JULY 2018

TOWARDS STIGMA-FREE HEALTH FACILITIES IN TANZANIA

A Guide for Trainers

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HP+
HEALTH POLICY PLUS

JULY 2018

This guide was prepared by Dr. Laura Nyblade and Christin Stewart (RTI International), Pfiraeli Kiwia and Willbrord Manyama (Kimara Peer Educators), and Rebecca Mbuya-Brown and Sara Bowsky (Palladium) of Health Policy Plus.

Suggested citation: Nyblade, L., C. Stewart, P. Kiwia, W. Manyama, R. Mbuya-Brown, and S. Bowsky. 2018. *Towards Stigma-Free Health Facilities in Tanzania: Guide for Trainers.* Washington, DC: Palladium, Health Policy Plus.

ISBN-13: 978-1-59560-177-3

Health Policy Plus (HP+) is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-15-00051, beginning August 28, 2015. The project's HIV activities are supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). HP+ is implemented by Palladium, in collaboration with Avenir Health, Futures Group Global Outreach, Plan International USA, Population Reference Bureau, RTI International, ThinkWell, and the White Ribbon Alliance for Safe Motherhood.

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ACKNOWLEDGMENTS

This guide was produced by the USAID and PEPFAR-funded Health Policy Plus (HP+) project in collaboration with the Tanzania Ministry of Health, Community Development, Gender, Elderly and Children. The HP+ technical team included Dr. Laura Nyblade and Christin Stewart (RTI International), Rebecca Mbuya-Brown and Sara Bowsky (Palladium), and Pfiraeli Kiwia and Willbrord Manyama (Kimara Peer Educators). We are grateful to Dr. Mangi J. Ezekiel of the Muhimbili University for Health and Allied Sciences (MUHAS), who served as principal investigator for the baseline assessment, and his colleague, Amon Sabasaba, who assisted. We would also like to thank our partners at USAID and PEPFAR for their support, including Erick Mlanga of USAID/Tanzania and Kent Klindera of USAID's Office of HIV/AIDS. We wish to thank the National AIDS Control Programme (NACP), particularly Subira Shoko, who served as the HP+ point of contact for this work as well as co-investigator in the baseline assessment. We are grateful to the regional medical officer of Morogoro, the staff of Mvomero and Kilosa District Hospitals, as well as the data collectors who helped gather the baseline assessment data that helped shape this guide. We are especially grateful to all those who gave their time and personal insights as respondents to the survey, including health facility staff and adults and youth living with HIV. Finally, we extend our gratitude to all those who contributed by taking part in the participatory dissemination and curriculum development workshops.

This guide adapts and builds on the following key documents:

- Kidd R., S. Clay, M. Stockton, and L. Nyblade. 2015. *Facilitator's Training Guide for a Stigma-Free Health Facility.* Washington, DC: Futures Group, Health Policy Project.
- Kidd R, et al. 2007. *Understanding and Challenging HIV Stigma: Toolkit for Action.* Academy for Educational Development, International Center for Research on Women and International HIV/AIDS Alliance.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
ARVs	antiretroviral drugs
CATS	community adherence treatment supporters
HIV	human immunodeficiency virus
HP+	Health Policy Plus
NACP	National AIDS Control Programme
PEP	post-exposure prophylaxis
PMTCT	prevention of mother-to-child transmission
STI	sexually transmitted infection
TOT	training of trainers
QQR	quantity, quality, route of entry
USAID	U.S. Agency for International Development

INTRODUCTION

In Tanzania, the USAID-funded Health Policy Plus (HP+) project is supporting Tanzania's national HIV response through adapting and testing a comprehensive package for stigma and discrimination reduction in health facilities for high-prevalence countries, which includes for the first time an additional adolescent-specific component.[1] This process entails conducting baseline assessments of stigma and discrimination in two health facilities in the Morogoro region, which will provide the evidence to design tailored stigma and discrimination-reduction interventions that will then be piloted in the two facilities. An endline assessment will be carried out three months later to assess the impact of the stigma and discrimination reduction interventions. Participatory training of staff and capacity building of a group of trainers will be a part of the facility interventions.

This training guide has been written for the training of trainers (TOT) component of the intervention and will be used as the primary resource at the Training of Trainers Workshop for Stigma Reduction in the two participating health facilities mentioned above. This guide was originally developed in English and translated into Swahili for finalization and use in Tanzania.[2]

Before offering stigma and discrimination-reduction workshops, facilitators should read and understand this guide and use it to prepare teaching materials, including case studies. The contents are intended to provide guidance and do not prevent facilitators from using their own creativity to prepare additional teaching materials as needed.

Users of This Guide

This guide was prepared for use by health facility staff who, through participation in the TOT described above, have the capacity to facilitate stigma and discrimination-reduction workshops for their fellow staff members.

Overall Goal

The overall goal of this guide is to eradicate stigma and discrimination in health facilities through the provision of participatory capacity development for all levels of facility staff.

Steps in Changing Attitudes

The training program is focused on action – not just understanding stigma and discrimination and how they negatively impact health services, but concrete action to stop stigma and discrimination. Each exercise is intended to "trigger" participants to change their attitudes, adopt new behaviors, and take action to address stigma and discrimination in their health facilities.

Steps for change

(1) We realize that WE are stigmatizing: stigma does not just occur, but WE are responsible for stigma.

(2) We see that we may be driving our clients away from health facilities because of our behavior and attitudes.

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[1] Adapted from the total facility approach to stigma and discrimination reduction developed by HP+'s predecessor project, the Health Policy Project (HPP).

[2] The Swahili version is available for country adaptation at: http://www.healthpolicyplus.com/pubs.cfm?get=9231.

(3) We know how it feels to be stigmatized, having reflected on our own experience of stigma and listening to other stories.

(4) We realize that all people living with HIV, including those at higher risk of acquiring HIV, and young people (ages 15–24) seeking sexual and reproductive health services are worthy of our respect. We have many things in common, including a desire to be accepted by and contribute to our families and communities.

About the Exercises in This Guide

Each exercise is laid out in the following format so that they are easy to follow and facilitate:

Facilitation Notes: Brief background information on the topic and notes to facilitators about the overall aim of the exercise and any extra advice on how to facilitate it.

Objectives: The aim of the session: what participants will know or be able to do by the end of the session.

Time: Estimated amount of time needed for the session. The time needed will vary according to the size and energy of the group.

Materials and Preparation: Basic materials like flipcharts, markers, and masking tape are not always listed, as these should be readily available for all sessions. Preparation includes things to consider before you start the exercise. This includes arrangement of the room or chairs and materials needed for the exercise, e.g., copies of case studies or role-plays. If small groups will be used, there will be a reminder to plan your “group splitter”—how you will divide participants into small groups.

Facilitation Steps: The activities that will be taken by the person leading the exercise: step-by-step. Note that Step 1 tells you how to introduce the exercise, so that participants will be clear about what they are being asked to d0. Questions or instructions from the facilitator to the participants are written in *italics*.

Processing: Most exercises have a processing step, after the main activity of the exercise, which helps participants reflect on what the new learning from the exercise means to them and how it may change the way they see or do things. This is an important step in a stigma reduction exercise, as it leads to the beginning of action and change.

Summarize: Try to give a good summary at the end of an exercise. Use points that have been raised by the participants and add some of your own. Each exercise has one or two “key takeaway messages” to include in your summary.

Core Exercises

Some of the exercises have been identified as Core exercises. This means that they have been tried and tested in many places and are viewed as critical exercises to include in any stigma-reduction training.

Menu of Exercises

This menu is a quick reference for trainers. It contains a list of all the activities in the guide, broken down into “core” and “non-core” activities, along with the approximate time needed for each activity. The menu is intended for use by trainers to plan their training sessions in alignment with training time available and health facility needs. It is recommended that all core activities be implemented at each facility, with additional activities included as time allows and in keeping with the interests and needs of health facility staff.

Core Activities

#	Name	Time Required
1	Opening activities	1 hour (depending on “ice breakers” and energizers used to bring participants together as one learning group)
2	Naming stigma through pictures	1 hour and 45 minutes
3	Our experience as stigmatizer and stigmatized	1 hour 15 minutes
4	Analyzing stigma in health facilities	45 minutes
5	Fears about non-sexual transmission/QQR	1–2 hours
6	Overcoming fear with standard precautions	45 minutes
7	Breaking the sex ice	45 minutes
8	The blame game: Things people say	1 hour
9	Confidentiality and stigma	1 hour
10	Stigma-free services for adolescents and young people	45 minutes–1 hour
11	Writing a code of practice and action plan	2 hours

Non-core activities

#	Name	Time Required
12	Panel discussion with people living with HIV	1 hour
13	How stigma impacts human rights	1 hour
14	Effects of stigma on the HIV epidemic	45 minutes
16	Forms, effects, and cause of HIV-related stigma: Problem tree	2 hours
17	Challenge the stigma—and be the change!	45 minutes

Participatory Training Techniques Used in This Guide

This guide uses a range of different methods and techniques. The table below provides tips on how to make the best use of each one.

Method	Description/Reason	Tips
Warmup games, songs, energizers	Use games, energizers, and songs to keep energy and interest level high	Facilitators can develop their own styles and games Use “group splitters” (different methods to organize participants into groups) as energizers to get participants to move around and mix up Songs can be great for building group spirit, but may not work in all settings

Method	Description/Reason	Tips
Discussion	Participants reflect on their own experiences, share with others, analyze issues, and plan for action together Discussion is an important step in any exercise, as it gives participants an opportunity to process what they are learning Can be in pairs, small groups or in plenary	Use open questions to start the discussion Observe carefully to ensure everyone is able to participate Use rephrasing skills to increase the group's understanding and affirm participants' contributions Ask your co-facilitator to record key points in a large-group discussion
Small group work	Enables greater participation especially if some participants find it difficult to participate in large group discussions Small groups can be used to carry out tasks, dividing up topics to cover more aspects of a subject The size of small groups can vary, but aim for groups of 3–5 participants. This will help ensure that all the group members have a chance to participate	Plan your "group splitters" (ways to organize participants into groups quickly and efficiently) Keep changing the members in a group for each exercise Give clear instructions and check that groups have understood the tasks Plan the report back process (e.g., use round-robin method, gallery, 2-4-all, or individual group presentations; see more details below)
Buzz groups	Two people sitting next to each other quickly discuss their first thoughts on a topic provided by the facilitator(s) A quick way to get a discussion or brainstorm started	Buzz groups are a trainer's way of getting instant participation and creating safety so that participants are not working alone After a few minutes get a point from each pair to start the brainstorm, then allow others to contribute extra points
Card storms	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 clustered into categories and discussed. Card storms are more flexible than brainstorms, as the cards can be moved around, taken away, or organized to suit particular topics Problem and solution trees use card storms	Make sure you give out plenty of cards; don't limit the number of ideas participants can contribute Involve participants in clustering the cards into categories and then reading through or summarizing the categories Use the categories to take analysis further (e.g., with small group work or role-plays) Don't forget to "process" your card storm. For example, ask the group what stands out, what they learned from the points, etc. For participants with mixed literacy skills, work in pairs, or have facilitators write the cards and read through the card storm together
Case Studies	Stories or scenarios based on real-life situations provide a focus for discussion in small or large groups Case studies can help focus participants and make abstract ideas real	Have a range of case studies to tackle different aspects of a topic Give characters local names to make them more relatable (change names from the original people to ensure confidentiality) Give participants questions following the case studies to focus the discussions Ask each group to report back from their case-study discussions

Method	Description/Reason	Tips
Role Plays/Drama	Participants act out the situations or themes or act out analysis of an issue or try out solutions to a problem as a way of reporting what they have discussed Role-play can also be used to help with skills practice Drama helps make things real	Give clear instructions or descriptions of what you want to be role-played Give a time limit to ensure role-plays are brief and to the point Always process the role-play; get participants to debrief the plays. Ask key questions like *What did you see happening? Does this really happen? What would help to solve this situation?*
Rotational Brainstorms	Another form of brainstorming done in small groups. Each group is given a topic or question and begins by recording ideas on a flipchart. After a few minutes, each group rotates to the next flipchart and adds points to the existing list. During the exercise, each group contributes ideas to all topics.	Use this technique when there is a range of linked topics or questions Remember to prepare your group splitter and to stick up your questions on flipcharts before you start For report back, use a “gallery” approach: the facilitator leads all participants together as a group past each of the flipcharts
Picture Tools	This guide includes a set of picture tools (Appendix 1), which help participants to identify different forms of stigma These pictures can also be used in other ways, e.g., to start discussions or as the basis for a story or role-play	Make sure pictures are selected and prepared ahead of time (Appendix 1 has a selection of pictures that can be used) Ensure that everyone can see the picture (e.g., enough copies, large enough sizes) Ask probing questions to get as much information as possible Remember, there are no wrong answers: everyone will see slightly different things in the same picture For participants with visual impairment, you can describe the pictures in detail or use them to tell a story
1-2-4-all	A more creative way to report back after an activity. Participants reflect alone about what they have learned (or a particular question). Then pair up with a partner to share ideas. Then pairs join with another to discuss and agree on key feedback points for the large group.	Encourage participants to make notes during the reflection time Use bells or drumbeat to signal changeover time During plenary feedback ask groups not to repeat points that have been mentioned

TRAINING TIPS

During the training-of-trainers (TOT) workshop, we will be discussing and trying out various training techniques and methodologies to enable trainers to facilitate the stigma reduction exercises contained in this guide effectively. This section includes some extra tips to help you prepare for your training sessions during and after the TOT to make sure you are confident and prepared to deliver high-quality, effective stigma reduction training.

