations or their businesses suffer—people stop buying

from them.

Strategies to Combat Stigma: 1) involve community leaders and CBOs in promoting anti-stigma work; 2) use PLHIV and key populations as role models and facilitators; 3) organise community meetings, peer group meetings, and home visits; 4) organise drama performances; 5) make links between the clinic and community; and 6) educate community members about key populations and PLHIV.

CHURCH/FAITH GROUPS

Forms of Stigma: Gossip about church members who are assumed to have HIV or who are MSM. Silence and fear. Lack of adequate knowledge about HIV among church leaders (e.g., pastors, deacons) results in silence. Some HIV-positive and key population church members are asked to leave the church.

Strategies to Combat Stigma: Use churches as place to discuss stigma. Get the faith group to recognise that they stigmatise, i.e., blame and judge people for getting HIV or being LGBTI. Educate faith group leaders on stigma and help them play a lead role in anti-stigma action. Encourage them to become counsellors in a non-stigmatising way and role models for treating PLHIV in non-stigmatising ways.

MEDIA

Forms of Stigma: Incorrect, fear-inducing messages on AIDS and PLHIV. Disseminate the message that AIDS = immediate death. Contradictory information, so the community is confused.

Strategies to Combat Stigma: Provide up-to-date and correct information. Avoid threatening images. Give a more positive and hopeful view of PLHIV, e.g., pictures which show PLHIV who are in good health and living normal lives, and who still can actively contribute to their families and society. Involve PLHIV in educating media workers on these issues. Present positive media images on MSM and other LGBTI people.

F4. Human Rights—PLHIV and Key Populations

Facilitator's Note: This exercise looks at how the rights of PLHIV and key populations are violated—and what might be done to address these human rights violations.

During the initial brainstorm, where participants are naming the rights violated, probe further on **how** the rights are violated. During the second activity, where groups are working on solutions, push them to come up with **realistic solutions**.

Objectives: By the end of this session, participants will have:

- Identified different rights which could be violated in the case of PLHIV and key populations
- Developed realistic strategies for protecting the rights of PLHIV and key populations

Source: BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer's Guide

Time: 1 hour

Materials: Photocopies of the scenarios

Handouts: F-FS2: WHAT ARE HUMAN RIGHTS?
F-FS3: HIV, STIGMA, AND HUMAN RIGHTS

Steps:

WHAT ARE HUMAN RIGHTS? (Buzz Groups):
Ask pairs to discuss two questions:

- What are human rights?
- What are examples of human rights?

Report Back:

Take each question, one at a time, and ask pairs to give one point each. Record the first discussion on a flipchart and the second discussion on individual cards (so the cards can be used in the following exercise, on which rights get violated).

<p>EXAMPLE RESPONSES</p> <p>What are human rights?</p> <ul style="list-style-type: none">• Fundamental things which every person must have because they are human• To be treated fairly by everyone, regardless of who we are and what we do, i.e., regardless of our gender, age, occupation, sexual orientation, etc.• Practices that protect human beings against ill treatment or violence <p>Examples of human rights</p> <p>Right to: life, food, water, work, shelter, clothing, health, freedom, education, protection, dignity and respect, privacy (confidentiality), religion, sex, have children, get married, own land and property, vote, freedom of movement, freedom from discrimination.</p>
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VIOLATION OF HUMAN RIGHTS (Small Group Activity):

Divide into groups of three and ask each group to select one human right listed in Step One. **Group task:**

- Decide on how the right might be violated if the person is HIV positive or a key population.
- Discuss—How could this violation be challenged?

Report Back.

Ask each group to describe how the right might be violated—and what could be done to address this violation.

<p>EXAMPLE RESPONSES</p> <p>Right to Quality Healthcare</p> <p>Example of Violation: Rushed treatment or being kept waiting—even when you have an appointment, no bedding, no cleaning of rooms, etc.</p> <p>Solution: Training of health workers; discipline and suspension. Review and update policies and enforce them. Ensure that policies include key populations.</p> <p>Right to Marriage</p> <p>Example: MSM not allowed to get married as a gay couple. This is currently against country's</p>

laws. In some countries, people are forced to have an HIV test before marriage.

Solution: Lobby for amendment of laws; education; alternate ways of childrearing (adoption).

Right to Have Children

Example: HIV-positive women who have children are viewed as putting their unborn child at risk. Told not to have children; or if they already have children, told not to have any more. Tubal ligation of HIV-positive women to prevent them having any more children.

Solution: Education and empowerment of women—know they have the right to say ‘no’ and speak out and get support.

Right to Employment

Examples: Fired (or denied promotion) on the basis of (assumed) sexual orientation.

Solution: Legal action against companies. Amendment of workplace policies. Support groups to help fired employee. Get lawyers and speak up—go to authorities and get resolution.

Right to No Torture

Example: MSM are abused verbally, physically, emotionally, and psychologically.

Solution: Education. Countries which have signed human rights declarations should be pressured to ratify those laws.

FINDING SOLUTIONS (Case Studies):

Divide into small groups and give each group one of the case studies (below). Ask them to read the case study and discuss:

- Which rights have been violated?
- How well do you think the character in the story was able to stand up for their rights in the situation given? What could you do if you were the person whose rights were violated?
- As a health worker, what do you think should have been done to empower people to stand up for their rights?
- What do you think should have been done to protect the person’s rights? What examples do you have from your own experience?

Report back and processing:

Ask groups to present the key points from their discussions, giving the main strategies to challenge the violation.

Case Studies

Susan is a sex worker. People in her community suspect that she is a sex worker and do not respect her because they think sex work is wrong. She tries at all times to practice safer sex with her clients, but her boyfriend refuses to use condoms. She knows that he has other girlfriends in their community and suspects that he is not using condoms with them because she keeps getting the same STI. The first time she went to the clinic to get treatment for the STI, the nurse reluctantly treated her and told her that she needs to use condoms, “*doing what you do.*” Knowing that she got the STI from her boyfriend, she tried to talk to him to go and get treated and use condoms, but he became angry and beat her up. He continued to demand unprotected sex from her and she got infected with the STI again. When she returned to the

clinic, the same nurse saw her but refused to treat her, saying, *“You are wasting precious resources by what you are doing on the streets. There is no point treating you because you will just come back again.”*

Linda is a sex worker who prides herself in her professionalism in her work: she insists on condoms with her clients, even when they offer her more money for unprotected sex; she does not even give oral sex without a condom; she makes sure she has regular health check-ups; and she is able to take care of her children and other family members with her earnings. One day, when she refused to have unprotected sex, a client raped her. Afraid that she would be arrested if she told the police that she had been raped by a client, she did not report the incident, but rushed to the clinic to get post-exposure prophylaxis (PEP). The nurse refused to give her PEP, stating that a police report was needed to give it to her. Afraid to tell the nurse her story, she went home and prayed that she had not been infected with HIV.

Terry is a gay man who is HIV positive. When his CD4 count fell below 250, he enrolled in the ART programme. When he went for the first meeting, he was told to bring his ‘girlfriend’ as his adherence supporter. At the next appointment he came with his male lover, and told the nurse that this man was his treatment supporter. The nurse said, *“Is this your partner? I’m sorry, but I told you to bring your girlfriend, not your boyfriend. He doesn’t look like a dependable guy. We need someone who can be responsible. Looking at you guys, I don’t think you can be reliable enough to adhere to the medication.”*

James is a gay man who went to a clinic for an STI checkup. The nurse said, *“If you have an STI, then you must be given an HIV test.”* The nurse bullied James to take the test. When the results were revealed, the nurse said, *“I’m sorry, you are HIV positive. You need to stop this gay thing! That’s where it all started.”* There was no post-test counselling and the staff sent him out of the clinic without even treating him for the STI. He felt totally humiliated.

Barbara, a nurse, dislikes MSM – they make her uncomfortable and she thinks they are immoral. When they come to get help from her, she gives them dirty looks, rushes through medical examinations, and does not provide the information and condoms they need to avoid getting or transmitting HIV. These clients don’t say anything, but they do notice that they are not being treated as well as other clients. The hospital manager has noticed that clients are reluctant to be treated by Barbara and that many of them leave her consultation room looking dejected.

Case A (Susan): Refusal to Treat Sex Worker Who Returns for STI Treatment

HR Violations: Right to health. Right to treatment. Right to dignity.

Solutions:

- Challenge the health worker—“It is your duty to provide health care. I am not asking for special treatment. I just need help to cure this STI.”
- Seek assistance from the facility manager.

Case B (Linda): Refusal to Provide PEP without Police Report

HR Violations: Right to health. Right to freedom from inhumane treatment.

Solutions:

- Explain to the health worker the circumstances—that PEP needs to be administered

quickly and the police report takes a long time.

Case C (Terry): Discrimination at Clinic—Told to Bring “Girlfriend” as Treatment Supporter

HR Violations: Right to health. Right to treatment. Freedom of choice (to choose his own ‘buddy’ or treatment supporter).

Solutions:

- Don’t wait—challenge the homophobic health worker while you are in the clinic.
- Clarify the procedure: a treatment supporter is not just one’s partner; it could be a family member and could be male or female.
- Challenge the health authorities directly, saying that ARVs are available to all citizens.
- Ask the health worker—“*What policies are you using in making this decision?*”
- Make the health worker understand the issues of same-sex relationships.
- Seek assistance from other service providers to intervene on your behalf. Demand to see the person who is in charge of the centre.

Case D (James): Discrimination at Clinic – No Consent, No Counselling, and No Results

HR Violations: Right to freedom of speech. Right to counselling, confidentiality, and consent (3 Cs). Right to treatment.

Solutions:

- Don’t wait—challenge the stigmatising health workers while you are in the clinic.
- Ask the health worker—“*Why are you giving the results like this—is this professional?*”
- Ask to see the manager and complain about service. “*The staff are not treating me fairly. I am only asking to be given treatment – let’s focus on treatment, not who I sleep with.*”
- The problem here is not the policy—it is the attitudes of the health worker—she is not doing her job—performance and attitude problems.

Case E (Barbara): Discrimination at Clinic—Rushed Treatment and No Provision of Information

HR Violations: Right to health care. Right to information. Right to freedom from discrimination.

Solutions:

- Approach the facility manager to complain. The manager has a responsibility to ensure that she protects the rights of clients visiting the facility and makes sure that they receive proper care and treatment.
- The manager should investigate the issue and, if she finds that Barbara has been acting unprofessionally, she should remedy the situation through negotiation or discipline/punishment, and prevent this behaviour from continuing.

CLOSING ACTIVITY:

Hand out cards with a human right written on each card. Ask each person to read his/her card, going round the circle: Each person stands up and says—“I am human and I have a right to ... ‘be loved,’ ‘get married,’ ‘have a family,’ ‘good quality health care,’ ‘food and shelter,’ ‘job of my choice,’ ‘education,’ ‘be treated with confidentiality,’ ‘be safe from violence,’ ‘equal justice,’ ‘vote.’”

SUMMARISE:

- PLHIV and key populations have human rights like anyone else and should be able to access those rights. But their rights are abused because of stigma and fear.
- In most English-speaking Caribbean countries, the penal code does not criminalise sexual orientation, it only criminalises sexual activity which is ‘against the order of nature.’
- ‘Against the order of nature’ refers to any type of sex other than a man and a woman having vaginal sexual intercourse. ‘Against the order of nature’ could refer to:
 - a) Anal sex – done by heterosexuals, homosexuals, and bisexuals
 - b) Oral sex – done by heterosexuals, homosexuals, and bisexuals
 - c) Masturbation—done by heterosexuals, homosexuals, and bisexuals
- Because of criminalisation and stigma, key populations are forced to operate in a climate of secrecy and find it difficult to get information and advice on safe sex practices. As a result, they are more vulnerable to getting HIV and may be more likely to pass HIV to others.
- The fear of being arrested prevents key populations from asserting their rights—in fact, they accept the violation of their rights as part of their stressful lives as key populations. As a result, they find it difficult to make complaints to the police for fear of being arrested, or challenge the stigma they face in health facilities and other public services.
- In the Caribbean, there is a clause in the constitution of many countries saying that everyone is free from discrimination on the basis of race, colour, creed, or political opinion. This list, however, does not include sexual orientation. Many Caribbean countries have signed international conventions to protect human rights, but in practice many do not provide legal protection for PLHIV and key populations.
- Sexual practices between consenting adults in private should not be criminal, as they are part of a private morality that is not the law’s business.
- The penal code should be amended so that key populations are protected under the law. If the penal code is amended, it will be easier to :
 - a) Protect key populations from abuses of power and protect their human rights.
 - b) Incorporate key populations into the national response to HIV and AIDS.
- **Key populations are more at risk for HIV infection because of their limited access to human rights.** Because they lack rights and have limited power, it is difficult for them to control sexual decision making and other choices that will lead to a healthy lifestyle. For example, it is difficult for them to access and use condoms and lubricant, and negotiate safe sex with partners. This makes them vulnerable to getting HIV.

- Once key populations get HIV, they are exposed to more discrimination and violation of their rights. (See next exercise.)



F5. How Social Inequality Leads to Denial of Human Rights and Vulnerability to HIV

Facilitator’s Note: HIV is a human rights issue because of social inequality—HIV affects people who are the most vulnerable, e.g., key populations (including LGBTI), women, youth, and the poor. Because their rights are often violated, they are more vulnerable to getting HIV. Once they get HIV, their rights are further eroded, making it more difficult for them to access health services.

Objectives: By the end of this session, participants will have analysed the links between the following issues:

- Social inequalities
- Denial of rights
- Vulnerability to HIV
- HIV and key population stigma

Source: BONELA Human Rights and HIV: Trainer’s Guide (D3)

Time: 1 hour

Steps:

EFFECT OF HIV ON DIFFERENT GROUPS:

Divide into small groups and assign each group a target group, e.g., LGBTI, sex workers, women, youth, and poor people.

Discuss:

How does HIV affect your target group—before and after getting HIV?

EXAMPLE RESPONSES

Group	Vulnerability to HIV	Effects after getting HIV
LGBTI	Forced to hide sexual orientation. Less access to health services and information on HIV prevention. May not use safe sex practices and become exposed to HIV.	LGBTI are already stigmatised. When they get HIV, it adds one more layer of stigma. Result: they receive poor treatment at health facilities and, as a result, fail to get adequate treatment and care.
Sex workers	Less access to health services to protect themselves from HIV – get condoms and access STI treatment	Sex workers are already stigmatised. HIV adds one more layer of stigma. Result: poor treatment at clinics.
Women	Economic dependency and fear of violence by male partners make it difficult for women to negotiate safe sex—make them vulnerable to HIV.	HIV-positive women often blamed for “bringing HIV home,” kicked out of the house, and lose economic support. May get re-infected by their partners.
Youth	Young girls – limited control over sexual decisionmaking, vulnerable to sexual abuse, and greater physiological risk of getting HIV. Boys—vulnerable to sexual abuse by older men or women.	Young girls – blamed and shamed for getting HIV, even if they have little control over sexual decisionmaking or were subjected to sexual abuse. Boys—confusion about sexual identity if abused by men; self-stigma.
The Poor	Little information and access to HIV prevention. Poor women have little education, so they are often forced by poverty to do commercial sex work—which exposes them to HIV.	Cannot hide HIV—easily seen by neighbours. Attend public clinic, where status gets known. Rich people can hide status—go to private doctors. Financial cost involved in caring for PLHIV can cripple poor households.

REPORT BACK:

Ask each group to report and then discuss the following:

- How do inequalities and denial of rights lead to HIV infection and discrimination?

SUMMARISE:

Summarise the main points made by participants. You might include some of the following points:

- **Vulnerable groups**, such as MSM, sex workers, women, children, and poor people are **more at risk of HIV infection because of their limited access to human rights**. Because they lack rights and have limited power, it is difficult for them to control sexual decisionmaking and other choices that will help them avoid getting HIV. For example, it is difficult for them to access and use condoms and negotiate safe sex with partners. This makes them more vulnerable to getting HIV.
- Once individuals who are members of vulnerable groups get HIV, they are often exposed to more discrimination and violation of their rights.
- A **human rights-based approach** focuses on the obstacles facing key populations (including women) to accessing their rights. It recognises that people have different vulnerabilities related to their gender, age, economic status, sexual orientation, etc.
- A human rights-based approach recognises that **the main causes of disease are social problems**, e.g., gender inequality, poverty, and stigma and discrimination. We need to deal with these underlying problems to prevent diseases such as HIV.

F6. Challenge the Stigma—and Be the Change!

Facilitator’s Note: This exercise looks at how to challenge stigma towards key populations in one’s day-to-day work as a service provider. The same exercise could be adapted for use in learning how to challenge stigma towards PLHIV.

Participants learn how to be assertive and then practice this skill in a series of paired role plays. The aim is to help people see that acting against stigma can be done whenever it happens.

Objectives: By the end of the session, participants will have the skills to challenge stigma and change the situation, using an assertive approach.

Target Groups: All groups

Sources: Cambodia MSM and Sex Worker Stigma Toolkits (E3)

Time: 1 hour

Steps:

Introduction:

Explain that the session is aimed at practising how to challenge stigma in an assertive way, i.e., looking the stigmatiser in the eye and saying what we think, feel, and want in a clear, forceful, and confident way, but without being aggressive or showing anger.

Paired role playing:

Explain that we will now practice how to challenge stigma and discrimination in different common work situations, taking one issue at a time. Then give the following instructions:

Role Play 1:

Everyone stand up, find a partner, and face your partner. You are both health workers. Decide in each pair who is A and who is B. (Wait until they decide.) Now make a role play about the following situation—A complains to B about a client, saying that the client (who is assumed to be MSM) is disgusting and immoral. Health worker B should respond in a strong and confident way. Play!

EXAMPLE ROLE PLAY

A: Why are we wasting our time on him? He is mentally sick and a danger to everyone.

B: He is no different from anyone else. He just happens to love men, not women.

A: But he is having sex with men, which is against our culture and religion.

B: There is nothing in our religion to say that men cannot have sex with men.

A: Okay, but I don’t know why we have to treat him. He should go somewhere else.

B: As health professionals, we have a code of conduct. We need to treat all our patients equally. We cannot stop serving a person because we don’t like him. It is part of our responsibility as professionals to provide medical care to everyone.

After two minutes, ask a few pairs to show their role plays (one at a time) in the centre of the circle. After each role play, ask, “*How did the ‘challenger’ do? Was she/he convincing and effective? What made a difference in the way s/he challenged the other health worker?*”

Example Comments on role plays:

- Good eye contact—looked directly at her colleague. Strong voice. Spoke with confidence.
- Didn't criticise the stigmatiser—simply explained her duties/responsibility as a health worker.
- Good arguments—*"He is no different from anyone else."* *"There is nothing in our religion..."*
- She was not afraid to disagree with the first health worker. Did not back down, apologise, or allow the health worker to dominate her. She patiently insisted that the health worker do her job.

After each performance, ask other participants if they have a better way of challenging the stigmatiser and let them take over the challenger's role in the play and show their approach. After each new attempt, ask, *"What made a difference?"* (e.g., good arguments, strong voice level, body language, confidence, etc.)

Then repeat the paired role playing for other scenarios. For each new scenario, the partners should take turns playing the 'stigmatiser' and 'challenger' roles.



Other scenarios:

- A health worker refuses to examine an MSM client, saying he is disgusted with the MSM's sexual behaviour. Try to challenge the stigmatiser.
- One health worker refuses to treat a sex worker who is waiting in line. Try to challenge the stigmatiser.
- Two men enter the clinic and say they are a couple and have come for a HIV test. The counsellor says they should go to another clinic. Try to challenge the stigmatiser.

PROCESSING:

Ask, *"What have you learned about the best ways to challenge stigma?"*

EXAMPLE RESPONSES

- Avoid getting upset—stay calm. Don't raise your voice.
- The best approach is to say it honestly, clearly, and simply: *"This is wrong."*

- When I challenged her politely but firmly, she denied that she was stigmatising.
- Avoid condemning this person and telling him/her he is wrong.
- Ask questions to help clarify why this person is stigmatising the client.
- Help the person think about her behaviour and how it affects the client.
- Get the stigmatiser to think about her own experience of being stigmatised—and how it felt.
- Help the person deal with her fears towards the client.
- Explain your argument for treating the client in the same way as other clients.
- Encourage the person to take responsibility for caring for the client.

SUMMARISE:

- We can all challenge stigma on an individual level, using an assertive approach.
- When stigma leads to discrimination, however, you may need to develop policies or a code of practice to protect clients. Involve senior managers in this process.
- The most powerful responses to people who are stigmatising are those which make the stigmatiser stop and think, rather than attacking responses which make the stigmatiser defensive. Examples of strong responses:
 - *You are probably not aware that you are stigmatising.*
 - *MSM did not choose to become MSM. This just happens; it is natural.*
 - *We have a code of conduct as professionals to serve everyone.*

Then explain and discuss the following list of assertiveness techniques:

- Tell people what you think, feel, and want clearly and forcefully.
- Say “I” feel, think, or would like.
- Don’t apologise for saying what you think, or put yourself down.
- Stand or sit straight in a relaxed way.
- Hold your head up and look the other person in the eye.
- Speak so that people can hear you clearly.
- Stick with your own ideas and stand up for yourself.
- Don’t be afraid to disagree with people.
- Accept other people’s right to say “No” and learn how to say “No” yourself.



F7. Confidentiality

Objectives: By the end of this session, participants will be able to describe:

- An individual's right to confidentiality
- The potential effects of a health worker violating confidentiality

Time: 1 hour

Steps:

TRUST GAME (15 minutes):

Ask participants to think of a secret they would not want anyone else to know. Ask them to write the secret on a piece of paper, fold it up, and not show it to anyone. Now ask each person to pass their paper to the left.

Ask:

- How does it feel to have **your own secret** in someone else's hands?
- How does it feel to have **someone else's secret** in your hands?

Now ask the papers to be returned, and participants can destroy their papers.

PROCESSING:

- What does this tell us about confidentiality?
- What should be kept confidential?
- What rules should we have about confidentiality?

How does it feel to have your own secret in someone else's hands?

- Anxious. Not trusting they will keep it a secret. Unsure how he or she will use the information.

How does it feel to have someone else's secret in your hands?

- Privileged. Powerful – I know something that others don't. Worthy of the other person's trust. Unsure what to do—should I keep the secret or look at it?

What does this tell each of us about confidentiality?

- Carrying someone else's secret can be a burden. When someone gives us his or her trust, I should keep it. Someone is putting her or his trust in me, so I should respect that.

What should be kept confidential?

- What people tell us should be kept confidential.
- Information which could increase stigma or discrimination, e.g., a person's HIV status.
- Information which could increase the risk of physical or emotional violence.
- Information which could be used by the authorities in a harmful way against the person.

What rules should we have about confidentiality?

- Keep confidential information to yourself. Someone should only share information which the person concerned wishes to be shared—no one should be forced to share information about her or himself.

SUMMARISE:

- Secrecy and confidentiality are often viewed as the same thing, but they are different:
 - a) **Secrecy** is information known to you alone—it is not shared. If your HIV status was a secret, it would mean that you would not tell anyone.
 - b) **Confidentiality** is information that is managed by the person who owns the information. It is shared with others on a controlled basis. You decide with whom you are willing to share this information, expecting that access to this information will be restricted (respected) according to your wishes. Knowing that your HIV status is confidential means that you have control over who knows your HIV status.
- We all like to think that we are trustworthy. But clients are unlikely to trust you just because you are a health worker. Whoever you are, trust has to be built and maintained.
- This is the basic idea of confidentiality—that you only tell others whom you trust about certain information which is sensitive, e.g., your HIV status. You trust (expect) that they will keep this information confidential—not share it with others.
- All health workers, irrespective of their employment status, are required by their own ethical codes of practice (and often by law) to keep the information that they learn about their patients confidential.

DRAMA:

Ask participants to act out the following drama:

Norman is a young MSM. He visits the clinic to get tested for HIV. During his pre-counselling session, he discloses to the nurse that he has a male partner. He gets tested and, while waiting for the results, overhears nurses gossiping about him. He gets very upset and leaves the clinic. His partner consoles him and he returns the next day to get the results and post-test counselling. The nurse—a new nurse—tells him he is HIV positive. He is upset and because of the earlier experience, he feels that everyone must be talking about him, so he is very guarded in his responses to the nurse. He notices that she seems very uncomfortable with him. As a result, there is very little communication. The nurse fails to get him to talk about how he is going to manage his health and his future life. He remains largely silent and does not ask for any advice about what he should do. The nurse keeps talking about ‘his girlfriend’ but Norman knows she means his male partner. He avoids any discussion about his partner and leaves without any information about how to manage his future life.

He feels very angry and refuses to go back to the clinic. He goes to a private clinic and starts to take ARVs. But he finds he cannot afford this treatment and he stops.

Discuss:

- What was wrong with the way Norman was handled?
- How could Norman’s confidentiality have been maintained?

SUMMARISE:

What is confidentiality?

- Confidentiality is about sharing sensitive information with only those who really need to know, or those who the patient decides of his or her own free will to tell. The person most affected by the information—the patient—is the owner of the information. Others must respect his or her wishes about sharing it.
- Each MSM and sex worker should be encouraged to disclose information about their sexual practices, so the health worker can make a proper diagnosis. The health worker must treat this information with respect. The MSM or sex worker patient has the right to control who receives this information.
- **Every person has the right to confidentiality**—the right to decide what aspects of his or her life are private and what can be released into the public domain (a bit like Facebook). This includes the right to confidentiality regarding a person’s HIV status.
- **Confidentiality is a human right—an essential part of the human right to privacy.** This right is protected by the constitutions of many countries. It protects the individual’s home, life, and reputation, plus personal information, such as medical records.
- A health worker may discover things about a patient, such as his sexual orientation, that are considered private. The health worker should keep this information confidential.
- The health worker should protect the information provided by a patient and not disclose this information to any third party. Whatever is discussed between the health worker and patient should remain a private issue between the two of them.
- The information should not normally be shared without the specific permission/consent of the owners. Information shared between health workers about a client must always be done for the purpose of enhancing the health of the client.

Why confidentiality?

- If a health worker breaks confidentiality, she or he puts the patient at risk of being rejected by the family and facing other forms of stigma and discrimination.
- The health worker builds a relationship of trust with the client by agreeing to keep information confidential.
- If a person feels his sexual orientation will remain confidential, he will be more open to providing the information needed by the health worker to make a proper diagnosis, and more likely to seek counselling, testing, treatment, and support.

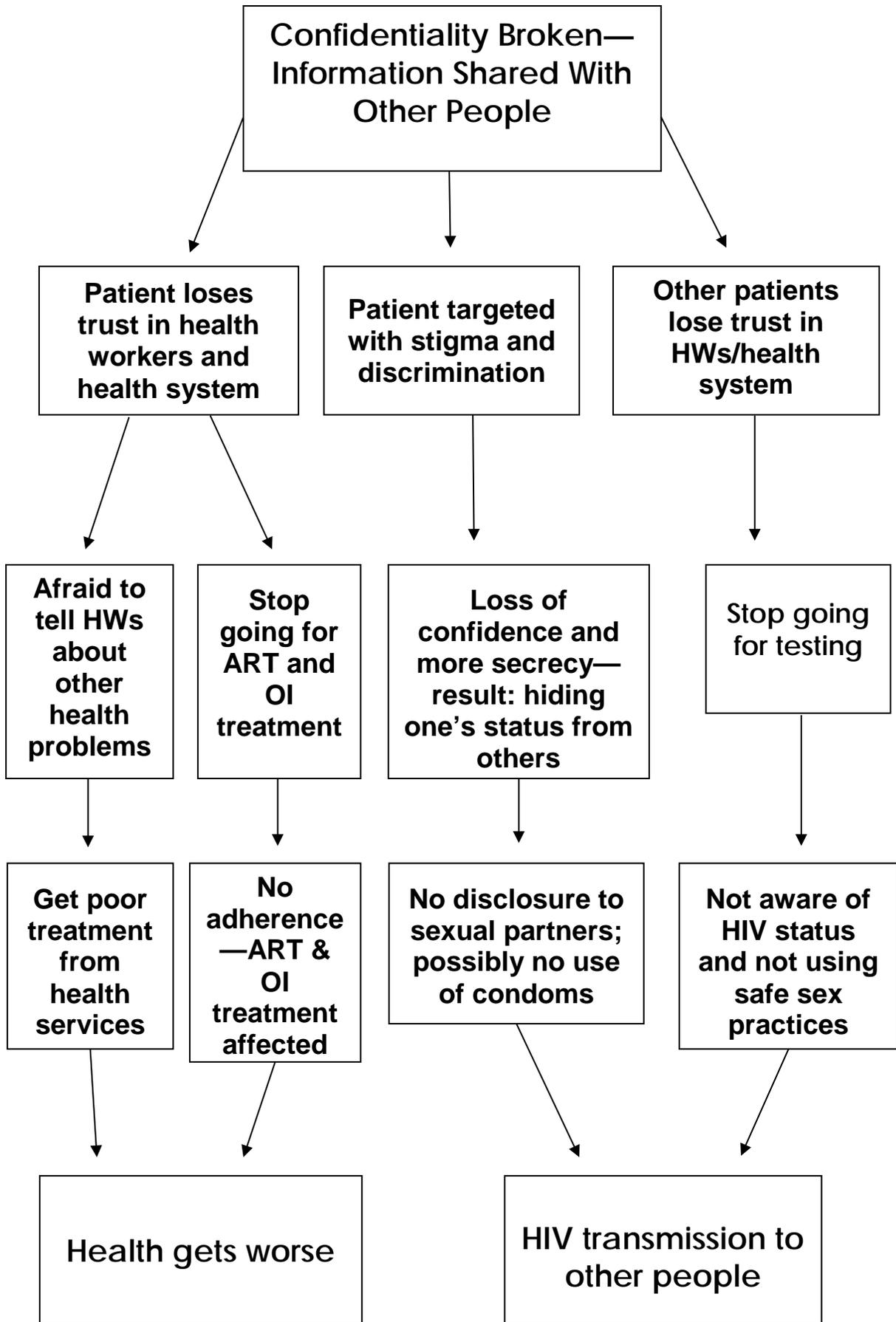
What happens if confidentiality is not respected?

Failure to respect the right to confidentiality will drive the HIV epidemic underground:

- MSM and sex worker patients will be afraid to be tested for HIV because they fear that the information will be released to the public and they will be victimised.
- The patient may lose trust in health workers and become afraid to share other important information about their health, and as a result not get the best treatment for their condition.
- The patient may be subjected to stigma and discrimination by family, employer, etc.
- Once stigmatised, the patient may avoid health services, which have exposed him/ her to stigma and, as a result, may not access treatment, care, and support.
- The patient may lose confidence and become more secretive about his HIV status; for example, not telling sexual partners. As a result, they may pass HIV on to others.

Health workers have a duty to maintain confidentiality.

- Health workers have a duty to maintain the confidentiality of the information they learn about their patients. Many health workers working in the HIV field criticise the practice of confidentiality, saying that the practice helps to create stigma and therefore creates a block to prevention efforts. However, the truth is that the **lack of confidentiality leads to stigma**—PLHIV or key populations are afraid that their HIV status or their sexual orientation or behaviour will be exposed and they will be stigmatised, so they stay away from health services that they feel will not keep their information confidential.



F8. Counselling Skills and Value Judgements

Facilitator's Note: This exercise helps health workers explore how their value judgements about key populations could affect the quality of their counselling in an HIV clinic. Sometimes these judgements lead to stigma, e.g., clients may be 'rushed through' a session, given inappropriate advice, or avoided or referred on to other counsellors because a health worker refuses to see them.

It is important that health workers have the skills to counsel MSM, sex workers, and other key populations and are willing to ensure equal access to these services to all clients.

The exercise provides counselling skill practice. The main focus of the practice sessions is to make health workers aware of the ways in which they may judge clients and how their judgements affect the quality of the counselling.

Explain that pairs will practice the first part of the counselling session, where the counsellor is trying to establish rapport and find out the client's concerns.

Objectives:

By the end of this session, health workers will be able to:

- Describe counselling situations which challenge their value judgements
- Demonstrate how to use counselling skills to counsel clients from different backgrounds
- Explain how their own value judgements could impact on their counselling sessions

Target Group: Health workers and other service providers

Sources: Draft Toolkit on Stigma Reduction in Health Care Settings

Time: 1 hour

Materials: Scenarios listed at end of exercise—give one to each group

Steps:

Listing Scenarios (Buzz Groups):

Divide into pairs and ask: "What situations might feel less comfortable to deal with as counsellors?" Give an example if needed, e.g., a man talking about his male partner, or a sex worker who has been beaten by a client. Record responses on the flipchart—and then select a few scenarios for the practice described below.

Counselling Practice:

Divide into groups of three people. Explain that, in each group, one person will play the counsellor, one person the client, and one person the observer. Each 'client' will be given a role to play (without letting the counsellor know what the role is). Explain that all of the role plays will focus on the start of the counselling session. The role of the counsellor is to build rapport with the client, ensure confidentiality, and find out what the client's concerns are. The role of the observer is to note whenever questions or statements from the counsellor contain a value judgement.

Then hand out the scenarios (one to each group) and ask the groups to play the counselling session.

Large Group Discussion:

Bring the group back together and **ask:**

- Clients—How were you treated? Do you feel you were being heard?

- Counsellors—How did the session go?
- Observers—What happened? Did the counsellor make any value judgements?

Emphasise that the aim of the session is not to assess counselling skills, but to help everyone become more aware of the ways in which we might make judgements about clients when we are counselling.

Stop-Start Counselling Practice:

Invite one pair to show the group a few minutes of their session in the centre of the circle. After a few minutes, shout ‘Stop!’ and ask—“*How did it go? Did the counsellor make any value judgements?*” Then invite other participants to take over the counsellor’s role and continue the role play. Explain that you or other participants will shout ‘Stop!’ when the counsellor makes a value judgement.

PROCESSING:

Ask:

- What have we learnt from this?
- How might our own value judgements interfere with the counselling process?
- What can we do if we find that our own judgements or inexperience are affecting the service we offer to a particular client?

EXAMPLE RESPONSES

- Ask a colleague to take over.
- Take it to a supervision session.
- Refer the client to a specialised service.
- Make an appointment so that you have time to research and ask other people who may have some experience.
- Be honest with the client and say that this aspect is new to you.

SUMMARISE:

Draw out the main points from the discussion. Make some of the points below to add key things which may be missing:

- We need to be aware of how our values and judgements can impact on our counselling practice.
- We need to accept and respect clients as they are, since this is one of the cornerstones of counselling.
- Treat each client as an individual and be open to what they need to discuss. We need to respect each client’s issues and explore the context in which they live to help frame good decisions.
- All clients have a right to access our counselling service, and with the same quality.
- Remember the key counselling principles—we need to accept everyone and be nonjudgemental.

ROLES FOR CLIENTS—COUNSELLING ROLE PLAYS

1. You are a man and have been with your male partner for two years. Two days ago, he told you that he had fallen in love with someone else and was leaving you. He also said that you should get checked for HIV. You are feeling very sad and start crying during the counselling session.
2. You are a sex worker as a way of surviving, but you hate what you do and worry all the time about HIV. You are scared to tell the counsellor what you do, but you want to find out if she can help you find a way to get out of sex work.

3. You sell sex as a way of surviving and really enjoy meeting different people and earning money. There are some sexual practices, e.g., anal sex, that you want to ask the counsellor about, to see if there is a risk of HIV and get some advice about it—but you are not sure how the counsellor will react.
4. You have tested positive for HIV and are feeling very angry. All you can talk about to the counsellor is how it is all your wife’s fault, and you will make sure she is ‘punished’ when you get home.
5. You are a woman and have come to find out information about HIV risks. Your husband has started insisting on anal sex; you feel embarrassed to ask, but you need to know how to protect yourself.
6. You are an 18-year-old, unmarried, and sexually active young woman. You want to find out how to protect yourself against pregnancy and STIs and learn more about the risks of different kinds of sex. Your boyfriend is asking to have anal sex and you are unsure how to respond.
7. You are a prisoner and have been brought to the health facility because you are sick. You want to tell the counsellor that you have been forced to have anal sex with other prisoners and find out what you can do.
8. You are a young man and have realised that you are more attracted to other men than to women. You want to talk to the counsellor about how you are feeling and where to meet other gay men.
9. You have returned to the clinic after telling your husband about testing HIV positive last week. Your husband has left you and the children and he is threatening to tell the whole family.

F9. Writing a Code of Conduct for a “Stigma and Discrimination-free Health Facility”

Facilitator’s Note: This exercise is designed to get health workers to write codes of conduct for health facilities which are free of stigma and discrimination towards key populations. The same exercise could be adapted for use in developing a code of conduct for health facilities free of stigma towards PLHIV. The example given below is for health workers, but a similar process could be used to develop codes of conduct for police officers, social workers, and other groups.

This exercise describes a process for bringing together health workers and key populations. (The same exercise could be applied to health workers and PLHIV.) It should be done only after the health workers have gone through other exercises in the Facilitator’s Guide on their own as a group, which would help prepare them for this exercise. In particular, it would be useful if health workers have already done **Exercise A10**, where they identify stigma and discrimination in health facilities.

The idea of bringing the two groups together is to ensure that health workers take their cues from key populations regarding the health services they need, rather than deciding for them.

The output of this session will be practical guidelines, agreed upon by both parties, which can be used to guide health practice. Applying the new guidelines on a daily basis will help to reinforce what was learned during the workshop. Health workers will begin to internalise new, non-stigmatising ways of working, which will become standard practice. This will ensure that the rights of key populations are supported and that they receive high-quality and comprehensive services.

Objectives: By the end of this session, participants will have produced guidelines for running health facilities on a stigma-free basis.

Target Group: Health workers

Sources: Toolkit on Stigma Reduction in Health Care Settings

Time: 1 hour

Handout: F-FS5: DEVELOPING A CODE OF CONDUCT FOR A STIGMA-FREE HEALTH FACILITY—EXAMPLE

Steps:

HOW ARE KEY POPULATIONS TREATED IN HEALTH FACILITIES?

Put up a list of the major forms of stigma in health facilities and their effects on key populations—which were identified in exercise A10.

EXAMPLE RESPONSES

Stigma and Barriers in the Clinic:

- LGBTI people are laughed at or harassed in the waiting room.
- Bureaucratic and unfriendly treatment and insulting language is used.
- Health staff gossip about LGBTI and sex workers and show their disapproval/judging.
- Break confidentiality—health facility staff tell other staff and patients about LGBTI and sex worker patients.
- Blaming and shaming - *"You deserve to get this because of your disgusting behaviour."*
- Health staff lack skills to diagnose and treat STIs triggered by anal or oral sex.
- If MSM comes for HIV/STI testing and counselling, he is asked, *"How many women have you had sex with?"* and told he doesn't need to be tested when he answers *"Zero."*
- Health staff are uncomfortable talking about sexual practices without judgement.
- Health workers assume that all patients are heterosexual. For example, they may say to a gay man, *"When you are with 'your girlfriend.'"*
- Some health workers are more concerned about the patient's sexual orientation than dealing with the illness.
- Invasive questioning, e.g., *"Where did you get this STI? What kind of sex do you have? When was the last time you had sex with woman? How do you have sex with a man?"*
- Some key populations are reluctant to access health services because they do not want to reveal their sexuality for fear they will be discriminated against.
- Some patients are forced to lie about their situation because of fears of being stigmatised—so health workers lack the information needed to make a full diagnosis.

Effects

- Key populations feel insulted, humiliated, and angry, and feel they have no solutions to their health problems.
- Key populations stop using the health facilities and do not get their STIs treated.
- Key populations resort to other forms of treatment, e.g., use of private doctors who treat them with more confidentiality and less stigma, or self-treatment.

- It may affect their self-esteem/self-confidence and they may deny their sexual risk and take more risks in their sexual behaviour (e.g., not using condoms).

FINDING SOLUTIONS TO STIGMA (Small Groups):

Divide into small groups of four people—two key populations and two health workers in each group. Ask each group to write a set of guidelines for a stigma-free health facility.

EXAMPLE RESPONSES

Charter for Change – Building a Stigma-Free, User-Friendly Health Facility

- **Treat all patients with equality, respect, dignity, and privacy.**
- **Ensure that care for key population patients is not denied, delayed, or referred elsewhere, and that it is the same quality as the care provided to other patients.**
- **Ensure that all staff are trained in patients’ rights and the right of key population patients to equal and confidential care.**
- **Ensure that staff are trained in the skills to diagnose and treat STIs in sexual minority patients and talk comfortably about sexual activities without judgement.**
- **Challenge stigmatising words and actions when you see them.** Get health workers to think about how their words and actions can hurt.
- **Encourage health workers to talk openly about their concerns about LGBTI and sex worker patients** and correct myths about them. This will help people see that these are not shameful things that have to be hidden. Talking openly about key population patients will also empower key populations and help relieve some of their self-stigma.
- **Normalise same-sex behaviour.** Get people to regard LGBTI patients as ‘people with a different sexual orientation or gender identity,’ not ‘people with bad behaviour.’
- **Educate other patients and the community on key populations**—that key populations are like anyone else; deserving of respect, acceptance, and equal treatment.
- **Build working relations between health workers and key population support groups** and invite the groups to advise health workers on services provided to key population patients.

INDIVIDUAL COMMITMENTS (Small Groups):

Then divide into two groups—key populations and health workers. Ask each group to brainstorm what they can do to contribute to the goal of zero new HIV infections.

EXAMPLE RESPONSES:

SEX WORKERS, MSM, and Other LGBTI	Health Workers
<ul style="list-style-type: none"> • Insist on 100% condom use with all partners (male and female). • Use water-based lubricant for anal sex. • Use dental dams for oral sex for female sex workers. • Go for regular checkups at the clinic for STIs, including HIV. 	<ul style="list-style-type: none"> • Distribute condoms without stigma. • Ensure access and affordability of water-based lubricants that are necessary for safe anal sex. • Provide STI diagnosis and treatment for key populations on a stigma-free and confidential basis.

<ul style="list-style-type: none"> • Educate peers about safe sex. • If HIV positive, learn how to live in a healthy way, access ARVs, adhere to treatment. • If HIV negative, learn how to remain negative. • Work through LGBTI associations to assert human rights and health demands. 	<ul style="list-style-type: none"> • Provide counselling for key populations in a nonjudgemental way. • Provide regular checkup on the health of key populations. • When providing information on HIV transmission, include information on getting HIV through anal or oral sex.
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Optional Activity:

Ask the key population representatives to brainstorm answers to the following question: “*What goes into making a health facility LGBTI and sex worker friendly?*”

<p>EXAMPLE RESPONSES</p> <ul style="list-style-type: none"> • The health workers are friendly and do not judge us. • The health workers treat us the same way as other patients. • We like and trust the health workers. • The health workers promote our privacy and keep our information confidential. • The health workers are sincere and want to help us. • The health workers explain things simply and clearly. • The health services are easily available, e.g., medicines are available, the equipment is good, the clinical services are high quality, etc.

SUMMARISE:

- Health workers all have a specific type of job to do that involves helping people. Just because someone is MSM or a sex worker, that doesn’t mean they should be treated any differently.
- Once health workers become more comfortable with key populations and the type of issues that key populations face, they will be able to provide better service.
- Once key populations become more comfortable talking about their concerns and issues with health workers and other service providers, the more often they will seek help, which will improve their own health and therefore the overall public health.
- Staying silent helps no one. Key populations and service providers must work together to find realistic solutions to problems facing the LGBTI and sex worker community.
- If discriminatory behaviours are tolerated and no one holds people accountable to doing their job and treating people equally, it tears the fabric of the community.
- Finding ways to provide better services to key population patients is in the best interest of the health and safety of the entire community.

TIPS ON HOW TO PROVIDE NON-DISCRIMINATORY SERVICES:

Here are some tips on how to provide non-discriminatory services to key population patients:

- Build a relationship of trust and make the patient feel safe to express himself/herself freely. Remember—it has taken a lot of courage for the patient to be open to you about his/her situation.

- Emphasise that you will handle the information s/he provides in a confidential way.
- Let the person talk first. Listen attentively to what s/he says. Lean forward and show with your body that you are listening carefully to what s/he is saying.
- Don't probe into his/her sexual activities. Don't ask directly whether he has sex with men or women. Wait until s/he is comfortable to raise this subject himself/herself. It may take several visits before s/he is comfortable.
- To avoid talking about the patient himself, make up a 'typical' MSM and discuss how he could practice safer sex. Or talk about oral and anal sex, pointing out that they are practiced by both men and women.
- Be aware of your own personal feelings and avoid judging or condemning his/her sexual behaviour in words or body language.
- If you don't know that the patient is LGBTI or a sex worker, don't make assumptions about his/her relationships or sexual behaviour and activities.
- You cannot always tell whether someone is LGBTI—and they will not necessarily be open to you. So, don't assume that his partner is the same sex. Instead of referring to the partner as 'wife/husband' or 'girlfriend/boyfriend' or 'him/her,' use the word 'partner.'
- Avoid using words like 'normal' to describe sex between a man and a woman and 'abnormal' to describe sex between the same sex.
- Once the person reveals that s/he is LGBTI or a sex worker, help him/her to become aware of his/her rights. If appropriate, refer him to the local support group.

F10. Ten Steps for Moving to Action

Facilitator's Note: This exercise provides a structured process of action planning.

Objectives: By the end of the session, participants will be able to work out a detailed strategy for taking action against stigma towards PLHIV or key populations.

Target Groups: Key populations

Source: Understanding and Challenging HIV Stigma: Toolkit for Action

Time: 3 hours

Handout: F-FS11: TEN STEPS FOR MOVING TO ACTION

Steps:

ACTION PLANNING:

Divide into small groups (four or five members) for this exercise. After each step, get a quick report back and then move to the next step.

SITUATION ANALYSIS:

Ask: "What forms of HIV and key population stigma are common in your community? What are some of the underlying causes of stigma and discrimination?" Record the responses on a flipchart.

EXAMPLES—Forms of Stigma and Causes

- Many faith groups preach that PLHIV and LGBTI are sinners.
- Homophobia—people have very little understanding about MSM and other LGBTI.
- Lots of secrecy and silence around sex—people find it difficult to talk.
- LGBTI are shamed by their families; pressured to become ‘real men’ and ‘real women’ and often forced to leave home; made fun of by the public; mistreated at clinics; harassed by police; fired at work when their identity becomes known; kicked out of churches.
- High levels of fear and hopelessness among PLHIV and key populations.
- Service providers have no training on how to provide services to key populations.
- Lack of trust in public health facilities by PLHIV and key populations.
- In the face of stigma (homophobia), LGBTI hide their sexual activities.
- Being forced to hide puts their health at risk.

VISION:

Ask: “What will the situation in our community look like in two years after our anti-stigma programme?”

EXAMPLES—VISION

- Key populations will not feel persecuted by the rest of the society and will no longer have to hide their sexual orientation.
- More support and closeness from parents and family—no rejection from family.
- Less gossip and name calling towards PLHIV and key populations.
- Key populations will be able to access medical, legal, and social services.
- MSM and sex workers will be included in the national HIV prevention strategy.
- People will be able to talk about LGBTI people without condemning them for immorality or treating homosexuality as a taboo topic.
- Health workers will have the skills to diagnose and treat STIs in gay men and MSM.
- More hope and more self-esteem by PLHIV and key populations.

ACTIVITIES:

Ask: “What activities will you carry out to reach that goal?”

EXAMPLES—ACTIVITIES

- Advocacy to get political commitment to the change process
- Training workshops for LGBTI groups, service providers, and community leaders
- Community and peer group meetings and awareness raising in schools
- Community participatory education on LGBTI and their rights
- Formation and operation of PLHIV and key population support groups

- Participatory assessments, data gathering, and analysis on stigma
- Mini-campaigns on specific issues, e.g., change in the penal code
- Production of information, education, and communication (IEC) materials to inform people about LGBTI
- Use of media as an advocacy and mobilisation tool
- Legal test cases to give some visibility to the issue

PRIORITY ACTIVITIES:

Ask: “Which activities are the most important?”

RESOURCES:

Ask: “What resources do we need to do these activities?”

- Funds and materials for the training workshops
- Skilled and committed personnel

OBSTACLES:

Ask: “What things might block our activities?”

EXAMPLES—OBSTACLES

- Religious and cultural beliefs
- Legal context, i.e., no change in penal code
- Lack of empowerment of LGBTI community
- Denial, homophobia, and lack of commitment
- Apathy and sense of fatalism—people feeling they cannot do anything
- Poverty—people too busy just trying to survive

INDICATORS:

Ask: “What things will show that we have been successful?”

EXAMPLES—INDICATORS

- Social, medical, and legal interventions—people are doing things
- More education around prevention methods for LGBTI and sex workers
- Increased use of government health services by key populations
- Key populations having more say in defining the national strategy for HIV prevention
- Lower number of STIs and lower HIV prevalence in the LGBTI community
- Fewer hate crimes directed towards LGBTI people
- Media—less homophobic language in their articles, and more understanding and support in the way they report about LGBTI issues, e.g., without sensationalising
- Sex education in schools includes LGBTI issues—so children learn about these issues
- Lower statistics re: suicide

ANNEX A: GLOSSARY

The definitions below have been taken from existing ILO, UNDP, and WHO guidelines and technical standards, as well as the UNAIDS terminology database.

Definitions in this glossary were borrowed from the following documents:

- GNP+, ICW, Young Positives, EngenderHealth, IPPF, UNAIDS, UNFPA, and WHO. 2007. “Creating a Supportive and Enabling Environment for the Sexual and Reproductive Health of People living with HIV: Legal and Policy Considerations with areas for Action.”
- GNP+. 2008. “The People Living with HIV Stigma Index: User Guide.”

AIDS: The Acquired Immune Deficiency Syndrome is a cluster of medical conditions and is often referred to as opportunistic infections and cancers, and for which, to date, there is no cure.

Actionable drivers: Factors that bring about stigma that can be addressed through programs. Such drivers can include societal-level factors, such as structural facilitators (i.e., harmful laws and policies) and individual-level factors, including lack of awareness and knowledge of stigma and its harmful consequences, misconceptions around HIV transmission that lead to fear of acquiring HIV through contact with infected people, and linking people with HIV with behaviours considered to be improper or immoral.

Blame: To blame someone is to suggest that they are responsible for something wrong; to find fault with them; to accuse them.

Discrimination (Enacted Stigma): Discrimination involves treating someone in a different and unjust, unfair, or prejudicial manner, often on the basis of their belonging, or being perceived to belong, to a particular group. It is often viewed as the end result of the process of stigmatisation. In other words, when stigma is acted upon, the result is discrimination. Discrimination consists of actions or omissions that are derived from stigma and directed towards those individuals who are stigmatised. For example, HIV-related discrimination occurs when someone is treated differently (and to their disadvantage) because they are known to be living with HIV, suspected of being HIV positive, or closely associated with people living with HIV (such as their partner or a member of their household).

Discrimination occurs at many different levels. It can occur within a family or community setting. For example, when people:

- Avoid people living with HIV or do not allow them to use the same eating utensils as other members of the household; or
- Reject people living with HIV by not allowing them entry or membership into a group, or by not being willing to be associated with them.

It can also occur within an institutional setting; for example, when:

- People living with HIV are segregated from other patients in a health facility or denied access to healthcare services or medical insurance because they are HIV positive;
- When a supervisor does not uphold the rights of a positive person and discloses their HIV-positive status without their consent to work colleagues; or
- HIV-affected children are denied entry into school.

Discrimination against people living with HIV, or those thought to be infected, is a violation of their human rights and is something that the legal system in a country can address.

Discrimination: Is a term used in accordance with the definition given in the ILO Discrimination (Employment and Occupation) Convention, 1958 (No. 111), to include HIV status. It also includes discrimination on the basis of a worker's perceived HIV status, including discrimination on the ground of sexual orientation.

Human rights: A right is something to which one has a just claim or entitlement. Rights exist at local, national, and international levels. Human rights are those rights that one has because one is a human being. These include the rights to life, privacy, freedom of expression, freedom of association, an adequate standard of living, education, and health. Human rights are founded on the dignity and worth of each person. People are entitled to enjoy their rights regardless of their race, colour, sex, language, religion, political or other opinion, national or social origin, or other status (including HIV status). Human rights are legally guaranteed by human rights law, which exists to protect individuals and groups from actions that interfere with their freedom and dignity, and promote access to the things that help people realise their rights. Human rights law exists at the international level (e.g., treaties and covenants) and at the national level (e.g., constitution, bill of rights, domestic laws).

Internalised stigma: Internalised stigma, also referred to as “felt” stigma or “self-stigmatisation,” is used to describe the way a person living with HIV feels about themselves, and specifically if they feel a sense of shame about being HIV positive. Internal stigma can lead to low self-esteem—a sense of worthlessness and depression. Internal stigma can also result in a person living with HIV withdrawing from social and intimate contact, or excluding themselves from accessing services and opportunities, out of a fear of having their status revealed or being discriminated against because of their HIV-positive status.

Key populations at higher risk: These include young people, women, men who have sex with men, transgender people, sex workers, people who inject drugs, prisoners, and migrants.

Layered stigma: Refers to HIV stigma that is layered on top of stigma already experienced by certain vulnerable groups (i.e., men who have sex with men, commercial sex workers, people who inject drugs, women, and youth).

Men who have sex with men: This includes not only men who self-identify as ‘gay’ or homosexual and have sex only with other men, but also bisexual men and heterosexual men who may, nonetheless, at times have sex with other men.

Self-esteem: How you value or respect yourself. For example, when we refer to someone as having low self-esteem, it means that that person does not value themselves or have confidence in their ability or the contribution they can make generally.

Sex and gender: There are both biological and social differences between men and women. The term ‘sex’ refers to biologically determined differences, while the term ‘gender’ refers to differences in social roles and relations between men and women. Gender roles are learned through socialisation, and vary widely within and between cultures. Gender roles are affected by age, class, race, ethnicity, and religion, and by geographical, economic, and political environment.

Sex workers: These people are female, male, and transgender adults, 18 years of age and over, who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income generating. This term is widely used in preference to ‘prostitute.’ The term ‘sex worker’ is intended to be non-judgemental, focusing on the conditions under which sexual services are sold. Alternative formulations are: ‘women/men/people who sell sex.’

Shame: This is a feeling of dishonour, disgrace or condemnation. To be ashamed of oneself refers to one having this feeling of shame.

Universal precautions: These are measures taken to prevent transmission of infection while providing healthcare, including methods of handling waste products, as well as precautions to prevent exposure to blood or other body fluids, taken with all patients regardless of diagnosis.

Stigma: Stigma refers to a sign of disgrace or shame. It originates from the ancient practice of branding or marking someone who was thought to be ‘morally flawed’ or to have behaved badly and therefore ought to be avoided by other members of society. Stigma is often described as a process of devaluation. In other words, if one is stigmatised, one is discredited, seen as a disgrace, and/or perceived to have less value or worth in the eyes of others. HIV-related stigma often builds upon and reinforces other existing prejudices, such as those related to gender, sexuality, and race. For example, the stigma associated with HIV is often based upon the association of HIV and AIDS with already marginalised and stigmatised behaviours, such as sex work, drug use, and same-sex and transgender sexual practices. HIV-related stigma affects those living with HIV and—through association—those who they are associated with, such as their partner or spouse, their children, and the other members of their household.

Transgender: This is an umbrella term encompassing a diversity of gender expression, including drag queens and kings, bi-genders, cross dressers, transgender people, and transsexuals. ‘Transgender’ is a term that transcends the restricting and extant categories of gender identity, is more neutral regarding etiology, and encompasses the vast complexity of gender manifestations and identities.

Vulnerability: This term refers to socioeconomic disempowerment and cultural context for work situations that make workers more susceptible to the risk of infection, and situations which put children at greater risk of being involved in child labour.

ANNEX B: FACT SHEETS

Chapter A: Naming the Problem

A-FSI: HIV Stigma and Discrimination

Handout for Exercises A1 to A4

What is stigma?

Sometimes we treat people badly because of how they look or what we suspect they do. We isolate them, e.g., refusing to sit beside a person living with HIV in the clinic; or we gossip about people living with HIV and call them names because of the way they look. When we isolate or make fun of other people, this is called ‘STIGMA.’ It makes the person feel ashamed or disgraced.

Stigma is a process where we (society) create a ‘**spoiled identity**’ for an individual or a group of individuals. We **identify a difference** in a person or group—for example, a physical difference (e.g., physical disfiguration) or a behavioural difference (e.g., people assumed to be promiscuous) – and then **mark that difference as something negative**—as a sign of disgrace. In identifying and marking differences as ‘bad,’ this allows us to stigmatise the person or group. **Stigmatised people lose status** because of these assigned ‘signs of shame,’ which other people regard as showing they have done something wrong or bad (sinful or immoral behaviour).

Stigma is the belief or attitude which leads to discrimination. The action resulting from stigma is **discrimination**—unfair treatment, e.g., people living with HIV being kicked out of the house or given poor treatment in health facilities. When we stigmatise people living with HIV, we **judge** them, saying they have broken social norms and should be shamed or condemned, or we **isolate them**, saying they are a danger or threat to us (because of our fear of getting HIV through physical contact with them).

How do people stigmatise?

The main **FORMS** of stigma include:

- **ISOLATION AND REJECTION**—based on ignorance and fear about HIV transmission or about the behaviours of a marginalised group. The person stigmatised is forced to sit alone and others avoid contact with them.
- **SHAMING AND BLAMING**—gossip, name calling, insulting, judging, and shaming. Stigmatised people are ‘blamed and shamed’ for assumed ‘bad behaviour,’ for breaking social norms.
- **DISCRIMINATION (ENACTED STIGMA)**—unfair treatment, such as refusing to provide health services to HIV-positive or marginalised clients, treating them last, or testing clients without their consent.
- **SELF-STIGMA**—People living with HIV or marginalised groups stigmatise themselves in reaction to stigmatisation from society. They accept the blame and rejection of society, and withdraw from social contact or exclude themselves from accessing health and other services out of fear of having their status revealed.
- Some health workers are stigmatised for working with HIV clients or clients from marginalised groups.
- **LAYERED STIGMA**—Marginalised groups (e.g., sex workers, men who have sex with men, transgender persons, people who inject drugs, prisoners, etc.) are already stigmatised. When they get HIV, they are doubly stigmatised—getting another layer of stigma.

What are the EFFECTS of stigma on those stigmatised?

- Feelings of sadness, loneliness, rejection, hopelessness, and self-doubt.
- Shame, loss of self-esteem, and feeling they are no longer accepted by others.
- Self-blame. Stress. Depression. Suicide. Alcoholism.
- Feelings of guilt, denial, self-hatred, and depression.
- Discrimination—kicked out of the family, being poorly treated in health facilities, etc.

What are the EFFECTS of stigma on the HIV epidemic?

Stigma or the fear of stigma **stops** people living with HIV and key populations from:

- **Accessing health services**—getting tested for HIV and STIs, getting information on how to avoid HIV transmission, and getting condoms and lubricant
- **Openly discussing their sexuality with health workers** and providing complete information about their sexual practices
- **Accessing treatment** (antiretroviral therapy or treatment of opportunistic infections)
- **Using other services**—for example, a pregnant woman living with HIV is discouraged from HIV testing and making use of the PMTCT program
- **Disclosing to their partners**
- **Protecting their own health and the health of their sexual partners**—for example, by insisting on condom use with partners, using clean needles and syringes for drug use, accessing treatment to reduce viral load
- **Disclosing their HIV status and getting counseling, care and support**—Because of stigma, People living with HIV and other key populations are afraid to tell others about their HIV status. As a result, they may have difficulty negotiating condom use, accessing services, support, and treatment for HIV, and they may pass HIV to their partners.

What are the CAUSES of stigma?

The three main causes or drivers of HIV-related stigma are:

- **LACK OF AWARENESS THAT THEY ARE STIGMATISING:** People are often unaware that their attitudes, words, and actions are stigmatising towards other people, and of the resulting negative consequences.
- **MORAL JUDGEMENTS**—People make judgments about others. They say that people living with HIV or other key populations have done something bad or wrong (sinful or immoral behaviour), so they should be shamed or condemned.
- **FEAR AND IGNORANCE**—Lack of knowledge and misconceptions about HIV transmission leads to fear about getting HIV through casual contact—as a result, we may isolate or reject people who are assumed to be HIV positive. The fear and ignorance may also be rooted in lack of understanding about the lives and sexuality of marginalised groups—so out of ignorance, they may judge key populations unfairly. They are prejudiced towards people who are seen as behaving differently.

What can we do to challenge stigma?

STOPPING STIGMA will take a huge effort by everyone. **The starting point is to change ourselves**—the way we think and act towards people living with HIV or other key populations.

After we have changed ourselves, **we can start to educate others**. It takes courage to stand up and challenge others when they are stigmatising—but this is one of the ways to stop stigma. Breaking the silence and getting people talking openly is the first big step. Make stigma as a problem both visible and viewed as unacceptable.

Make our public services stigma-free:

- Ensure that people living with HIV and other key populations receive the same standard of quality care as other clients
- Provide a friendly and welcoming environment—friendly face, body language, and voices
- Avoid stigmatising or coded language for HIV-positive and other clients
- Ensure confidentiality—don't let others know the status of HIV-positive clients
- Speak up and challenge service providers who are stigmatising in a polite but firm way
- Train service providers on clients' rights and the right of people living with HIV and key populations to equal treatment and confidentiality

A-FS2: Effects of Stigma on the HIV Epidemic

Handout for Exercise A8

What are the effects of stigma on the HIV epidemic?

Stigma or the fear of stigma **stops** people living with HIV and key populations from:

- **Accessing health services**—getting tested for HIV and STIs, getting information on how to avoid HIV transmission, and getting condoms and lubricant
- **Openly discussing their sexuality with health workers** and providing complete information about their sexual practices
- **Accessing treatment** (antiretroviral therapy or treatment of opportunistic infections)
- **Using other services**—for example, a pregnant woman living with HIV is discouraged from HIV testing and making use of the PMTCT program
- **Disclosing to their partners**
- **Protecting their own health and the health of their sexual partners**—for example, by insisting on condom use with partners, using clean needles and syringes for drug use, accessing treatment to reduce viral load
- **Disclosing their HIV status and getting counselling, care and support.** Because of stigma, People living with HIV and other key populations are afraid to tell others about their HIV status. As a result, they may have difficulty negotiating condom use, accessing services, support, and treatment for HIV, and therefore be at more risk for transmitting HIV to their partners.

What does this mean?

It is the fear of being stigmatised which stops people living with HIV and key populations from taking appropriate action to protect their health and the health of their partners. It is this fear which stops key populations from accessing health services, finding out their own status, and negotiating safe sex/drug use practices with partners. This increases the risk that they will contract HIV and that they will then pass HIV to their partners.

If, on the other hand, people living with HIV and key populations are treated with kindness, support, and care, they will be more likely to access health services and take precautions in their sexual relationships.

A-FS3: Stigma in Health Facilities—Forms, Effects, Causes, and Solutions

Handout for Exercise A10

Forms of stigma towards HIV-positive clients or key populations

- Clients are kept waiting a long time—other clients are treated first.
- Unfriendly looks. Gossip. Name calling. Blame clients for ‘immoral behaviour.’
- Some health workers refuse to treat the clients, or refer them to other staff.
- Break confidentiality—reveal the status of HIV-positive clients or the identity of key populations to other health staff and clients—without the consent of the person.
- Use gloves and masks for routine tasks which don’t involve the handling of bodily fluids.
- Force clients to be tested without their consent and without adequate counselling—and don’t provide the results of the HIV test to the client.
- Give rushed instructions and don’t allow the clients to ask questions.

Effects of stigma on HIV-positive clients or key populations

- Feel isolated, humiliated, and demoralised—lose self-esteem
- Stop going to the health facility and look for other, less stigmatising health facilities (e.g., private doctors who provide more confidentiality) or do self-treatment
- Clients who are HIV positive may hide or stop their use of medication
- May not access information and services needed for HIV prevention and treatment
- Undermines self-esteem; as a result, they may take more risks in their sexual behaviour (e.g., not using condoms)
- May force key populations to hide their sexual orientation, sex work, or drug use; as a result, they may have sex or use drugs in hidden places where it is difficult to obtain protection (e.g., condoms or clean needles) or negotiate for safer sex.

Causes of stigma towards HIV-positive clients or key populations

- Some health workers may not be aware they are stigmatising
- Judgemental attitudes based on culture or religion
- Fear and lack of accurate information about HIV transmission

What can we do to challenge stigma in our health facilities?

- Ensure that all clients receive the same standard of quality care
- Provide a friendly, welcoming environment—friendly face, body language, and voices
- Train health workers on the right of people living with HIV and other key populations to equal care and confidentiality.
- Train health workers how to counsel HIV-positive clients and other key populations, i.e., not judgemental, neutral or supportive language, and appropriate body language
- Speak up and challenge health workers who are stigmatising in a polite but firm way

A-FS4: Stigma and ARV Treatment

Borrowed from:

Antiretroviral (ARV) Treatment Fact Sheet 12: Stigma and ARV Treatment. International HIV/AIDS Alliance.

How does stigma relate to ARV treatment?

- Stigma and discrimination are still among the biggest challenges for people with HIV.
- Stigma discourages patients from taking drugs correctly—it reduces adherence to ART.
- Stigma prevents people from accessing HIV testing, care, support, treatment and prevention.
- Preventing and reducing stigma and discrimination is vital so that people are not discouraged from using or helping others with ARV treatment.
- ARV treatment that is effective and is easily accessible and affordable for everyone who needs it is a powerful way to reduce stigma and discrimination in affected communities.