Before the Training

- Meet with your co-facilitator to plan your agenda and divide the tasks between you so that each of you has clear roles and responsibilities. Agree who will lead which exercise, but remember even if you are not leading, you are the co-facilitator. (See "Work as a Team" below for tips on working with a co-facilitator.)
- Discuss the materials and any other resources you may need, and agree who, how, and when they will become available.
- Prepare all the materials and resources you will need.
- Prepare a detailed timetable for use by facilitators. (See "Manage Time" section and "Less is More" box for tips on planning your timetable; as well as Appendix 2, which offers a timetable template.)
- Check out the venue, if possible, so that you can plan how you will use the space.

At the Start of the Training

- Arrive early (at least one hour before participants are scheduled to arrive) to give yourself enough time to get organized.
- Prepare the room and materials; write your initial flipchart headings.
- Double check on logistics such as tea, lunch, etc., to make sure all is in order.
- Introduce yourselves as the facilitators and think of a short, simple way for participants to introduce themselves.
- Use icebreakers, games, or songs to help participants relax, have some fun, and feel free in the group.
- Set ground rules. Agree on rules to ensure that everyone gets an equal chance to participate. For stigma reduction training, it is important to make sure that ground rules include agreeing to make the training a safe space. (See box for additional tips on creating a safe space for participants.)

Creating a Safe Space

It is important that the ground rules include making the training a safe space. Facilitators should help participants identify some rules that they agree will help make the space feel safe.

During the Workshop

Assume that the training group includes people living with HIV

- Facilitators should always assume that some participants are living with HIV and should never assume that HIV-positive participants have disclosed their HIV status to others.

- Facilitators should keep this in mind throughout the workshop and work from the foundation of this assumption with respect and sensitivity.
- It is possible that, in the course of the workshop, a participant may disclose their HIV-positive status to the group, possibly for the first time. Facilitators should be aware of this possibility and prepared to handle the disclosure in a supportive and sensitive manner.

Do not feel the need to disclose your HIV status

- If facilitators are living with HIV, they should not feel the need to disclose their status.

Manage space

- Change the space and arrangement of chairs and tables to suit your activity and provide variety.
- Start off with a circle or semi-circle so that everyone can see each other.
- Let participants know that this is not a workshop where they sit in the same chair and next to the same people for the whole time.
- Change the way the chairs face from time to time, to suit the activity.
- Where possible, make arrangements for some training activities to take place outside of the training room in the open air.

Manage time

- Good time management begins *before* the training, with making realistic plans for content and timing.
- Leave enough time. Exercises usually take longer than anticipated. When planning your timetable, include more time for each exercise than you think you will need. It is much easier to add things than to take things out (see box).
- In a short training program there is not enough time to go into all the issues in depth. You will need to manage time carefully or your overall objective will be lost.
- Agree how much time you need for each session – and work to these time limits. Don’t allow sessions to drag on too long! Close on time! Don't drag things on at the end of the day.
- Leave time for wrap-up and reflection at the end of each session.
- During breaks, check with your co-facilitators about how the timing is working out, and adjust the remaining agenda/exercises as needed.

Less Is More

A common mistake facilitators make is trying to pack in too much content. This can lead to participants feeling rushed or missing out on important information.

In stigma reduction trainings, where participants are faced with emotionally challenging content, it is especially important to make sure they have enough time to process the material without feeling rushed.

Work as a team

- Take turns in the lead role.
- Support each other. If one facilitator runs into trouble, the other can help her/him out. Avoid criticizing your fellow facilitators in front of participants.

- Meet at the end of each session to debrief how the day went and plan for the next session. Give each other feedback.
- Having a team of facilitators helps to keep energy and interest levels high and offers participants a variety of training styles.[3]
- Clearly define the roles and responsibilities of each co-facilitator ahead of time.

Record discussions on flipcharts

- Recording notes during plenary discussions on the flipchart provides a permanent visual record, helping participants know what has been discussed and what needs to be added. Note: participants and facilitators should not record any names on the flipcharts to protect confidentiality.
- Writing down points triggers other ideas and provides the basis for a summary of the discussion. Notes also help you as facilitators if you are going to write a report.
- Always remember to read aloud what is written on the flipchart; this enables participants with visual impairments or low literacy skills to know what has been recorded and to be involved in recapping ideas.
- One facilitator should guide the discussion, while the other can write on the flipchart. Try to avoid facilitating and writing on a flipchart at the same time to allow you to focus on what participants are saying. If you are facilitating alone, ask someone in the group to help you with the recording.
- Write only the main points or key words, not everything that participants say.
- Use **participants' own words** so that they recognize their own contributions.
- Write big and clearly so people at the back of the room can see.
- When participants are working in small groups, encourage them to identify a group member to take notes and report out to the full group when time allows for plenary discussion.

Work with feelings

- Training about topics such as HIV and stigma can trigger strong emotions and feelings.
- Feelings are a powerful tool. Use them with the group to develop dramas and role-plays, to build on stories, and as examples for the future.
- It important for facilitators to validate feelings expressed by participants. Facilitators should avoid dismissing, minimizing, or discrediting participants' feelings. For example, if someone shares a story that is personal and sad or frightening, the facilitator should acknowledge and validate the contribution, saying something like, *"Yes, this sounds very sad and frightening, thank you for sharing this,"* before moving on to address the topic at hand or ask others to share similar experiences. This can help participants feel heard and reinforce the safety of the training space.
- Understanding how stigma feels is part of the process of changing stigma.
- To support participants to explore their feelings and share experiences and thoughts openly, it is important to create a safe, non-threatening space. Allow enough time for

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[3] Current plans call for a team of three facilitators—one health worker, one adult living with HIV, and one youth living with HIV. Youth trainers will be at least 18 years of age, have already disclosed their HIV status openly, and have past experience facilitating group training.

participants to share their experiences, and help create an atmosphere where participants know they will be heard.

- Encourage participants not to shy away from discomfort—some level of discomfort is a natural part of learning about stigma. At the same time, becoming overwhelmed emotionally does not help participants learn and can be unhealthy. It's important for participants to pay attention to how they are feeling and take care of themselves. They should feel free to take a break if they need to.
- Facilitators should also pay attention to how participants are doing emotionally, and notice if one or more participants seems to be overwhelmed. If so, consider taking a break, and during the break check in with any participants who seem to be having a hard time, making sure they want to continue.
- If possible, facilitators should have a counselor or other mental health specialist on hand during the training, or available to participants afterwards, in case the training triggers overwhelming emotions or past trauma.
- After an emotional session, you may want to take a break or do a song to help people come out of the strong emotion and pick up their spirits. Movement is particularly good at helping participants "reset" themselves after an emotional session. You can have participants shake their arms and legs, literally "shaking off" their discomfort. You can also lead participants in taking a few deep, cleansing breaths together. Have them breathe in through their noses and breathe out through their mouths with a sound or a sigh—or whatever sound comes naturally to them.

Be prepared to handle difficult questions

Some participants may find learning about HIV-related stigma and discrimination extremely difficult, because it can challenge some of their most strongly held beliefs and ideas. This means that as a facilitator you may experience some hostility and resistance and be faced with some difficult questions.

If you are working with one or more co-facilitators, brainstorm together all the difficult questions that you think the participants might ask, and discuss how you could handle them.

- Remember that if participants are asking questions it means that they are engaged and are thinking through the things that they are learning during the training course. It also means that you have created a safe space where participants feel comfortable to express their views and explore issues openly.
- Take advantage of opportunities for meaningful, heartfelt exchange. If participants express doubts or challenge the content, this is a chance to help them—and the group—have a deep discussion that allows people to open up their minds and hearts to new ideas.
- **Don't silence the questioners**—allow them to express themselves so that any prejudices can come out, rather than be repressed. However, don't let discussions get out of hand and do gently challenge negative attitudes.
- **Remember that you will not be able to change everyone's attitudes** immediately. Your main focus is to provide information and opportunities for analysis and discussion.
- **Keep participants' focus on everyone**'s right to equal treatment and access to healthcare.

- Encourage reflection. Facilitators can use gentle questioning to encourage participants to reflect about what they're asking, instead of answering them directly. This can help participants feel more active and in charge of their learning, and avoid setting up a confrontation between facilitators and participants.
- **Don't be afraid to say you do not know**. You can always refer the question back to the group: "*What do others think?*" Or promise to find out the answer for a later date.

Be aware of power dynamics

- Facilitators should always be aware of power dynamics—both between facilitators and participants and among participants themselves.
- Training groups often include a mix of genders, ages, and religious and cultural influences. However, these stigma reduction trainings have some additional unique factors that can affect power relationships. The "total facility" approach means participants will include a mix of ages, levels of education, and professional designations (e.g., nurses, doctors, guards, receptionists).
- Power dynamics and relationships can show up in lots of different ways. As a facilitator, an easy way to spot these relationships is to notice where participants are sitting and who is participating. Ask yourself:
    - Who is sitting at the front of the room?
    - Who is sitting in the back?
    - Who is speaking up?
    - Who is staying quiet?
    - Who am *I* calling on? Who am *I* paying attention to?
- Notice if there are any patterns. Are men speaking up more often than women? Are medical staff speaking up while support staff stay quiet? Where there seems to be an imbalance, do your best to even it out, making the relationships as equal as possible. Some ways to do this include:
    - Asking participants to "take off their hats" as they come in—setting aside their role as "doctor" or "nurse" or "guard" and becoming training participants. Tell them they can pick their hats up as they depart at the end of the training.
    - Asking participants to notice these patterns for themselves and come up with ideas as a group for how to "level the playing field."
    - Using creative group splitters (see "Use Creative Group Splitters" box) to mix participants into more diverse groups.
    - Changing the group composition regularly.
    - Playing "musical chairs": have half of those in the front of the room switch with someone at the back of the room, or from one side to the other.

At the End of Each Training Session or Workshop

- Plan how you are going to bring the session to a close.
- Always include a wrap-up and summary to help participants process and reflect on what has been learned and experienced in the session/workshop.
- If possible, make the wrap-up participatory, not just the facilitator talking through what's happened, but participants telling the facilitator and each other what they

think happened, and what they are taking away. This will help facilitators identify whether any key points have been missed or misunderstood that may need to be revisited in later exercises.

- Include in your summary one or two key takeaway messages from each exercise.
- After you have wrapped up the topic, you might want to use a song or a game as one of the final activities.
- Carry out the evaluation as planned at the beginning of the training.
- Debrief with your co-facilitators. Review each exercise and give each other feedback (Appendix 3: Post-training Debrief).
- Collect any flipcharts or cards that you might use for a report or the documentation of the training. If trainers have access to a smart phone, it can be helpful to take pictures of the flipcharts to use for reference during later reporting or planning.

Use Creative "Group Splitters"

Many of the exercises require participants to work in small groups. As a facilitator, you can use the process of splitting into groups to keep energy high, ensure that participants are mixing and talking to each other rather than staying with the same people all the time. You can also keep participants interested by using different ways of breaking into groups. There are so many ways to divide into groups (try not to use "1,2,3 – all the ones together" too much—challenge yourselves to avoid using these more than twice!). Here are some ideas for "group splitters":

- **Actions:** Write or draw different actions on slips of paper (e.g., feeding a baby, dancing, walking as if you are in a hurry). Or whisper an action in someone's ear. Ask each participant to take a paper without showing anyone. When you shout, "1, 2, 3," ask them to start doing the action and find others who are doing the same.
- **Songs:** Write song names on slips of paper (use common songs that everyone will know e.g., Happy Birthday, the national anthem, popular songs of the time), then ask each participant to take a slip and start singing until they find others singing the same song. Whisper a song title in participants' ears if anyone has a visual impairment or low literacy skills.
- **Animal sounds:** Write the names of, or draw different animals, on slips of paper. Each participant must make the noise of their animal and find others making the same noise
- **Same clothing:** Before you divide the group, look at the clothes people are wearing and see if you can divide them by colors (e.g., "Everyone who is wearing stripes come together," "Everyone who is wearing sneakers," etc.). Facilitators should adapt this to their community. If there are sensitivities about clothing colors due to politics, or if there are women in the group wearing mourning, or if there is a clear difference among participants' clothing because of religion or tribe or profession, this technique should not be used.
- **Things in common:** This is a bit of a random way but you can use it approximately and then mix people if necessary. Adapt it to your community. Say things like, "Everyone who lives close to the river," or "Everyone who attended ____ school," etc.
- **"Fire on the mountain, run run run":** Make this into a chant–everyone runs around in a circle and then you say, "Be in threes," or, "Be in pairs" and participants move quickly to those next to them to form a group.
- **Birthday line:** Ask participants to stand in a line in the order of their birthdays (e.g., January at one end, December at the other end). To make it more fun, ask participants to do so without talking. Once they are in a line, you can then count them off into groups.