How can stigma affect a person's ability to take ARV treatment?

- When stigma stops a person from accessing services such as HIV testing, prevention, care and support, it also reduces their access to ARVs.
- Stigma causes psychological problems, such as worry, sadness, guilt, shame and losing hope. These can cause difficulties for a person who is starting or trying to adhere to ARV treatment.
- Being seen taking ARVs may make someone afraid that they will be identified as having HIV.
- Secrecy and not being able to disclose one's HIV status may make it difficult for a person to keep ARV medicines at home or to carry them around during work or recreation time.
- Stigma can isolate a person with HIV from their family, friends and community. This means the loss of important sources of support for ARV treatment.
- Women, young girls and children are often more vulnerable to stigma than men, because of low social economic status and negative cultural beliefs. They might therefore have greater difficulties in getting access or adhering to ARV treatment.
- Stigma can also affect carers of people with HIV, including health workers. This can prevent them from offering support to people taking ARVs, or from getting ARV treatment if they need it themselves.

What can help to reduce the effects of stigma on ARV treatment?

- Increase people's knowledge about HIV and encourage them to recognise that stigma and discrimination exist.
- Raise awareness of the benefits and availability of ARV treatment.
- Ensure that people on ARV treatment receive good support from their family, friends and community.
- Include prevention in messages about ARV treatment. This means showing people that prevention is still necessary for people taking treatment and that it is possible to avoid opportunistic infections such as TB, by taking medicines to prevent them.

- Provide safe and confidential spaces for people to discuss their issues about HIV and ARV treatment.
- Provide psychological and social support as part of treatment support, such as counselling and support groups.
- Involve people with HIV, especially those taking ARVs successfully, in providing support and information to others. In this way, those who need ARV treatment can see the positive results of treatment, and experiences can be shared with the community and health workers who are responsible for referring people for ARV treatment.
- Involve a wide range of people to provide a supportive environment for ARV treatment—such as health workers, families, communities, NGOs, community groups, traditional healers and faith-based organisations.
- Develop ‘treatment friendly’ communities by providing community education and support. This means helping people to understand better about:
 - a) HIV and its transmission,
 - b) prevention and treatment, and
 - c) how to support people with their ARV treatment.
- Ensure respect for the rights of those who are stigmatised or vulnerable and ensure their access to ARV treatment, e.g. women, children, sex workers, men having sex with men, injection drug users.

Chapter B: Sex, Morality, Shame and Blame

B-FS1: Blaming and Shaming

Handout for Exercises B2 and B3

When we shame and blame others, we are often using stereotypes—negative things we say and believe about people living with HIV and other key populations. In using negative stereotypes, we describe and name other groups according to a set of characteristics we believe are bad, labelling them as different from us in a negative way. Often we believe these misconceptions are facts about other people, when in fact they are false. This belief or assumption leads to prejudice, which can result in stigma and discrimination.

We often stigmatise or condemn people without knowing their actual behaviour. As humans, we often believe or assume the worst about other people. For example, we assume that everyone who is HIV positive is sexually active, but this assumption may be wrong.

We are **socialised to judge** other people based on assumptions about their behaviour. People living with HIV, men who have sex with men, transgender people, sex workers, people who inject drugs, prisoners, and migrants are regarded as breaking social norms—so some people think that they deserve to be condemned and punished.

As health workers, we have a professional obligation to remain objective and non-judgemental with clients and avoid letting our personal beliefs and attitudes become barriers to providing compassionate and high-quality care to clients.

It is important to examine one's feelings, thoughts, and attitudes about HIV, particularly in relation to our work as health workers. HIV is associated with fear, death, and immorality, so there are lots of myths and misconceptions. If we do not address our feelings and attitudes about HIV, we may consciously or unconsciously stigmatise HIV-positive patients, reducing the quality of care in our health facility.

We are not saying you have to change your opinions, but you need to realise that your opinions have an impact on other people. Some of these opinions are very judgemental towards people living with HIV and key populations. As a result, people living with HIV and key populations feel hurt, humiliated, and depressed, and this affects their access to health services and how they protect their sexual health.

Whether we agree with someone or not, we don't have a right to judge or belittle them. We should **treat them as human beings** who deserve our respect and empathy. To stigmatise is to wipe out their humanity and treat them as having no value. Try to put yourself in the shoes of the other person—how would you feel if you were 'blamed and shamed?' Even if you don't like the person, understand and respect him/her.

So how should we treat people living with HIV and other key populations? We should give them: a) respect and affection; b) support and encouragement; and c) space, place, and recognition. If we treat them well, they will keep their self-esteem and feel empowered and take charge of their lives, accessing health services and taking care of their sexual health.

Chapter C: Key Populations

C-FS1: True/False Questions re: Key Populations

Handout for Exercise C1

What Do You Know about MSM?

- Becoming MSM does not just happen. Men decide or learn that they want to be MSM.
- If you hang around with and become friends with MSM, you will also become MSM.
- MSM are mentally ill, but they can be cured.
- Sex between two men is against religion.
- Sex between two men is a product of Western influences.
- Sex between two men is motivated by love, sexual pleasure, and/or economic exchange.
- MSM are all the same. You can identify them by the way they dress and behave.
- In many countries, it is illegal for men to have sex with men.
- MSM have an increased risk of getting HIV and other STIs because of having unprotected anal sex.
- MSM engage in the same sexual practices as other couples.
- MSM do not want long-term partners and are only interested in casual sex.
- Men who have sex with men may also have sex with women.
- Safe sex for MSM is different from safe sex between a man and a woman.
- MSM are not at risk of getting HIV so they do not have to practice safe sex.
- There is no stigma against MSM, they stigmatise themselves.

ANSWERS

Becoming a man who has sex with men does not just happen. Rather, men decide or learn that they want to be MSM.

FALSE. Wanting to have sex with other men is part of some men's nature. It is like being right handed or left handed. It is inborn and cannot be explained or predicted. It is not known what makes some men desire men while other men desire women. Some studies suggest there are genetic influences, while other people believe it is a mixture of genetics and social influences. A man who has sex with men cannot simply be taught to be sexually attracted to women. There is no scientific evidence to prove that people can change their sexual orientation through exerting their will.

Men have sex with men for many different reasons. Some men, who may call themselves homosexual or gay, are attracted to other men and enjoy having sex with them. Other men have sex with men in all-male environments, like prisons, where there are no women available and they want to release sexual tension. Some men have sex with other men because they need money and can earn money by having sex with men. Some men are married to women and have sex with their wives, but they also have sex with men out of desire.

If you hang around with and become friends with MSM, you will also become an MSM.

FALSE. Simply spending time with or being close to a MSM will not change you to become MSM. Being MSM does not pass from person to person like a disease, nor can people be talked into a sexual orientation that is not their own.

MSM are mentally ill, but they can be cured.

FALSE. Being MSM is not a mental illness. In the past, psychiatrists tried to show that men wanting to have sex with other men had a mental illness, but they failed. Starting in 1973, the medical profession no longer treated being gay as an illness. However, some parents still wrongly send their sons who are gay to clinics or psychologists to be 'cured.' If being MSM was accepted by everyone, no one would feel the need to 'cure' it.

Sex between two men is against religion.

TRUE/FALSE. Religions have different views and interpretations of men having sex with men. Islam and some Christian churches consider men having sex with men a sin, other religions consider it a weakness which can be cured, and some feel it is an acceptable and normal sexual orientation.

In all religions, there is a difference between the texts and daily practice. Some people read the holy books literally and use these texts to condemn MSM. Others use the texts as a source of inspiration, but in daily life they accept MSM as human beings. Others emphasise that religious teachings mention compassion and tolerance of other people. There are many MSM who find ways to keep their faith and be who they are. There are many religious people who are faithful to their religions and accepting of MSM.

Sex between two men is a product of Western influences.

FALSE. Historical research shows that homosexuality existed in Asia and Africa long before Europeans arrived in these regions. Research has shown that 5–10 percent of people in every community in the world are attracted to the same sex. In all countries of the world, men who have sex with men existed in the past – it was secret, but they existed. Today it is relatively more open, and it is estimated that there are MSM living in every community, although because of stigma and discrimination, the majority are in hiding.

Sex between two men is motivated by love, sexual pleasure, and economic exchange.

TRUE. The same things that motivate sex between a man and a woman motivate men to have sex with other men. The reasons may include love and companionship, sexual pleasure, or a way of earning money in exchange for sex.

MSM are all the same. You can identify them by the way they dress and behave.

FALSE. As with all people, MSM are individuals who look and behave in different ways. Some MSM wear their hair longer and dress in a feminine way, while others may have short hair and dress and act like other men. In some cases, MSM are married and have families or act one way in public and another way in private. Many MSM dress and act no differently from men who do not have sex with men. It is impossible to tell whether someone is a man who has sex with men just by the way they look and behave.

In many countries, it is illegal for men to have sex with men.

TRUE. In many countries, the penal code prohibits men from having sex with other men.

MSM have an increased risk of getting HIV and other STIs because of having unprotected anal intercourse.

TRUE. At least 5–10 percent of all HIV infections worldwide are due to anal intercourse between men. Unprotected anal intercourse carries a higher risk for contracting STIs, including HIV, than vaginal intercourse. This is because the rectum tears very easily, leaving openings for HIV to be transmitted. Anal sex also requires a lot of lubrication and a condom to be practiced safely. Water-based lubricant, which is safe to use with condoms, is often not accessible. Oil-based lubricant, e.g., Vaseline, will cause the

condom to deteriorate and break. However, MSM can reduce the risk of contracting HIV by practicing safe sex.

MSM engage in the same sexual practices as other couples.

TRUE. MSM use many of the same sexual practices as heterosexual couples, including kissing, masturbation, touching, anal sex, and oral sex. These activities are not restricted to sex between a man and woman or sex between two men, but are commonly practiced by both groups. Some of us, for example, assume that all MSM practice anal sex but, in fact, many do not and there are many heterosexual couples who practice anal sex.

MSM do not want long-term partners and are only interested in casual sex.

FALSE. Many people think that MSM are interested only in sex, that their relationships are shallow and based only on physical attraction, not love. But, in fact, MSM are equally capable of deep, long-term, loving relationships as non-MSM are with women. Some MSM may have lots of sexual partners and some MSM may have only a single partner and a permanent relationship.

Men who have sex with men may also have sex with women.

TRUE. Some MSM enjoy sex with both men and women. Other MSM may prefer sex with other men, but have sex with women to hide their MSM status. In many cases, MSM are married and have sex with their wives in addition to having sex with other men.

Safe sex for MSM is different from safe sex between a man and a woman.

FALSE. The concept of safe sex for MSM is no different from the concept of safe sex for sex between a man and a woman. In both cases, the aim is to prevent the exchange of body fluids and blood through using barrier methods, such as condoms, dental dams, etc.

It is recommended that strong condoms and water-soluble lubricant be used for anal sex to prevent the condoms breaking. (The same technologies are recommended for heterosexuals practising anal sex.) Condoms should also be used for oral sex practised on a man.

MSM are not at risk of getting HIV so they do not have to practice safe sex.

FALSE. HIV or STIs can be transmitted from one man to another man or woman through unprotected oral, anal, or vaginal sex, so MSM should use protection.

There is no stigma against MSM, they stigmatise themselves.

FALSE. Stigma towards MSM does exist in society and it may include discrimination in hiring practices, arbitrary harassment by police, or being excluded from family decisions and activities, among many other forms of stigma. The stigma and discrimination experienced by MSM may lead to self-stigma. Living in a society where MSM are often condemned, rejected, and isolated, MSM may internalise some of the negative attitudes from the community and develop feelings of shame about who they are. Self-stigma is induced by stigma that exists in the larger society.

What Do You Know about Sex Workers?

1. Sex workers love money and are too lazy to work. They could easily get other jobs.
2. Sex workers all do the same job.
3. Sex work is the quickest way for poor women to make money.
4. HIV is the only serious problem sex workers face.
5. Sex workers are sex maniacs; they love having sex with anyone.
6. Sex workers show off and sell their bodies, so they deserve to be raped.

7. Sex workers hide their work to avoid being stigmatised by families and the community.
8. Sex workers are promiscuous and their relationships with men never last.
9. Sex workers are highly vulnerable to HIV because they find it difficult to negotiate for safe sex with clients and their own partners.
10. When sex workers come to a health facility, they receive the same treatment as everyone else.
11. Programs to reduce HIV among sex workers should be done without involving sex workers.
12. In many countries, sex work is illegal.
13. Laws that criminalise sex work stop sex workers from selling sex.
14. Sex workers are afraid to report to the police cases where they have been beaten or raped by their clients because their work is illegal and they think that they have no rights.
15. Arresting and imprisoning sex workers are the best methods to stop sex work.

ANSWERS

1. **Sex workers love money and are too lazy to work. They could easily get other jobs.**
FALSE. The majority of sex workers have taken up this work because they are poor, have difficulty finding other work, have little education, are the sole breadwinner, and/or have children to support. Often sex workers have taken up this work because they are providing financial support for several family members. They like money for the same reasons as anyone else: they need money to live. Many sex workers are not happy with sex work, would like to get out of it, but feel they have no alternative.
2. **Sex workers all do the same job.**
FALSE. There are several different categories of sex workers. Some operate on the street, others work in bars or hotels, and others operate from designated homes. Some are stationary, some are mobile. Some target truck drivers and others focus on tourists or visitors in hotels. Some work on a full-time basis, others on a part-time basis. Some have other jobs and do sex work in the evenings. Some do survival or transactional sex.
3. **Sex work is the quickest way for poor women to make money.**
TRUE. Sex workers can make money quickly through this work. Earnings from sex work help women to pay the rent or build a house, put food on the table, send their children to school, support other family members, and buy new clothes. Many sex workers want to remain in this work because of the financial benefits. They can make considerably more money as sex workers than in unskilled labor, e.g., as a day laborer. Many sex workers would leave this work if they could find other work with similar financial pay.
4. **HIV is the only serious problem sex workers face.**
FALSE. Sex workers have many problems, and their job is very dangerous. Clients exploit and abuse them because they think they can do anything to them once they have paid them. They regard sex workers as women without rights. As a result, some clients refuse to pay them the agreed amount, beat them, and rape them, in some cases involving gang rape. They are also abused by pimps and by the police. They also face harassment and violence at the hands of their long-term partners.
5. **Sex workers are sex maniacs; they love having sex with anyone.**
FALSE. Most sex workers do not get pleasure out of sex with clients; it is just a way of making money. When they are with a client, they want him to do it quickly and leave. In fact, having sex with a stranger can be very painful due to the lack of sexual arousal, which is needed for vaginal lubrication.

Sex work often results in medical problems, such as acute and chronic pelvic pain, pathological vaginal discharge, genital ulcers, skin disease, pain during urination, bladder and kidney infections, and STIs.

6. **Sex workers show off and sell their bodies, so they deserve to be raped.**
FALSE. While sex workers do show off their bodies to attract men to hire their services, this is no justification for rape. Sex workers are not ‘asking to be raped.’ The way someone dresses does not give anyone the right to rape them. Payment by a client does not give him the license to exploit or abuse the sex worker. She is deserving of respect and fair treatment, like anyone else.
7. **Sex workers hide their work to avoid being stigmatised by families and the community.**
TRUE. Sex workers often do everything possible to ensure that while they are working, family members or family friends do not find out what they are doing. While family members may know that they are supported by money from sex work, it is still heavily stigmatised by the family and the community. Sometimes the community stigmatises the entire family if one member is known to be a sex worker. The stigma associated with this work is so painful that it forces the women to carry the burden of their secret life alone, and usually away from home.
8. **Sex workers are promiscuous and their relationships with men never last.**
FALSE. Sex workers have sex with many men – this is the nature of their work – but most do have lasting relationships with their regular partners or husbands.
9. **Sex workers are highly vulnerable to HIV because they find it difficult to negotiate for safe sex with clients and their own partners.**
TRUE. Sex workers are relatively powerless and often don’t feel they have the strength to insist that their clients use condoms. Some clients offer to pay more for sex without a condom. Because sex workers are often poor and supporting many family members, they feel inclined to accept, even though they know this puts them at risk.
10. **When sex workers come to a health facility, they receive the same treatment as everyone else.**
FALSE. Sex workers are sometimes stigmatised by health workers because of their work. Sex workers often wait longer, even when they arrive at the health facility early, and they may receive an incomplete diagnosis or inadequate counselling for their health problems.
11. **Programs to reduce HIV among sex workers should be done without involving sex workers.**
FALSE. There is a need to involve sex workers in planning and implementing HIV prevention programs. Sex workers have much more knowledge of the sex work culture and what is involved in changing peer norms; and they have contacts with a largely hidden and marginalised sex worker population. Getting them actively involved is crucial to the process of stopping HIV transmission.
12. **In many countries, sex work is illegal.**
TRUE. The penal code in many countries prohibits the selling of sex. Sex workers can be arrested for charging for sex. In some countries, selling sex itself is not criminalised, but some other aspects of sex work, such as ‘pimping’ and running a brothel, may be criminalised. In addition, in some countries, sex workers may be arrested for other offences, e.g., loitering, public nuisance, offences against public morality, etc.
13. **Laws that criminalise sex work stop sex workers from selling sex.**
FALSE. Rather than stopping sex workers from selling sex, this law makes sex workers go underground, hiding their activity from the police. In going underground, sex workers are less careful

about their sexual practices. Because they feel under threat, they are less willing to negotiate safe sex with clients, making them and their clients more vulnerable to HIV. Abolishing this law would not increase the number of sex workers; it would remove a barrier to the national strategy of ensuring no new HIV infections.

14. **Sex workers are afraid to report to the police cases where they have been beaten or raped by clients because their work is illegal.**

TRUE. Most sex workers do not report to the police cases of rape, physical violence, or theft by their clients, because of this fear of being arrested. In some cases, sex workers are harassed by the police who demand that sex workers give them free sex or money.

15. **Arresting and imprisoning sex workers are the best methods to stop sex work.**

FALSE. International experience in dealing with sex work has shown that severe punishment does not change behaviour. The minute the women are released from prison, they go straight back to sex work.

What Do You Know about People Who Use Drugs?

1. The main reason people start using drugs is simply that they are bad people.
2. Not everyone who starts injecting illegal drugs, such as heroin, becomes addicted.
3. Cigarettes and alcohol are also addictive, like heroin, but they are legal substances.
4. Once people who use drugs become addicted, their main motivation for continuing to take drugs is to get that feeling of pleasure induced by the drug.
5. People who are addicted to drugs love their drugs and don't want to quit. They could stop at any time.
6. People who are addicted to drugs who want to give them up are able to do so the first time they try.
7. People who have quit drugs often start using them again, for a number of reasons.
8. The only reason why PWID prefer to use injections is that injecting produces a strong and immediate effect.
9. It is not drug use or injecting drugs which is the major cause of HIV transmission, but the practice of sharing needles and syringes among PWID.
10. HIV is the only health problem faced by PWID.
11. Using harsh punishment, including locking people up, is the best method to treat PWID.
12. Needle and syringe programmes (NSPs), which provide sterile needles and syringes to people who inject drugs, result in more drug use and more PWID.
13. The discarding of used syringes is a potential source of HIV transmission.
14. Laws which criminalise possession of injecting equipment stop people who inject drugs from injecting.
15. Drug addiction creates a huge burden on the family.

ANSWERS

1. **The main reason people start using drugs is simply that they are bad people.**
FALSE. People don't take drugs simply because they are bad people. Different people have different motivations for starting to use drugs, including: to make use of leisure time as a form of recreation, experiment, respond to peer pressure, relieve pain or depression, or forget poverty and misery. The reasons are complex and multiple, and often have to do with social or economic factors, such as unemployment, poverty, rapid social and economic change, etc.

2. **Not everyone who starts using illegal drugs, such as heroin, becomes addicted.**
TRUE. Many people use drugs without being addicted. They take drugs on an occasional, experimental basis. People who inject drugs become addicted only when they inject drugs on a regular basis over a period of time, varying from a few weeks to many years. Drug use becomes habitual and the people using drugs become dependent on them. Drug use and drug addiction are two different things. In the United States, for example, out of 25 million people who use drugs, it is estimated that only 1–2 million (8%) become addicted.
3. **Cigarettes and alcohol are also addictive, like heroin, but they are legal substances.**
TRUE. Cigarettes also produce an addictive effect on the body. Nicotine is one of the most addictive substances known—smokers develop a dependence on nicotine quickly. Many people want to stop this habit, but they find it very difficult to stop. If they stop, they feel very uncomfortable. Tobacco prices are low, so many people become addicted. Smoking has serious effects on the body – prolonged use can cause lung, heart, and blood vessel damage, and cancer. WHO estimates that smoking is responsible for one out of five deaths, or 3 million people per year; more than 50 percent of smokers will die prematurely as a direct result of tobacco-induced illnesses. In spite of these adverse consequences, it is a legal substance.
4. **Once people who use drugs become addicted, their main motivation for continuing to take drugs is to get that feeling of pleasure induced by the drug.**
FALSE. People *start* taking drugs to get a pleasurable feeling, but once they are addicted, their main motivation for taking drugs is to *overcome the feelings of withdrawal*. The initial attraction to drugs is the feeling of happiness that the drugs induce in the body. These pleasurable feelings produce strong memories, which are stored in the brain and create a desire to take more drugs—in order to bring back those pleasurable feelings. But once people become addicted, they have withdrawal or painful symptoms when the drug wears off, including: fast heart beat, anxiousness, increased blood pressure, perspiration, and pains in the body. At this stage, their main motivation in taking the drugs is to deal with these symptoms of withdrawal, i.e., to get back to ‘normal.’ Their main focus is to feel normal—not to feel happy, but to feel ‘normal.’
5. **People who are addicted to drugs love their drugs and don’t want to quit. They could stop at any time.**
FALSE. Many people don’t understand the nature of addiction. They assume that it is easy for people who are addicted to drugs to stop—that it is only a matter of will. They assume that people who are addicted to drugs ‘just don’t want to quit their bad habits,’ that they are ‘weak people.’ They don’t see that drug addiction is beyond the control of the drug users—the craving for drugs makes it difficult for them to break the addiction—not because they don’t want to, or are weak, lazy, or don’t try, but because of the power of the addiction. Drugs create a strong physical dependency which forces the person who uses drugs to continue taking drugs. Addicted drug users experience very painful withdrawal symptoms when the drugs wear off. These feelings have such a powerful effect on the body that people who are addicted to drugs would ‘do anything’ to get the drugs to get over the painful withdrawal feelings and get back to normal.
6. **People who are addicted to drugs who want to give them up are able to do so the first time they try.**
FALSE. Most people who are addicted to drugs who try to give up drugs may make several attempts before they succeed. It would be unusual for a person to succeed the first time. They may want to quit drugs, but the physical pain of withdrawing is too much and before they know it, they are out looking for drugs again. They may recover from drug use and then relapse several times, particularly in the

early stages of treatment. Even when they break free, they are still vulnerable to addiction, and might return to drugs 5 or 10 years later.

7. **People who have quit drugs often start using them again, for a number of reasons.**
TRUE. It is hard to break the drug habit. Many people quit, for a short or long time, and then start using drugs again. The reasons for this include: a) they were forced to quit by others—it was not their decision; b) they start feeling better and tell themselves that taking drugs will cause no harm; c) they are persuaded by other users to take drugs again.
8. **The only reason why people who use drugs prefer to use injections is that injecting produces a strong and immediate effect.**
FALSE. This is only one of the reasons why PWID prefer to use injections. There are a number of others. Most people who use drugs are poor and want to get more out of the drugs they buy. Injecting is an effective way of getting the drug into the body, since all of the drug is used. If you inhale the drug, much of it is lost in smoke. In addition, injecting can be done much more quickly than smoking, so those who inject them are less exposed to police action. Injecting takes little time, can be done anywhere, and the needle and syringes are easily disposed of.
9. **It is not drug use or injecting drugs which is the major cause of HIV transmission, but the practice of sharing needles and syringes among people who inject drugs.**
TRUE. Drug use itself does not transmit HIV (e.g., inhaling drugs does not transmit HIV), nor does injecting drugs, if you are using your own sterile equipment. The problem is the sharing of needles and syringes, especially with many other people. HIV spreads among PWID mainly because of the sharing or reuse of needles and syringes which have become contaminated with HIV infected blood. Small amounts of blood, which are not necessarily visible, can remain in the needle and syringes after they have been used. HIV could survive up to one week in the blood left in the syringe or needle. If the equipment is reused, this blood will be directly injected into the bloodstream of the next person who uses the equipment. If the blood is infected with HIV, then HIV can be passed on to that person.
10. **HIV is the only health problem faced by injecting drug users.**
FALSE. Injecting can also lead to drug overdose, abscesses, septicaemia, thrombosis, scarring, circulatory problems, collapsed veins, and poor healing of wounds.
11. **Using harsh punishment, including locking people up, is the best method to treat people who are addicted to drugs.**
FALSE. International experience of dealing with drug addiction over the years has shown that severe punishment does not change behaviour. If anything, it just makes the situation worse.
12. **Needle and syringe programmes (NSPs), which provide sterile needles and syringes to PWID, result in more drug use and more PWID.**
FALSE. Studies of NSPs have shown that these programmes do not lead to more use of drugs by PWID, nor do they encourage other people to start injecting drugs. NSPs encourage safe use of drugs and personal responsibility by PWID, and thus slow or stop HIV transmission. Using sterile needles and syringes to inject drugs without any sharing is the most effective approach for limiting HIV transmission.
13. **The discarding of used syringes is a potential source of HIV transmission.**
TRUE. The discarding of used syringes around places of injection can be a danger to local communities—creating a risk of needle stick injuries or the reuse of contaminated needles. Public health authorities should arrange for the safe retrieval and disposal of used needles.

14. **Laws which criminalise possession of injecting equipment stop people who inject drugs from injecting.**

FALSE. Laws which criminalise possession of injecting equipment discourage people who use drugs from acquiring and using their own injection equipment (a safer way of injecting) and push people who use drugs into sharing injection equipment, which increases their vulnerability to HIV. Abolishing such laws would not increase the number of PWID—it would remove a barrier to safer use of injection equipment.

15. **Drug addiction creates a huge burden on the family.**

TRUE. There are huge financial pressures on a family who are supporting a person who uses drugs — the cost of paying for daily fixes and detoxification or other forms of treatment, and the lost earnings because the addict cannot hold a job. In addition to this huge financial burden, there is the psychological cost of worrying about the theft of family property, the loss of family status, etc.

C-FS2: Glossary for Sexual Minorities

Handout for Exercise C4

Borrowed from:

BONELA. 2010. Sexual Minorities, Human Rights, and HIV/AIDS: Trainer's Guide. Gaborone, Botswana: Botswana Network on Ethics, Law, and HIV/AIDS. (Compiled by Jonathan Boland)

Biological sex is the biological distinction between men and women and refers to the biological characteristics of a person at birth. Most people are born male or female, but some people are born with full or partial genitalia of both sexes, or with underdeveloped genitalia, or with unusual hormone combinations. We say these people are “intersex.” (See below)

Bisexual is someone who is physically, emotionally and/or sexually attracted to both men and women. Bisexual people engage in the same types of relationships as everyone else.

Coming out (of the closet) is the life-long process of discovering, defining, and proclaiming one's sexual orientation and/or gender identity that is different from the majority in a society.

Gay is used to describe both men and women whose sexual orientation and emotional and sexual attraction is directed toward people of the same sex. The word “gay” is preferred to “homosexual” because the latter can have negative connotations, is outdated and is linked to a time when homosexuality was considered to be a mental disorder.

Gender defines one's perception, feeling or identity of being male or female.

Gender expression is the physical manifestation of one's gender identity, usually expressed through appearance, body language, voice and/or clothing. For example a gay man may have effeminate hand gestures or dress in women's clothing; at the same time, his appearance or clothing may be no different from straight men. Gender expression is fluid and whether someone identifies as male or female, an individual may express themselves in ways that are culturally typical to either gender. Transgender people usually have a gender expression that matches their gender identity rather than their birth sex.

Gender identity is a person's sense of themselves as male or female, and does not necessarily refer or correlate to one's sexual orientation or gender expression. It is who we are as a man or woman, regardless of whether we have male or female sexual organs. While most people's gender identity matches their biological sex, this is not always the case. For example, when a person feels that their personality, their inner self is different from their biological sex, we say that the person is “transgender.” A transgender person may decide to wear clothing of another gender, decide to change his or her biological sex (“gender reassignment surgery”), or do nothing at all.

Gender role refers to the behaviours and desires to act in certain ways that are viewed as masculine or feminine by a particular culture. A culture usually labels behaviours as masculine or feminine, but these behaviours are not necessarily a direct component of gender or gender identity. Often, when a man acts in a feminine manner, he is assumed to be homosexual, but this may not be true because gender roles and sexual orientation are different.

Heterosexual: Someone who is emotionally and sexually attracted to a person of the opposite sex.

Straight is a term used to describe people who are heterosexual and predominantly attracted to people of the opposite sex.

Heterosexuality is physical, emotional and/or sexual attraction to persons of the opposite sex.

Homophobia is the fear, anger, intolerance or lack of acceptance toward people who are lesbian, gay, bisexual, transgender, or intersexed.

Homosexual: Someone who is emotionally and sexually attracted to a person of the same sex. Homosexuals include gay men and lesbians. The term “homosexual” is an academic term and is generally not accepted by gay people as it is associated with abnormality.

Homosexuality is physical, emotional and/or sexual attraction to persons of the same sex.

In the closet describes a person who is not open about his/her sexual orientation or gender identity.

Intersex is a general term used for a variety of conditions in which a person is born with sexual organs that do not fit the typical definitions of female or male. For example, a person might be born appearing to be female on the outside, but having mostly male-typical anatomy on the inside. Another example is a person who is born with genitals that seem to be “in-between” the usual male and female types. Intersex people are usually assigned a gender at birth. This process is often arbitrary and many intersex people choose either to identify with a different gender later in life or choose to embrace their identity as an intersex person who is both male and female. Intersex is a biological variant and not a sexual orientation, nor does it refer to sexual behaviour. Approximately 1 in every 2,000 people is born Intersex.

Lesbian is the preferred term for women who identify as gay. “Gay” has largely been associated only with men, so many women wanted a separate term that applied specifically to women’s sexual orientation.

Lifestyle is how a person chooses to live and behave and is sometimes defined by the type of social life. Being lesbian, gay, bisexual, transgender, or intersexed is not a choice, and therefore is not considered to be a lifestyle. To call it a lifestyle is incorrect and offensive to LGBTI people.

LGBTI is an inclusive acronym commonly used to talk about the entire Lesbian, Gay, Bisexual, Transgender and Intersex population. Transgender and Intersex is often linked with the lesbian, gay, and bisexual group because they face similar struggles in being harassed or discriminated against due to their gender expression. However, transgender and intersex people may be gay, heterosexual or bisexual.

Men who have sex with men is a behavioural term used to refer to biological males who have sex with biological males. This term is used primarily in health settings, and it is used for a variety of reasons. One reason is that it recognizes that many men may have sex with other men, but do not necessarily consider themselves to be gay. They do not consider their sexual encounters with other men in terms of a sexual identity or orientation. Some men who have sex with men are married and/or are also having sex with women. Some men temporarily have sex with men due to circumstances, such as being confined to a facility (e.g., prison) or a period of separation from the opposite sex (i.e., during military training). The term “MSM” has become popular in the context of HIV/AIDS work because it addresses a behaviour that puts men at risk of getting HIV. For this same reason, some argue that the term is too focused on sexual behavior and not enough on other aspects of relationships such as emotions, affection, dating, love, companionship, family.

Sex is the biological distinction between men and women and refers to the biological characteristics of a person at birth. Most people are born male or female, but some people are born with full or partial genitalia of both sexes, or with underdeveloped genitalia, or with unusual hormone combinations. We say these people are “intersex.”

Sexual behavior differs from sexual orientation and alone does not define someone's identity. Any person may be capable of sexual behavior with a person of the same or opposite sex, but an individual knows his or her own longings—erotic and emotional—and which sex is more likely to satisfy those needs. Sexual behaviour alone does not define sexual orientation. A personal awareness of having a sexual orientation that is not exclusively heterosexual is one way a person identifies herself or himself as lesbian, gay or bisexual.

Sexual identity is the personal and unique way that a person perceives his or her own sexual desires and sexual expressions.

Sexual minorities is an inclusive, umbrella term used to describe any person who does not identify as heterosexual or does not fit into what one's culture defines as their appropriate "gender box." This group can include lesbians, gay men, bisexuals, transgender people, intersex people, men who have sex with men who do not identify as gay, women who have sex with women who do not identify as lesbian, and others who consider themselves to be a sexual minority.