OPENING ACTIVITIES

Facilitators' Notes

The opening session of any training is very important, so take time to plan and prepare. Arrive at the venue at least one hour before participants are scheduled to arrive to set up the chairs and ensure logistics are in place (e.g., materials, refreshments). Agree on your opening game or song.

These opening activities are designed to break the ice and help participants to relax and feel safe together.

Try to create a warm and friendly atmosphere where everyone can participate. Remember to listen carefully to contributions from the group members; this will encourage others to listen too.

Objectives

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

- Break the ice and help to build a safe and friendly atmosphere
- Get participants to state their expectations about the training
- Explain objectives and program and agree on rules for the training program

Time

- *1 hour*

Materials

- Nametags (Use large print, only first names, so names will be visible to facilitators and other participants. Optionally, add something fun like stickers that participants choose to personalize their nametags.)
- Markers
- Flipcharts
- Code of conduct flipchart

Steps

1. Arrival: When participants arrive, ask them to register and make a nametag.

2. Opening speech: Health facility manager explains the importance of the stigma and discrimination-reduction training.

3. Welcome: Introduce yourselves as the facilitators and welcome participants.

4. Ice breaker and introductions: Song or game to break the ice followed by short paired introductions (*This is____, he/she works at _____, and he/she likes____.*)

5. Expectations: Discuss in pairs: "*What do you hope to learn from the training?*" Then ask pairs to report. Write up points on a flipchart.

6. Objectives: Explain the objectives of the training program, written on flipchart, and relate them to participants' expectations.

OBJECTIVES: By the end of the workshop we will:

- Have greater knowledge, understanding, and skills to enable us to decrease the level of stigma in service provision at healthcare facility level.
- Have explored our values and attitudes and be able to understand the impact that they could have on service provision.
- Have skills needed to help others to have a greater understanding of the lives and experiences of clients living with HIV—both adults and adolescents (10–19 years) and young people (15–24 years).
- Have agreed on specific things we can do to provide friendly and welcoming health services for all clients.

7. Timetable: Hand out timetable and explain the starting and stopping times. Explain that punctuality is important because there are many topics to be covered in a short time.

   Tip: Either hand out one day at a time or hand out a less detailed timetable for participants, while holding onto a detailed timetable for facilitators. This will leave facilitators the freedom to adjust timing of activities as they go along based on how long activities are taking or if there are any areas of misunderstanding.

8. Workshop rules: Ask participants to brainstorm workshop rules. Record points on flipchart, which can then be taped on the wall.

   Be sure to ask participants, *"What would make this feel more like a safe space?"* and do your best to accommodate.

   Things to include:

- Cellphones on silent or vibration mode.
- Start and end on time.
- Active participation.
- What is said in the room stays in the room, and there will be no documentation of who said what.
- Respect each other's views.
- Do not blame each other – focus on our own practices.
- Commitment that training leads to action!

9. Code of practice: In keeping with this focus on action, at this first session introduce participants to the idea of the "code of practice" and action plan they will be developing. Although this will be developed in a separate activity, it's important to introduce participants to it now. Facilitators should post a flipchart with "Code of Practice/Action Plan" written on it and encourage participants to post issues that they feel are important to address in the code of practice and action plan as they arise. Facilitators should check in on the list from time to time, remind participants to add to it, and share the issues that have been captured, to keep this in the forefront of participants' minds throughout the training.

   Additions: Some groups may want to establish a practice of thinking through action steps each time they finish a particular topic or module. This is entirely appropriate and demonstrates that participants recognize that challenges related to stigma and discrimination are present in the facilities where they work and are asking themselves, “What can be done to overcome this challenge?” If participants choose to adopt this practice, their suggestions should be captured and posted on the flipchart labeled “Code of Practice/Action Plan.”

NAMING STIGMA THROUGH PICTURES (CORE)

Source: Adapted from Kidd R., S. Clay, M. Stockton, and L. Nyblade. 2015. *Facilitator's Training Guide for a Stigma-Free Health Facility.* Washington, DC: Futures Group, Health Policy Project.

Facilitators' Notes

This is one of the best exercises to use at the beginning of a training session, because it is simple, everyone can participate, and it opens the discussion about stigma.

Participants look at pictures showing stigma (Appendix 1: Picture Tools) and describe different forms of stigma in health facilities. Our objective is to get health workers to name the problem: to say that stigma exists and to identify what stigma looks like. There is also an opportunity to start discussing why stigma occurs and to identify some of the causes of stigma.

It is important to make sure that this exercise includes a focus on adolescents and young people. Facilitators should be sure to include a few pictures featuring adolescents or young people in those posted, and they should draw out issues related to adolescents and young people when summarizing.

Objectives

By the end of this activity, participants will:

- Be able to identify different forms of stigma in different contexts
- Have begun to understand why stigma happens
- Have begun to understand the effects of stigma
- Be able to discuss examples of stigma from their own health facilities and communities

Time

- *1 hour and 45 minutes*

Materials

- Pictures (large for posting on wall)
- Tape for posting pictures
- Flipchart with picture questions
- Markers

Preparation

- Select pictures and print large copies for use during the training (include several that focus on adolescents and young people).
- Stick the pictures on the wall.
- Decide how you will divide participants into small groups (use "Creative Group Splitters.")
- Write up picture questions on flipchart (and have a copy ready to give to each group).

Steps

1. Ask everyone to move around and look at the pictures. After a few minutes, divide participants into groups of two or three. Ask each group to select one picture.

2. Ask groups to discuss the following questions:
    - What is happening in the picture in relation to stigma?
    - Why do you think it is happening?
    - Does this happen in your community? In your health facility?

3. Ask each pair to report back by holding up their picture to show it to their fellow participants and answering the questions. The facilitator records key points of forms, causes, and examples on flipchart.

4. Processing: Ask the large group, *"Does anyone have anything to add about what is happening in these pictures? What are the major forms of stigma that we have seen in the pictures?"*

5. Summarize: Refer back to the pictures and points from the groups to make some of the following points:
    - We have been socialized to stigmatize others – to judge or devalue them.
    - We are often not aware that we are stigmatizing.
    - Adolescents and young persons living with HIV are potentially doubly stigmatized (for being HIV-positive and for being young)—an example of layered stigma.

6. Discuss definitions and dimensions below.

Textbook Definitions

- Stigma is defined as a "spoilt identity."
- To stigmatize is to label someone, to see them as inferior because of an attribute they have.
- Stigma is a process:
    1. Point out or label differences, e.g., "He is different from us; he coughs a lot."
    2. Attribute differences to negative behavior, e.g., "His sickness is caused by his sinful and promiscuous behavior."
    3. Separate "us" and "them," e.g., shunning, isolation, rejection.
    4. Loss of status followed by discrimination (loss of respect, isolation).
- Discrimination is the action resulting from stigma, when a person is treated differently, e.g., neglected when seeking support, judged, chased from home or school, fired from work, stopped from attending meetings, not allowed to use the village well.

Other Important Dimensions

- People do not always know that their actions are stigmatizing.
- Stigma differs in intensity – it is sometimes blatant, sometimes subtle.
- Stigma may be targeted at people who are *assumed or suspected* to be HIV-positive or who are assumed to belong to a marginalized or stereotyped group (see below), or assumed to hold some other attitude or belief, or engage in a behavior that is not socially acceptable.
- Stigma is often targeted at already marginalized or stereotyped/scapegoated groups.
- Other diseases (such as TB) are stigmatized because they are associated with HIV.
- Stigma disrupts social relations, cutting the stigmatized person or group off from others, leaving them without the social safety nets of family, friends, and community.
- Stigma can result in young people being afraid to ask for information or support when they need it. They may fear they will be judged or excluded if they even talk about HIV or ask questions related to sex when they are still in youth and adolescence.

OUR EXPERIENCE AS STIGMATIZER AND STIGMATIZED: REFLECTION (CORE)

Sources: Adapted from:

- Kidd R., S. Clay, M. Stockton, and L. Nyblade. 2015. *Facilitator's Training Guide for a Stigma-Free Health Facility.* Washington, DC: Futures Group, Health Policy Project.
- Kidd R, et al. 2007. *Understanding and Challenging HIV Stigma: Toolkit for Action (Module A).* Academy for Educational Development, International Center for Research on Women and International HIV/AIDS Alliance.

Facilitators' Notes

This activity has two parts, both of which center on individual reflection. The first part draws out participants' own experience of being stigmatized. It asks them to think about a time in their lives when they felt stigmatized and to use this experience to help them understand how it feels to be stigmatized. Reflecting on this painful experience helps participants see how hurtful stigma and discrimination can be.

The second part focuses on participants' experience of stigmatizing others. It asks them to think about a time in their lives when they stigmatized others. Reflecting on this gives participants a chance to reflect on their own behavior in light of the pain people experience when they are stigmatized. Together, these two parts enable participants to see both sides of the story, the part that they play in creating a stigmatizing environment, and therefore the part they can play in making their facility stigma free. This sets up a sense of empathy and agency that they will carry forward throughout the training.

The exercise requires a lot of trust and openness within the group, so it should not be used as the first activity. Wait until participants are beginning to open up with each other and are now ready to share some of their own experiences.

You should also note that the exercise looks at stigma in general, not HIV-related stigma in particular. This is why the instructions are, *"Think of a time in your life when you felt isolated or rejected for being seen as different from other people."* Give participants a few examples (e.g., being made fun of because you came from a poor family, or being made fun of in school because you were smaller than others or poor at football). The examples will help participants understand what type of experiences they are expected to think about. This exercise needs a good introduction to help participants break out of their initial discomfort about reflecting and sharing their own experiences with others. One way of getting started is by the facilitators sharing their own experience and feelings first. It is important to set ground rules for this exercise. Emphasize that the sharing is voluntary and no one is forced to share. Emphasize the importance of confidentiality and that what is shared should stay in the room. Participants should only share *their own* stories (not their partner's).

This exercise can trigger painful memories or experiences for some participants.

As the facilitator, you should be ready to deal with the emotions raised. (Refer to "Work with feelings" on p.8 for tips.)

It can be helpful to schedule this exercise right before a tea break, to give participants a chance to reset before the next exercise.

Objectives

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

- Describe some of their personal experiences of being stigmatized
- Describe how it feels to be stigmatized
- Recognize that we have all played the role of stigmatizer in some situation in our lives
- Recognize that their own actions play a part in creating stigma in their health facility, and that their own actions can likewise help make their health facility stigma free

Time

- *1 hour and 15 minutes*

Materials

- Blank paper
- Markers or crayons for participants who want to use drawing for their reflections

Preparation

- Move chairs apart so that everyone is sitting alone
- Make sure there is enough space for participants to move freely for the final piece of the exercise

Part 1: How Stigma Feels (Reflection)

Steps

1. Individual reflection: Ask participants to sit on their own and close their eyes. Then say, "*Think about a time in your life when you felt isolated or rejected for being seen to be different from others. What happened? How did it feel? What impact did it have on you?*" Allow a few minutes for reflection. If time allows, offer participants the option of writing down some key words or drawing to process the reflection. Tell participants, *"These reflections can be kept private and do not need to be shared with anyone else."*

2. Sharing in pairs: After you observe that participants are ready say, "*Share your experience with someone with whom you feel comfortable. If you prefer to remain silent, this is okay too. There is no pressure on anyone to share."* Give the pairs a few minutes to share their stories with each other if they choose. Some participants may wish to continue reflecting or processing on their own through drawing or writing.

3. Sharing in plenary: Invite participants to sit in a complete circle. Ask, "*How was the reflection?"* Take a few answers and then ask if anyone would like 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. They can reflect on the process of the exercise and how it made them feel if they don't feel comfortable sharing specific stories.