Sexual orientation refers to whether one is emotionally and sexually attracted to members of the same sex or the opposite sex. Three sexual orientations are commonly recognized: a) homosexual (gay or lesbian), b) heterosexual or c) bisexual. While scientific studies have shown that an individual cannot change his/her sexual orientation at will, sexual orientation might change throughout a person's lifetime. So an individual's sexual orientation can move along the continuum as time passes.

Transsexuals are people who have had some type of surgical alteration to their genitalia and/or hormone treatments that change their bodies' appearance in alignment with their gender identity.

Transgender is an umbrella term for people who may clearly identify their gender as the opposite of their biological sex. For example, a person who is biologically male but feels like a female. Transgender people often feel that they are trapped in the wrong body; for example, an individual may have the sexual organs of a female, but feels male. This person may identify as a "transman". Someone who has the sexual organs of a male but feels female may identify as a "transwoman".

Transgender is used to describe people who identify their gender as the opposite of their biological sex. Consequently, transgender people often feel that they are trapped in the wrong body; for example, an individual may have the sexual organs of a female, but feels male. This person may identify as a "transman." Someone who has the sex organs of a male but feels female may identify as a "transwoman."

Transvestites or **cross dressers** wear clothes usually worn by people of the opposite biological sex. They do not, however, usually identify themselves as having a gender identity different from their biological sex or gender role. The motivations for cross dressing vary, but most transvestites enjoy cross dressing and may experience sexual excitement from it. The vast majority of transvestites are heterosexual.

Women who have sex with women is a term similar to that of men who have sex with men. It is used to describe women who have sexual relationships with other women but who may not identify as lesbian or bisexual.

C-FS3: LGBTI—Frequently Asked Questions

Handout for Exercise C4

How Do Two Men Have Sex?

People have sex for a variety of reasons, including love, pleasure, stress relief, showing affection, and deepening a bond. Many think of vaginal penetration by a penis when they hear the word ‘sex,’ but there are more activities that constitute sex. MSM engage in many of the same sexual practices as heterosexual people, which could include oral sex, kissing, touching, rubbing, foreplay, anal sex, mutual masturbation, etc.

How Do Two Women Have Sex?

See answer to the previous question. Two women may have sex in the same variety of ways as any other two people. If penetration of the vagina or anus is desired, a finger or dildo might be used.

Does Anal Sex Hurt?

No, with practice. The anus and rectum are not designed for penetration, so it can be uncomfortable at first and take some getting used to. The sphincter is a muscle that wraps around the anus; like any other muscle, it needs to be trained to do something new. A lot of water-based or silicone-based lubrication is highly recommended. Once the receptive partner is able to relax and be comfortable with the experience, it can be pleasurable for both people. For men in particular, the prostate, a gland located next to the rectal wall just a few centimeters inside the anus, is an erogenous zone. Penetration by another’s penis, finger, or object is the best way to reach it. Once the penetration becomes familiar to the body, it is a completely healthy and enjoyable experience. If anal sex hurts, relax and be patient with yourself and your partner.

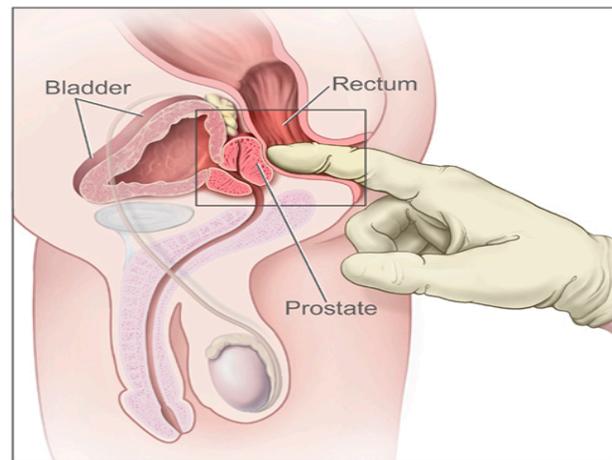


Photo credit: National Cancer Institute

What Does It Mean To Be Gay?

Men who call themselves gay are physically, emotionally, and sexually attracted to and fall in love with other men. Women who call themselves gay or lesbian are physically, emotionally, and sexually attracted to and fall in love with other women. Their sexual feelings toward people of the same sex are normal and natural for them. These feelings usually emerge when they are teenagers and continue into and throughout adulthood.

How Do I Know If I'm Gay?

Our sexual identities develop over time. You may not know what to call your sexual feelings. You don't have to decide how to label yourself right now. Most adolescent boys, for example, feel intensely sexual during the years around puberty, usually between ages 11 and 15, when their bodies start changing and their hormones are flowing in new ways. Your sexual feelings may be so strong that they are not directed towards particular persons or situations, but seem to emerge without cause. As you get older, you will learn more about who you are and to whom you're attracted, which is uniquely different for all of us.

What Causes Homosexuality?

Perhaps a better question is "What determines sexual orientation?" The factors that determine sexual orientation are complex. There is a growing understanding that human beings have a basic sexuality that

is expressed in relationships that are homosexual, bisexual, or heterosexual. The distinctions between these categories are fluid and may overlap. Although the causes are not known, some researchers believe that one's basic sexual orientation is predisposed at birth.

Is Homosexuality Healthy?

Studies have shown that people's sexual orientation has no bearing on their mental or physical health and emotional stability. Mental health professionals agree that homosexuality is not a choice, and is not a mental disorder that needs to be treated. What does have an unhealthy affect on LGBTI people is when their loved ones or society try to change or demonise them.

Isn't Homosexuality Immoral?

Anthropologists report that lesbians and gay men have been part of every culture throughout history. In some cultures throughout history, homosexuality has even been praised and celebrated. Many cultures and religions have demonised homosexuality at times when populations were thinning and procreation was encouraged, or at times when being different from the norm was seen as something detrimental to the community. Today, these ideas are seen as both absurd and also highly damaging to the healthy growth of any society or community. The only thing that makes same-sex relationships different from heterosexual ones is the gender of the two people in the relationship. Otherwise, gay people live the same lives as everyone else.

Is Being Gay or Lesbian Normal?

Yes. It's perfectly natural for people to be attracted to members of their own sex. Lesbians and gay men are represented in every socioeconomic class, educational level, and race. People of any sexual orientation can participate in family life and even raise children.

Scientific experts agree that a person's sexual orientation is determined at a very young age, maybe even at birth, and is not a choice. It's normal and healthy to be yourself, whether you're gay or straight. What's really important is that we learn to like ourselves and accept each other's differences.

Isn't Being Lesbian or Gay Against Religion?

A common myth about LGBTI equality is that it is universally opposed by people of faith. Leading Christian denominations are home to passionate debate about LGBTI issues and equality. Some people interpret religious texts in a way that limits the purpose of sex to having children (procreation). This kind of interpretation limits the ongoing value of physical intimacy for everyone and condemns people who do not or cannot have children as much as it condemns LGBTI people. Most religious books mention compassion as the most important state of mind.

Many religious people have made the decision to accept gay and lesbian people and to treat discrimination as irrational and hateful. The United Methodist Church, the Episcopal Church, the Presbyterian Church USA, and others continue to openly debate issues of gay and lesbian inclusion, the blessing of same-sex unions, and the ordination of gay clergy, with growing support for full inclusion. Both Archbishop Desmond Tutu and the Dutch Reformed Church have publicly apologised for the persecution of lesbian and gay people by the Church in Southern Africa. For more information, visit www.welcomingresources.org

When Do Gay Men and Lesbians First Know?

There is no set age at which a person becomes aware that she or he is lesbian or gay. Some gay, lesbian, and bisexual people become aware of their orientation during adolescence or earlier. People can realise their sexual orientation at any point during their lives. Because of strong societal pressures to be heterosexual, some people don't identify as gay, lesbian, or bisexual until later in life, perhaps even after they have been heterosexually married for years.

Research indicates that most gay and lesbian people sensed they were different when they were in primary school. Most young gay men first notice attraction to other men between the ages of 12 and 17, and most lesbian women first notice attraction to other women between the ages of 16 and 20.

What is the Difference Between ‘Sexual Preference’ and ‘Sexual Orientation?’

Preference implies choice, while *orientation* does not. ‘Sexual orientation’ is a term used instead of ‘sexual preference’ by most gay, lesbian, and bisexual people because it better represents their life experiences.

I Don’t Believe in Bisexuality. Don’t They Just Need to Pick a Side?

Most bisexuals are absolutely certain that they are attracted to both sexes; there is no confusion. Many people identify as bisexual for their entire lives, which proves it is not just a phase. It is natural for people who are coming to terms with their sexuality to feel confused but, for many, bisexuality is a lifelong, committed sexual orientation.

For those who identify as bisexual for a short period of time, that does not make it any the less valid as a sexual orientation. Life is a continuous process, and few of us remain exactly the same over long periods of time. We are in a constant state of figuring out who we are.

Individual people are all unique and do not always fit into these comfortable little categories. Bisexual people engage in a wide variety of relationships, just like everyone else. They simply have more options.

How Many Gay Men and Lesbians Are There?

While this number is difficult to measure, the Kinsey Institute suggested that approximately 10 percent of the population is lesbian or gay. Other research studies have suggested that anywhere between 2 percent to 10 percent of the human population has a sexual orientation that is not heterosexual. LGBTI people are found in many walks of life, among all racial groups, at all socioeconomic levels, and in every country around the world.

Do Lesbians or Gay Men Hate the Opposite Sex?

No. Lesbians are lesbians because they desire loving relationships with women, and gay men are gay because they desire loving relationships with men. Neither forms relationships because they hate the opposite sex.

Do Lesbians and Gay Men Want To Be the Opposite Sex?

No. Within the LGBTI community, there are many people who have challenged and discarded stereotypical gender roles, but this does not mean they are trying to be the other sex. Being gay, lesbian, or bisexual involves celebration and affirmation of one's identity, not a rejection of it.

Aren’t Transgender People Sick and in Need of Counselling?

A person’s gender identity is not causing any harm to themselves or others. If a transgender person wants to undergo a transition from their biological sex to their desired sex by taking hormones and/or an operation, counselling is highly recommended for those individuals to guide them through the difficult transition process. Transgender people are healthy, productive members of society. They simply identify much more with the gender that does not match their biological sex and strive in many ways to cope with that cognitive dissonance.

It’s important to note that it doesn’t matter what someone’s genitals look like, how they express themselves, and who they’re attracted to when it causes no harm to anyone. We just need to respect each other’s identities.

Do Gay Men and Lesbians Have Long-Lasting Relationships?

Longstanding relationships are common and both exist and break up for the same reasons that heterosexual relationships do. However, because of the social stigma expressed against lesbians and gay men, these partnerships are frequently invisible. Same-sex marriages are currently not recognised and many benefits for legal spouses are denied to domestic partners in many countries. When same-sex marriages are not recognised, it sends a message to gay people that they aren't meant to have long-lasting relationships, and that simply isn't true.

Should LGBTI People Be Banned From Certain Jobs?

Sexual orientation and gender identity do not affect one's job qualifications or performance. Unfortunately, some people believe that some LGBTI people should not be allowed to hold certain positions, such that of a teacher or healthcare provider. For example, they feel that LGBTI people are sexually irresponsible, less trustworthy than others, and bad role models, particularly with children. In fact, it is well documented that the overwhelming majority of those who molest or abuse children are heterosexual men. There is no correlation of homosexuality and gender identity with illegal activity or poor job performance. Anything stating otherwise is a homophobic myth.

How Can a Same-sex Couple Raise Children When Kids Need Both a Mother and a Father?

Studies from several different countries show that children of same-sex parents grow up no differently from people with opposite-sex parents. The same is true for single parents. Many children are not raised by a mother and father. Some are raised by adopted parents, extended relatives, grandparents, single mothers, or single fathers. If children can be raised by two people who will love and care for them, that's all that matters. Being raised by male or female 'role models' makes no difference in childhood development. Good role models are important, but the gender of those role models is not.

Won't Gay Parents Make Their Children Gay?

Research has shown that children of lesbian or gay parents are no more likely to become gay or lesbian than children of heterosexual parents. Most LGBTI people have heterosexual parents, and that didn't make them straight. LGBTI people are just as likely to be good parents as anybody else. Of course, children growing up in non-traditional families may face a certain amount of societal prejudice. Fewer and fewer children are growing up in two-parent, heterosexual, and nuclear families. LGBTI families are one of the many diverse families that exist.

Why Do Gay People Have to Flaunt their Homosexuality?

Gay men and lesbians are often accused of 'flaunting it' (wearing buttons, talking and writing about homosexuality, showing affection in public, etc.). Many cultures teach that it is more acceptable to be silent or invisible ('in the closet'). Any openness about LGBTI identity is labeled 'blatant' or as 'flaunting.' However, 'blatant' heterosexuality is rarely questioned. In society, the assumption of heterosexuality is so strong that unless one proclaims a gay identity, then heterosexuality is assumed. LGBTI people just want to be themselves, to be accepted for who they are, and to be treated fairly without fear.

Why do Gay People Want Special Rights?

LGBTI people want equal rights, not special rights. LGBTI people are not seeking anything special or different from the rest of the population. They want to be treated equally, just like everyone else. They want the right to safety, security, privacy, the right to work, the right to have an education, and the right to have consensual relationships.

Why Should People Be Informed about LGBTI Issues?

Becoming informed about lesbian, gay, bisexual, transgender and intersex issues helps reduce heterosexism, homophobia, and transphobia. This makes it easier for everyone to live more open and productive lives in their work and home communities. The culture as a whole is therefore enriched. For LGBTI youth, who are more likely to experience depression and rejection by friends and/or family,

acceptance and understanding could be a matter of life or death. The risk of suicide in gay adolescents is two to three times greater than for their straight counterparts.

Why should I Support LGBTI Equality and Acceptance?

You should support LGBTI rights because:

- Our LGBTI friends and family members deserve the same rights as everybody else.
- LGBTI people exist in every country, culture, and profession. LGBTI are our police, social workers, nurses, teachers, construction workers, shop clerks, janitors, and lawyers.
- LGBTI youth face constant harassment and abuse in schools due to being different in this way, and some commit suicide due to the lack of acceptance.
- Your loved ones need you to take a stand for fairness. By being open about yourself and your family, you are already helping to dispel misinformation and fear.
- The most productive society is one that treats all of its members equally, regardless of who they are. Freedom and equality are pillars of a flourishing and healthy community.

C-FS4: Our Multiple Social Identities

Handout for Exercise C2

- All of us have many social identities—nationality, race, class, ethnicity, biological sex, gender identity, gender expression, sexual orientation, age group, language, religion, education, type of work, marital status, having children/no children, family type, ability/ disability, or health status.
- Key populations are marginalised and stigmatised on the basis of some of these identities or characteristics. They are forced to live within a world dominated by identities which exclude them. As marginalised groups, they are expected to conform to those identities and, when they don't, they become targets for stigma and discrimination.
- In thinking about key populations, we often limit ourselves to thinking about one of their characteristics, e.g., biological sex, sexual orientation, gender identity, use of drugs, occupation (in the case of sex workers), status as prisoners or migrants, disability, etc. In other words, we don't treat them as whole people, with a full set of identities. We treat them as having only one identity—their stigmatised identity.
- In focusing narrowly on this single identity, we stop dealing with key populations as human beings—we forget their humanity and get a feeling of power and superiority over them.
- So we need to change our ways of thinking about key populations as having a single identity and look at them as people with a full set of identities—they are our children, our brothers or sisters, our friends, workmates, church members, or community members, not just men who have sex with men, sex workers, or people who use drugs. We need to respect them by treating them like anyone else.
- There are also layers of stigma. People who experience HIV stigma may also be stigmatised on the basis of other stigmatised identities. For example, a woman could be stigmatised as a woman, a sex worker, a PWID, a person living with HIV, a woman without children, or as an HIV-positive woman who is pregnant. Each layer of stigma magnifies the level of stigma. This makes it even more difficult for them to access health and other services and to get out of their hidden, marginalised existence.

C-FS5: What Is Sex? What Is Gender?

Handout for Exercise C3

- **Sex** describes the *biological and physiological characteristics that define men and women*. Men have a penis and testicles and produce sperms to make babies. Women have a vulva, vagina, and ovaries, and produce eggs to make babies.
- **Gender** refers to the socially constructed roles, behaviours, activities, and characteristics that a given society considers appropriate for men and women. People are expected to perform ascribed gender roles and have certain characteristics. Men are expected to be strong, play the role of breadwinner, and marry/have sex with women. Women are expected to be gentle, hard-working, and marry/have sex with men.
- **Sex** is physical, while **gender** is social or cultural, e.g., a woman can give birth to children but a man cannot (sex); women can raise children and so can men (gender). Sex is fixed or inborn, but gender can change—it is socially constructed.
- Boys and girls are taught how they should behave to become ideal men and women according to their culture. From an early age, children are taught that boys and girls have **different roles** and should behave differently, e.g., girls work in the home, cooking, washing, and cleaning; boys do physical work outside of the house. Girls are discouraged from playing rough games like football, boys from playing with dolls or dressing in girls' clothes. Girls and boys are expected to respond differently to the same experience. For example, while it is acceptable for girls to cry, crying is seen as a weakness in boys.
- These different expectations of boys and girls and men and women are expressed in slogans such as, 'Act like a real man,' 'Boys should never cry,' and 'Girls should behave properly' (e.g., girls should never initiate or talk about sex).
- Sexual minorities who behave differently from these expectations are often stigmatised and harassed. For example, gay boys are often forced by their parents to change the way they dress or act, or the roles they play in the family—to become a 'real man.'
- Perceptions of gender roles strongly influence how society views sexual minorities. For example, gay men or men who have sex with men have no biological differences (sex) from men who are not gay/MSM. However, they often challenge traditional perceptions of gender roles and stereotypes—they refuse, for example, to get married or to conform to traditional stereotypes of what is considered to be masculine (e.g., not expressing emotion, not doing household tasks, etc.).
- Men who have sex with men also challenge heterosexual norms of sexual practice (penis-anus instead of penis-vagina) and, because of this, they are also stigmatised. In some countries, sex between men is considered illegal and men found having sex with other men can be severely punished.¹
- Transgender people who do not accept the gender ascribed to them and/or consider themselves as a member of the opposite gender are often severely stigmatised. In the eyes of other people, they

1 Ottosson, D. 2009. "State-Sponsored Homophobia: A World Survey of Laws Prohibiting Same-Sex Activity between Consenting Adults." Retrieved March 6, 2010, from http://ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2009.pdf. The report points out that no less than 80 countries consider homosexuality illegal, and five of them – Iran, Mauritania, Saudi Arabia, Sudan, and Yemen – and in parts of Nigeria and Somalia, homosexual acts are punishable by death.

do not behave appropriately to their gender characteristics and roles. Transwomen (people whose biological sex is male, but whose gender identity is female), for example, who have a man's body but do not consider themselves as men but as women, dress and behave like women and want people to treat and view them as women. Because their behaviours are seen as inappropriate and not masculine, they are often mocked, humiliated, and, in some cases, subjected to violence.

- Transgender persons in the past were categorised as 'men who have sex with men.' However, transwomen do not identify themselves as male—and should not be included in this category.
- Growing up in the same society, sexual minorities have internalised the same set of gender roles and stereotypes—'Be a real man, don't cry,' etc. When sexual minorities are shamed by their families for not following these gender roles and expectations, it makes them feel abnormal, they begin to stigmatise themselves, and become confused about their own identity and behaviour.

C-FS6: Men Who Have Sex with Men and Stigma

Creating a Supportive and Enabling Environment for the Sexual and Reproductive Health of People living with HIV: Legal and Policy Considerations with areas for Action. GNP+, ICW, Young Positives, EngenderHealth, IPPF, UNAIDS, UNFPA, WHO, December 2007

Men have sex with men in every culture and society, although the extent varies from region to region. The term “men who have sex with men” describes a wide variety of sexual practices and identities, including: gay men, bisexuals (including married men who have sex with men), prisoners who self identify as heterosexual but have sex with men while they are in prison; male sex workers who see themselves as heterosexual but sell their bodies for sex with men.

MSM are at increased risk of getting HIV because of having multiple sex partners, irregular condom use, and injecting drug use. Sex between men involving unprotected anal sex carries a very high risk of HIV infection; and the risk is greater for the receptive partner. At least 5–10% of HIV infections worldwide are estimated to occur through sex between men, though this figure varies considerably between countries and regions.

Many MSM also have sex with women; if HIV-positive they can transmit the virus to their female sexual partners or wives through unprotected sex; and they can also be infected by female partners.

Men who sell sex to other men are at particularly high risk, because their turnover of partners tends to be high, and they may be pressured or paid more to have unprotected sex. When male– male sexual behaviour overlaps with drug use, the risk of HIV infection may increase through the shared use of injecting equipment or unsafe sex or both.

MSM have limited access to information on HIV prevention strategies and to condoms and water based lubricant, because of stigma and discrimination.

In many countries sexuality is still a taboo subject for discussion and sex between men is socially disapproved of, legally prohibited and criminalized². As a result, health workers often discriminate against men who have sex with men and police may harass or arrest them. Furthermore, many men who have sex with men may fail to be open with health workers, meaning that anal STIs may go undiagnosed and untreated. Many governments fail to acknowledge that sex between men happens and that unprotected anal sex contributes to the transmission of HIV; and many national AIDS programmes do not give sufficient attention to the needs of men who have sex with men.

Guideline 4 of the **International Guidelines on HIV/AIDS and Human Rights** states:

Criminal law prohibiting sexual acts (including adultery, sodomy, fornication and commercial sexual encounters) between consenting adults in private should be reviewed, with the aim of repeal. In any event, they should not be allowed to impede provision of HIV prevention and care services.

2 *As of 2005, nearly 70 countries had legal prohibitions against sex between individuals of the same sex. SIDA 2005. “LGBTI issues in the world: A study on Swedish policy and administration of lesbian, gay, bisexual, transgender and intersex issues in international development cooperation.” Stockholm: Government offices of Sweden.*

C-FS7: Transgender People and Stigma

Borrowed from:

Creating a Supportive and Enabling Environment for the Sexual and Reproductive Health of People living with HIV: Legal and Policy Considerations with areas for Action. GNP+, ICW, Young Positives, EngenderHealth, IPPF, UNAIDS, UNFPA,WHO, December 2007

Transgender is an umbrella term for people whose gender identity does not match their sex assigned at birth. For example, a person who is biologically male but feels like a female. Transgender people often feel that they are trapped in the wrong body; for example, an individual may have the biological sex characteristics of a female, but feels male. Some transgender people may take hormones and/or sex reassignment surgery to transition to the desired sex.

Transgender people can be gay, straight, or bisexual just like non-transgender people. Just because someone is transgender, does not mean that they are gay.

Transgender people are heavily stigmatised. Many are rejected by their families and find it difficult to get a job and access accommodation, education, and health services. Because of limited economic opportunities and adverse reactions from family and peers to their gender and sexuality, many transgender people enter into sex work and/or start using drugs. These activities along with failure to adopt safer sex and injecting practices makes them more vulnerable to getting HIV. .

The legal status of transgender people ranges from complete non-recognition or being treated as mentally ill to extremely complicated legal situations regarding legal identity, particularly in relation to documents, which then affects the access of transgender people to services.

Many people who transition from one sex to another change their names to better match their gender identity or expression. A legal name change is an expensive and labour-intensive process, involving changes to all records and forms of identification. During this process, different agencies may have different names on record, and a certain amount of confusion may result, making it more difficult to access services.

An additional confusion is the legal designation of sex, for example, the “male” or “female” on legal documents such as a driver’s license and birth certificate as well as on medical records. Many transgender people still have a legal sex that does not match their gender identity or appearance. This disparity means that every time they show identity documents, their transgender identity is revealed. As a result, transgender people may be reluctant to show identification, again acting as a barrier to accessing services, including health care.

There are few transgender-sensitive HIV prevention activities. In addition, access to HIV treatment, care and support may be limited due to low socioeconomic status, fear of one’s transgender status being revealed, the lack of knowledge about caring for transgender persons by health workers, and discrimination (e.g. exclusion from services such as ARV therapy programmes, verbal harassment and mistreatment).

C-FS8: Women and Girl Children and Stigma

Borrowed from:

Creating a Supportive and Enabling Environment for the Sexual and Reproductive Health of People living with HIV: Legal and Policy Considerations with areas for Action. GNP+, ICW, Young Positives, EngenderHealth, IPPF, UNAIDS, UNFPA,WHO, December 2007

Young women have a high risk of getting HIV once they become sexually active. Lack of educational opportunities and financial necessity leaves many girls with few options but to get married at a very young age or engage in intergenerational sex. For example, in Africa and Asia, 50–60% of girls are married before they reach 18. In most countries, girls in their late teens are at least twice as likely to be married as boys. As such, low levels of education and the resulting lack of opportunities for financial security and independence mean that many girls enter relationships which directly put them at risk of HIV infection.

Young HIV-positive women often face judgmental attitudes from health workers who believe they should not have children and face the same pressures as all HIV-positive mothers about breastfeeding.

Many health programs fail to help young girls to acquire the knowledge, negotiation skills and assertive behaviours needed to practice safer sex, or the ability to say no to sex.

Often young HIV-positive women, as well as women in resource poor settings, lack even the most basic information such as the need for: a) regular cervical smear tests (pap smears), b) safer sex to prevent re-infection and c) early treatment of opportunistic infections. In addition ARV treatment programmes often fail to take the specific needs of young women into account. HIV-positive women and girls often require different treatment and care plans from men as the psychological pressures women face are often very different to those of men, often linked to women's and girls' traditional roles as unpaid care-givers within the household. A further barrier to accessing treatment and other health services is gender inequality within families.

Many women have to obtain permission from a husband or a relative in order to seek care. This is particularly difficult when women have to ask for money or take time away from household chores, and even more difficult if they have not disclosed their HIV-positive status to family members. ARV therapy provided to women may be used by male relatives or male partners/relatives may be prioritized for treatment if the household only has enough money to afford one lot of treatment.

HIV-positive women have a two- to six-fold increased risk of pre-cancerous cervical cell abnormalities, and can develop invasive cervical cancer up to ten years younger than HIV-negative women. Progression to high-grade lesions is more rapid and lesions are more resistant to treatment in the presence of HIV. In HIV-positive women, lower genital tract cancers in the vagina and vulva are also prevalent.

C-FS9: Sex Workers and Stigma

Handout for Exercise C5

Borrowed from:

Creating a Supportive and Enabling Environment for the Sexual and Reproductive Health of People living with HIV: Legal and Policy Considerations with areas for Action. GNP+, ICW, Young Positives, EngenderHealth, IPPF, UNAIDS, UNFPA,WHO, December 2007

Sex work has many dimensions, including: a) all sexes - men, women and transgender persons; b) all sexual orientations—heterosexual, homosexual, and bisexual; c) a wide range of ages; d) varying legal status and work environments; e) high mobility; f) sexual transactions for cash, favours or goods; g) dynamic supply and demand patterns influenced by social changes; and h) overlap between sex work and drug use.

The majority of sex workers have few other income sources, often because their education and marketable skills are limited. Individuals who have low-income jobs may supplement their income with part-time sex work, and many women engaged in transactional sex do not identify as sex workers.

Some sex workers enjoy the work, others hate it. Some work in brothels, with others, some on the streets or as escorts. Sex workers can be men who sell sex to men, or transgender people who sell sex to men.

HIV prevalence among sex workers is higher than in the general population. Sex workers are vulnerable to HIV because they have more sexual partners; and may not be in a position to negotiate condom use, due to financial pressures, or because of violence or rape. However, even when condoms are used with clients, the rate of condom use with regular sexual partners is lower.

Female sex workers have limited access to reproductive health and family planning information. HIV programming for sex workers has tended to focus on preventing sex workers from infecting their clients rather than responding to sex workers' sexual and reproductive health needs.

Sex work is legal, regulated or illegal. In countries where sex work is illegal, criminalization drives sex workers underground away from services, and often leads to distrust of police and health workers. As a result many sex workers in those countries may not access health services and may have no information on HIV/STI prevention and lack the skills to negotiate with their clients.

Sex workers may see their day-to-day survival, an improvement of their rights, reducing violence and other factors as more urgent than HIV prevention—a disease they may lack the power to prevent anyway. In most countries, sex workers who are known to be HIV-positive are more likely dismissed from their workplaces. Upon losing their jobs, they may work underground, pushing them further away from health care services.

Some national responses have understood the role of sex work in the HIV epidemic, and have been willing to take a pragmatic approach in order to engage sex workers in HIV and STI prevention activities. However, in many other countries, government staff find it difficult to work with sex workers, since sex work as a criminal activity should be reported to the authorities.

C-FS10: Prisoners, Migrants, and Stigma

Prisoners—Basic Facts

HIV prevalence among prisoners is higher than in the general population. Many prisoners are from groups already vulnerable to HIV (e.g., PWID, MSM, sex workers, and migrants). Some are infected before going to prison; others become infected while they are in prison.

Prisoners also have a high prevalence of hepatitis B and C, syphilis, and tuberculosis (TB), and prisoners are often co-infected with two or more of these infections. TB is a common and growing problem in many prisons, closely related to overcrowding. TB poses a high risk for prisoners living with HIV.

There are fewer women in prison than men, but female prisoners often have more health problems. Many suffer from chronic health conditions resulting from lives of poverty, drug use, family violence, sexual assault, pregnancy, malnutrition, and poor preventive healthcare.

Overcrowding, poor conditions, and inadequate medical services affect the provision of healthcare for prisoners, which is usually given low priority. The prisons system is a “public safety or law enforcement activity, rather than a public health activity.”

Behaviours with a high risk of HIV transmission are common in prisons, including injecting drug use, tattooing, and male-to-male sexual relations, including rape. These behaviours are often denied by prison officials and many do not allow the distribution of condoms on grounds that this condones illegal and ‘immoral’ behaviour

Sex takes place in prison, but this does not necessarily mean that prisoners are gay. In some cases, prisoners have sex for survival purposes, or they are raped.

The existence of male-to-male sex is denied by many prisons officials and many do not support condom distribution to prisoners, saying that this would condone illegal and “immoral” behaviour.

Migrants—Basic Facts

Migrants with undocumented status are people who do not have a visa to enter, stay, or work in a country. Due to their uncertain status, they tend to take low-paying, cash-only jobs. As a result, they are often exploited, work long hours, suffer poor health, and live in substandard and often illegal housing. If female, they are more likely to be sexually and physically abused.

Mobility increases vulnerability to HIV, both for those who are mobile and for their partners back home. Migrant and mobile workers are often more vulnerable to HIV infection because of isolation resulting from stigma and discrimination and differences in language and culture, separation from regular sexual partners, lack of support and friendship, and lack of access to health and social services. When these factors are combined with lack of legal protection, vulnerability to HIV infection is further increased.

Many countries require that immigrants be tested for HIV as part of their medical exam prior to entry. Testing is often mandatory and done without appropriate counselling or safeguards to protect confidentiality. An HIV-positive test result means that the person is denied entry or deported.

Stigma and discrimination towards migrants discourage them from accessing health services in the host country. Many migrants are forced to take low-paid jobs that do not include healthcare, so they have to pay for health services—something which few can afford. Illegal migrants have the additional burden of trying to access health services while avoiding being reported to authorities.

Chapter D: HIV Update

D-FS1: HIV and AIDS—The Basics

Handout for Exercise D1

What Is HIV?

HIV stands for Human Immunodeficiency Virus:

- **Human**—HIV only affects human beings—it needs a human host
- **Immunodeficiency**—HIV creates a deficiency within the body's immune system, making it more open to disease and infection
- **Virus** – HIV is one of a family of viruses known as 'retroviruses'

HIV attacks the body's immune system. The immune system is the body's defense against sickness and disease.

Most people who become infected with HIV do not notice that they have been infected. Soon after being infected, some people may suffer flu-like symptoms for a few weeks. Otherwise, there are no signs of early HIV infection. However, the virus remains in the body and can be passed to other people. At this stage, the person is HIV positive but she/he does not have AIDS.

HIV invades a host CD4 cell and then uses the machinery of the cell to make copies of itself. The copies (new viruses) leave the host cell and go on to infect more cells. The host cell becomes damaged and eventually dies—weakening the immune system. HIV can exist alongside antibodies produced to fight against it by the host cell.

HIV invades the body like termites invading a house. To begin with there is no visible damage. The virus is hiding inside white blood cells (CD4 cells) and multiplying—just like termites are hiding inside and eating up the timber which holds the house together, slowly weakening the house structure. Nobody realises that anything is wrong. One day, a strong wind comes along and knocks the house down.

What is AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome –

- **Acquired**—not born with; something that a person gets from someone else
- **Immune**—the body's immune system—the part of the body which fights off germs
- **Deficiency**—the immune system is not working properly to fight off disease/infection
- **Syndrome**—a set of illnesses that attack the body when its immune system is weak

AIDS is the advanced stage of HIV infection, when the body's immune system has become very weak. HIV slowly destroys the power of the body to fight infection and disease. The person starts to become seriously sick and vulnerable to a group of diseases or 'opportunistic infections' that a healthy person without HIV would probably not contract. This is the 'syndrome.' The symptoms of AIDS include swollen glands, weight loss, frequent fever, diarrhoea, cough, and skin problems.