4. Processing: Ask:

   - *What did we learn about stigma?*
   - *What feelings are associated with stigma?*
   - *How has this exercise changed your understanding of stigma?*

- *What might this mean for addressing stigma in your health facility?*

5. Summary:
   - This exercise helps us get an inside understanding of how it feels to be stigmatized: shamed or rejected. It helps put us into the shoes of people who experience stigma, including adolescents and young people. It helps us understand how painful it is to be stigmatized.
   - The feelings of being stigmatized are very painful and the impacts last a long time.
   - Stigma destroys people's self-esteem. People begin to doubt themselves. They feel very isolated at a time when they need the support and company of other people.
   - Everybody has felt isolated or treated like a minority at different times in their lives. We have all experienced rejection or exclusion by others.

Part 2: How It Feels to Stigmatize (Reflection)

Steps

1. Individual reflection: Ask participants to sit on their own and close their eyes. Then say, "*Think about a time in your life when you isolated or rejected other people because they were different. What happened? How did it feel? What was your attitude? How did you behave?*" Allow a few minutes for reflection. If time allows, offer participants the option of writing down some key words or drawing to process the reflection. Tell participants that these can be kept private and do not need to be shared with anyone else.

2. Sharing in pairs: After you observe that participants are ready say, "*Share your experience with someone with whom you feel comfortable. If you prefer to remain silent, this is okay too. There is no pressure on anyone to share.*" Give the pairs a few minutes to share their stories with each other if they choose. Some participants may wish to continue reflecting or processing on their own through drawing or writing.

3. Sharing in plenary: Invite participants to sit in a complete circle. Ask the group to discuss the experience. Ask, *"How was the reflection? How did it feel to see yourself in the role of stigmatizer?"* Take a few answers and then ask if anyone would like 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. They can reflect on the process of the exercise and how it made them feel if they don't feel comfortable sharing specific stories.

4. Processing: Ask:
   - *What did we learn about stigma?*
   - *What feelings are associated with stigma?*
   - *How has this exercise changed your understanding of stigma?*
   - *What might this mean for addressing stigma in your health facility?*

5. Summary:
   - This exercise also helps us understand that stigma isn't something that "just happens" somewhere "out there." Just as we have all experienced stigma and rejection at some point, we have all also been a stigmatizer in some situation in our

lives. Understanding this, while at the same time understanding how painful it is to be stigmatized, can motivate us to create change.

- Often, we do not even realize that we are stigmatizing someone. We may have learned certain attitudes and behaviors from our parents, family, and friends, and never have taken time to reflect or to think about the judgments we make.
- Becoming aware of our own role in stigmatizing is the first step we can take towards change.
- It is not uncommon for painful memories and emotions to arise during an exercise like this. These memories and emotions are helpful, as they can deepen our understanding of stigma and of our role in the process of stigma. We are bringing up these experiences so we can build on them to address stigma in the health facility and in our own lives beyond work.

6. Shake it out:

- This exercise can bring up painful memories and emotions. After summarizing, the facilitator should invite participants to stand up and literally “shake off” any difficult emotional state they may find themselves in by shaking their arms and legs vigorously or swinging their arms in a circle from left to right, or any other movement that they feel will help them reset for the next exercise.

PANEL DISCUSSION WITH PEOPLE LIVING WITH HIV (NON-CORE)

Source: Adapted from Kidd R., S. Clay, M. Stockton, and L. Nyblade. 2015. *Facilitator's Training Guide for a Stigma-Free Health Facility.* Washington, DC: Futures Group, Health Policy Project.

Facilitators' Notes

This exercise provides an opportunity to help participants understand more deeply some of the issues people living with HIV face — both adults and adolescents/young people. It provides an opportunity for participants to ask questions to increase their understanding of the needs of people living with HIV (especially in relation to health). It provides an opportunity for members from the Network of People Living with HIV to tell their story and be listened to.

At least one panelist should be a young person to ensure that this perspective is included in the conversation. Ideally, two young people should be included (one male and one female). Kimara Peer Educators can invite community adherence treatment supporters (CATS), who are themselves young people, to participate in the panel. It is important that young people participating in the panel understand that, while they may come from an organization or youth group or be peer educators, their primary role on the panel will be to represent youth living with HIV rather than their organization or job.

If an adolescent or a young person is available to give testimony, selection criteria should be used to ensure that any young person invited to participate is comfortable and prepared. At a minimum, the young person should (1) have already publicly disclosed their HIV status, and (2) have previous experience with public speaking. Regardless of previous public speaking experience, a young person participating in the panel may need additional specific focused support from facilitators to ensure that the young person is comfortable participating as well as prepared for the panel.

It is important to ensure that the panelists are briefed about the exercise and aware of what is being asked of them (see "Preparation" below).

The facilitator at the panel should be able to act like a friendly TV chat show host and should ensure that the session is handled with sensitivity and that the questions asked are not too intrusive or inappropriate.

This exercise has worked well with groups of healthcare workers, and if facilitated well can result in real change of attitudes and greater understanding.

Objectives

By the end of this session, participants will have:

- Listened to firsthand experiences from members of key populations and people living with HIV (the panelists)
- Have a greater understanding of the challenges faced by groups who face stigma
- Have explored and discussed experiences of stigma in health facilities and ideas for making services more friendly and accessible

Time

- *1 hour*

Materials

- Questions from participants (share with panelists in advance)

Preparation

- Invite panelists from outside, e.g., members of the Network of People Living with HIV.
- Discuss the exercise with the panel in depth, ensuring that they are well briefed about what is being asked of them.
- Ask the participants in the audience to submit their questions in advance of the exercise (the night before or during a break) to allow time for facilitators to edit the questions. Explain that they can ask anything they would like to know to help them understand more about living with HIV.
- Read through the questions and combine any similar ones. Edit out any that are offensive, e.g., judgmental, related to personal sexual behavior, etc. Arrange questions in a way that will help panelists to warm up and discuss openly. For example, don't start with the most intense or difficult questions; rather, start with some more gentle questions to ease into the discussion. You can even give the panelists the questions in advance so that they can prepare.
- Arrange the room with a table at the front for the panel.

Steps

1. Introduce the exercise in the style of a TV or radio chat show (shows in which a host invites a few people to talk about a particular topic, often from their own life experiences). Introduce the panel (or let them introduce themselves) and explain that the aim is to really listen to the voices of the panel as they answer the questions that came from the audience.

2. Try to have about 10 questions. Allow the panel to discuss for up to an hour. If it feels appropriate, the audience can come in at the end with further questions. It can be useful to reflect together and share what participants have learned, either at the end of the exercise, or the following day.

   Examples of discussion questions:

   - *What did we learn from this panel discussion?*
   - *What key messages and information will you be taking away from this discussion?*

ANALYZING STIGMA IN HEALTH FACILITIES (CORE)

Source: Developed by 3C. TRIZ technique developed from www.liberatingstructures.com.

Facilitators' Notes

Participants are asked to imagine the worst possible scenario of a health facility that stigmatizes clients in every way possible. They then reflect on whether any of these things are happening in their own facility.

Objectives

- To explore the ways in which poor health services can create an environment of fueling stigma
- To explore ideas for advocating for change

Time

- *1 hour*

Materials

- Flipcharts (enough for each group to have at least one piece of flipchart paper)
- Markers or crayons

Preparation

- Arrange seats in small groups
- Give flipcharts and markers, crayons if possible, to each group
- Think of a group splitter

Steps

1. Introduce the exercise: This exercise helps us to think about what needs to change or be let go of if we are really going to tackle stigma in health facilities.

2. Divide participants into groups. Give each group a flipchart and crayons. Ask participants to discuss the following in their groups: *"What would the most stigmatizing health facility in the world look like?"*

   Assign half the groups to focus on stigma towards clients under 18 specifically. Have half of these groups focus on adolescents and young people living with HIV.

   Have groups use the flipchart to capture the discussion. Encourage them to be creative, have fun, and exaggerate ideas. They can write words randomly or draw pictures to capture their ideas.

3. Report back: Ask groups to stick up their flipcharts and to look at each other's. If you think they need to present or explain, allow a few minutes. Otherwise participants can ask groups questions to clarify what they see.

   Have prompt questions for the groups focusing on adolescents and young people that ask *"Is it different if the adolescent or young person is pregnant, has an STI, is perinatally infected or not?"*

4. Are we doing any of that? **("1-2-4")**: Use 1-2-4-all to identify whether there are practices that currently exist that are perpetuating HIV-related stigma and discrimination. Have participants reflect on the following question:

   "Are there things that we, as health workers, or that organizations are doing that are contributing to the stigma?"

   Participants think alone, then pair up and share ideas. Finally, a pair teams up with another pair to make a group of four and shares ideas. Invite participants to come to the large group and ask groups of four to share their key ideas in the large group.

5. Planning change (buzz and brainstorm): Ask participants to discuss the following with a partner close to them:

   What are some first steps that we can plan to start changing these practices?

   Take a point from each pair and ask participants to make a note of any actions they think they can put into practice when they return to the health facility.

6. Summarize using these takeaway points:

   - Imagining the worst scenario can help us identify the things that need changing in the current scenario.
   - Envisaging health services provided in a friendly and welcoming environment to both clients and staff does not have to be unrealistic or idealistic. It is something we can strive for as health workers and it would result in improving the whole service, including the morale of the staff and working conditions.

HOW STIGMA IMPACTS HUMAN RIGHTS (NON-CORE)

Source: Adapted from Kidd R., S. Clay, M. Stockton, and L. Nyblade. 2015. *Facilitator's Training Guide for a Stigma-Free Health Facility.* Washington, DC: Futures Group, Health Policy Project.

Facilitators' Notes

This exercise looks at how stigma can affect the rights of people living with HIV (both adults and adolescents/young people) and what might be done to address these human rights violations.

The exercise uses an initial brainstorm and case study discussions to help participants understand how rights can be violated and then to explore some possible realistic solutions.

Objectives

By the end of this session, health workers will have:

- Recognized that people living with HIV (both adults and adolescents/young people) have rights
- Identified different rights that could be violated because of stigma and discrimination
- Developed realistic strategies for protecting the rights of people living with HIV (both adults and adolescents/young people)

Time

- *1 hour*

Materials

- Photocopies of the case studies
- Flipcharts and markers

Preparation

- Arrange seats in small groups

Steps

1. What are human rights? (buzz groups): Ask pairs to discuss, with a partner, two questions:

    - *What are human rights?*
    - *Can you think of some examples of human rights that link to healthcare?*

2. Report back. Take an answer from each pair and record on a flipchart.

    Sample responses:

    - What are human rights?
        - Fundamental things that every person must have because they are human
        - To be treated fairly by everyone, regardless of who they are and what they do, regardless of gender, age, occupation, sexual orientation, etc.

    - Practices that protect human beings against ill treatment or violence
- Human rights linked to health:
    - Right to healthcare
    - Right to privacy
    - Right to make decisions

3. Case studies: Divide participants into small groups and give each group a case study. Ask them to read the case study together and discuss the questions.
4. Report back (1-2-4-all):
    - Ask participants to spend a few minutes alone, reflecting on what they have learned about rights and stigma.
    - Now ask them to pair with someone from a different group and to share some key points from their discussion.
    - Ask pairs to join with another pair and agree on two key learning points that they want to share with the group.
    - Listen and record points from each group of four.
5. Summarize, using points raised by the participants and adding from those below if not mentioned:
    - People living with HIV (both adults and adolescents/young people) have human rights like anyone else and should be able to access those rights, but their rights are often abused because of stigma and fear.
    - Raising awareness among health workers about people living with HIV (both adults and adolescents/young people) can help to protect clients' rights and ensure that they have access to healthcare. Developing a code of conduct to reduce stigma and make facilities more welcoming is one way of protecting human rights.
    - We need to ensure that people living with HIV and AIDS, adolescents, and young people are involved in making decisions about their lives.

Case Study A

Mrs. Makamba is 47 years old and the sister in charge at a health facility. She has four grown children and is well respected in her community. Mrs. Makamba is HIV-positive and gets antiretroviral drugs (ARVs) from a private health facility—she spends a lot of her salary on this treatment.

Recently, when she went to the private health facility to collect her monthly prescription, Mrs. Makamba met a colleague from her own facility. The colleague guessed that she was HIV-positive and told her that she was smart not to go to their clinic because the services were not as good. The next day the colleague told Mrs. Makamba's status to others at work. Mrs. Makamba is aware that there is a lot of gossip about her, especially among juniors.

Discussion

- Which rights have been violated?
- How well do you think Mrs. Makamba is able to stand up for her rights in the situation given?

- What could you do if you were Mrs. Makamba?
- As a health worker, what do you think should be done to protect Mrs. Makamba's rights?

Case Study B

Susan is 18 years old and living with HIV. She went to the clinic where she receives antiretroviral therapy (ART) to inquire about family planning. The provider scolded her and refused to give her contraception because of her age and HIV status. Susan felt ashamed and did not return to the clinic for ART.

Discussion

- Which rights have been violated?
- How well do you think Susan is able to stand up for her rights in the situation? What could you do if you were Susan?
- As a health worker, what do you think should be done to protect Susan's rights?

Case Study C

James 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 being promiscuous. That's where it all started." There was no post-test counseling, and the staff sent him away from the clinic without even treating him for the STI. He felt totally humiliated.

Discussion

- Which rights have been violated?
- How well do you think James is able to stand up for his rights in the situation? What could you do if you were James?
- As a health worker, what do you think should be done to protect James' rights?

Case Study D

Barbara, a senior nurse, dislikes people living with HIV—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 them with the same quality of care as her other clients. These clients don't say anything, but they do notice 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.

Discussion

- Which rights have been violated?
- Do you think that the clients living with HIV are able to stand up for their rights in the situation? What could you do if you were one of the clients?
- As a health worker, what do you think should be done to protect these clients' rights?

Case Study E

Asha is 16 years old, unmarried, and visibly pregnant. She has been noticing a rash and vaginal discharge and goes to the health facility for treatment. The receptionist looks up when she comes up, looks pointedly at her belly, then clucks her tongue disapprovingly, and tells her to go sit down and wait. Asha waits patiently, but notices that many patients who arrived after her are being called back to see the nurse. After waiting for several hours, Asha is the only client still waiting and is finally called back to see a nurse. The nurse begins by looking pointedly at her belly, shaking her head and asking "How did you get yourself into this situation? I know your family, and I'm sure they taught you better than this." When Asha tells the nurse about the rash and discharge, the nurse tells her it is an STI, and scolds her further, saying, "Well, it's no wonder, with the way you have been behaving. What did you expect?"

Discussion

- Which rights have been violated?
- Do you think that Asha is able to stand up for her rights in this situation? What could Asha do differently?
- As a health worker, what do you think should be done to protect Asha's rights?

EFFECTS OF STIGMA ON THE HIV EPIDEMIC (NON-CORE)

Source: Adapted from Kidd R., S. Clay, M. Stockton, and L. Nyblade. 2015. *Facilitator's Training Guide for a Stigma-Free Health Facility.* Washington, DC: Futures Group, Health Policy Project.

Facilitators' notes

This exercise helps participants understand how stigma toward people living with (or suspected to have) HIV (both adults and adolescents/young people) fuels the HIV epidemic.

To prepare for the exercise, review the case studies and make any changes needed 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, health workers will be able to:

- See how stigma or the fear of being stigmatized affects people living with HIV (both adults and adolescents/young people), including their ability to access health services and practice safe sex
- Understand how stigma impacts on the HIV epidemic

Time

- *45 minutes*

Materials

- Photocopies of the case studies

Preparation

- Copy case studies; prepare tables and chairs for group discussions

Steps

1. Introduce the exercise
2. Divide into groups: Use a group splitter to divide participants into four groups, and give each group a case study. Ask them to read the case study together and answer the questions included in the case study.
3. Report back and processing: Organize a report back. Ask each group to report on what they discussed. Ask:
    - *How does stigma result in the continuing spread of HIV?*
    - *What can we do to change this?*
4. Summarize: Summarize the main points that participants have made during the exercise. In giving your summary, you may use some of the following points if participants have not already mentioned them.

    Stigma or the fear of stigma stops people living with HIV from the following:

    - Accessing health services, for example, getting tested for HIV and STIs, getting information on how to avoid HIV transmission, and getting condoms

- Openly discussing their sexuality with health workers and providing complete information about their sexual practices
- Accessing treatment (antiretroviral therapy [ART] or treatment of opportunistic infections [OIs])
- Returning for care and treatment if they have stopped for any amount of time
- Using other services, for example, a pregnant woman living with HIV and not yet on ART is discouraged from making use of the prevention of mother-to-child transmission (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 and accessing treatment to reduce viral load

Case Study A

Aisha works as a secretary in the administration department of a teaching hospital. Several of her friends are nurses, and she often meets them in the wards. Aisha has been engaged to her fiancé for the last 18 months and hopes to get married soon.

Aisha recently received a letter from her cousin in the United States, telling her that he had tested HIV-positive. He is not sick and has reassured her that he will be fine, but he is telling his close family members and advising them to find out about their status as well.

Aisha asked one of her colleagues who works in the lab if she would test her, and the result came back positive for HIV. She was shocked, as she has had sex only with her fiancé and could not believe the result, but her colleague assured her that the test result had been confirmed, and she slowly realized that it must be true.

Aisha now feels that her world has come to an end—she cannot bring herself to tell her fiancé and feels she must break off her engagement. She has begged her friend not to tell anyone else. She does not know what to do.

Discussion

- What happened in the story?
- Why do you think Aisha feels she cannot tell her fiancé or colleagues about the test?
- What can help Aisha in this situation?
- What would you do if you were Aisha's friend who conducted the test?
- What would you do if Aisha presented to you for treatment and told you she has not disclosed to her fiancé?

Case Study B

Kwasi was a migrant laborer. He worked for 10 years in the capital city, returning three times a year to his village to see his wife Ana and his two sons. While he was away, his wife gave birth to a girl and another boy.

After a while Kwasi started to suffer from a constant fever. He went to a clinic where he tested HIV-positive. When his employer discovered he was HIV-positive, he was fired.

Kwasi found it difficult to get other work, so he returned to his village. When he arrived home, he told no one. He didn't want to face any more shame. Ana asked him what was wrong, but he kept silent.

He survived one more year before dying. During this year, one of his sons started to get sick, too. After he died, Ana went for an HIV test and learned that she was HIV-positive.

Discussion

- What happened in the story?
- Why did the employer fire Kwasi?
- What are the consequences of Kwasi not disclosing his HIV status to his wife?
- What can be done to change this?

Case Study C

Kofi, who was living with HIV, became sick and was referred to a healthcare facility. He was admitted for four days in the general ward. Alone and without relatives he received minimal care from the health workers, who knew his HIV status. With no one to take care of his laundry or change his soiled clothes and wash him, except for a friend who came whenever he had some free time, the nurses moved him to an isolation ward, a place no one bothers to visit. He died there four days later.

Discussion

- What happened in the story?
- Why didn't Kofi receive the care he needed at the healthcare facility?
- Does this happen in our health facility?
- What can be done to change this?

Case Study D

Deo is 16 years old. He has just learned his HIV status and begun ART. He and his girlfriend have been having sex, but have not been using condoms every time. Deo is worried that he may have passed on the virus to his girlfriend, and knows she needs to get tested for HIV, but he is afraid to tell her that he is HIV-positive. He is sure she will leave him, and worries that she might tell all of her friends and soon everyone would know he is living with HIV. Unsure what to do, he decides not to tell her, but to make sure he uses a condom whenever they have sex. He promises himself that if she starts looking sick, he will tell her right away and encourage her to get tested.

Discussion

- What happened in the story?
- Why didn't Deo tell his girlfriend about his HIV status?
- What are the consequences of Deo's not disclosing his HIV status to his girlfriend?
- What can be done to change this?
- Do health workers have any role to play?

FEARS ABOUT NONSEXUAL TRANSMISSION/QUANTITY, QUALITY, AND ROUTE OF ENTRY (QQR) (CORE)

Source: Adapted from Kidd, R., et al. *Understanding and Challenging HIV Stigma: Toolkit for Action (Module B).* 2007. Academy for Educational Development, International Center for Research on Women and International HIV/AIDS Alliance.

Facilitators' Notes

In this exercise, health workers identify specific forms of contact with people living with HIV that they fear might result in their becoming infected with the virus. Then they explain the reasons behind their fear. The trainer presents the QQR (quantity, quality, route of entry) tool, and the group can then explore whether the fear is real or not.

Fear of HIV transmission is one of the main drivers of stigma, and it is important to allow health workers, especially those with little training on HIV issues (e.g., clerical workers, guards) 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.

Objectives

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

- Name their fears in relation to specific forms of contact with people living with HIV, including both adults and adolescents/young people
- Explain why HIV cannot be transmitted through nonsexual casual contact

Time

- *1–2 hours*

Materials

- QQR written on a flipchart
- Copies of QQR handout
- Index cards
- Cards with Tanzania statistics written on them (see Step 5 below)
- Tape

Preparation

- Think of a group splitter
- Write "QQR" on a flipchart
- Make copies of QQR handout
- Hand out cards to each group

Steps

1. Divide into pairs and ask:

    - *"What fears do some health workers or people have about nonsexual casual contact with people living with HIV (both adults and adolescents/young people) at work or in other situations?"*

- Ask pairs to write single points on cards and tape on the wall. Examples of responses:
    - Accidents, e.g, getting HIV through an accidental needle prick
    - Contact with the blood of a HIV-positive woman while delivering her baby
    - Contact with the blood of an HIV-positive patient while suturing
    - Infecting other people through food cooked by a person living with HIV
    - Helping to lift an injured person living with HIV who has open sores on their body
    - Using a public toilet at a facility that has been used by a person living with HIV
    - Sharing dishes, utensils, etc., with a person living with HIV at a facility

2. **Ask participants to prioritize**

- *"Which of these fears should we focus on? Which are your biggest fears?"*

3. **Take one fear at a time and ask the pair that raised the fear to explain the reasons behind it.**

Examples of responses:

- Public toilet at the facility: A man living with HIV sits on a toilet, his sweat gets onto the seat, and the next person who sits on the seat comes into contact with the sweat and through this acquires HIV.
- Contact through food: A woman living with HIV cooks food for her family. While cooking, she cuts her finger, the blood gets into the food, and through eating the food her family acquires HIV.
- Carrying an injured person: While carrying an injured person, the carrier comes into contact with the person's blood from an open cut and acquires HIV.

4. Then respond to each of the statements using information drawn from the QQR fact sheet. Hand out and discuss the fact sheet.

Examples of facilitator responses to fears raised by participants:

- Public toilet at the facility: There is no HIV in sweat, so one cannot get HIV by coming into contact with sweat. There are only small quantities of HIV in urine or feces, and HIV does not survive once it is outside the body.
- 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.
- Carrying injured person: While carrying the injured person the carrier might come into contact with the person's blood and get HIV. There is a slight chance of this, but it is unlikely for the same reasons given above: HIV does not survive very long outside the body.
- Needle prick or contact with blood during delivery or suturing: All of these are possible ways that HIV might be transmitted. A needle prick would allow HIV to go directly into one's body, one of the conditions for getting HIV. The other forms of contact could lead to infection only if the health worker has an open cut. In this case,

HIV could attach itself to the mucous membrane. Other factors are involved for HIV transmission to occur as well. For example,

- o People with undetectable viral loads (<40 copies/ml) cannot transmit the virus
- o People treated with post-exposure prophylaxis within 72 hours of exposure have very little chance of contracting HIV

5. Write up the following points on cards (one per card):

    - 41.3 percent of health facility respondents said they routinely use double gloves when caring for people living with HIV
    - 17.2 percent say they avoid physical contact with anyone who is HIV-positive
    - 53.6 percent say they use gloves for all aspects of care with people living with HIV (even types of care that don’t require gloves)
    - 75.2 percent say they use extra precautions with people living with HIV that they don’t use with other patients
    - 53.5 percent say they are worried about getting HIV from touching the clothing or bedding of a person living with HIV

6. Hand out the cards: Hand out the cards to different participants. Tell the group that you want to share some findings from the baseline study in Tanzania. Ask those with cards to read them out.
7. Brief presentation on QQR
8. Wrap-up and processing. Give participants a few minutes to reflect on the tool and ask questions.

QQR Handout

There are three conditions, all of which need to be present, for HIV to be transmitted:

There must be enough QUANTITY of the virus in body fluids. HIV is found in large quantities of blood, semen, vaginal fluids, and breastmilk, so in these fluids there is a risk of transmission. HIV is found in small quantities in saliva, vomit, feces, and urine, but not at all in sweat or tears, so in these cases there is no risk.

There must be enough QUALITY: the virus must be STRONG ENOUGH. We now know that people living with HIV who have undetectable viral loads (<40 copies/ml) are not able to transmit the virus through sexual contact (see box). The risk of a person living with HIV whose viral load is undetectable passing the virus through other exposures is negligible. There has never been a documented case of HIV transmission from an HIV-positive child to another person. 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.