What is the difference between HIV and AIDS?

- HIV is the **virus that causes AIDS**. It develops slowly in the body over a long period of time and, as it develops, destroys the body's capacity to fight infection and disease.

- AIDS is the **advanced stage of HIV infection**, when HIV has destroyed the CD4 cells which protect the body's immune system. The body is then susceptible to infections, including TB, septicaemia, pneumonia, and fungal infections.

A person infected with HIV can remain healthy for many years with no physical signs or symptoms of infection. A person with the virus, but no symptoms, is '**HIV positive**.' Most people living with HIV do not even know that they have the virus.

Once a person living with HIV begins to get sick and develop opportunistic infections, she/he is said to have **AIDS**. 'AIDS' is a clinical definition describing people with HIV who have a CD4 count of below 200 or one of a number of infections, including TB; rare cancers; and eye, skin, and nervous system conditions. (A CD4 count is a test to count the number of CD4 cells—infection-fighting blood cells which are attacked and killed by the HIV virus. Once these cells are destroyed, the body's immunity is lowered and it becomes susceptible to different opportunistic infections.)

How does HIV harm the body?

CD4 cells protect our bodies. They attack germs that get into the body so that we do not get sick. They are part of our body's immune system.

When a person gets HIV, **the virus invades the CD4 cells and damages these cells** so that the cells can no longer perform their function of keeping the body healthy. Germs then take advantage of the weakened immune system and attack the body.

This weakening of the immune system takes place over a period of time. People do not get HIV and die straight away. For a while, the infected person feels healthy and feels no sign of sickness. But, over time, the immune system becomes weak.

The body gets weaker and is attacked by diseases such as TB, pneumonia, cancer, and meningitis—what are called '**Opportunistic Infections**.' When the body is too weak to fight these diseases, the person is said to have '**AIDS**'—a collection of diseases that attack a person after HIV has made the body weak. When the body becomes so weak, the person can die.

Where does HIV come from?

Nobody knows where HIV came from. Nobody knows exactly how it works or how to cure it. When AIDS first appeared, people blamed AIDS on certain groups, such as poor people, sex workers, men who have sex with men, or migrant labourers, who were marginalised and more vulnerable to HIV infection because of poverty and lack of access to services or information. Many believe that only the people in those groups are at risk of getting HIV and that 'it can't happen to me.' Confusion about where AIDS comes from and who it affects also leads many people to deny that it even exists.

How is HIV transmitted?

There are three ways that HIV is passed from human to human:

- **Sex:** If one person is HIV positive, HIV can be passed from his or her infected blood, semen, or vaginal fluids directly into another person's bloodstream through the lining (mucous membrane) of the vagina, penis, or rectum. During sex, it is normal that friction will cause tiny scratches (or micro-abrasions) in these linings, and this is how HIV gets into the bloodstream.
- **Mother-to-child transmission:** HIV can be passed to a baby during pregnancy, delivery, and breastfeeding. However, not all babies born from HIV-positive mothers will have HIV. About one-third of all babies become infected with HIV if the mother has not been treated with ARVs.

- **Blood transfusions and unsterilised equipment:** HIV can be transmitted by HIV-infected blood transfusions, contaminated injecting equipment (syringes/needles), or razors. People who inject drugs often get HIV because they share needles, and this is how the virus is spread. Care should be taken with needles for injections and razors, to make sure they are sterilised again before each new person uses them. Open wounds should be kept covered by all of us, whether we are people living with HIV or caregivers.

For HIV to spread, HIV found in an infected person's blood, semen, or vaginal fluids has to get inside the other person's blood supply through the cuts in the skin.

How is HIV not transmitted?

HIV can live only inside a human body. **It cannot survive outside the human body** – it starts to die as soon as it is exposed to the air. If it is exposed to heat (for example, if someone bleeds into a cooking pot) it will die.

HIV **cannot pass through the skin on the outside of your body unless there is an open cut**. It is easier, however, for HIV to pass through the skin on the private parts (during sex) because the skin there is much thinner and has small openings where HIV can pass through. Infections in **the genital area** (e.g., STIs) provide an easy way for HIV to enter the bloodstream—this is why people with STIs are at higher risk of getting HIV than other people.

HIV **cannot be transmitted through saliva, tears, vomit, faeces, or urine**, although small amounts of HIV have been found in these fluids. HIV is not found in sweat.

HIV **cannot be transmitted through unbroken skin (skin not broken by cuts) – or casual contact**, such as touching someone with HIV or something they have used (e.g., clothing), sharing **eating or drinking utensils**, or using the same toilet seats.

Caring for people living with HIV is not risky if the person follows sensible precautions, such as disposing of sharp needles safely and keeping cuts covered.

HIV is not contagious—it cannot be transmitted by casual contact!

How to prevent HIV infection?

- If you have sex with many partners, or you are unsure of your partner's sexual relations, **always use or insist on a condom during sex**.
- Protect yourself from contaminated bodily fluids.
- **Use disposable syringes** obtained from a reliable source. Never reuse syringes.
- **Women who are pregnant or intending to get pregnant**—get access to PPTCT services to prevent HIV transmission to the unborn child.
- **Blood transfusion**—insist on having blood that has been tested for HIV from a licensed blood bank. It is safer when a known person donates blood for you.
- **Skin piercing instruments**—use sterilised instruments or sterilise the instruments yourself—boil for 20 minutes or rinse thoroughly, using 1 percent bleach solution.
- **Follow standard precautions to protect yourself and your patients**. In addition, cover cuts and wounds with waterproof plasters. If you do not have plasters, use a piece of clean cloth to cover the wounds.

FREQUENTLY ASKED QUESTIONS

If you stay with one partner, you cannot become infected with HIV.

FALSE. Individuals who are faithful to their partner may still be at risk for HIV if their partner has sex with other people. In addition, individuals who have sex only with their partner may have been infected with HIV from someone else in the past. They may have the infection without knowing it, and without their current partner knowing it. Only a long-term, faithful relationship with someone who has not been previously infected can be considered ‘safe.’

Is it true that I can get HIV from someone even if they tested negative?

Yes. Many people choose to have unprotected sex because they think their partner is negative. Too often, people forget about or do not know about the ‘window period.’ When a person contracts HIV, it takes up to three months for that person to test positive. During this “window period” is when viral loads are highest— a time when a person is most infectious.

Can you tell if someone has HIV by looking at him or her?

No. The only way to know if someone is infected with HIV is through an HIV test. Most people living with HIV look healthy and do not have symptoms for many years. However, the virus remains in their body and can be passed on to other people. People with HIV look ill only during the last stages of AIDS, when they are near death.

Can mosquitoes transmit HIV from human to human?

No. HIV cannot live outside the human body or a vacuum, as in syringes. Malaria is a parasite that survives in mosquitoes, which is why it can be transferred to humans. HIV (H = Human) is a virus that cannot survive in mosquitoes. HIV is not transmitted by mosquitoes or other bloodsucking insects. Most insects do not pass blood from one person to another when they bite humans. The malaria parasite enters the bloodstream in mosquito saliva, not blood.

Can HIV be transmitted through razor blades or sharp instruments?

There is a slight risk if a razor is being used quickly to make incisions or cuts on many people, one after the other, without washing it. It is better—and more hygienic—to sterilize sharp instruments by boiling them, washing them thoroughly with rubbing alcohol, or using new razors every time. If a shared razor is covered in blood, you should wash it thoroughly before using it.

Can I get HIV from touching someone who has open cuts and sores?

No. Unless someone is covered in blood and you are badly injured with open wounds, there is no risk. Your skin protects you. If you are bleeding, your blood flows outward; it does not suck things into your bloodstream! If you are caring for someone (with HIV or not) and she/he were bleeding, use gloves and wash well before and afterward.

Can I get HIV by cleaning up the diarrhoea of an HIV client?

There is no risk. Diarrhoea does not contain HIV unless it has blood in it, and it would still have to get inside your bloodstream. Use gloves or cover your hands.

How long can you live if you get HIV?

This depends on several factors. If you are healthy and can eat well and get lots of love and support, you can live for many years. If you can access antiretroviral (ARV) drugs and take them consistently, you can live for many years.

Remember that HIV and AIDS are different things. With HIV, you have the virus but you are mostly healthy. With AIDS, it means your immune system has become significantly weakened and you might have a number of opportunistic infections. It is important to treat these infections. Finding out you are HIV positive is not a death sentence.

Is it true that condoms are not really safe?

When used correctly and consistently, condoms can protect men and women from becoming infected with HIV. Latex condoms are not 100 percent effective but, after abstinence, they are the most effective way of preventing STIs, including HIV infection. Some groups have reported inaccurate research suggesting HIV can pass through latex condoms, but that is not true. In fact, standard tests show that water molecules, which are five times smaller than HIV molecules, cannot pass through latex condoms. Make sure your condoms are not out of date and store them in a cool place. Don't use Vaseline or oil on them, as this can make them break. Water-based and silicone-based lubricants are safe and lower the risk of HIV transmission. Never use more than one condom at a time.

Circumcised men do not need to use condoms.

FALSE. In the recent past, research has indicated that men who are circumcised may have a lower risk for HIV transmission than those who are uncircumcised. The research is not final; however, it looks promising. But this does not mean that circumcised men cannot contract HIV. It only means their chances of infection are lower. They still need to use condoms correctly every time they have intercourse.

Is there any cure for HIV/AIDS?

There is no cure, but treatments that slow down the impact of HIV are available. The combination of treatments is called ARV therapy. In some countries, ARVs are free for any citizen who has been diagnosed with AIDS: has at least one opportunistic infection or a CD4 count below 250.

Can a man cure HIV or STIs by having sex with a virgin?

No. A man will still have the virus in his body after sex and he will probably have infected the virgin as well. This myth has caused many men to rape young girls, further spreading HIV and causing physical and psychological damage to young women.

Can anal sex spread HIV?

Yes. Anal sex is high risk for HIV because the rectum is a mucous membrane and it tears very easily—this provides the virus with an entry point into the bloodstream. HIV can pass through pre-ejaculate or semen during anal sex. One should use a condom and water-based or silicone-based lubricant when having anal sex.

Can men get HIV if they are the insertive partner?

Yes. In both vaginal and anal sex, HIV can pass through a man's urethral opening or under the foreskin. Studies released in 2008 show that getting circumcised can reduce the risk of HIV transmission by as much as 60 percent.

Can oral sex spread HIV?

If there are no cuts, sores, or STIs present, oral sex is very low risk for HIV. Saliva contains a natural enzyme that kills HIV. Many couples choose to practice oral sex instead of vaginal or anal sex because it is a much safer activity regarding HIV infection. However, oral sex is high risk for spreading other STIs, such as gonorrhoea and chlamydia.

Is HIV transmitted more easily during dry sex than wet sex?

Yes. HIV can be transmitted more easily during dry sex because the lack of lubrication causes cuts and tearing of the skin and the mucous membranes of both men's and women's genitals. These cuts provide the virus with an easy way to enter the bloodstream.

Can HIV be transmitted through the sharing of needles while using drugs?

Yes. HIV can be transmitted from one person to another when they share needles while using drugs. Sharing needles during injection drug use carries a very high risk for HIV transmission. Infected blood is

easily passed from one person to another via an infected needle or other equipment used to prepare or inject drugs.

Why can't a mother typically give HIV to her baby in the womb?

HIV is not passed from mother to foetus because the blood of the mother and the blood of the baby are separate. Inside the womb, the baby floats in a bag of water. The baby is attached to the women's uterus by the placenta, a temporary organ. The baby does not come into contact with the mother's blood at all, except during delivery. The mother's blood is in her own blood vessels.

There are thin membranes that separate the placenta from the lining of the mother's womb. This prevents the mother's blood from mixing with the baby's blood, but allows oxygen and nutrients to pass from the mother's blood to the baby's blood.

During childbirth, there is a lot of bleeding, and HIV can pass from blood in the vagina through a baby's eyes, nose, or mouth. If the mother is HIV positive, it is recommended that she get involved with a PMTCT (Prevention of Mother-to-Child Transmission) program to lower the risk of transmission.

D-FS2: QQR—Quantity, Quality, and Route of Transmission

Handout for Exercise D1

Borrowed from:

International HIV/AIDS Alliance, ICRW, and AED (2007). Understanding and Challenging HIV Stigma: Toolkit for Action. Brighton, UK: International HIV/AIDS Alliance, International Center for Research on Women, and Academy for Educational Development.

What is QQR?

For HIV transmission to take place, the **quality** of the virus must be strong, a large **quantity** must be present, and there must be a **route of transmission**.

Quality

For transmission to take place, the *quality* of the virus must be strong. **HIV does not live on the surface of the skin - it lives inside the body. HIV cannot survive outside the human body—it starts to die as soon as it is exposed to air.** If it is exposed to heat (eg if someone bleeds into a cooking pot), it will die. The only place the virus can survive outside the body is in a vacuum (like a syringe) where it is not exposed to air.

Quantity

For transmission to take place, there must be enough **quantity** of the virus in body fluids to pose any risk. HIV is found in **large quantities** in blood, semen and vaginal fluids and breast milk—so in these fluids there is a risk of transmission. HIV is found in **small amounts** in saliva, vomit, feces and urine, and not at all in sweat or tears—so in all of these cases there is no risk of transmission, unless blood is present. Thus cleaning or bathing a patient is also quite safe, provided all wounds are covered. It is easiest to transmit HIV when someone tests negative because it is during the “window period,” that someone has the highest quantity of virus. Once infected, it can take someone up to 3 months to test positive for HIV.

Route of Transmission

For HIV transmission to take place, the virus must get inside your bloodstream. Our body is a closed system. Healthy skin is an excellent barrier against HIV. HIV cannot pass through unbroken skin or even broken skin very easily. If you cut yourself, the blood flows outwards, away from the bloodstream. If you touch someone else’s cut, blood will not swim into your bloodstream!

Common sense and everyday hygiene mean that many concerns that people worry about would not really happen in everyday life. For example you wouldn’t share a toothbrush if it was covered in blood; you would wash if you cut yourself; you would wear gloves or cover your hands if you are cleaning up someone’s diarrhea.

These three conditions—**Quantity, Quality, and Route of Entry (QQR)** - help to explain why HIV cannot be transmitted by such activities as

- Touching the skin or sweat of a person living with HIV
- Changing the clothes of or serving food to a person living with HIV
- Taking the blood pressure of a person living with HIV
- Shaking hands with someone living with HIV
- Hugging someone with HIV
- Kissing someone with HIV when your mouths are clean and clear of cuts or sores

Other Factors that Increase the Risk of Sexual Transmission

- **Viral load of infected person.** Higher viral load increases risk of HIV transmission. The highest viral loads occur at the initial stage of HIV infection (before an individual even tests positive for HIV) and the final stages of AIDS.
- **Having multiple partners.** If you have sex with multiple people regularly and do not use condoms with all partners, HIV can pass quickly through your sexual network. Remember, a viral load (quantity) is highest right after infection. So, if you got infected last week and have unprotected sex with someone else today, you will most likely pass on the virus. This is during the window period, before you even test positive.
- **Presence of cuts or wounds.** Wounds or cuts on either partner increase the chance of HIV entering the bloodstream.
- **Presence of other sexually transmitted infections (STIs).** STIs cause sores or broken skin, making it easier for infected blood to get through the skin into the bloodstream.
- **Having sex during the menstruation period or when a woman is bleeding.**
- **Not using a water-based or silicone-based lubricant during anal sex.** Lack of lubricant could cause additional tearing to the rectum and even lead the condom to break.

The HIV Transmission Equation

Human host with HIV—someone has to carry the virus in order to infect someone else.

- **Body fluid that carries large amount of HIV—**blood, semen, vaginal fluid, breastmilk
- **Opening into the bloodstream—**needle holes, mucous membranes such as the vagina, rectum, urethral opening of the penis and foreskin, esophagus, eyes, cuts/tears in the vagina, anus, penis or mouth
- **Activity that can move these fluids between people—**unprotected sex (anal, oral, or vaginal), sharing injection needles, breastfeeding, blood transfusion

= POSSIBILITY OF HIV INFECTION

D-FS3: Antiretroviral (ARV) Therapy

How HIV Makes the Body Sick

There are many different kinds of cells in our bodies. One is the **white cell**, also known as **CD4 cells**. White cells (CD4 cells) are found in our blood. Each person has many white blood cells. The cells are very small—one cell is smaller than a grain of sand.

White blood cells protect our bodies. The white cells are like a fence around the body, protecting it from diseases. They attack germs that get into the body so that we do not stay sick. White blood cells keep our bodies healthy. They are part of our body's **immune system**—the system which protects us against sickness.

Once a person becomes infected with HIV, the virus begins to live and spread in the white blood cells. **HIV attacks and damages the white blood cells** so that the blood cells cannot do their work of keeping the body healthy. Germs then take advantage of the weakened immune system and attack the body.

This weakening of the immune system takes place over a period of time. People do not get HIV and die straight away. During part of this time, a person often feels perfectly healthy and feels no sign of sickness. But, over time, the immune system gets weak. The body has to work harder to try to fight off other germs and diseases.

The body gets weaker and is attacked by different diseases, including TB, pneumonia, bowel infection, cancer, and meningitis. These diseases are known as 'opportunistic infections,' or AIDS- related diseases. When the body is too weak to fight these diseases the person is said to have **AIDS**—a collection of diseases that attack a person after HIV has made the body weak. When the body becomes weak, the person can die.

What is Anti-Retroviral (ARV) Therapy?

ARV therapy is a combination of medicine—usually two or more medications – that are taken by an HIV-positive person to **slow down the growth of HIV in the body**. ARVs help to improve the immune system, and this helps the body protect itself against AIDS-related diseases. ARVs reduce the viral load and prevent the destruction of CD4 cells (increase CD4 count). If ARVs are properly taken, they can help a person live a healthier, more productive, and longer life.

ARV therapy is not a cure for HIV or AIDS. The medicine will reduce the amount of virus in the body and make people feel healthier, but HIV is still in the blood. So once people start to use ARV therapy, they should continue with it for the rest of their lives. **ARV therapy is life-long.** If people stop taking treatment, HIV will continue to grow and they will become sick again.

People taking ARV therapy need to **take their medicine at the right time and in the right way each day**. If they stop or forget to take their medicines, HIV will become stronger and may become resistant to the medication—meaning that the medication will no longer work.

ARV therapy is given to people who are HIV positive but do not yet have AIDS and to those who have AIDS. **BUT not every HIV-positive person needs ARV therapy.** Only those people whose immune systems have been seriously weakened by HIV need ARV therapy.

Once a person discovers that he or she is HIV positive, he or she will get tests from health staff –

- **Viral Load Test:** This measures the amount of HIV in the blood.
- **CD4 Count Test:** This blood test measures the amount of white blood (CD4) cells.

The tests help to see if a person needs ARV therapy (when the CD4 count is low) and, once a person starts ARV therapy, to see how well the medicine is working—to see if the immune system is getting stronger (indicated through a viral load test).

ART is usually started during the final phase of HIV infection, when the CD4 count is less than 200. Treatment is started before the patient is too sick from opportunistic infections. If started too late, the patient will be too sick for the immune system to fight off opportunistic infections.

When people start taking ARV therapy, their bodies may react to the medicine. These **side effects** may include: stomach pain, nausea and vomiting, diarrhoea, skin rash, excessive tiredness, headaches, tingling feeling in fingers and toes, and sleep disturbances. People should not stop taking the medicine when they have these side effects, but they should report them to the health staff.

Advantages of ART

People living with HIV remain healthy longer—they are able to lead a normal life and contribute to family income.

- Being productive and healthy means there is less chance of depression.
- ART reduces the viral load—so there is less risk of infecting others.

Disadvantages of ART

Cost—the cost is high, but some government hospitals are providing ARVs free of charge with support from the Government and donors.

- Side effects—but most side effects disappear after a few months.
- Adherence—drugs need to be taken in a timely manner for the rest of person’s life.
- Drug resistance—drugs must be taken correctly or the virus can mutate and become resistant to a particular drug—ARV then becomes useless for that person.

Non-Adherence and Drug Resistance

The correct dosage of drugs should be taken on a regular and ongoing basis.

- Some patients, after 6–12 months, when they feel better, want to stop taking ARVs.
- This is dangerous—and should be discouraged.

If patients stop treatment, even for a short period, this could result in:

- Rapid decline in health, increase in OIs, and faster progression of HIV infection.
- Drug resistance—the first ARVs are no longer effective and can no longer be used—this reduces the number of treatment options.
- When HIV becomes resistant to one drug, it may become resistant to other drugs in the same group.
- Anybody infected by a patient who has drug-resistant HIV won’t be able to use those ARVs to which the virus is resistant—drug resistance is passed on with the virus.

Is ARV therapy the only medication available for people living with HIV?

No. People living with HIV often receive other medications for opportunistic infections, such as TB.

People taking ARV therapy should try to live **healthy and positive lives**—to help the ARV therapy fight the HIV in their bodies. Things they can do include:

- **Eating good food and drinking plenty of liquids** to strengthen their bodies and keep up body weight. (People living with HIV lose weight as a result of opportunistic infections or lose nutrients because of diarrhoea or vomiting.)
- **Being physically active.** People living with HIV will be healthier if they keep themselves busy.
- **Getting enough sleep and rest,** to allow their bodies to recover.
- **Keeping their bodies and homes clean**—to help reduce the germs which can bring unwanted diseases.
- **Practising safe sex (using a condom).** People living with HIV and taking ARV therapy are still HIV positive and can pass HIV to others. By practicing safe sex, they can also protect themselves from getting re-infected (increasing the amount of virus in the body).
- **Living with hope and getting emotional support from family and friends.** This helps people living with HIV feel loved, accepted, and better about themselves, strengthening them to live longer and more productively.

ANSWERS TO SOME QUESTIONS ON ARV THERAPY

What is ARV therapy?

This is the main medication for HIV. It uses a combination of medicine—usually two or more medications. It slows down the growth of HIV and improves the immune system.

Is ARV therapy a cure for HIV and AIDS?

No. ARV therapy is not a cure for HIV and AIDS. If a person takes ARVs properly, she/he will feel better and the viral load will be reduced to the point where it can no longer be detected in the body. However, it can never take the virus out of a person's body completely, so it is important to continue the medication.

How many extra years of life can ARVs give a person living with HIV?

ARV therapy can allow most people to live up to 10 years longer, depending on how advanced the HIV infection had been when the ARVs were started. New medications are likely to increase this period. The general lifestyle, diet, and ARV drug adherence of a person living with HIV will determine how well ARVs will work for him/her.

How is ARV therapy different from other medicine?

It is like other medicine in that it has side effects. The difference is that it requires 100 percent adherence to prevent HIV from becoming resistant to medication.

What is the danger of drug resistance?

The danger of drug resistance is that no other drugs are available to treat HIV and prolong life. The newly resistant HIV could then spread to other countries. This is why the use of ARV therapy requires a lot of responsibility and commitment from everyone.

What are possible side effects of ARV therapy?

Some patients will experience some of the following side effects: nausea, vomiting, diarrhoea, muscle pains, headaches, tiredness, changes in menstrual patterns, skin rashes, numbness in hands and feet, and changes in body shape.

D-FS4: Sexually Transmitted Infections (STIs)

What are STIs?

STI stands for Sexually Transmitted Infection. STIs are a group of infections that are passed from one person to another, mainly through sexual contact. HIV is a sexually transmitted infection.

While the main form of transmission is through having sex, many STIs also can be transmitted from a pregnant woman to her child during delivery. Some STIs also can be passed through unclean injection needles, skin-cutting tools (such as razors), and blood transfusions.

STIs often are overlooked because HIV gets the attention – but **STIs are dangerous**. In addition, STIs produce sores on genitals, which make it easier for HIV to get into the bloodstream during sex.

All STIs (except HIV, hepatitis B, and herpes) are easily treated and cured, but they can be **very dangerous—and even fatal—if they are left untreated**. If left untreated, they can be passed on to sexual partners, pregnant women can pass the STI to their babies at birth, and the STI can damage the sexual organs and lead to infertility. Gonorrhoea, for example, if left untreated, can lead to Pelvic Inflammatory Disease (PID), which makes it impossible to have a baby. Some STIs, if left untreated, can cause blindness, cancer, and heart problems; others can lead to death.

Who is at risk of getting STIs?

All sexually active people are at risk for STIs; however, heterosexual women and men who have sex with men get STIs, including HIV, more easily than heterosexual men and women who have sex with women. A woman's vagina has a larger surface than a man's penis, and vaginal walls have thin membranes that easily develop small tears, through which STIs can pass. Anal sex is high risk for transmission of STIs, including HIV, especially for the receptive partner. This is because the rectum has a large surface area and tears very easily. Use of condoms and water-based or silicone-based lubricant are recommended for both vaginal and anal intercourse.

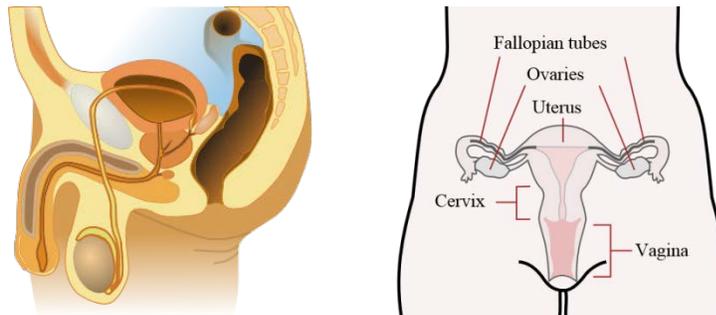


Photo credit: Tsaitqaist

Having an STI increases the risk of contracting HIV. STIs produce sores on the genitals, which make it easier for HIV to pass into the bloodstream during sex. The prevention and early treatment of STIs will reduce the spread of HIV.

How do you know if you have an STI?

Some STIs do not show symptoms at all and may be hidden in the vaginal canal or rectum. As a result, women and men who have sex with men often have no visible symptoms, making it more difficult for them to know that they have an STI—they have to depend on their sexual partner(s) or a health worker to tell them they have an STI.

What are the COMMON TYPES of STIs?

STIs include: chancroid (genital ulcer), chlamydia, gonorrhoea, genital herpes, genital warts, hepatitis B, syphilis, and HIV.

STIs fall into two categories:

- Those caused by **bacteria**, and which can be cured, such as chancroid, chlamydia, gonorrhea, and syphilis
- Those caused by **viruses**, which cannot be completely cured, such as genital herpes, genital warts, hepatitis B, and HIV.

What are the COMMON SYMPTOMS of STIs?

Sometimes, people who get STIs have no initial or visible symptoms. The person feels healthy, but the STI germs are inside his/her body, injuring his/her reproductive organs. The person can unknowingly pass an STI to someone. Even if symptoms appear to go away, the STI remains, so be sure to seek testing and treatment.

Common symptoms in **WOMEN** are:

- Unusual or excessive discharge and smell from the vagina
- Burning pain when urinating
- Sores, bumps, or blisters near or on the sex organs or mouth
- Burning or itching around the vagina
- Unusual itching around the sex organs, especially the pubic area
- Pain in the lower part of the abdomen
- Pain inside the vagina during sexual intercourse
- Unusual bleeding from the vagina when it is not the woman's regular monthly period
- Backache, fever, and chills

Common symptoms in **MEN** are:

- Discharge from the penis
- Burning pain when urinating
- Sores, bumps, or blisters on or near the sex organs
- Itching or irritation on or near the sex organs
- Unusual scratching around the genital area, especially around the pubic area
- Unusual pain inside the rectum during sexual intercourse
- Bleeding from the anus

Many women have no visible symptoms, so it is harder for them to know that they have an STI.

What are the symptoms of each STI?

- **Chancroid (genital ulcer)** – sores on or around the genitals. Sometimes the glands in the groin swell up and the sores may burst.
- **Chlamydia** - discharge from the penis or vagina, burning/pain when urinating (women do not experience this symptom).
- **Gonorrhoea** - signs in men include discharge from the penis and pain when urinating. Signs in women include sores in the vagina, a discharge, and pain when urinating.

- **Genital herpes** – small painful blisters/ulcers on the genitals or mouth; itching or burning before the blisters appear. The sores can come back, particularly if you are feeling weak or tired, or have a vaginal infection.
- **Genital warts**—small and bumpy warts on the sex organs—they are painless but sometimes itchy. The warts grow around the genitals and can sometimes cause problems in passing urine. Women with untreated genital warts may be at increased risk of developing genital cancers.
- **Hepatitis B**—flu-like feelings, tiredness, jaundice, dark urine, and light-colored bowel movements.
- **Syphilis** – a painless sore on the vagina or penis; a rash and flu-like symptoms. These signs disappear, but the disease is still growing in the body.

Do STIs affect one’s risk of getting HIV?

Yes. Having an STI increases the risk of contracting HIV. STIs produce sores in the genitals or anus, which make it easier for HIV to pass into the bloodstream during sex. Prevention and early treatment of STIs will reduce the spread of HIV.

Can a person get an STI from oral sex?

Yes. Oral sex is high risk for most STIs, including gonorrhoea and chlamydia, which can cause sores in the mouth. If there are no cuts, sores, or STIs present, oral sex is low risk for HIV. It is important to keep one’s mouth clean and clear from sores or cuts and to use a condom for oral sex to lower the risk of STI transmission. Saliva contains a natural enzyme that kills HIV, but provides no protection from other STIs. Many couples choose to practice oral sex instead of vaginal or anal sex because it is a much safer activity for HIV, but many forget that oral sex is high risk for other STIs.

Are STIs curable?

Yes. Most STIs are easily treated and cured, but can be very dangerous, and even fatal, if left untreated. STIs can damage sexual organs and lead to infertility. Gonorrhoea, for example, can lead to Pelvic Inflammatory Disease (PID), which makes it impossible for a woman to have a baby. Some STIs can cause blindness, cancer, and heart problems; others can lead to death.

What should a person do if she/he thinks she/he may have an STI?

The person should go to a clinic and get tested and treated. Many STIs can be treated and cured with antibiotics. However, viruses like HIV, hepatitis B, and genital herpes cannot be cured. Genital warts can be removed, but they can return. Patients should complete the full treatment. Otherwise, the germs will stay in the body and make the person ill later on. The person can also transmit disease to others. People who are treated for STIs should tell their partners, so they can also be treated.

What if the symptoms disappear?

The symptoms may go away, but the STI will remain. If it is not treated, it will continue to harm the body and can leave men infertile and women unable to become pregnant. Infection can be passed on to unborn babies, leading to miscarriages, stillbirths, handicaps, or death. The infection also can be transmitted to other people.

D-FS5: HIV Transmission and MSM—Risk Continuum

Handout for Exercise D2

Receptive anal intercourse without a condom: HIGHEST RISK. The rectum has a large surface area and the skin is lined with a mucous membrane, a very sensitive part of the body which tears very easily, especially if the insertive partner is not using lubricant. Once the skin of the rectum gets broken/cut, HIV in the sperm or blood from cuts on the penis of the insertive partner can get easily into the body and the bloodstream of the receptive partner, if they are not using a condom. Adolescent boys whose skin in the rectum is not fully mature are more likely to develop cuts during anal sex and are therefore at higher risk of getting HIV.

Insertive anal intercourse without a condom: HIGH RISK. This is also risky for HIV transmission, but not as risky as receptive anal sex. The skin on the penis is stronger than the skin in the anus. It is less prone to cuts, so it is less vulnerable to penetration by HIV. However, HIV contained in blood and rectal fluids can pass through the urethra of the penis, or under the foreskin of someone who is uncircumcised.

Receptive oral sex: VERY LOW RISK. Receptive oral sex is more risky than insertive oral sex. The person sucking is more at risk than the person whose penis is being sucked. Why? Sperm gets into the mouth of the person sucking and can penetrate the skin around the teeth, which can easily get cut. The skin is strong in most parts of the mouth, except around the teeth (the gums), so there is a potential for HIV entering the body through cuts or bleeding in the gums.

Insertive oral sex: VERY LOW RISK. The skin on the penis, especially if circumcised, is strong and less vulnerable to cuts. The person sucking may have cuts in the mouth, which produce blood, but saliva in the person's mouth protects the penis and the acid in the saliva neutralises the blood from the gums.

Oral sex is low risk for HIV but high risk for other STIs, such as gonorrhea.

Thigh sex: NO RISK. Sperm does not get into the anus or mouth, where it then could get into the body and the bloodstream.

Mutual masturbation: NO RISK. When men masturbate each other, the hands may come into contact with sperm, but the sperm remains outside the body, where it is exposed to air and dies. There is no risk if there are no cuts or broken skin on hands.