HIV must have a ROUTE OF ENTRY, enabling the virus to pass through the skin into the bloodstream of the uninfected person:

- Through a vein (e.g., a needle injection, which puts infected blood directly into the blood of the uninfected person)
- Through the lining of the anus or vagina (during sex), or through sores on the penis
- Our body is a closed system: healthy skin is an excellent barrier against HIV. HIV cannot pass through unbroken skin. Even if skin is broken, HIV cannot pass through it easily.

Post-exposure prophylaxis (PEP) refers to the use of antiretrovirals (ARVs) after potential exposure to HIV to prevent transmission of the virus. PEP must be started within 72 hours after possible exposure to HIV, but the sooner you start PEP, the better. PEP has little or no effect in preventing HIV infection if it is started later than 72 hours after HIV exposure. If you're prescribed PEP, you need to take it once or twice daily for 28 days depending on the regimen you are prescribed. PEP is highly effective. Following needlestick injuries, PEP reduces the average risk for HIV transmission after percutaneous exposure to 3 per 1,000 injuries (0.3 percent) and 1 per 1000 (0.1 percent) after mucocutaneous exposure. There is no risk of HIV transmission where intact skin is exposed to HIV-infected blood.

Undetectable Viral Loads and Viral Suppression

Undetectable viral load: ART can reduce a person's viral load to the point where it is so low (usually under 40 copies/ml depending on the test) that it cannot be detected by measurement. This is called "having an undetectable viral load."

Having an undetectable viral load:

- Prevents the sexual transmission of HIV
- Improves the health of a person living with HIV
- Does *not* fully clear the virus from the body or cure someone of HIV

Viral load suppression: When ART suppresses a person's viral load to 200 copies/ml or less, this is called being "virally suppressed." However, in Tanzania, viral suppression is currently defined as having a viral load of 1000 copies/ml or less.

Being "virally suppressed":

- Prevents the sexual transmission of HIV: studies show that when a person is virally suppressed they cannot transmit HIV to sexual partners
- Improves the health of a person living with HIV
- Does *not* fully clear the virus from the body or cure someone of HIV

Excellent adherence (taking ART as prescribed) is important to achieving and maintaining both an undetectable viral load and viral load suppression.

OVERCOMING FEAR WITH STANDARD PRECAUTIONS (CORE)

Source: Adapted from Kidd R., S. Clay, M. Stockton, and L. Nyblade. 2015. *Facilitator's Training Guide for a Stigma-Free Health Facility*. Washington, DC: Futures Group, Health Policy Project.

Facilitators' Notes

Standard precautions are practiced in many settings across the world.[4] They are used to protect health facility staff, clients, and visitors from exposure to blood-borne microorganisms. "Standard" means that these precautions should be applied with all clients, irrespective of their HIV status.

Standard precautions are one of the best methods to protect health facility staff. They provide a set of skills and procedures for health facility staff to protect themselves from infection and make the use of forced HIV testing as a means of protecting health facility staff unnecessary. Use of these precautions is also one way of ensuring that clients are not inappropriately treated—shunned or isolated, for instance—by separating real risks from those based on fear.

Standard precautions also protect clients from health facility staff living with HIV. Most assume that it is clients living with HIV and that health facility staff are HIV-negative, but this is not always the case. It is important to emphasize, however, that the risk of transmission from HIV-positive health facility staff to clients is very low, especially when proper standard precautions are followed.

This exercise is a short introduction to standard precautions.

Objectives

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

- Explain what "standard precautions" means
- Describe which standard precautions have been adopted in their own health facilities
- Understand how using standard precautions can help reduce stigma

Time

- 45 minutes

Materials

- Brainstorm questions written on flipcharts
- Questions for small group work written on flipcharts
- Copies of handout: What are standard precautions?

Preparation

- Prepare materials listed above

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[4] Readers may be more familiar with the term "universal precautions," which refers to the practice of avoiding contact with patients' bodily fluids by means of wearing nonporous articles such as medical gloves, goggles, and face shields. "Standard precautions," a more recent term, refers to a set of infection control practices used to prevent transmission of specific diseases (such as HIV) that can be acquired by contact with blood, body fluids, non-intact skin, and mucous membranes.

Steps

1. Introduce the exercise

2. What are standard precautions? (buzz and brainstorm): Ask participants to buzz and brainstorm the following questions while you record answers on the flipchart

    - *What is the meaning of "standard precautions"?*
    - *What is the difference between universal precautions and standard precautions?*

3. Small groups: Standard precautions practiced in health facilities: Divide participants into four groups and give each group a question to discuss:

    - *What are some standard precautions used in your facility?*
    - *What are the barriers to the use of standard precautions?*
    - *How does use of standard precautions help provide protection and overcome fear?*
    - *How does use of standard precautions help reduce stigma towards people living with HIV?*

4. Report back: Ask the groups to come back to the bigger group and take turns reporting their points on the flipchart

5. Summarize: Present and discuss the following points if they have not been mentioned:

    - "Standard precautions" has replaced the term "universal precautions." It is a broader term that includes not only safety for health facility staff, but for clients and visitors as well. It is also a broader term that covers safety from exposure not only to blood and bodily fluids, but also to other infections occurring in health facilities.
    - Standard precautions constitute a system for infection control used to make health facilities safe for health facility staff and clients. It involves the use of precautions designed to help minimize the risk of exposure to HIV and other infectious diseases by health facility staff and clients.
    - The first principle of standard precautions is that health facility staff apply them to ALL clients, regardless of whether 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 healthcare-associated infections, not just HIV.
    - The second principle is that standard precautions are designed to protect both health facility staff and clients from infection.
    - Standard precautions include the following:
        - Hand hygiene
        - Using barriers (surgical attire—including gloves, masks, etc.)
        - Aseptic techniques
        - Use and disposal of sharps
        - Instrument processing
        - Housekeeping and waste disposal
        - Respiratory hygiene and cough etiquette

BREAKING THE SEX ICE (CORE)

Source: Adapted from Kidd R., S. Clay, M. Stockton, and L. Nyblade. 2015. *Facilitator's Training Guide for a Stigma-Free Health Facility.* Washington, DC: Futures Group, Health Policy Project.

Facilitators' Notes

In our role as health workers, we often find it difficult to talk to our clients about sex. Talking about sex that is sometimes considered "immoral" or "abnormal" may increase our discomfort. Sometimes, health workers feel particularly uncomfortable speaking with adolescents and young people about topics related to sexual activity.

Our views as health workers about what is "appropriate" sex may lead to a lack of acceptance of people who do not conform to our own or society's views about what is proper sexual behavior. Our attitudes and beliefs about sex can lead to stigma against adults and young people living with HIV. We need to try to talk more openly about sex, especially if we are working in services linked to HIV and sexual health, so that our clients can ask questions freely and receive the right information to enable them to lead healthy lives.

There are two exercises to choose from: one is a secret survey; the other involves participants working in gender groups and asking questions about sex.

Objectives

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

- Explore their own feelings about talking about sex, with the aim of being able to talk more openly with clients to ensure they receive the information they need to live healthy lives
- Recognize that the taboo associated with talking about sex often links to stigma
- Acknowledge that the type of sex we have and at what age we choose to have it is a private matter and only one element of our life

Time

- *45 minutes*

Option 1: Secret Sex Survey

Materials

- Small slips of paper (10 for each participant). If it is a mixed group, use one color or shape of paper for women and a different one for men.
- Basket for collecting slips of paper

Preparation

- Move chairs apart so that no one is sitting too close to another participant

Steps

1. Introduce the exercise

   Note: 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 collate the answer slips and quickly record the results on a flipchart.

2. Explain that you are doing a survey about sex and that the survey is secret and anonymous. Tell participants, *"No one will know how you respond."* Tell participants that all they need for this exercise is a pen.

3. Hand out 10 slips of paper to each participant (one color for women, another for men).

4. Ask each question and tell participants to record their answers on a slip of paper with a YES or NO and fold it up. Collect the slips in a bowl or basket after each question and record the results on a flipchart (see below). Do not present these results until all the questions have been asked.

5. Present and discuss the results (one by one if you have time). You can allow a few comments for each question, e.g., *Is this what you would expect? How do you feel about these answers?*

6. Processing questions:

   - *How did you feel answering the questions?*
   - *What do we learn from the exercise?*

Questions

1. Can you talk openly and freely about sex to close friends?
2. Do you enjoy sex?
3. Do you enjoy having sex with multiple partners?
4. Did you use a condom the last time you had sex?
5. Have you ever taken an HIV test?
6. Have you ever had an STI?
7. Did you enjoy having sex as a young person?
8. Do you worry about pregnancy during sex?
9. Do you have fantasies about different kinds of sex?
10. Do you have dreams or fantasies about sex?

Example of results table

Q. Do you enjoy sex?	Yes	No
Women	11	2
Men	10	1

Option 2: Questions You Always Wanted to Ask About Sex

Materials

- Small slips of paper (10 for each participant)
- Two bags/baskets (or other type of container) for collecting slips of paper
- Flipcharts and markers for each group

Steps

1. Introduce the exercise

2. Divide into two groups (a men's group and a women's group). Facilitators should be aware that there may be individuals in the training group who don't feel comfortable identifying as a "man" or "woman," or who identify with a gender different from their biological sex. Facilitators should ask participants to join the group that most closely aligns with their gender identity.

3. Give a slip of paper to each person and ask them to write a question about sex for another gender. For example, for the women say, *"Write a question that you have always wanted to ask men about sex."* For the men say, *"Write a question you have always wanted to ask women about sex."* Emphasize that the questions are confidential and anonymous.

4. Collect the questions in a basket from each group and then hand the women's questions to the men and vice versa.

5. Ask each group to discuss the questions and write answers on a flipchart.

6. Ask the men's group and then the women's group to present their answers.

7. Processing: Ask, *"What did we learn from this exercise?"*

THE BLAME GAME: THINGS PEOPLE SAY (CORE)

Source: Adapted from Kidd R., S. Clay, M. Stockton, and L. Nyblade. 2015. *Facilitator's Training Guide for a Stigma-Free Health Facility.* Washington, DC: Futures Group, Health Policy Project.

Facilitators' Notes

In this exercise participants identify words used to stigmatize people living with HIV (both adults and adolescents/young people), as well as youth generally. The language can be very strong, so people need to understand WHY they are being asked to make lists of stigmatizing words for people living with HIV.

This exercise is called "Things people say" and allows participants to express stigmatizing words while attributing them to "people." While some words are those commonly used by the community, other words are those actually used by participants.

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

Extra tips for facilitators:

- In debriefing this exercise focus on "how participants feel about these names," rather than the words themselves. This helps to avoid embarrassed laughter that can often occur. The whole point of this exercise is to help participants recognize how these words can hurt.
- Challenge the laughter. Often participants will laugh out of embarrassment. This is a good opportunity to ask, "How do you feel about the laughter?"
- The rotational brainstorm is fun, but the real learning comes in the debriefing, so make sure you allow enough time and energy for this.
- You need to explore your own feelings about these issues before trying to facilitate this discussion with others.

Objectives

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

- Identify words used to stigmatize people living with HIV (both adults and adolescents/young people), as well as youth in general
- Recognize that these words hurt
- Understand the link between language and stigma

Time

- *1 hour*

Materials

- Flipcharts labeled as below:
    - Things people say about people who take ARVs
    - Things people say about young people living with HIV
    - Things people say about teenage girls who get pregnant
    - Things people say about single mothers
    - Things people say about young people

    - Things people say about mothers whose young daughters have become pregnant
- Markers
- Tape
- Roles based on the flipchart groups above written out on slips of paper and placed in a hat or basket for participants to select at random

Preparation

- Tape three flipchart sheets on different walls, each with a title: (1) People living with HIV (adults), (2) Adolescents and young people living with HIV, and (3) Youth in general.

Steps

1. Allocate roles to each person based on the groups listed on the flipcharts: adults living with HIV, a young person (under 18) living with HIV who has been on treatment since they were 8 years old, a 16-year-old living with HIV who has just started ART, adults living with HIV, youth in general, unmarried adult women with children, unmarried pregnant adolescents. There should be an equal number of people in each group.

   Note: One quick way to get participants into organized for this exercise is to have roles written out on slips of paper. Ask participants to pick pieces of paper out of a hat. That way everyone will know who they are (sometimes people forget).

2. Rotational brainstorm: 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 the said group. After two minutes, shout, *"Change!"* or sing a song and ask groups to rotate in a clockwise direction to the next sheet, read the points already on the list, and add new points. Continue until groups have contributed to all flipcharts and end up back at their original list.

3. Report back: Bring everyone together into a large circle. Ask one person from each group to read out the names on their flipchart, starting with *"I am a ....* (e.g., young person living with HIV) *and this is what you say about me ...."* (This is an important step).