Kissing: NO RISK. As long as there are no cuts or sores in the mouth, kissing is completely safe. The saliva of the infected person may get into the mouth, but saliva contains very low quantities of HIV.

Water-based or silicone-based lubrication is a must for anal sex. With a condom and lubricant, anal sex can be practiced and enjoyed safely.

Untreated STIs greatly increase one's risk of getting HIV. Many STIs cause sores, which make it easier for HIV to enter the body. MSM may not have symptoms of STIs, or cannot see the sores because they are inside the anus or mouth, which puts them at greater risk.

The risk of a man acquiring an HIV infection during unprotected receptive anal sex is **10 times higher** than during unprotected insertive anal sex (with a man or woman) or unprotected vaginal sex with a woman.³ The high risk of HIV transmission in receptive anal sex is because:

Anal sex is more traumatic than vaginal sex, sometimes resulting in abrasions and cuts that reduce the body's barrier to HIV infection.

Unlike the vagina, the anus and rectum have no natural lubrication.

Lack or misuse of inappropriate lubricants (e.g., Vaseline, oil) may worsen trauma or damage condoms. Some men who have sex with men do not use condoms for anal sex, and when they do, they may not use safe, water-based lubricants.

Sex between men need not always involve penetrative anal sex: oral sex, masturbation, and thigh sex carry a much lower risk of HIV transmission, and men may choose to avoid anal sex for their (or their partners') protection.

Use of condoms and water-based lubricants for anal sex considerably reduces the risk of HIV transmission. Water-based lubricants can be used with male latex condoms, as they do not damage the latex. Most male and female condoms already have water-based lubricant on them. However, adding lubricant is especially important for anal sex, as the lining of the anus does not produce its own natural lubrication and is sensitive to tearing.

Oil-based lubricants must NOT be used with the male condom, as they damage the latex and may increase the risk of condom breakage. Examples of oil-based lubricants include hand lotion, body lotion, baby oil, vegetable oil, cooking oil, massage oil, and petroleum jelly (e.g., Vaseline)

3 Varghese, B., J.E. Maher, T.A. Peterman, et al. 2002. "Reducing the Risk of Sexual HIV Transmission: Quantifying the Per-act Risk for HIV on the Basis of Choice of Partner, Sex Act, and Condom Use." *Sexually Transmitted Diseases* 29: 38–43.

D-FS6: Introduction to Universal Precautions

Handout for Exercise D4

Borrowed from:

- Engender Health (2004) Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers. Participant's Handbook. New York: Engender Health.
- Institute for Social Development Studies and ICRW (2008) Safe and Friendly Health Facility: Trainers' Guide (Vietnam). Hanoi: Institute for Social Development Studies and International Center for Research on Women

Health Workers Can Get HIV through Injuries on the Job

Healthcare workers can get HIV accidentally through injuries sustained on the job. Two main types of injury can lead to HIV transmission –

- needlestick injuries - skin pierced by contaminated needle or sharp instrument
- splashes on the nose, eyes, or mouth by blood or body fluids from infected clients.

The risk of HIV infection from these forms of occupational exposure is **very low**—

- the risk from a needlestick or sharp instrument injury is around 0.3%
- the risk from splashing blood or body fluids on nose, mouth, and eyes is about 0.1%.

Nonetheless staff need to avoid these forms of exposure.

Support staff who clean up and dispose of contaminated instruments are also at risk of getting HIV through their handling of these instruments.

Clients Can Get HIV when Health Workers Use the Wrong Practices

Clients themselves are also at risk of HIV infection when health workers do not clean their hands between clients, or use instruments which are not cleaned or sterilized properly. For example health workers may reuse contaminated needles which have been rinsed in water between injections, or the needle is changed but the syringe remains the same for many clients. The water will not kill the blood-borne micro-organisms and syringes become contaminated because negative pressure is generated when the needle is removed, drawing up whatever blood is in the needle into the syringe. The acceptable standard is: one sterile syringe and needle for each client.

The Community Can Also Get HIV through Improper Disposal of Medical Waste

The community is also at risk of HIV infection from the poor disposal of medical waste, such as contaminated sharps, and other practices:

- Improper disposal of medical waste, including contaminated dressings, tissues, needles, syringes and scalpel blades. These items can be found by children or others scavenging in open dumps. Medical waste is often scattered on the ground in areas where adults and children travel, putting them at risk of infections and injury.
- Not providing information to family members who are caring for people living with HIV on how they can protect themselves.

What are Universal Precautions?

Universal Precautions refers to practices performed to protect health workers from exposure to blood borne micro-organisms. 'Universal' means that these precautions should be applied universally - that is, with all clients irrespective of whether health workers know their health status or not.

What are Standard Precautions?

Standard Precautions has replaced the term 'Universal Precautions'. It is a broader term that includes not only safety for health workers but for clients and visitors as well. It is also a broader term which covers safety from exposure to not only blood and bodily fluids, but also to other health care associated infections.

Standard Precautions is a system for infection control used to make health facilities safe for health workers and clients. It involves the use of precautions which are designed to help minimize the risk of HIV exposure by health workers and clients.

The first principle of Standard Precautions is that health workers apply the precautions to ALL clients, regardless of whether or not they think the client may be HIV-positive or have any other infectious disease. It is important to emphasize, however, that Standard Precautions deal with all health care associated infections, not just HIV.

It is safer to act as if every client is infected, rather than to apply Standard Precautions to some clients and not to others. This is important because it is impossible to tell who is infected with viruses such as HIV and the hepatitis viruses based on appearance. Most blood borne diseases that pose a risk to health workers and clients cannot easily be detected and could be present in the blood of ALL persons, including health workers themselves. Diseases do not discriminate, and health care workers should not discriminate.

The second principle is that Standard Precautions are designed to **protect both health workers and clients** from infection.

The best way to prevent HIV infection in health care settings is to follow Universal Precautions on a consistent basis.

Universal Precautions in Health Care Settings

Universal precautions are simple infection control measures designed to help minimize the risk of exposure to blood and other bodily fluids by health staff and clients. Use the following precautions to avoid injury and reduce the risk of infection:

Handwashing

- Wash your hands with soap and water after coming into contact with blood, body fluids and contaminated items, whether you have worn gloves or not.
- Wash your hands immediately after removing the gloves and between client contacts to avoid transferring micro-organisms among the clients.

Gloves

- Wear gloves when coming into contact with blood, body fluids and contaminated items
- Put on clean gloves before touching eyes, nose, and mouth and non-intact skin.
- Put on a new clean pair of gloves between tasks or procedures on the same client after contact with blood or body fluids.
- Rinse gloved hands in 0.5% chlorine solution before removing the gloves.

- Remove gloves immediately before touching non-contaminated items and surfaces.
- If gloves are not disposable, wash and disinfect after use with each client.

Note: Health staff with open cuts or rashes should avoid direct client contact and should not handle contaminated equipment because breaks in the skin provide points for micro-organisms to enter the bloodstream and cause infection.

Eye Protection

Wear eye protection, face shield and mask to protect mucous membranes of the eyes, nose, and mouth during procedures (e.g., during delivery, cutting of the umbilical cord) and client care activities that might produce splashes or sprays of blood or body fluids.

Protective Clothing

- Wear clean, non-sterile gowns to protect skin and prevent clothes getting soiled during activities that might produce splashes or sprays of blood or body fluids.
- If possible, use a plastic or rubber barrier (e.g., apron) to protect clothing if large amounts of soiling are anticipated, as in during delivery.
- Remove a soiled gown immediately, placing it in a designated container for decontamination, and wash hands.

Instrument Processing

- Decontaminate, clean, disinfect, and/or sterilize the instruments using standard infection prevention procedures.
- Make sure that instruments are not used on another client before this processing has been done.

Handling Sharps

- Don't recap needles after use. This is the most common cause of needle stick injury.
- Don't bend, break, or cut needles after use.
- Don't remove the needle from the syringe before disposal.
- Dispose of used needles in a puncture-proof container immediately after use.

If injured by a contaminated needle or sharp instrument, wash the area immediately with soap and water and then apply PEP.

Maintaining a Clean Environment and Waste Disposal

- Make sure that liquid waste is placed in a container with enough disinfecting solution to be able to kill organisms.
- Make sure that all contaminated waste (bloody dressings, swabs, tissues, gauze, cloths soiled with body fluids, etc.) is placed in designated and clearly marked containers, collected and taken for incineration or other safe disposal.
- Immediately clean up surface spills of blood and body fluids with a disinfectant solution such as 0.5% chlorine solution, and clean the area with detergent and water.

Handling and Processing Soiled Linen

- When handling linen soiled by blood or body fluids, wear gloves and place items in designated and clearly marked bags. If using a plastic bag, use double bags.
- Transport the soiled linen in a way that avoids puncturing the bag or loss of soiled items on the way to the laundry.
- Wash soiled linen using detergent and germicide following standard infection prevention guidelines.

Summary

- Regard all blood, body fluids and objects as contaminated and infected.
- Follow the same procedures of cleanliness, sterility, hygiene and precautions, which you have followed for other viruses, e.g. Hepatitis B.
- Avoid accidental exposure to areas with broken or cut skin, scratches, rashes, acne, chapped skin, or fungal infections.
- Avoid accidental splashes of blood or body fluids, especially on eyes or mouth.
- Report needlestick injuries or accidental splashes to the clinic authorities.
- Dispose of all contaminated materials in an appropriate way.
- Use gloves, masks and protective eye shields when coming into contact with blood or body fluids of the clients.
- Wash hands thoroughly with soap—a) after coming into contact with blood and body fluids, b) before and after each procedure and c) after removal of gloves.

Remember –

- Assume that blood and body fluids from all persons are infected with HIV, regardless of the known or supposed status of the person.
- The aim of Universal Precautions is to isolate the virus and body fluids, not the client.

D-FS7: Fears of Getting HIV in Health Facilities & How to Overcome Fear through Universal Precautions

Handout for Exercise D4

Borrowed from:

- Engender Health (2004) Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers. Participant's Handbook. New York: Engender Health.
- Institute for Social Development Studies and ICRW (2008) Safe and Friendly Health Facility: Trainers' Guide (Vietnam). Hanoi: Institute for Social Development Studies and International Center for Research on Women

What are possible causes of infections in health facilities?

- Poor environmental hygiene.
- Poor handling of blood and bodily fluids
- Poor handling of contaminated needles, sharps and waste
- Poor processing of instruments
- Poor handwashing practices

What are other possible causes of infections in health facilities?

- Infections transmitted by coughing (e.g. TB, measles, chickenpox)
- Infections transmitted by worker's hands (e.g. Clostridium difficile, Staphylococcus aureus).

Who is at risk of getting HIV and how could they get it in health facilities?

- Everyone who enters the health facility—health workers, clients, and visitors
- Nurses and doctors - during surgery and when giving injections
- Lab technicians - when drawing blood
- Cleaners - when cleaning and disposing of medical waste, including sharps
- Clients through contact with health workers which involves blood or bodily fluids

What are other modes of HIV transmission outside health facilities?

- Unprotected sexual contact—through unprotected vaginal or anal intercourse
- Mother to child transmission (during pregnancy, delivery, or breastfeeding).
- Intravenous drug use with contaminated syringes
- Tattooing

What unnecessary safety practices are often used by health workers?

- Using gloves to serve food to a client, take a client's temperature, or do a physical examination where a client has no open sores or injuries
- Wearing masks to talk to a client with HIV even when the client does not have an airborne disease like TB
- Staying at a distance when attending to a HIV positive client
- Focusing your medical attention on those you suspect are not HIV positive.

All of these practices may be perceived by clients as stigmatising.

Why are these practices used?

- To make health workers feel safer
- Some health workers fear getting HIV through contact with HIV positive clients. They have incomplete knowledge about how HIV is transmitted
- Some health workers are judgmental towards people living with HIV, especially if they are sex workers, men who have sex with men, transgender persons, people who use drugs, prisoners, or migrants

How can we ensure protection from infection and avoid stigma?

- Train all health workers (including cleaners and guards) on Universal Precautions so they know how to protect themselves and their clients from infection
- Explain to clients about Universal Precautions so they know why certain precautionary practices are needed—this will make them feel less stigmatised

How do our practices as health workers lead to stigma?

- Some health workers insist that it is their right to be told who is HIV positive so they can protect themselves against HIV. They claim that not knowing who has HIV puts them at risk. They identify who have HIV by isolating HIV clients in separate rooms, or marking HIV clients' files, or simply telling other health workers. Or they use double gloves when they are with clients assumed to be HIV positive. These practices are wrong—they stigmatise HIV positive clients and create a climate of fear around them and they do not decrease the risk of HIV transmission in the health facility.
- There is no medical justification for the above practices - they do not protect the health worker because HIV is not contagious, it is not spread through casual contact. Trying to put clients into two groups - those who are HIV positive and those who are negative - can be counter-productive. Health workers may be more cautious with HIV positive clients and less cautious with HIV negative clients, even though some of the negative clients may be in the window period, when people are at their most infectious or have other blood-borne infections such as hepatitis.

How can Universal Precautions provide protection and help to overcome fear?

- Universal Precautions provides a better, non-stigmatising method for protecting health workers and their clients. Universal Precautions are based on the assumption that all blood and bodily fluids are potentially infectious, whether they are from a client or health worker, regardless of their known HIV status, and should be applied in all clients. Universal Precautions gives health workers more control over ensuring their own safety within the health setting, while ensuring the safety of their clients.
- We often assume that we as health workers are the ones who are getting infection, but in some cases we may be the ones who are passing the infection. So Universal Precautions protects both health workers and clients—and health workers should realise that they can potentially pass on infection to clients.
- Everyone in a health facility is at potential risk of contracting HIV - nurses, doctors, non-clinical health workers, clients, and visitors are all at risk in different ways. For example, medical staff are at risk during clinical procedures, while members of the cleaning staff are at risk of infection while cleaning instruments or disposing of waste.

- Knowing how HIV is actually transmitted is an important first step in preventing HIV infection in the health facility. It is equally important to learn how HIV is NOT transmitted so that health workers know how to properly protect themselves and others.
- Practicing correct precautionary measures and explaining why these precautionary measures are taken are two good ways to ensure that people in the health facility are adequately protected and clients feel less stigmatised by the necessary precautions.
- Infection in the health facility may occur through contact with blood or other body fluids, which may occur through broken skin, injuries with contaminated needles and/or sharp instruments, transfusion of infected blood or blood products, splashing of contaminated body fluid into the mucous membranes, or the use of contaminated razors.
- There is no evidence of transmission through other modes. Transmission does not occur through:
 - a) casual social contact such as talking, hugging, or sitting next to someone with HIV
 - b) working together with someone with HIV
 - c) feeding clients or taking their temperature with a thermometer

Chapter E: Coping with Stigma

E-FS1: Coming Out of the Closet

Handout for Exercise E5

Identifying oneself as lesbian, gay, bisexual, transgender or intersex (LGBTI) and disclosing this to other people is often referred to as 'coming out.' This process can take place at any time in a person's life. Coming to terms with confusion about identity can affect a person's social relationships, job, school work, and self-esteem both negatively and positively.

It can be a difficult time for many LGBTI people when they decide who to tell about their identity. In making this disclosure, they are often fearful of negative reactions, rejection, and causing distress to the person they are telling. Sometimes a person may 'come out' to supportive friends before talking to parents and family so as to rehearse their own part and judge reactions.

There are several theories about the elements of the 'coming out' process. Each has its own emphasis, but all of them are developmental models which regard 'coming out' as a series of stages. These stages do not necessarily last the same length of time, and there is no one age when the whole process begins and ends. These stages can be described as follows:

First-Step Awareness: In this stage, a person generally begins to feel 'different' from other people of the same sex, but perhaps isn't sure why. Sometimes they recognise that they are attracted to people of the same sex or that they don't conform to their gender, but mostly they feel they are not really interested in things which are culturally acceptable for their biological sex. Most people report feeling unusual when they compare themselves to other people of the same sex. Commonly this happens before or during early adolescence, when friendships and relationships between the sexes begin to change.

"I felt as if I had nothing in common with the other boys in my class. I didn't even have anything to talk about. I don't like sports. I don't like any of this stuff." Tebogo, age 18.

Being confused about one's identity may include or be prompted by:

- Feeling that perceptions of the self are altering
- Feeling and experiencing sexual arousal inspired by the same sex
- Sensing the stigma surrounding homosexuality
- Lacking knowledge about homosexuality
- Feeling of being trapped in the wrong body

Some people who think they are LGBTI will try to deny it to themselves and even seek help to eradicate their feelings. Others will try and avoid thoughts and feelings which remind them of what makes them different. In these situations, young people may avoid getting any information about sexuality to avoid confirming their suspicions about their sexual orientation or gender identity.

Some people have great difficulty in managing their relationships with peers and family. They may avoid situations in which they encounter opportunities for heterosexual pairing so that they are not forced to deal with their lack of sexual interest in members of the opposite sex or have it exposed. Alternatively, they may persevere with heterosexual relationships to try and 'convert' themselves, conceal their homosexuality from others, or try to take on behaviour that is stereotypical for their gender, even if that behaviour makes them uncomfortable.

In some extreme cases, people may try to avoid confronting their feelings by expressing strong homophobia or turning to alcohol and drugs to find temporary relief from them.

“I didn't even know what a lesbian was. I did wonder once if my admiration for the older girls in my school was just a bit stronger than it ought to have been but I was brought up to believe I would meet Mr. Right and settle down with kids so I just expected it to go away when we started to go out with boys.” Tshepo, age 21

Assuming an LGBTI identity: Living with confusion about identity is emotionally exhausting and potentially destructive. For some people, this period is followed quite quickly by a stage in which they come to accept their identity and are able to express it in a positive way. For both young men and women, interacting and mixing with other LGBTI people – in social settings or through support groups – can help them feel able to accept who they are by providing a safe environment for 'coming out.'

“I never even heard the word ‘transgender’ until I was in college. One of my classmates told me she was trans and told me about her experience. It was the first time I met someone who went through what I had been struggling with since I was a kid. I always felt like I was a girl trapped in a boy’s body. Now I know there are others like me and that I’m not sick.” Neo, age 23

Being fully comfortable with who you are: The final stage in the process of 'coming out' involves becoming open with one's LGBTI identity and recognising that it is a central aspect of 'who I am,' and 'how I want to live my life.' People begin to feel that being different is a valid way of life and develop a sense of contentment with being LGBTI. They often feel more confident, fully accepting of themselves, and able to combat the social stigma that they may suffer.

At this point, some people begin to feel proud of their sexuality and gender identity. The expression of this pride in being LGBTI is a powerful force in challenging the stigma attached to homosexuality and gender non-conforming by people with prejudiced attitudes, and provides positive role models to others less sure about 'coming out.'

“I think when I fell in love it all became so much more concrete for me. I was suddenly very certain of what I wanted and why I wanted it. I mean, I still found myself thinking every now and then, ‘Why am I gay?’, but I came more and more to think, ‘I’m gay because I love another man.’ And I’m proud of that. I’m proud of him, and I’m proud of me and I don't care who knows it.” Peo, age 17

E-FS2: What Do I Do if Someone Comes Out to Me?

1. **Listen carefully.** Coming out takes a lot of courage and may be the culmination of months or years of personally coming to terms with one's sexuality. The LGBTI person usually shares this information with an understanding of the risks involved. It may also be the case that this person simply wants to include you in his or her life and share something personal.
2. **Remain neutral and non-judgemental.** This is especially important when dealing with people who are just starting to come out to others. There is no way for an LGBTI person to predict your reaction accurately. Most of us have spent our entire lives in a society that teaches us to despise LGBTI people. They've come to you because they trust you! The things you say or do can have a very strong impact on this person. This exchange of intimate information should not be seen as an opportunity for you to advance a particular way of life or discuss the moral implications of homosexuality or non-conforming gender expression.
3. **Ask sensitive questions and be willing to learn.** Avoid asking questions that imply that there is something wrong with being gay, lesbian, bisexual, transgender, or intersex (e.g., "How did you become gay? How do gay people have sex?). Also, avoid asking questions that would have been considered rude within the relationship before this disclosure; this person has the same sensibilities as before. Some good questions to ask are:
 - How long have you known about your sexual orientation?
 - Has it been hard for you to carry this secret?
 - Have you told anyone about it?
 - How did they react? How did you feel?
 - Is there any way I can be of help to you?
4. **Be supportive.** Let them know that you are there to talk to, or just someone who will listen. For people just coming out, they may not be aware of resources available to them, or they may not feel comfortable approaching other people about the subject. You don't need to be an expert on the subject to be supportive. Just remember to be open-minded and patient. Treat them like anyone else, help them understand that they are not alone, and offer to help them find out more information about LGBTI issues and experience.
5. **Help the person avoid self-criticising and being self-destructive** (e.g., "*I'll never be in a healthy relationship.*") We have all been brought up in the same way and given the same type of homophobic messages. These messages affect LGBTI people more than anyone, so help them to accept themselves.
6. **Pay attention and treat what the person says seriously.** When a person chooses to come out to you, it may be because they are tired of living in secrecy. Being LGBTI and not being afraid to tell anyone can be frustrating. Make an effort to take an interest in what s/he has to say.
7. **Don't make their sexual orientation or gender identity the extent of your discussion.** While it is important to acknowledge a person's identity, it is not necessary to let this topic dominate your interactions. It is important to remember that the gay person has not changed. You may be shocked by their revelation, but remember that this is still the same person as before.
8. **Be honest and open.** It's okay to admit that you don't know everything, or even anything. It's also okay to admit feeling uncomfortable with this subject. Be honest, but emphasise your support for that person. Your own discomfort with the subject may come across as discomfort with the person or their

sexuality. If someone who has come out to you wants detailed information, it is perfectly acceptable to suggest that they speak with someone more educated on the subject.

You may well be tempted to break the bond you have with this LGBTI person. Though he or she has not changed, the information now confronts you and your own homophobia.

Additionally, here are some basic Do's and Don'ts for when someone comes out to you:

Do:

- Listen to what their life is like, and their experiences in the world.
- Take the time to seek information about the lives of LGBTI people.
- Accept that you are responsible for your negative reactions.
- Help the person set individual goals, even if they differ drastically from your own.
- Try to develop trust and openness by allowing the person to choose his or her own life.
- Be proud of the person's capacity for having loving relationships.
- Look for the injured feelings underneath the anger, and respond to them.
- Defend him or her against discrimination.
- Respect the person's right to find out how to find the right type of relationships.
- Say, "*I care about you and I support you. Thank you for trusting me enough to tell me this.*"

Don't:

- Blame your own feelings on the person.
- Rush the process of trying to understand the person's sexual orientation or gender identity.
- Assume that the person should see a professional counsellor.
- Criticise the person for being different.
- Expect the person to make up for your own failures in life.
- Try to force the person to conform to your ideas of proper sexual behaviour.
- Blame yourself because the person is gay, lesbian, bisexual, transgender, or intersex.
- Demand that the person live up to your idea of what a man or woman should be.
- Discriminate or stigmatise the person.
- Try to break up loving relationships.
- Insist that your morality is the only right one.

Chapter F: Moving to Action

F-FS1: Messages for Challenging Stigma

- **We are all responsible for challenging stigma, not just PLHIV and key populations.** We can all play a role in educating others and advocating for new attitudes and practice.
- **Be a role model.** Apply what you have learned in your own lives. Think about the words you use about PLHIV and key populations and try to change how you think, speak, and act.
- **Encourage political leaders and senior managers to speak out**—to talk to others about PLHIV and key populations and condemn stigma and discrimination.
- **Encourage PLHIV and key populations to speak out** – to help people understand how it feels to be the object of stigma and discrimination—and make sure that PLHIV and key populations are listened to.
- **Share what you have learned.** After the training, tell others what you have learned and get others talking about stigma and discrimination and how to change it.
- **Talk openly about HIV and key population stigma.** Show you are not afraid to talk about this issue. This will help people see that it is not a shameful thing that has to be hidden. Talking openly will also empower PLHIV and key populations and help relieve self-stigma.
- **Discuss stigma with family, colleagues, and friends.** What are the most common forms of stigma in your family, community, or workplace? What can be done to change things?
- **Avoid using stigmatising words.** Instead of saying ‘these sick people,’ use positive words such as ‘men who have sex with men’ or ‘brothers and sisters.’
- **Challenge stigma when you see it in your home, workplace, and community.** Speak out, name the problem, and let people know that stigma and discrimination towards PLHIV and key populations hurts them, makes them hide, and helps to fuel the HIV epidemic.
- **Act against stigma as a community.** Each community can look at stigma in their own situation and agree on practical things they can do to do to bring about change.
- **Saying ‘stigma is wrong’ is not enough.** Help people move to action—agree on what needs to be done, develop a plan, and then do it.
- **Think big! Start small! Act now! Have a big vision—but start with something small. And don’t wait – act now!**

Things You Can Do Yourself as Individuals

- Making a change has to start with YOU! Don’t tolerate stigma towards key populations—challenge it whenever you see it, e.g., in the home, school, clinic, workplace—everywhere!
- Watch your own language and avoid stigmatising words.
- Provide a caring ear and support to people living with HIV and key populations.
- Encourage PLHIV and key populations to use health facilities, VCT, and other services.
- Encourage people living with HIV and key populations to join support groups.
- Challenge stigma and discrimination when you see it happen.

Things You Can Do To Involve Others

- Use informal conversations as opportunities to raise and talk about stigma.
- Help normalise PLHIV and key populations. Help people understand that MSM are not ‘sick or morally bad people,’ but people like anyone else, who have a different sexual orientation, not through choice, but through nature.
- Encourage people to talk openly about their fears about PLHIV and key populations and correct myths and misperceptions about them.
- Form local support groups to provide mutual support for key populations.

Things to Get the Community Acting against Stigma

- Activities which get people to identify and analyse stigma towards PLHIV and key populations in the community:
- Testimonies by PLHIV and key populations about their lives;
- **Language watch**—school children or youth groups can make a ‘listening survey’ to identify stigmatising words used in the community, media, or in popular songs;
- **Drama** by a youth group based on real examples—as a trigger for discussion.
- **Community meetings** to discuss what has been learned from the above methods and make decisions about what the community wants to do to reduce HIV and key population stigma;
- **Training workshops** on HIV and key population stigma for service providers, NGOs, CBOs, and FBOs, and community leaders.

Things You Can Do at School

- Students to be assigned to do mini-research projects on HIV and key population issues;
- Integrate study on HIV and key population stigma into the life skills programme and other school subjects, e.g., getting students to read a story on the life of an HIV-positive or gay boy;
- Picture-drawing competitions and drama on these issues;
- Articles on HIV and key population stigma in the school newspaper;
- Get existing school clubs to discuss HIV and key population stigma;
- Invite PLHIV and key population resource persons to give testimonies on their experiences.

Things You Can Do in the Workplace

- Watch our language, remove stigmatising words, and challenge statements which make fun of people who are different;
- Challenge cases of homophobia in the workplace;
- Incorporate learning about HIV and key population stigma within workplace policies.

Things You Can Do in the Police Force

- Incorporate training on key populations into the training curriculum for police officers;
- Encourage all police officers to address cases of violence towards and victimisation of key populations seriously, focusing on the violence, not the sexual orientation of the victims;

- Work with human rights organisations to advocate for law reform related to key populations;
- Document the obstacles which block officers from serving the public in a stigma-free way.

F-FS2: What Are Human Rights?

Handout for Exercise F4

Sources:

Guide to an Effective Human Rights Response to HIV Epidemic: Using International Human Rights Law to Shape National Law in Eastern and Southern Africa. UNDP, New York, 2007.

HIV/AIDS and Human Rights in Southern Africa. AIDS and Rights Alliance for Southern Africa (ARASA), Windhoek, 2006.

What are human rights?

- According to the United Nations, “*Human rights are rights inherent to all human beings, whatever your nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. We are all equally entitled to our human rights without discrimination.*”
- Rights are basic and universal, and everyone needs them to live happy, meaningful lives.
- Human rights are about valuing human life, human dignity, equality, and freedom.

What are some examples of human rights?

All individuals have rights to: dignity, life, privacy (confidentiality), health, legal representation, religious expression, self-determination (autonomy), freedom from discrimination, property, freedom of speech, freedom of movement, and freedom of association.

Health workers have rights too, as employees. They have, for instance, rights to a safe working environment.

Where do human rights come from?

The idea that humans all have certain basic or natural rights has been around throughout history. The idea of rights can be traced back to:

- Different cultural values, such as the value of ‘botho’ (humanness) in Southern Africa;
- World religions, such as Christianity and Hinduism, which promote the ideas of equality;
- Humanitarian philosophy on the relationship between individuals and society. Philosophers in the 17th and 18th centuries argued that everybody is born equal and has certain rights to life, liberty, and property.

However, the concept human rights only became properly established in the form we know it today after the Second World War, with the Universal Declaration on Human Rights (UDHR) in 1948. The UDHR is a founding human rights document, originally endorsed by 14 states, that protects the human rights of all people in the world in terms of international human rights law.

Key characteristics of Human Rights:

Universality and Inalienability: Human rights are universal and inalienable. This means that all people everywhere in the world are entitled to them and they cannot be given away. As stated in Article 1 of the Universal Declaration of Human Rights, “*All human beings are born free and equal in dignity and rights.*”

Fundamental: Rights are necessary to live meaningful and fulfilled lives—so much so that they require special protection under law. It also means that they should not be taken lightly by others; they are not privileges – they are based on necessities for life.

Equality & Non-discrimination: Human beings are born free and equal in dignity and rights, without discrimination of any kind. Discrimination should not be based on race, colour, sex, ethnicity, age, language, religion, political or other opinions, national or social origin, disability, property, birth, or other status.

Protect Individuals from the State: The State’s power exists to support society’s interests; this means that the State is accountable to its people. However, the State has greater power and control than the individual. This means that there need to be laws which protect the State from violating human rights. It is said that the State has a **duty to respect human rights** – that is, not to violate human rights itself. These rights are usually enshrined in a constitution, which also sets out how the State can – and cannot – use its powers over individuals. There are other duties that the State has to enable human rights, i.e., to **protect human rights** (that one person does not violate the rights of another person by way of law) and fulfill human rights (to ensure that laws to protect rights are actually utilised to protect rights by providing resources towards this end).

Indivisibility: All human rights are necessary for the dignity of every person. Consequently, all rights have equal status.

Interdependence and Interrelatedness: Human rights are interdependent and interrelated. The realisation of one right often depends, wholly or in part, on the realisation of other rights. ‘Interdependent’ means that rights depend on one another to be fulfilled.

Recognise the Principle of Humanity: Some rights are absolute – that means that they cannot be limited or taken away. These rights include the right to life and the right to freedom from slavery.

Participation and Inclusion: Every person is entitled to participate actively, freely, and meaningfully in, contribute to, and enjoy civil, economic, social, cultural, and political development in which human rights and fundamental freedoms can be realised.

Human rights and legal rights—are they the same?

Human rights are different from legal rights. We all have human rights, but we know that, in some countries, the human rights that we have are not protected by our country’s laws. Legal rights are those rights which have been protected by our country’s laws. The difference here is that legal rights can be enforced in a court of law, whereas rights which have not been protected by our country’s laws cannot be enforced adequately by a court of law. So, whilst human rights are universal, legal rights are not – they vary from country to country. There is, however, international human rights law, which recognises a full range of human rights. There are also international human rights courts, such as the International Court of Justice, the African Court of Human and People’s Rights, and the International Criminal Court, which offer some protection of human rights beyond what is provided for in one’s country.

F-FS3: HIV, Stigma, and Human Rights

Handout for Exercise F4

Why is HIV stigma a human rights issue?

- Stigma violates the human rights of the one who is stigmatised because he or she is, or is perceived to be, living with HIV. As stigma is a negative belief or judgment or attitude about that person, it directly affects that person's rights to dignity. As HIV stigma usually results in an unfair bias or treatment against a person, it also affects that person's right to be treated as an equal and to be free from unfair discrimination. HIV stigma affects many other rights, including right to health.
- Stigma violates rights in a very pervasive manner. In other words, many rights are affected at once by stigma. For instance, when a person living with HIV is stigmatised by a health worker when he is denied respectful health services, his rights to dignity, equality, and a variety of health rights (e.g., to treatment, care, and support) are affected. This denial of rights may further impede rights to work and earn a living by virtue of illness.
- Stigma makes people more vulnerable to getting HIV. When their rights are denied, people find it more difficult to protect themselves from getting HIV. For example, when a gay man is refused treatment in a health facility, he will find it more difficult to access condoms and lubricant to protect himself from HIV.
- Violations of human rights block an effective response to the HIV epidemic. Stigma against people living with HIV and other key populations makes it difficult to provide them with HIV-related prevention, treatment, and care services. Because of stigma, those who are stigmatised feel disempowered and do not see themselves as having rights or being able to demand their rights.

What major rights are affected by HIV stigma?