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

   - How do you feel about these names?
   - Why do we use such hurtful language?
   - What does this show us about the link between language and stigma?
   - How does language like this affect the services we officer in our health facility?

5. Summarize:

   - The words used in this exercise show that when we stigmatize, we stop dealing with people as human beings. Using shaming words gives us a feeling of superiority over others.
   - Stigmatizing words are very strong and insulting. They have tremendous power to hurt, humiliate, and destroy people's self-esteem.

- Layers of stigma: People affected by HIV stigma are often those who are already stigmatized, e.g., women and young people. They do not have much power to challenge stigma.
- There is a strong link between stigma and gender. We have seen the stigma faced by girls and women if they do not fit into the usual expectations placed on them by society.

FORMS, EFFECTS, AND CAUSES OF HIV-RELATED STIGMA—PROBLEM TREE (NON-CORE)

Source: Adapted from Kidd R., S. Clay, M. Stockton, and L. Nyblade. 2015. *Facilitator's Training Guide for a Stigma-Free Health Facility.* Washington, DC: Futures Group, Health Policy Project.

Facilitators' Notes

This exercise may be performed as a summary session of all that has happened from start. It can also be performed as a stand-alone activity.

It reviews forms and effects and looks at the causes of HIV-related stigma on one page. This exercise uses the metaphor of a tree. The "stigma problem tree" is a method that describes the forms, effects, and causes of stigma by comparing them to the trunk (forms of stigma), branches (effects of stigma), and the roots (rooted causes or drivers of stigma) of a tree. Participants write each form, effect, or cause on a card and tape the card at the appropriate level of a tree diagram.

Explain the technique before dividing into groups.

Note: The placement of answers is not hard and fast. Things can go in different places.

Objectives

By the end of this exercise, participants will:

- Describe different forms of stigma and how stigma affects people
- Identify some of the root causes or drivers of stigma
- Summarize actions that can be taken to reduce stigma and discrimination that have been identified throughout the training

Time

- *2 hours*

Materials

- Tree diagram and example cards (see below)
- Cards and markers for participants
- Tape

Preparation

- Draw a large tree diagram on flipchart paper with the "Effects," "Forms" and "Causes" labeled at appropriate levels (see below).
- Write one example of the type of response expected at each level on a card and tape the cards at their respective levels.

Location	Part of tree	Feature	Examples
Top	Branches	EFFECTS	Loneliness
Middle	Trunk	FORMS	Name calling
Bottom	Roots	CAUSES	Lack of knowledge

Steps

1. Card storming: Divide into pairs or in threes. Hand out cards and markers. Ask pairs to write points on forms, effects, and causes – one point per card – and then tape them at the appropriate level of the tree. Remind them to consider HIV stigma as it affects various groups: people living with HIV, young people and adolescents, families, and healthcare providers.

2. Cluster common points and eliminate repetition.

3. EFFECTS: Divide into small groups and ask each group to analyze the effects of stigma on a specific group (e.g., men, women, children, young people and adolescents, etc.)

   Group A: If the person stigmatized is a woman, what are the effects on her?

   Group B: If the person stigmatized is a man, what are the effects on him?

   Group C: If the person stigmatized is an adolescent or young adult, what are the effects on them?

   Group D: If the entire family is stigmatized, what are the effects on them?

   Group E: If healthcare providers are stigmatized, what are the effects on them?

   Group F: What is the effect of HIV stigma on the HIV epidemic?

4. CAUSES (drivers): Continue the same process in the same groups. Ask groups to analyze the causes (drivers) of stigma for their group (e.g., women, men, young people and adolescents, etc.) and identify possible solutions.

Examples of responses

Effects of stigma

- Personal: Shame. Isolation. Withdrawal. Loneliness. Loss of self-esteem. Feel unproductive. Self-blame. Loss of hope. Stress. Alcoholism. Depression. Suicide. Death. Anger. Violence. Kicked out of home/health facility. Fired from work or untimely resignation. Forced to leave community/workplace. Drop out of treatment (lost to follow-up). Poor adherence to medication. Fear of disclosure. Avoid getting tested and using AIDS services.
- Family: Family quarrels, mutual blame, and conflicts. Family members leave/get kicked out of home. Divorce or separation.
- Community: Loss of productivity as people living with HIV are fired from work or forced to leave the community.
- Epidemic: Spread of infection. Fear makes people refuse to have HIV test – they prefer not to know.

Forms of stigma

- Shame and blame: Name calling. Finger pointing. Belittling. Scolding. Spreading rumors. Gossiping.
- Isolation: Rejection. Neglect. Separation of blankets, utensils, etc. Hiding in back room.

- Self-stigma: Blaming and isolating one-self. Giving up on one-self. Withdrawal from activities.
- Stigma by association: Family and friends of people living with HIV and health staff are also stigmatized.

Causes/drivers of stigma

- Moral judgments: View that people living with HIV are sinners, promiscuous. Breaking social norms. People's beliefs about pollution, contagion, impurity, sexuality, gender identity, sex work.
- Fear and ignorance: Lack of knowledge and misconceptions about HIV transmission leads to fear about getting HIV through casual contact – people isolate and reject others.
- Fear of infection, fear of the unknown, fear of death.
- Gender: Gender often plays a role in stigma. Women and girls tend to be more stigmatized than men and boys. For example, a young woman who is believed to be sexually active may be seen as immoral or "spoiled" and be punished accordingly, but a young man engaging in the same behavior may be judged less harshly as he is "just doing what young men do."
- Poverty: Economic position often plays a role in position. Poor people are often more stigmatized than rich people.
- Secondary stigma: Women, mobile workers (e.g., sex workers, truckers, migrant laborers), and unmarried pregnant girls are already stigmatized, so they get easily blamed.
- Appearance: The physical appearance of people living with HIV, e.g., thinness or skin rashes, is used as a basis for stigmatizing.
- Media images: Images of horrible death in the media make people scared of people living with HIV.

CHALLENGE THE STIGMA—AND BE THE CHANGE! (NON-CORE)

Source: Adapted from Kidd R., S. Clay, M. Stockton, and L. Nyblade. 2015. *Facilitator's Training Guide for a Stigma-Free Health Facility.* Washington, DC: Futures Group, Health Policy Project, which drew on "Understanding and Challenging Stigma Towards Men Who Have Sex with Men: Toolkit for Action (Cambodia)—Exercise E3."

Facilitators' Notes

The aim of this exercise is to explore how we can challenge everyday stigma, especially in our place of work.

Participants learn how to be assertive and then practice this skill in a series of paired role-plays. The practice helps participants to see that acting against stigma whenever and wherever it happens is one of the steps we can all take to begin to take action and bring about change.

Objectives

By the end of this session, participants will:

- Have practiced using assertiveness skills to challenge stigma
- Understood the importance of speaking out

Time

- *1 hour*

Materials

- Flipchart with definition of assertiveness
- Flipchart for recording responses
- Markers
- Tape

Preparation

- Write definition of assertiveness on a flipchart

Steps

1. **Introduction:** Explain that the session is aimed at practicing how to challenge stigma when it occurs in everyday settings.

2. **Buzz and brainstorm***:* In pairs ask participants what they understand by the term *assertiveness*. Record points on a flipchart. After you have enough responses share the assertiveness definition and emphasis on points.

Definition of Assertiveness

Saying what you think, feel, and want in a clear, honest, and confident way that is good for you and good for others. It does not involve showing anger or being aggressive and can come from a place of compassion.

Tips about being assertive:

- When addressing someone else's behavior state only the facts.
- Say *I* feel, think, or would like.
- Don't apologize 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

  Example: *"When you say I am promiscuous and that is why I am HIV-positive, I feel discounted and judged. I want you to stop saying these things about me."*

3. Paired role-playing (round 1): Explain that we will now practice how to challenge stigma and discrimination in different common work situations, using assertiveness. Ask participants to stand in two lines facing each other and to pair up with the person opposite them. Have participants make a role play about the following situation:

   You are both health workers. Health worker A (the stigmatizer) complains to health worker B (the challenger) about a client, saying that the client (who is assumed to be living with HIV) is disgusting and immoral. Health worker B should challenge that form of stigma by responding to health worker A using assertiveness skills. Play!

4. Paired role-playing (different scenarios): After two minutes, ask participants to stay with the same partners and do another role-play using the additional scenarios below. For each new scenario, partners should take turns playing the stigmatizer and challenger roles.

   Note: Facilitators can decide how many rounds to play based on the time available (leaving 30 minutes for debriefing, processing, and summarizing).

   Additional scenario 1: Health worker A (the stigmatizer) is observed by health worker B (the challenger) using double gloves as they care for a client living with HIV. Health worker B should challenge that form of stigma.

   Additional scenario 2: Health worker B (challenger) notices that an adolescent girl (age 16) who is unmarried and pregnant has been sitting in the waiting room for several hours. Health worker A (stigmatizer) is working at the front desk and responsible for calling clients back to be seen.

   Additional scenario 3: Health worker A (challenger) knows their colleague Rehema is living with HIV and notices that health worker B (stigmatizer) has been avoiding working with Rehema. Health worker A has also heard health worker B complaining to *other colleagues about Rehema, saying she is dangerous to staff and clients and shouldn't be allowed to keep working at the health facility.*

Additional scenario 4: Health worker A (challenger) hears health worker B (stigmatizer) telling a female client who is living with HIV that she should not have children.

5. Role-play debrief: 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 the challenger do? What approach did the challenger use? Did it work? What other approaches might be used?"*

   After each performance, ask other participants if they have a better or different way of challenging the stigmatizer 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?"* (Answers might include, e.g., good arguments, strong voice level, body language, confidence, etc.)

6. Processing: Ask, *"What have we learned about the best ways to challenge stigma?"*

7. Summarize:

   - We can all challenge stigma on an individual level using an assertive approach.
   - Professional policies and codes of conduct in health facilities should be implemented alongside individual action against stigma and discrimination to protect clients. Senior managers should oversee this process.
   - The most powerful responses to people who are stigmatizing are those that make the stigmatizer stop and think rather than feeling attacked and becoming defensive. Many of us are not aware that some of the things we say or do are stigmatizing.

CONFIDENTIALITY AND STIGMA (CORE)

Source: Adapted from Clay, S., C. Chiiya, M. Chonta, C. Stewart, and L. Nyblade. Unpublished. *Building Safe and Friendly Health Services for Ghana: Facilitator's Guide for Stigma and Discrimination-Reduction*. Washington, DC: Palladium, Health Policy Plus.

Facilitators' Notes

Confidentiality is an important topic to discuss in the context of stigma in health facilities for a number of reasons. Some clients are afraid to use services because they fear that there is a lack of confidentiality. If they take an HIV test, will their results be confidential? There can be also a tension between confidentiality and stigma: sometimes health workers emphasize confidentiality so much that someone who is living with HIV may feel it is wrong to be open about their status. One example of this is that many young people who were born with HIV have been told not to disclose their status to anyone, sometimes to protect them (or their families) from stigma, and so they feel unable to talk to others, even if they want to ask questions or have concerns.

This exercise involves a simple game where participants write down private information they do not want anyone else to know and then hand it to another participant. It is very important to ask everyone to promise not to read someone else's paper. The discussion or processing after the game is where the issues will really emerge.

Objectives

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

- Understand an individual's right to confidentiality
- Explain the link between confidentiality, power and stigma
- Acknowledge the potential effects of a health worker violating confidentiality

Time

- *1 hour*

Materials

- Flipcharts labeled with small group questions
- Slips of paper for participants

Preparation

- Write flipchart question
- Prepare small slips of paper for each participant
- Write small group questions as headings on different flipcharts
- Handouts

Steps

1. Group activity: Trust game

   Hand out a slip of paper to everyone. Ask participants to think of a piece of private information they would not want anyone else to know. Ask them to write the private information on a piece of paper, fold it up, and not show it to anyone. Now ask each person to pass their paper to the person on the left. Stress that no one should open the papers.