- **Right to equality and dignity:** people living with HIV, sex workers, men who have sex with men, transgender persons, people who use drugs, migrants, and prisoners are often stigmatised and shunned, which violates their right to equal and respectful treatment. Some HIV-positive prisoners are forced to stay in separate/segregated rooms.
- **Right to liberty and security of persons:** Some people living with HIV are forced to take an HIV test without their consent. Some men who have sex with men are arrested, tested for HIV without their consent and denied access to a lawyer. Immigrants are often forced to test for HIV and deported if they test positive.
- **Freedom from inhumane or degrading treatment:** Some people living with HIV are often treated badly in the home (e.g., neglected and poorly cared for) and by some health workers. Some men who have sex with men are beaten and harassed for not looking like a 'real man.' However, authorities do not always take any action to investigate, prosecute, or redress this violence.
- **Right to information:** MSM clients are not given enough/correct information about HIV—this prevents them from fully understanding how to protect themselves from acquiring or transmitting HIV.
- **Right to healthcare:** Men who have sex with men, transgender persons, sex workers, people who use drugs, migrants, and prisoners are discouraged from using some health facilities (e.g., unfriendly treatment, name calling, and lack of confidentiality); as a result, they stop getting STIs

treated, testing for HIV, etc. Some people living with HIV are denied access to family planning or other reproductive health services.

- **Right to privacy:** Some health facilities disclose medical information about HIV-positive clients and conduct HIV testing without counselling and consent, and without providing results. Men who have sex with men, transgender persons, sex workers, people who use drugs, migrants, and prisoners have the right to keep facts about themselves confidential, but their sexual orientation, occupation, or drug use is often disclosed to others without their consent. This violates their right to privacy.
- **Right to shelter/housing:** People living with HIV, sex workers, men who have sex with men, transgender persons, people who use drugs, migrants, and prisoners have been denied access to housing or kicked out of the house by their families or landlords.
- **Right to work:** There are many cases of people living with HIV, men who have sex with men, transgender persons, sex workers, people who use drugs, and migrants who have been fired, not promoted, or blocked from further study when the employer discovers their identity.
- **Right to equal protection by the law:** If sex workers, men who have sex with men or drug users report a case of sexual harassment, the police often refuse to take up the case and make fun of them.
- **Right to sexual expression:** This is violated by the penal code in many countries, which criminalises sexual intercourse between people of the same sex.
- **Right to marry and found a family:** Some countries force people to take an HIV test before getting married. In some cases, a woman living with HIV may be forced to have an abortion or be sterilised, rather than being provided with information and services to prevent mother-to-child-transmission of HIV. Few countries allow same-sex couples to get married.

What can we do?

- People living with HIV and other key populations should know that they have rights and responsibilities, and if their rights are violated, they should do something about it. If their rights are violated, they have a right to seek redress, e.g., by using existing provisions within the law.
- They should also know about: (a) legal remedies available if their rights are violated; (b) legal obligations of the state in protecting their rights; and (c) their right to lay criminal charges against a perpetrator of violence (including their sexual partners).
- They need to understand the obligations of the police and the courts to protect the rights of vulnerable groups within society, such as abused women, children, and sexual minorities.

What happens when human rights are not respected?

- It undermines the national response to HIV and threatens social cohesion and stability.
- People living with HIV will continue to be secretive about their HIV status and not disclose voluntarily—and this secrecy will continue to fuel the epidemic.
- It creates an atmosphere of fear and denial.
- Vulnerable groups, such as sex workers, men who have sex with men, transgender persons, drug users, migrants, and prisoners, are persecuted.
- Discrimination in employment leads to loss of productive workers living with HIV or members of key populations.

What will happen if the rights of people living with HIV and key populations are respected?

- Their vulnerability to HIV will be reduced and they will be able to live a life of dignity without discrimination. They will feel that their rights are protected.
- Feeling safe, they will take more responsibility for their own health and the health of others. A protected human rights environment will help to normalise HIV/AIDS.

What are the roles of individuals and the state in ensuring human rights?

- Individuals have responsibility to exercise their rights without violating other people's rights.
- People should be aware of their rights and become active to ensure access to justice.
- The State has a responsibility to recognise, uphold, and protect rights.
- The role of the state is to create a **positive environment in which people can access their human rights**.

Why is a rights-based approach needed to counter stigma and discrimination?

An environment in which human rights are respected ensures that sexual minorities are able to live a life of dignity, without discrimination; in this situation, they are able to access their right to health services and take responsibility for their own health.

How does the state do this?

- The state has a responsibility to protect human rights through ensuring respect for, protection, and fulfillment of human rights—in particular, the rights to non-discrimination, health, information, education, and employment, and freedom from degrading treatment;
- Human rights treaties: ratification and implementation;
- Policy development: guidelines;
- Laws: review, revise, and create in accordance with relevant human rights considerations;
- Availability and affordability of justice: structures in place; and
- Appropriateness of justice: culturally sensitive, language sensitive, etc.

How does the state stand to benefit from a rights-based approach?

- The 'public' is not a homogenous grouping of people with the same needs and circumstances, but a heterogeneous grouping of people with varying needs.
- People living with HIV and other key populations are vulnerable to getting HIV because they are a discriminated minority—the stigma and discrimination blocks them fully accessing health services (in the same way as other citizens) and taking responsibility for their sexual health.
- There is a need to use awareness of vulnerabilities to guide public policy.
- People need to know that their 'coming out' will be safe. Openness about one's sexual orientation or other behaviours is built on trust. People need to be assured about their safety and security to come out and gain full access to health and other services.
- This creates openness and trust through the law and protective structures.
- Without a human rights approach, we are exposing those uninfected by HIV because people living with HIV and key populations will continue to be secretive about their sexual relationships

and HIV status and not disclose voluntarily. A protective legal framework will normalise HIV/AIDS; ideally, it will normalise the rights of people living with HIV and key populations.

F-FS4: Hate Violence

Cases of violence against LGBTI people are common in the Caribbean, but often they are not reported. Many LGBTI people are fearful of seeking help from the police due to laws that make same-sex sex illegal. Regardless, there are basic pieces of information and strategies that every LGBTI person and their allies should know when it comes to violence against the LGBTI community.

Hate violence is any act of intimidation, harassment, physical force, or threat of physical force directed against any person, their family, or their property, motivated by hostility to their real or perceived identity (e.g., sexual orientation) with the intention of causing fear or intimidation, or to deter the free exercise or enjoyment of any rights or privileges secured by the law.

When hate violence is punishable under a criminal statute, it is a hate crime. Hate violence can be done by any community member, and even by police officers who abuse their power.

All hate-motivated incidents occur because the perpetrator:

- Have a perception about their victim's identity
- Have a prejudice against that perceived identity (e.g., LGBTI people are weak, gay people are easy targets, transgender people are evil, LGBTI people are deserving of abuse, people in this group will be ignored by police, etc.).

There are many excuses and explanations of hate violence but, in the end, the root cause is fear. This fear is mostly due to ignorance: fear of the unknown, fear of the 'other,' fear of perceived enemies. These fears have the potential to generate violence.

Hate violence can send any or all of the following messages to a community of people who share the victim's identity:

- You're not welcome here.
- We hate you.
- You don't deserve to exist.
- If you say anything, we'll beat you.
- You don't deserve respect or equality.

What can I do if I am threatened by hate violence?

If you feel trapped in a situation, and either running away from or overpowering your opponent is not an option, here are some recommended **nonviolent responses**:

- Your objectives must be reasonable. You must believe you are fair, that you have rights, that you did nothing to deserve the violence, and communicate this to your opponent.
- Maintain as much eye contact as possible.
- Make no abrupt gestures. Move slowly. Don't say anything threatening, critical, or hostile.
- Don't be afraid of stating the obvious; say simply, "*You're shouting at me*" or "*You're hurting my arm.*"
- Someone in the process of committing an act of violence has strong expectations as to how his/her victim will behave. If you manage to behave differently (e.g., in a nonthreatening manner) you can interrupt the flow of events that would have culminated in an act of violence. You must create a scenario new to your opponent.

- Seek to draw out your opponent's better nature; even the most brutal and brutalised among us have some spark of decency, which the nonviolent defender can reach.
- Don't shut down in response to physical violence; you have to be spontaneous. The best rule is to resist as firmly as you can without escalating the anger or the violence. Try varying approaches and keep trying to alter your opponent's picture of the situation.
- Get your opponent(s) talking and listen to what they say. Encourage them to talk about what they believe, wish, or fear. Don't argue, but at the same time, don't give the impression you agree with assertions that are cruel or immoral. The listening is more important than what you say. Keep the talk going and keep it calm.

What can I do after I have become a victim of an incident, or after witnessing an incident?

A public response is one option to assert the power of a particular community. A well-organised, well-publicised response to an incident of bias can:

- Counter feelings of helplessness that a victim or victim's family may be experiencing
- Counter feelings of helplessness that the LGBTI community may be experiencing
- Send a message back to offenders or potential offenders that abusive and oppressive behaviour will not be tolerated by the LGBTI community and allies
- Be useful in helping police get information about a suspect
- Put pressure on legal systems to pay attention to the case if they are being unresponsive

Regardless of your passion for doing something about an incident of hate violence, it is helpful to step back a bit to think about potential drawbacks. **Consequences** of going public and **risks** of a widely publicised outcry to an issue of injustice may include:

- Loss of victim confidentiality
- Victim-blaming media coverage
- Suspect flight
- Harassment
- Stigmatisation from your family and community
- Additional violence

It is also important to know that **the law is often flawed** because:

- Police and other service providers may underreport
- They are often not adequately trained to identify these types of crimes
- Many do not encounter what we call hate violence
- People are embarrassed or worried about the public reaction if they raise their voices

Reporting: While a crime may not be identified in the media as anti-LGBTI, here are some things to look for:

- The victim or accused is identified as being LGBTI
- The incident occurred in an area frequented by the LGBTI community
- The incident occurred in or around an LGBTI-supportive institution
- Anti-LGBTI language was used during the incident
- Anti-LGBTI graffiti was used

What can I do to help protect the LGBTI community from hate violence?

- Ask yourselves and your allies how you can work to better document and address violence against LGBTI people and build for safer communities.
- Once you've had a few conversations with others about it, you may decide to intentionally document the experiences of LGBTI people in your area. Documentation can be a critical step to raising awareness of the issue—within and beyond our communities – and a tool to reach, organise, and support the leadership of people most affected.
- Organise a story-telling project to document ways in which people have intervened without relying on the police in situations involving violence.
- Memorise as much information about the incident as you can, and write it down as soon as you are somewhere safe. It is better to organise later than put yourself and other people at further risk at the moment.

F-FS5: Developing a Code of Conduct for a Stigma-free Health Facility - Example

Handout for Exercise F9

Examples of stigma in health facilities towards HIV-positive clients or key populations

- Provide substandard care—making less time for clients, keeping them waiting, treating them last, referring them to other providers, and providing poor services;
- Avoid touching clients and use gloves and masks for routine tasks which don't involve the handling of blood and bodily fluids;
- Bureaucratic and unfriendly treatment, and insulting or scolding language;
- Gossip by health staff about clients, and blaming clients for getting HIV;
- Break confidentiality—reveal the HIV status or other marginalised identities to other health staff, or to family members, without the consent of the clients;
- Force clients to be tested without their consent and without adequate counselling—and don't provide the results of the HIV test to the client;
- Force clients to sit in a separate area or on a separate bench, or to be hospitalised in a separate, segregated room/ward (this applies to HIV-positive clients).

Effects on those stigmatised

- Patients feel insulted and humiliated, and receive no solutions to their health problems;
- Patients may stop using the health facility and not get their sexually transmitted infections or opportunistic infections treated;
- Patients have to find other forms of treatment, e.g., private doctors who treat them with more confidentiality and less stigma, or self-treatment; and
- It may affect the clients' self-esteem/self-confidence, and they may deny their sexual risk and take more risks in their sexual behaviour (e.g., not using condoms).

Example of a Code of Conduct: Building a Stigma-Free Health Facility

- Treat all clients with equality, respect, dignity, and privacy.
- Ensure that all clients receive the same high-quality medical care without discrimination, regardless of their HIV status, sexual orientation, gender, or other characteristics.
- Ensure that care for all clients is not denied, delayed, or referred elsewhere, and that it is the same quality as the care provided to other clients.
- Treat the medical information of clients as confidential.
- Ensure that all clients receive the necessary information with which to make informed choices regarding their healthcare and are able to give their informed consent to the services available to them.
- Respect clients' rights to express their views and become actively involved in their own healthcare.

- Provide avenues for the effective resolution of clients' complaints regarding stigma and discrimination.

F-FS6: Code of Conduct

Handout for Exercise F9

For a variety of reasons, every individual has the need and desire for proper medical care throughout his or her life. Lesbian, gay, bisexual, transgender, and intersex (LGBTI) people are no different and deserve the same healthcare as anyone else.

Every patient has the right to **confidentiality** about their medical issues and anything they share with a medical practitioner, unless they are causing harm to another human being or someone is causing harm to them; **privacy** during any medical exams or tests; and **equal treatment** without judgement of their behaviour or identity.

Too often, LGBTI people are judged, harassed, or even subjected to the extreme of being denied basic medical care. Therefore, we encourage the use of the following affirmations in your health practice, clinic, or hospital to ensure equal treatment of all patients and clients:

-
- I/we will give everyone the same type of medical care, to the highest quality possible, at our facility, regardless of their identity or behaviour.
 - I/we welcome lesbian, gay, bisexual, transgender, intersex individuals; men who have sex with men; women who have sex with women; and any other sexual minorities (henceforth referred to by the acronym LGBTI) and their families into my/our practice and offer all health services to patients on an equal basis, regardless of sexual orientation, gender identity, sexual behaviour, marital status, and other non-medically relevant factors.
 - I/we believe that LGBTI identities are within the spectrum of normal human experience and are not in themselves pathological, 'unnatural,' or sinful. I/we therefore do not promote or support attempts to change patients' sexual orientation or gender identity.
 - I/we respect the visitation and healthcare decisionmaking rights of LGBTI patients/clients, their unmarried partners, their non-biological children, and any others they may define as family for the purposes of visitation and healthcare decisionmaking.
 - I/we commit to taking steps to make my practice fully inclusive to LGBTI people, as reflected in written forms, policies and procedures, appropriate training for all clinical and administrative staff, and standardised assessments.
 - I/we commit to taking steps to learn about the unique health concerns of LGBTI individuals and families so that I/we can provide the highest quality care to all people.
 - I/we will maintain confidentiality about an individual's identity and/or behaviour, just as we would keep medical records of any client completely confidential.

F-FS7: Code of Conduct for Police Officers

Every individual has the right to feel safe and protected. Occasionally, police officers do not take crimes reported by lesbian, gay, bisexual, transgender, and intersex (LGBTI) people seriously. We encourage all police officers to adopt the following practices to ensure **equal treatment of all people**. Even though same-sex sexual activity is illegal in the Caribbean, an individual must be **caught in the act** to press charges. Therefore, any LGBTI person reporting a crime should be treated just as anyone else and no further reporting is necessary.

Interacting with LGBTI Victims of Crime and Violence

- Validate the victim's experience and do not blame the victim. Laughter due to a lack of a familiarity with the LGBTI community is also unacceptable and harmful to the victim.
- LGBTI victims may have feelings of self-hatred or discomfort toward their sexuality and therefore may feel the violence is deserved. It is part of your job to remind the victim that violence is never acceptable.
- Identity (e.g., sexual orientation or gender identity) of the individual should be handled with care. It is important to keep in mind that trauma is being experienced and outing an individual as LGBTI could increase the trauma.
- If the crime and/or violence committed is due to anti-LGBTI sentiments, this should be included in the report.
- Don't expect a certain type of behaviour from the victim, and do not base your desire to help on how they behave.
- Remember some basic duties for being a law enforcement agent:
 - a) Seeking justice
 - b) Re-establishing a sense of safety
 - c) Alleviating trauma and supporting the victim(s)
 - d) Decreasing violence and preventing future incidents
 - e) Finding the perpetrator and holding him or her accountable
 - f) Empowering and comforting local communities affected by the trauma

NOTE: Traditionally, LGBTI communities are filled with intricate networks of information sharing because this community's information is not commonly shared in places such as the news media or community gathering spots. If an LGBTI person is targeted and harmed, many within the LGBTI community will know about it and also be affected by that violence. This also means they will be paying close attention to how the police handle the situation.

F-FS8: LGBTI Guide for Media Workers

INTRODUCTION

Fair, accurate, and inclusive news media coverage plays an important role in expanding public awareness and understanding of lesbian, gay, bisexual, transgender, and intersex (LGBTI) people. However, many reporters, editors, and producers continue to face challenges in covering these issues with little information.

There is a need for journalists to distinguish between opposing viewpoints on LGBTI issues and the defamatory rhetoric that fuels prejudice and discrimination. While defamatory comments may be newsworthy, they should no longer be used simply to provide ‘balance’ in a news story or be used to sensationalise LGBTI people.

In an era when gay, lesbian, bisexual, transgender, and intersex people are just starting to come out of the closet to friends and family, the best news coverage on LGBTI people allows readers, viewers, and listeners to form their own conclusions based on factual information and appropriate context. We ask that the media and journalists help give them that opportunity in your coverage of LGBTI issues.

A GUIDE TO COMMON PROBLEMATIC TERMINOLOGY

- **Offensive:** ‘homosexual’ (n. or adj.)
- **Preferred:** ‘gay’ (adj.); ‘gay man’ or ‘lesbian’ (n.)

Please use ‘lesbian’ or ‘gay man’ to describe people attracted to members of the same sex. Because of the clinical history of the word ‘homosexual,’ it is deemed as offensive by many LGBTI people. Please avoid using ‘homosexual’ except in statements. Please also avoid using ‘homosexual’ as a style variation simply to avoid repeated use of the word ‘gay.’ The Associated Press, *New York Times*, and *Washington Post* restrict usage of the term ‘homosexual.’

- **Offensive:** ‘sexual preference’
- **Preferred:** ‘sexual orientation’

The term ‘sexual preference’ is typically used to suggest that being lesbian, gay, or bisexual is a choice and therefore can and should be changed or ‘cured.’ ‘Sexual orientation’ is the accurate description of an individual’s enduring physical, romantic, and/or emotional attraction to members of the same and/or opposite sex, and is inclusive of all people.

- **Offensive:** ‘gay lifestyle’ or ‘homosexual lifestyle’
- **Preferred:** ‘lesbian,’ ‘gay,’ ‘bisexual’

There is no single LGBTI lifestyle. LGBTI people are diverse in the way they live their lives. The phrase ‘gay lifestyle’ is used to insult lesbians and gay men, suggesting that their sexual orientation is a choice and therefore can and should be ‘cured.’

- **Offensive:** ‘gay agenda’ or ‘homosexual agenda’
- **Preferred:** ‘lesbian and gay civil rights movement’ or ‘LGBTI rights movement’

LGBTI people are as diverse in political beliefs as other communities. ‘LGBTI civil rights movement’ accurately describes the historical efforts, by gay and straight people alike, to achieve understanding and equal treatment for LGBTI people. Notions of a so-called ‘homosexual agenda’ are rhetorical inventions of anti-gay extremists seeking to create a climate of fear by portraying the pursuit of civil rights for LGBTI people as sinister.

- **Offensive:** 'special rights'
- **Preferred:** 'equal rights' or 'equal protection'

Anti-gay extremists frequently characterise civil rights and equal protection of the law for LGBTI people as 'special rights' in an attempt to energise opposition to family recognition, anti-discrimination protections, and equal opportunity laws. LGBTI people seek equality and *equal* treatment under the law. LGBTI are not looking for anything *special*, but instead want to enjoy all of the same rights and responsibilities under the law as everyone else.

- **Problematic:** 'transgenders,' 'a transgender'
- **Preferred:** 'transgender people,' 'a transgender person'

'Transgender' should be used as an adjective, not as a noun. Do not say, "*Tony is a transgender.*" The correct phrase would be "*Tony is a transgender man.*"

- **Problematic:** 'hermaphrodite'
- **Preferred:** 'intersex person'

The word 'hermaphrodite' is an outdated, stigmatising, and misleading word, usually used to sensationalise intersex people, and is seen as offensive.

OTHER ISSUES RELEVANT TO MEDIA

Religion: A common myth about LGBTI equality is that it is universally opposed by people of faith. Leading Christian denominations are home to passionate debate about LGBTI issues and equality. Some people interpret religious texts in a way that limits the purpose of sex to having children (procreation). This kind of interpretation limits the ongoing value of physical intimacy for everyone and condemns people who do not or cannot have children as much as it condemns LGBTI people. Most religious books mention compassion as the most important state of mind.

Many religious people have made the decision to accept gay and lesbian people and treat discrimination as irrational and hateful. The United Methodist Church, the Episcopal Church, the Presbyterian Church USA, and others continue to openly debate issues of gay and lesbian inclusion, the blessing of same-sex unions, and the ordination of gay clergy, with growing support for full inclusion. Both Archbishop Desmond Tutu and the Dutch Reformed Church have publicly apologised for the persecution of lesbian and gay people by the Church in Southern Africa. For more information, visit www.welcomingresources.org.

HIV transmission is tied to specific high-risk behaviours that are not exclusive to any one sexual orientation. Avoid suggesting that simply being gay makes one part of a 'high-risk group' or that risk of HIV infection increases simply by having sex with someone of the same sex. Also avoid suggesting that being lesbian or WSW (a woman who has sex with women) means that someone has no risk at getting HIV. This is untrue, and could put people at greater risk.

MSM, the acronym coined by the U.S. Centers for Disease Control for 'men who have sex with men,' should not be used to describe openly gay or bisexual men individually or collectively, except in specific clinical or statistical contexts. When MSM do not self-identify as gay or bisexual, the term may be a useful as a description of that discrete category of people.

Choice: Anti-gay activists have long spread the myth that sexual orientation is a choice and changeable—but only for lesbians and gay men, not heterosexuals. They often claim homosexuality is a form of mental illness or emotional disorder that can be 'cured' through psychological or religious intervention. Relying heavily on the testimony of so-called 'ex-gays,' anti-gay activists claim that

homosexuality is a curable condition, and therefore lesbians and gay men do not need or deserve equal rights or protection from discrimination.

Mental health professionals agree that homosexuality is not a choice and not a mental disorder that needs to be treated. The potential risks of 'reparative therapy,' often attempted by traditional doctors and faith-based organisations, are great, including depression, anxiety, self-hatred and self-destructive behaviour. Accepting people for who they are has much more positive effects on the LGBTI individual and society as a whole.

F-FS9: REDI Counselling Framework

Handout for Exercise F8

Borrowed from:
 Engender Health and Population Services International (2010) Promoting Condom Use and Interpersonal Communication for Most-at-Risk Populations at Health Care Facilities: A Manual for Trainers. Toolkit used in Ethiopia. New York: Engender Health.

What is REDI?

REDI: Rapport Building, Exploration, Decision Making, and Implementing the Decision

<p>Phase 1: Rapport Building</p> <ul style="list-style-type: none"> • Welcome the client • Make introductions • Introduce the subject • Assure confidentiality 	<p>Phase 3: Decision-Making</p> <ul style="list-style-type: none"> • Help the client identify what decisions s/he needs to make in the session • Help the client identify the options for each decision and the advantages and disadvantages of each option • Help client make his/her own informed decision
<p>Phase 2: Exploration</p> <ul style="list-style-type: none"> • Explore client's needs, concerns, risks, sexual life, social context, circumstances • Assess the client's knowledge and give information, as needed • Help the client to determine his HIV and STI risk 	<p>Phase 4: Implementing the Decision</p> <ul style="list-style-type: none"> • Help the client make a concrete, specific plan for carrying out the decision • Help identify skills that the client will need to carry out the decision • Practice skills with the health worker's help • Make a plan for followup

Note: The points below are suggestions for areas to address in each phase of REDI. They are not meant as a checklist to follow in strict order, nor are they to be read or recited to the client. The interaction should always be tailored to the client's situation.

Phase 1: Rapport Building

1. Welcome the client:
 - Greet the client warmly.
 - Help the client feel comfortable and relaxed.
2. Make introductions:
 - Identify the reason for the client's visit.

- Ask general questions, such as name, age, number of children, etc.
3. Introduce the subject of sexuality:
 - Explain the reasons for asking questions about sexuality.
 - Put it in the context of HIV and STIs, and assure the client that you discuss HIV and STIs with all clients.
 - Explain that the client does not have to answer all of your questions.
 4. Assure confidentiality:
 - Explain the purpose of and the policy on confidentiality.
 - Create an atmosphere of privacy by ensuring that no one can overhear your conversation, even if you are not able to use a separate room.

Phase 2: Exploration

1. Explore the client's needs, risks, sexual life, social context, and circumstances:
 - Assess what the client understands about his or her sexual and reproductive health (SRH) condition or situation, what worries or concerns he or she might have, and what he or she specifically hopes to accomplish through the visit.
2. Explore the context of the client's sexual relationships:
 - What sexual relationships is he or she involved in, what is the nature of the relationships (including any violence or abuse), and how does he or she feel about the relationship?
 - How does he or she communicate with partners about sexuality, family planning, and HIV and STIs?
 - What does he or she know about his or her partners' sexual behavior outside of the relationship?
3. Explore the client's pregnancy history and knowledge of and use of family planning methods, including condoms.
4. Explore the client's HIV and STI history, present symptoms, and knowledge of partners' HIV and STI history.
5. Explore other factors about the client's circumstances that may limit his or her power or control over decision making, such as financial dependence on partners, tensions within an extended family, and fear of violence, among others.
6. Assess the client's knowledge and give information, as needed:
 - Assess the client's knowledge of pregnancy-related care (if appropriate), post-abortion care (if appropriate), family planning, HIV, and STIs.
 - Correct misinformation and fill in gaps, as needed.
7. Assist the client in perceiving or determining his or her own pregnancy (or partner's pregnancy) risk or HIV and STI risk:
 - Ask the client if he or she feels at risk for unintended pregnancy or for HIV and STI transmission, and explore why or why not.
 - Ask the client if he or she thinks that his or her partners may be at risk for unintended pregnancy or HIV and STI transmission, and explore the reasons.

- Explain HIV and STI transmission and pregnancy risks (as necessary), relating them to the individual sexual practices of the client and his or her partners.
- Help the client to recognize and acknowledge his or her risks for HIV and STI transmission or unintended pregnancy.

Phase 3: Decision Making

1. Identify what decisions the client needs to make in this session:
 - Help the client to prioritize the decisions by determining which decisions are the most important to address today.
 - Explain the importance of the client's ability to make his or her own decisions.
2. Identify the client's options for each decision:
 - Many health workers and clients believe that in most areas of SRH, the client's decision-making options are limited. An important role of the health worker is to lay out the various decisions that a client could make and explore the consequences of each. This empowers the client to make his or her own choice, which is a key element of supporting the client's sexual and reproductive rights.
3. Weigh the benefits, disadvantages, and consequences of each option:
 - Make sure the discussion centers on options that meet the client's individual needs, taking into account his or her preferences and concerns.
 - Provide more detailed information on the options that the client is considering.
 - Consider who else would be affected by each decision.
 - Explore with the client how he or she thinks that partners or family members may react to the course of action (e.g., suggesting condom use or discussing sexuality with partners).
4. Assist the client to make his or her own realistic decisions:
 - Ask the client what is his or her decision (i.e., what option he or she chooses).
 - Have the client explain in his or her own words why he or she is making this decision.
 - Check to see that this decision is the choice of the client, free of pressure from spouse, partner, family members, friends, or health workers.
 - Help the client to assess whether his or her decision can actually be carried out, given his or her relationships, family life, and economic situation, among other issues.

Phase 4: Implementing the Decision

1. Make a concrete, specific plan for carrying out the decision:
 - Be specific. If a client says that he or she is going to do something, find out when, under what circumstances, and what his or her next steps will be in each situation. Asking a client "What will you do next?" is important in developing a plan to reduce risk. For example, if a client says that he will start to use condoms, the health worker should ask, "How often?" "Where will you get the condoms?" "How will you pay for them?" "How will you tell your partner that you want to use them?" and "Where will you keep them so you will have them with you when you need them?"

- Ask about possible consequences of the plan: “How will your partner(s) react?” “Do you fear any negative consequences?” “How will the plan affect relationships with your partners?” “Can you communicate directly about the plan with your partners?” and “Will indirect communication be more effective at first?”
 - Ask about social supports. Who in the client’s life can help the client carry out the plan? Who might create obstacles? How will the client deal with a lack of support or with individuals who interfere with the client’s efforts to reduce risk?
 - Make a “Plan B”—that is, if the plan does not work, then what can the client do?
2. Identify skills that the client will need to carry out the decision (see #3).
 3. Practice skills, as needed, with the health worker’s help:
 - Partner communication and negotiation skills
 - a) Discuss the client’s fears or concerns about communicating and negotiating with partners about condom use, family planning, maternal health concerns, safer sex, or sexuality, and offer ideas for improving communication and negotiation.
 - b) For a client who fears that it may be difficult to negotiate condom use for HIV and STI prevention, discuss whether it might be easier to introduce condoms for pregnancy prevention.
 - c) Role play with the client possible communication and negotiation situations.
 - Condom-use skills:
 - a) Demonstrate correct condom use on a penis model, describe the steps, and ask the client to repeat the demonstration to be sure that he or she understands.
 - b) Discuss strategies for making condom use more acceptable to partners.
 - c) Provide samples of condoms (if possible) and make sure that the client knows where and how to obtain more.
 - Skills in using other family planning methods:
 - a) Make sure that client understands how to use other family planning methods that s/he has selected by asking the client to repeat back basic family planning information that you have provided and encouraging him to ask for clarification.
 4. Make a plan for follow-up:
 - Invite the client to return for a follow-up visit to provide ongoing support with decision making, negotiation, and counseling.
 - Explain timing for medical follow-up visit or resupply of contraceptives.
 - Make referral for services not provided at your facility.

F-FS10: Confidentiality

Borrowed from:

BONELA. 2010. Human Rights and HIV: Trainer's Guide. Gaborone, Botswana: Botswana Network on Ethics, Law, and HIV/AIDS.

What is confidentiality?

- Confidentiality is about having control over the sharing of sensitive information—such as a person's HIV status—with only those who really need to know or those who the HIV-positive person decides of his or her own free will to tell. The person most affected by the information—the HIV-positive person—is the owner of the information. Others must respect his or her wishes about sharing it.
- Each person living with HIV should be encouraged to disclose this information to those whom s/he trusts and who will treat this information with respect. Never forget that the HIV-positive person has the right to control who receives this information, and what the person with whom the information is shared does with it.
- **Every person has the right to confidentiality**—the right to decide what aspects of his or her life are private and what can be released into the public domain (A bit like Facebook). This includes the right to confidentiality regarding a person's HIV status.
- **Confidentiality is a human right** - an essential part of the right to privacy. This right is protected by the constitution of many countries. It protects the individual's home, life and reputation, plus personal information such as medical records.
- A health worker may discover things about a client, such as HIV status, that are considered private. The health worker should keep this information confidential and has an ethical responsibility to do this.
- The health worker should protect the information provided by a client and not disclose an illness to any third party. Whatever is discussed between the health worker and client should remain a private issue between the two of them.
- The information should not normally be shared without the specific permission or consent of the owners. Information shared between healthcare workers about a client must always be done for the purpose of enhancing the health of the client, and not for self-protection.

Why confidentiality?

- If a health worker breaks confidentiality, she or he puts the client at risk of being rejected by the family and facing other forms of stigma and discrimination.
- The health worker builds a relationship of trust with the client by agreeing to keep information confidential.
- If a person feels his or her HIV status will remain confidential, he or she will be more likely to seek counseling, testing, treatment and support.

What happens if confidentiality is not respected?

Failure to respect the right to confidentiality will drive the HIV epidemic underground:

- People suspecting they are HIV-positive will be afraid to be tested because they fear that the information will be released to the public and they will be victimized.

- The client may lose trust in the health workers and become afraid to share other important information about their health (e.g. cough or STI symptom), and as a result not get the best treatment for their condition.
- The client may be subjected to stigma and discrimination by family, employer, etc.
- Once stigmatized, the client may avoid health services, which have exposed him/ her to stigma, and as a result may not access treatment, care and support.
- The client may lose confidence and become more secretive about her HIV status, for example not telling sexual partners. As a result they may pass HIV on to others.

Health workers have a duty to maintain confidentiality

- Health workers have a duty to maintain the confidentiality of the information they learn about their clients. While this code of practice is very clear, and applies equally to HIV, some health workers look for loopholes to get around this practice in the case of HIV, e.g. ‘shared confidentiality’ and rules around needle stick injuries.
- Many health workers working in the HIV field criticize the practice of confidentiality, saying that the practice helps to create stigma and therefore creates a block to prevention efforts. However, the truth is that the **lack of confidentiality leads to stigma**—people living with HIV are afraid that their status will be exposed and they will be stigmatized, so they stay away from health services that they feel will not keep their information confidential.

F-FS11: Ten Steps for Moving to Action

Handout for Exercise F10

STEP	EXAMPLES
1. WHERE ARE YOU NOW? (SITUATIONAL ANALYSIS)	This helps you to look at what is currently happening around stigma. Ask: "How have things been in the past?" and "How are they now?" "Where is the stigma in the workplace?" and other, similar questions
2. WHERE DO YOU WANT TO BE? (VISION)	How would things look if you could really make a difference? Create a 'vision' of the future in which there is reduced stigma.
3. HOW WILL YOU GET THERE? (ACTIVITIES)	What kind of activities can you do to help reduce stigma? Brainstorm all of your ideas—practical new actions to solve the problem.
4. WHERE WILL YOU START? (PRIORITISE)	What are the most feasible actions to start with? What is the most important action?
5. WHAT DO YOU NEED? (RESOURCES)	Identify any resources, skills, or training that will help with your action—and any partners who can help. Don't stop at this point, even if you have no funds.
6. WHAT MIGHT GET IN THE WAY? (OBSTACLES)	Identify any obstacles that might prevent your action from being successful. Try to strategise on how to overcome these obstacles.
7. HOW WILL YOU KNOW THAT YOU ARE SUCCESSFUL? (INDICATORS)	Decide how you will measure your success. Identify 'indicators' or signs that will show you that stigma is reduced, e.g., clients having more say in the way the health facility is run.
8. ACTION	Start the activities you have planned. Assign tasks to specific people.
9. MONITORING	Check how you are doing and whether anything is changing.
10. REPLAN	Make changes to your plans based on what you learn from the monitoring.

F-FS12: Advocacy

Borrowed from:

BONELA. 2010. Human Rights and HIV: Trainer's Guide. Gaborone, Botswana: Botswana Network on Ethics, Law, and HIV/AIDS.

Advocacy is a systematic and organized effort to change unhelpful practices or behaviour.

What skills are needed for advocacy work?

You will need the skills to be able to:

- Plan a campaign which will succeed in changing people's behaviour
- Tell people what the issue is, and make them support you
- Find others who agree with you and are prepared to back you up
- Negotiate - deal with the different actors involved in making change

Choose an issue

Select a specific human rights violation which you want to focus on eg property grabbing from women when HIV enters the home. Ask yourself -

- Is the issue widely felt i.e. by many people?
- Is it deeply felt - are people angry, frustrated etc?
- Will it result in a real improvement in people's lives?
- Can you win on this issue?

Identify and Brief Key Leaders

Look for key leaders who will support your campaign and influence others. Then consider what their interest is in the issue. Don't assume that they are opposed. They may already be convinced of the need to address the HR violations. Find out their ideas about the issue and get them on board. Avoid making them look bad.

In many cases the leaders will not be adequately informed about the issue. Your job is to explain the issue and its importance clearly and persuasively. Tell them how the human rights violation affects not only the people living with HIV, but the whole community, how it destroys families and has a serious affect on children. Use words and arguments from their perspective. Put yourself in their shoes, learn as much as possible about their situation, and tailor what you are saying to their own interests and concerns.

Create some ownership of the need to change on the part of the leaders. Involve them in thinking though the issue themselves. Get them talking and help them see the issue from their own experience.

Ten Steps in an Advocacy Campaign

- Clearly state the problem or issue
- Develop a goal and a set of objectives
- Identify the target audience(s) to engage
- Identify groups who are affected by the campaign
- Formulate the advocacy message and identify the methods to get the message out to the target audience (eg meetings, drama, etc)
- Prepare a plan of action and schedule of activities

- Identify resource requirements (human, organisational, financial)
- Get support from other key players eg NGOs, government etc.
- Identify monitoring and evaluation criteria and indicators
- Assess success or failure, and determine next steps

ANNEX C: VISUAL AIDS

This section includes two sets of pictures to be used as triggers for discussion in the training sessions. The trainers should photocopy them and use them in the training.

The first set - **STIGMA PICTURES (A1 to A14)** – are used in Exercise A1. These pictures show different forms of HIV and key population stigma and discrimination as a starting point for discussion. Pairs of participants select a picture, discuss the meaning of the picture, and then present what they have discussed. The pictures could also be given to participants to take home with them to have conversations with friends and family – and get others talking about stigma.

The first set of pictures were borrowed from:

- Understanding and Challenging HIV Stigma: Toolkit for Action (AED, ICRW, AIDS Alliance, 2007)
- Sexual Minorities, Human Rights, and HIV/AIDS: Trainer’s Guide (BONELA, 2007)

The second set – **FEARS CARDS (B1 to B26)** - are used to get participants to name some of their own fears about getting HIV through different forms of casual contact with a person living with HIV – or the fears of the community. This process starts a discussion on how HIV is transmitted.

The second set of pictures (FEARS CARDS) were borrowed from:

- We Are All in the Same Boat: Using Art and Creative Approaches with Young People to Tackle HIV related Stigma. (UNESCO, 2010)

CREDITS

All of the pictures were produced by Petra Rohr-Rouendaal

Stigma Pictures (Exercises A1 to A14)

A1

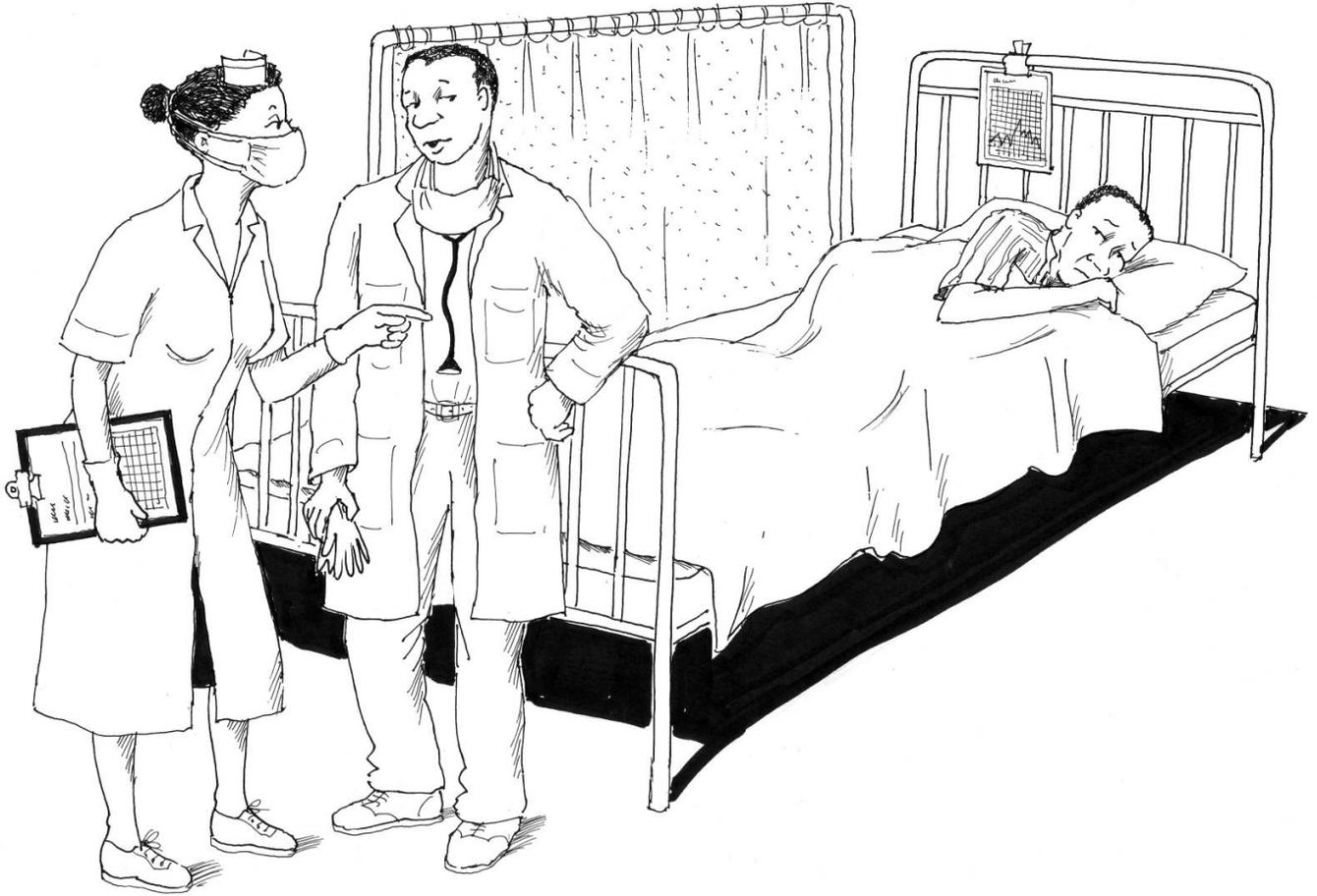














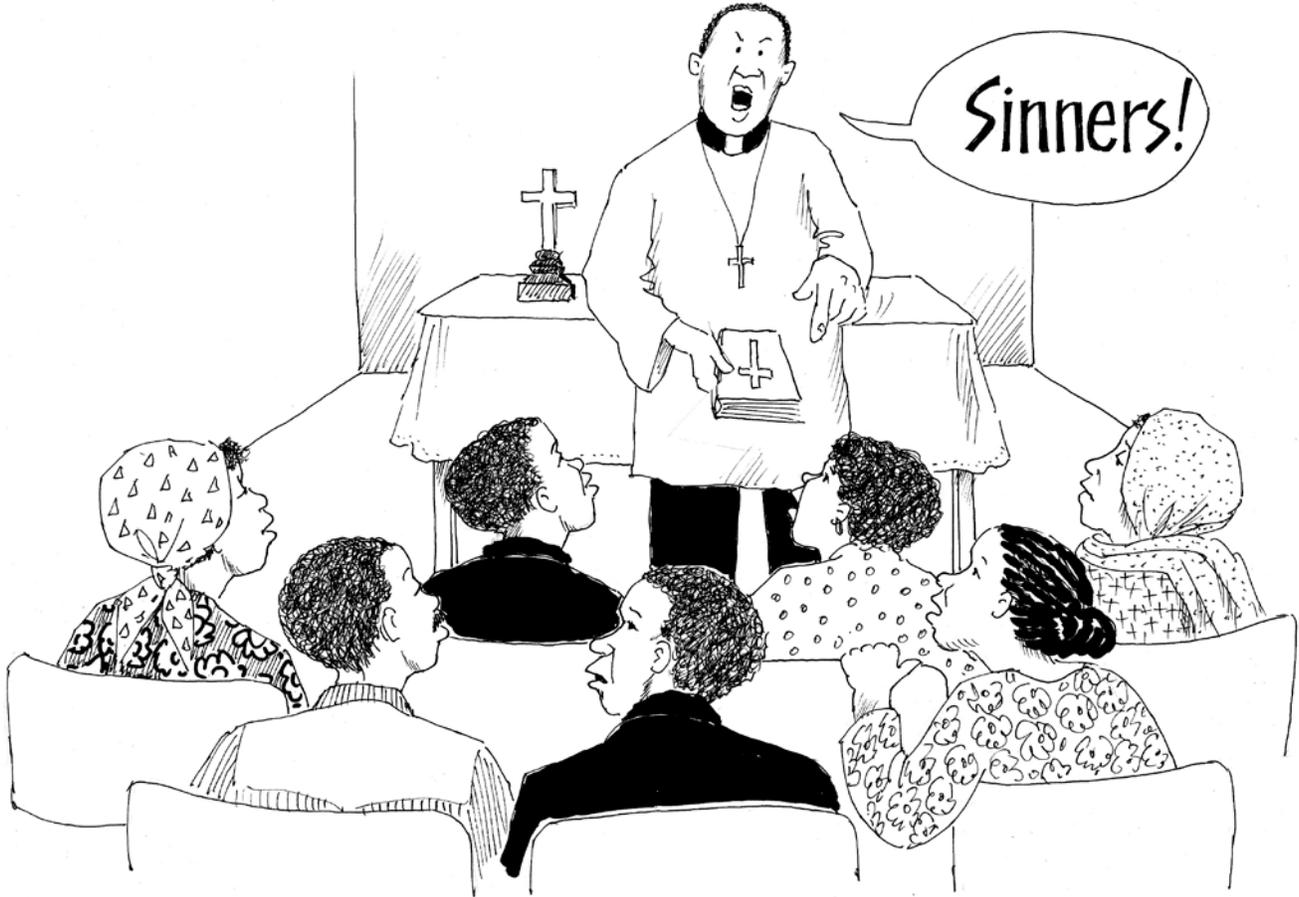








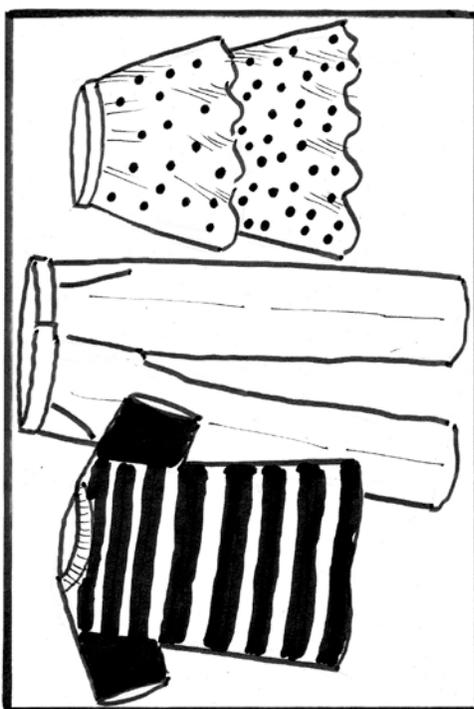
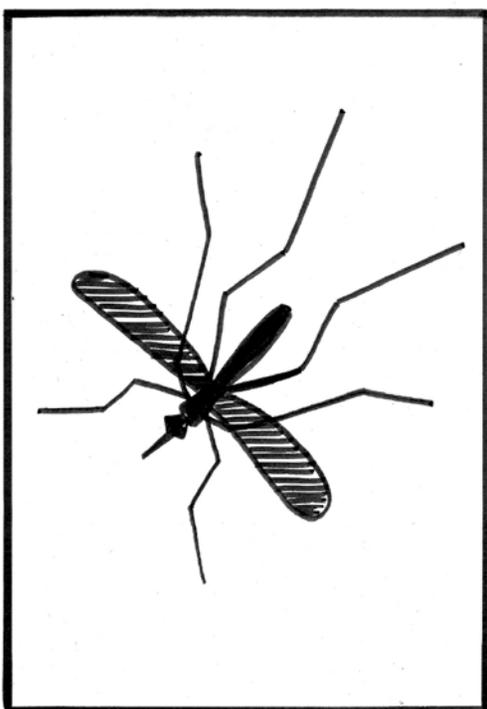
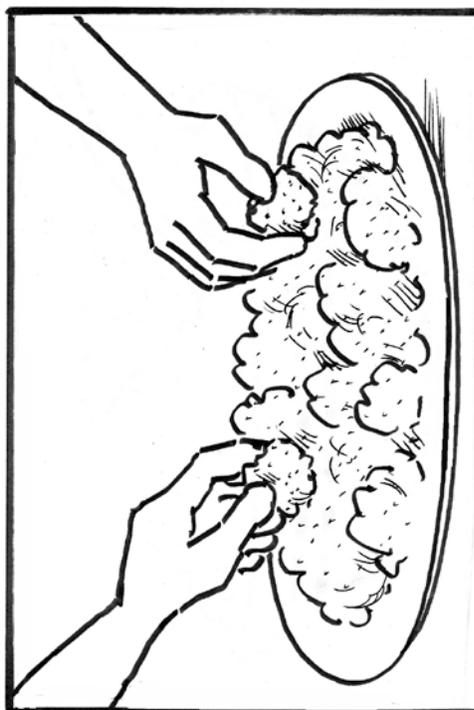






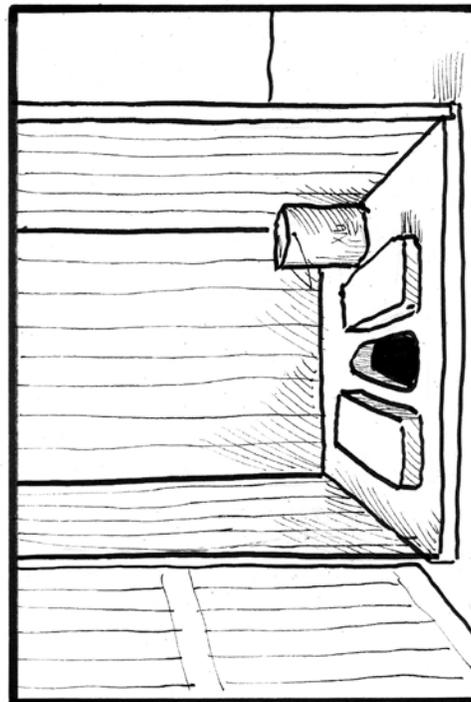
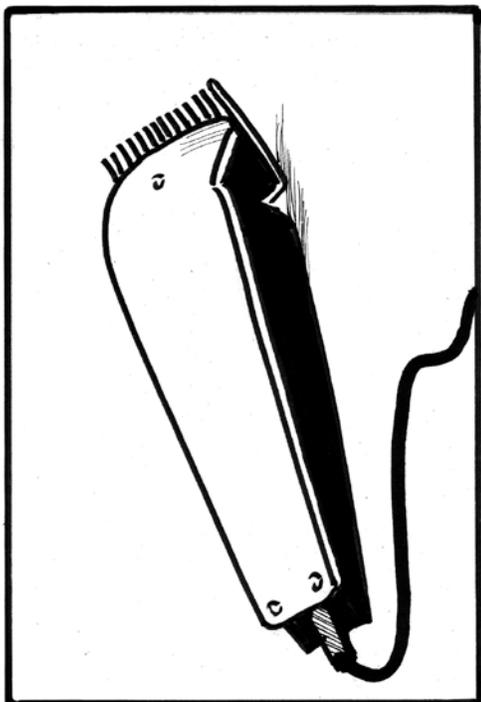
Fears Cards (Exercises C1 to C26)

C1 - C4

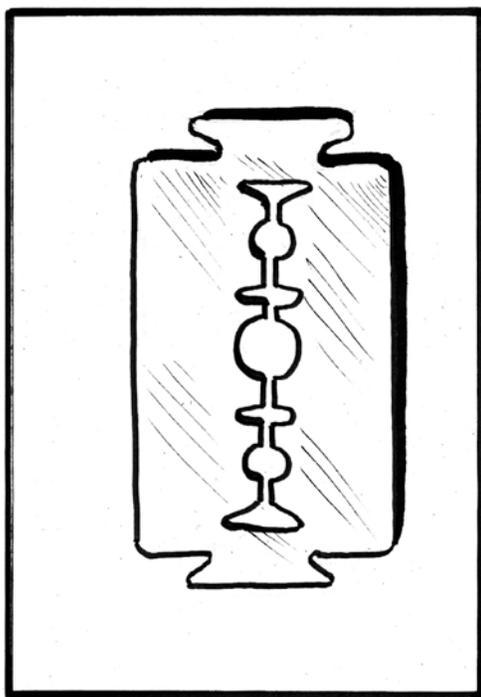


Fears Cards (Exercises C1 to C26)

C5- C8

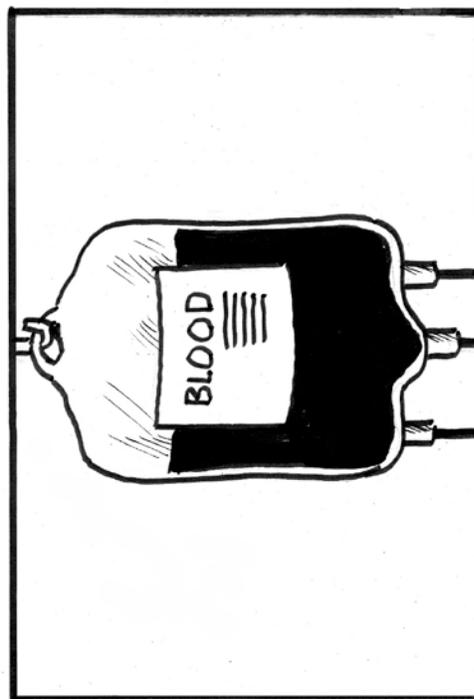
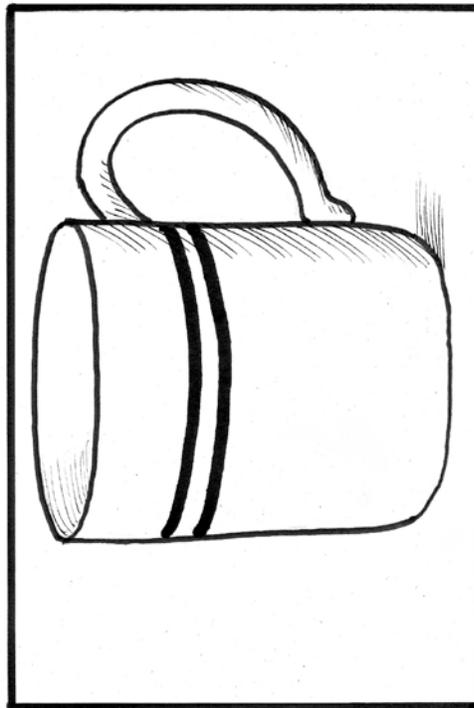
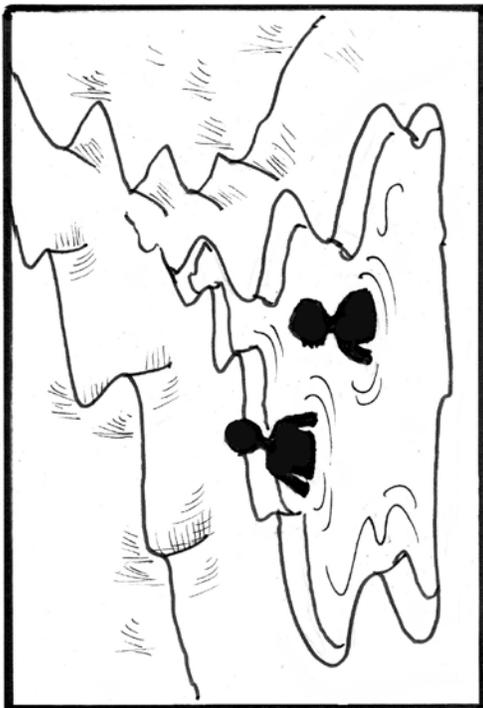


v



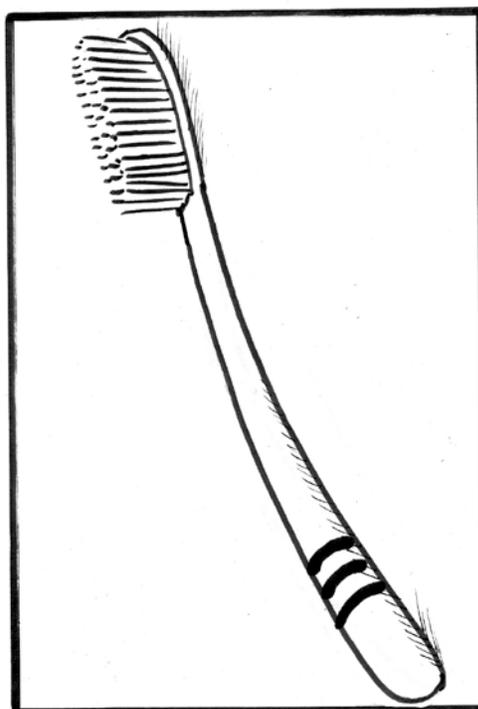
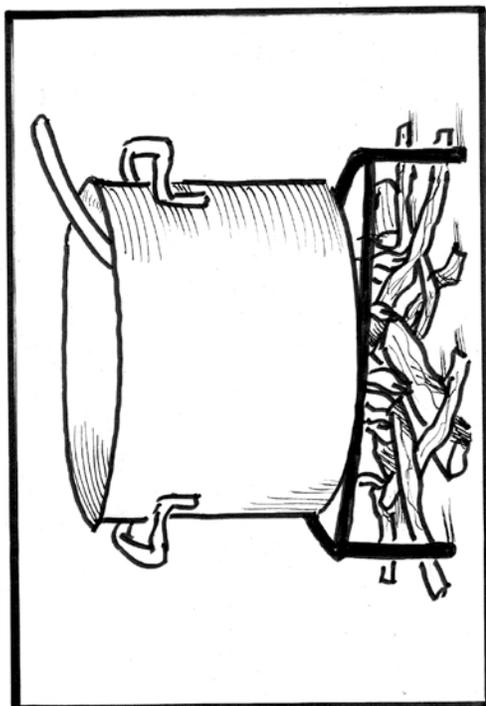
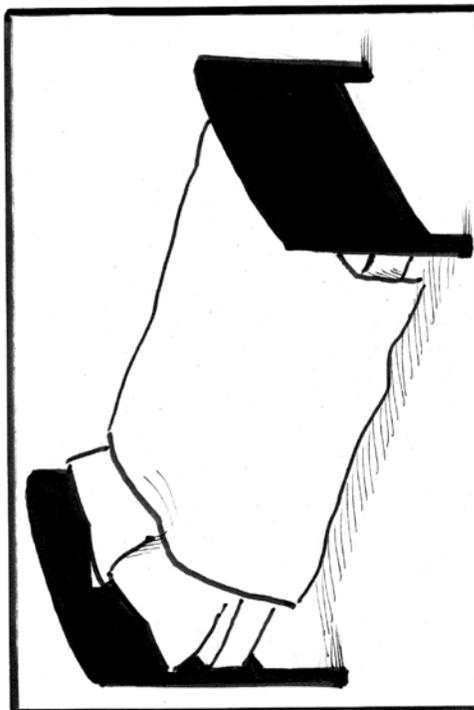
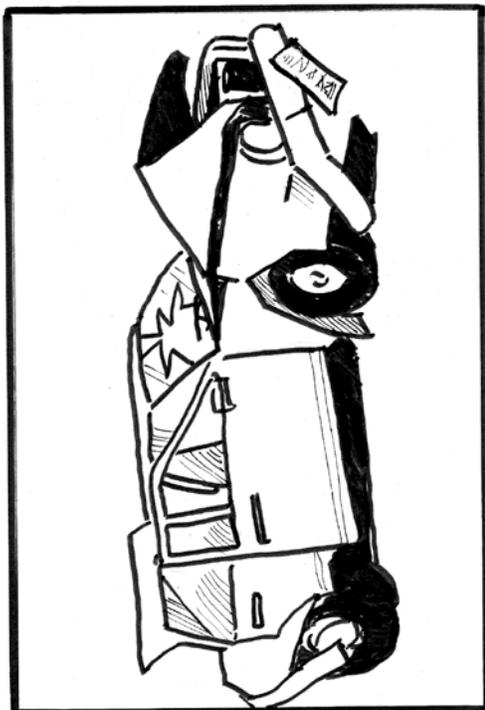
Fears Cards (Exercises C1 to C26)

C9 – C12

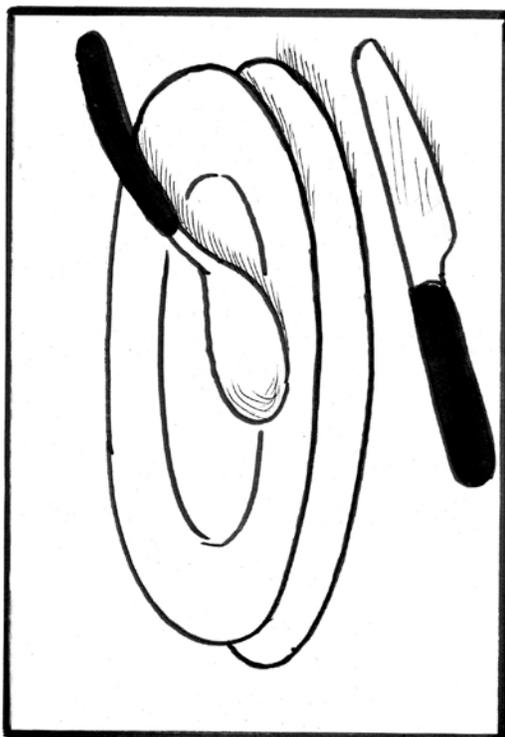
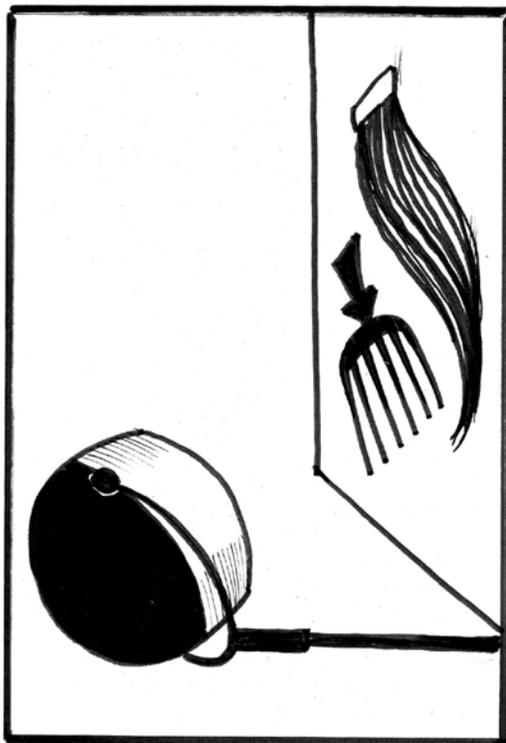


Fears Cards (Exercises C1 to C26)

C13 - C16

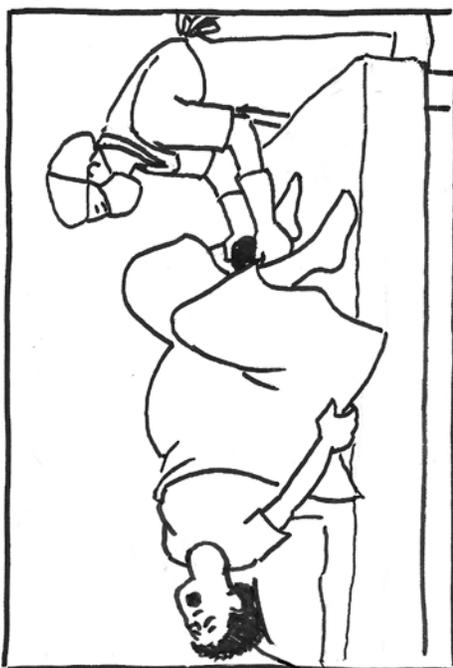
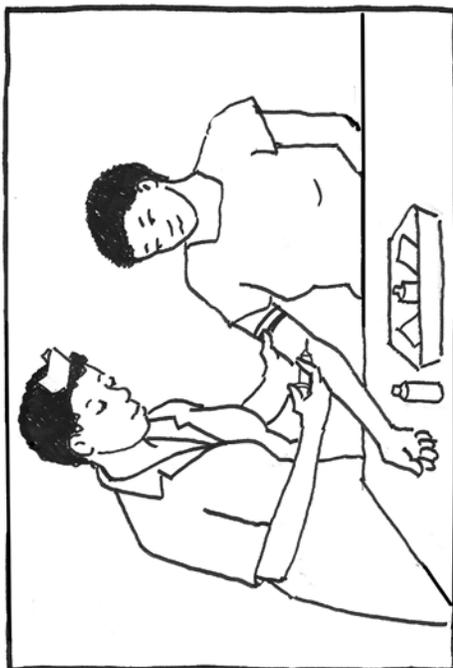


Fears Cards (Exercises C1 to C26)
C17 - C20



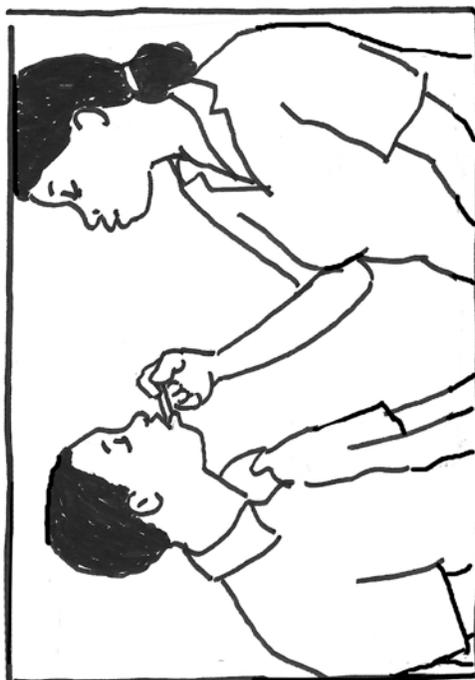
Fears Cards (Exercises C1 to C26)

C21 - C24



Fears Cards (Exercises C1 to C26)

C25 – C26



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