2. Ask participants:
    - *How does it feel to have your private information in someone else's hands?*
    - *How does it feel to have someone else's private information in your hands?*
3. Now ask the papers to be returned and participants can destroy their papers.
4. Processing. Ask:
    - *What does this tell us about confidentiality?*
    - *What is the link between confidentiality and stigma?*
5. Group work: Break into small groups and give each group a question:
    - *What happens when someone breaks confidentiality in the health facility?*
    - *How is confidentiality monitored in our facility?*
    - *What measures can be taken to ensure that confidentiality is maintained in our health facility?*
    - *How can we assure our clients that we maintain confidentiality?*
    - *Should confidentiality for clients under 18 be different from that for adults?*
    - *Are the rules related to confidentiality for clients under the age of 18 clear? If not, what do we feel confused about?*
    - *How is* confidentiality for clients under 18 handled at our facility?
    - *What measures can be taken to improve confidentiality for clients under 18?*
6. Report back: Ask each group to present their answers and allow time for discussion
7. Summarize:
    - Secrecy, privacy, and confidentiality are often viewed as the same thing, but they are different.
        - *Secrecy* is information known to you alone; it is not shared and is often associated with bad behavior or something that is not good and should not be shared. If your HIV status were a "secret," it would mean that you would not tell anyone and that it is a something bad.
        - *Private* information is a general term used when information is private between two friends, a few people, or family members, and does not carry a negative tone or implication of judgment or shame.
        - *Confidentiality* is information that is managed by the person who owns the information. It is shared with others on a controlled basis. You decide whom you are willing to share this information with, expecting that access to this information is 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 work in a health facility. Whoever you are, trust must be built and maintained.
- Shared confidentiality is when information is shared within an institution for the benefit of the patient. For example, a doctor may need to know you are taking ARVS if they are prescribing medicine for you. Information is not shared with anyone outside of the health facility.
- Emphasize that even if a young person is living at home, if they are over 18 years of age, their health information is confidential and may not be shared with parents or guardians.
- Include confidentiality for adolescents and young people (referring to ART guidelines as needed).

8. 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.

STIGMA-FREE SERVICES FOR ADOLESCENTS AND YOUNG PEOPLE (CORE)

Facilitators' Notes

This exercise gives participants an opportunity to dive more deeply into the issue of stigma faced by adolescents and young people accessing HIV and other sexual and reproductive health services. The exercise begins with a warm-up, a reflection designed to help participants get in touch with their younger selves. During the group work and plenary discussion, participants reflect on what is going well in their facility for young people, and what could be done better. These ideas are captured and will feed into the writing of the code of practice and action.

Objectives

- Identify some ways that adolescents and young people seeking HIV and other sexual and reproductive health services are being stigmatized
- Identify ways that this stigma can be addressed (to include in writing the code of practice and action plan)

Time

- *45 minutes—1 hour*

Materials

- Flipcharts
- Markers
- Tape

Steps

1. Warm-**up: Reflection "I remember when…"**

   Ask participants to close their eyes and think back to when they were young, around 16 years old. Ask them to remember something happy, such as a vivid experience that stands out from that time, to help them get in touch with this younger version of themselves. For some participants, this may not be very long ago; for others it may be a very distant memory.

   Ask them to keep their eyes closed and to start a silent conversation with this younger version of themselves. Have them pose the questions below to this younger self. This will be a private reflection that will not be shared with the group:

   - *Do you feel comfortable talking to adults?*
   - *How are you feeling about sex? Have you started having sex?*
   - *Whom do you talk to about sex? How would you feel about talking to a health worker at the local clinic or hospital about sex?*
   - *What positive or supportive interactions have you had with health workers?*
   - *Have you had any experiences at a clinic or hospital that made you feel criticized, ashamed, or uncomfortable?*
   - *What is one thing you would worry about in talking to a health worker about sex?*

- *What is one thing a health worker could say or do to make you feel more comfortable and willing to talk openly about your sexual health concerns?*
- *Imagine as this younger self that you are given an HIV-positive diagnosis. How would this affect your feelings about sex and about discussing sex or sexual health concerns with adults, including health workers?*

Ask participants to open their eyes and jot down a few notes for themselves about this reflection if they want to. These will be kept private.

2. Small group work: Part 1—comfort/discomfort: Divide participants into small groups of three to five. Give each group two pieces of flipchart paper and some markers. On the first flipchart, have them divide the sheet into two parts. Title the left column "Comfortable with" and the right column "Uncomfortable, concerned, or confused about." Ask them to discuss the following questions with their groups and jot down key points in the appropriate column:

   - *How comfortable do we feel talking with young clients (15–24) about sex and providing HIV and other sexual and reproductive health services to these clients?*
   - *What do we feel uncomfortable, concerned, unclear or confused about serving young clients (15–24)?*

3. Small group work: Part 2—Doing well/ways to improve: Staying in the same groups, have participants label the second flipchart, with the left column "Doing Well" and the right "Ways to Improve." Discuss the following questions, drawing on all that they have learned about stigma throughout the workshop, and their own experiences as health providers (and as young people):

   - *What are some ways your health facility is doing well providing services to young clients (ages 15–24)?*
   - *What are some things that you see happening at the facility that could be stigmatizing towards youth?*
   - *What could you as health workers do better? What could the facility do better?*
   - *What would be needed to make this happen?*

4. Sharing in plenary: Invite participants to share some highlights from their conversation. Go section by section. Start with comfort/discomfort and ask for some highlights from participants on this issue. Then go into the doing well/ways to improve responses and ask for highlights on this issue.

5. Processing:

   - *What did we learn about stigma faced by adolescents and young people in our facility?*
   - *What is important to take away from this conversation as we move into writing the code of practice and action plan?*

6. *Summarize:*

   Summarize, drawing on key points from the conversation. You may want to have a "parking lot" where questions that can't be addressed or answered immediately are captured for further investigation/exploration.

WRITING A CODE OF PRACTICE AND ACTION PLAN (CORE)

Source: Adapted from Kidd R., S. Clay, M. Stockton, and L. Nyblade. 2015. *Facilitator's Training Guide for a Stigma-Free Health Facility.* Washington, DC: Futures Group, Health Policy Project.

Facilitators' Notes

A code of practice could be developed on a gradual basis over the training or at the end of the workshop as a single activity. This exercise describes how to develop a code of practice and action plan as a single activity at the end of the workshop or as a separate workshop.

To integrate this stand-alone activity throughout the training, facilitators can put up a flipchart at the beginning of the workshop labeled "Code of Practice." As issues come up throughout the workshop that participants think are important to address in the code of practice, they should be added to this flipchart.

Facilitators should ensure that the code of practice and action plan make specific mention of providing stigma-free services for adolescents and young people living with HIV.

Objectives

By the end of this session, participants will have:

- Described what a stigma free health facility would look like in general, and for adolescents and young people in particular (code of practice)
- Identified actions by health workers and managers to create a stigma-free facility in general, including specific reference to a stigma-free environment for adolescents and young people (action plan)

Time

- *2 hours*

Materials

- Cards for participants
- Flipchart for each group
- Tape
- Markers

Steps

1. Existing forms of stigma and discrimination in health facilities (card storm): Divide into pairs and give each pair a marker and several cards. Ask them to write one point per card. "*What are some of the key forms of stigma that we have identified during the training that happen in our own health facilities? What are some of the forms we have identified specifically towards adolescents and young people?* Stick cards on wall and ask a participant to read through them.

2. Review participant contributions from flipchart: Facilitator shares what participants have put up on the "code of practice/action plan" flipchart that has been up since the beginning.

3. Code of practice for a stigma free health facility (Group work): Divide into groups (from the same department or facility or from similar jobs).

4. Give each group two flipcharts and ask them to write:

   On the first: *"A Stigma- free health facility is one in which ...,"* and ask groups to make a list of practices to create a stigma-free health facility.

   On the second: *"A stigma free health facility for adolescents and young people is one in which...."* Ask groups to write down anything that needs to be included/done to make the facility stigma free for adolescents and young people.

   Give them one or two examples to help them get started. If necessary ask the question, *What if your sister, brother, or child were a person living with HIV; how would you like them to be treated in the health facility?*

5. Report back: Ask the groups to report on an alternating basis – one point per group. As groups report discuss points and agree on any changes or additions.

   Sample responses: "A stigma free health facility is one in which...":

   - Clients are treated equally and with respect and dignity, regardless of who they are
   - All clients receive the same high-quality medical care without discrimination, regardless of their HIV status, age, gender, or other characteristics
   - Medical information of clients is treated confidentially
   - Health services are provided free of judgmental attitudes
   - Health workers speak to clients in a respectful and dignified manner
   - Health workers listen to clients with care and empathy, and without judgment
   - Clients are able to give their informed consent to the services available to them
   - Client's circumstances (e.g., their criminalized existence) are not a barrier to their accessing health care and treatment
   - Clients' complaints about stigma and discrimination are dealt with effectively
   - Standard precautions are used with all clients

6. Action plan (groups): Ask the same groups to do the following:

   - *Make a list of three changes you will do to create a stigma-free health facility after the training*
   - *Make a list of three things you would like the managers to do to create a stigma-free health facility.*

APPENDIX 1: PICTURE TOOLS

Source: Kidd, R. and S. Clay. 2003. *Understanding and Challenging Stigma: Toolkit for Action—Trainer's Guide*. ICRW and Change Project. Illustrations by Petra Rohr-Rouendaal.

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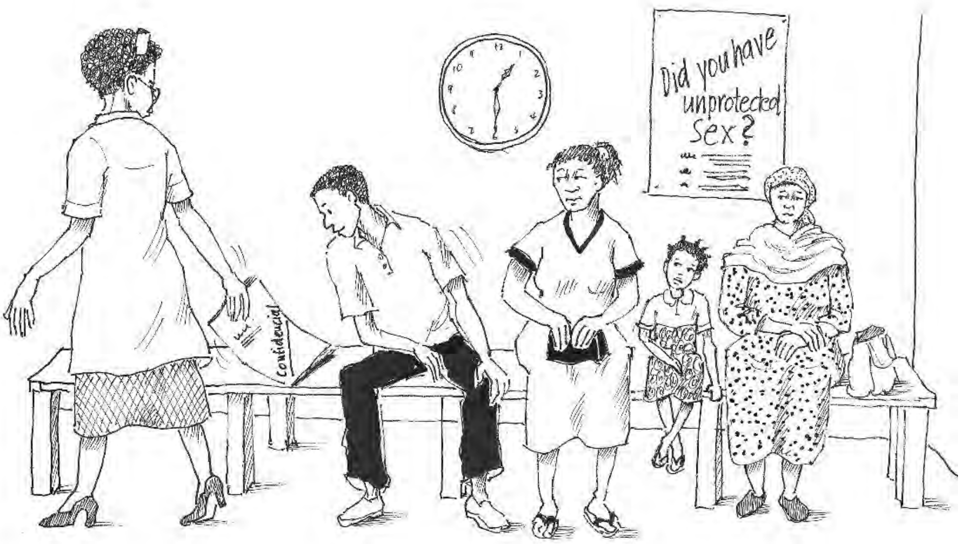

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Health Care is a Right not a Privilege

4


CHILD HEALTH WEEK
You don't get HIV from hugging someone
Doctor
Use Condoms every time you have sex!

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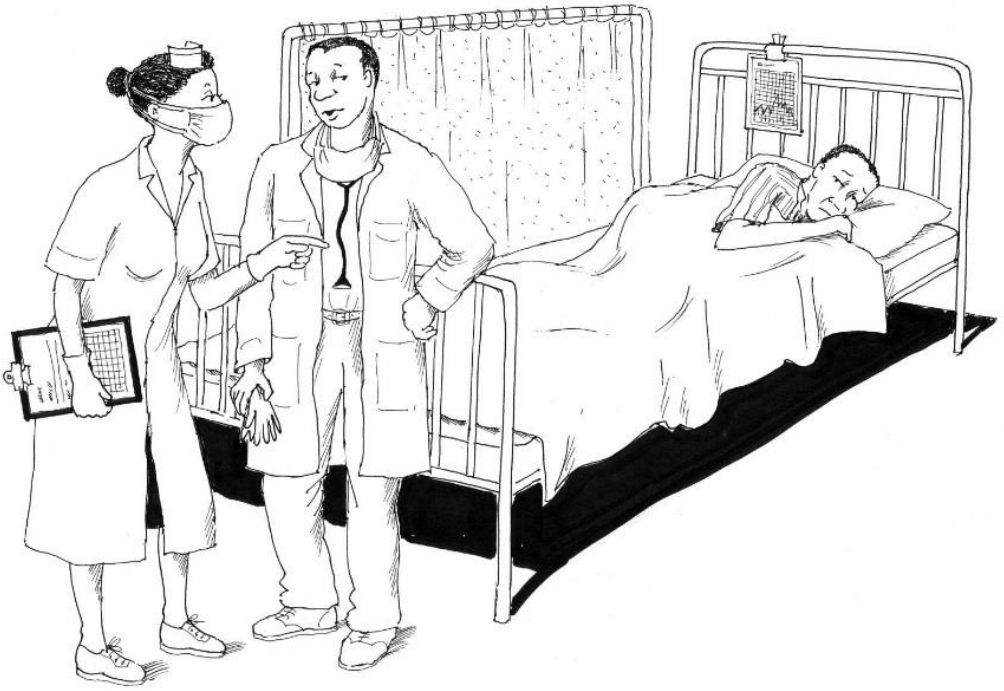

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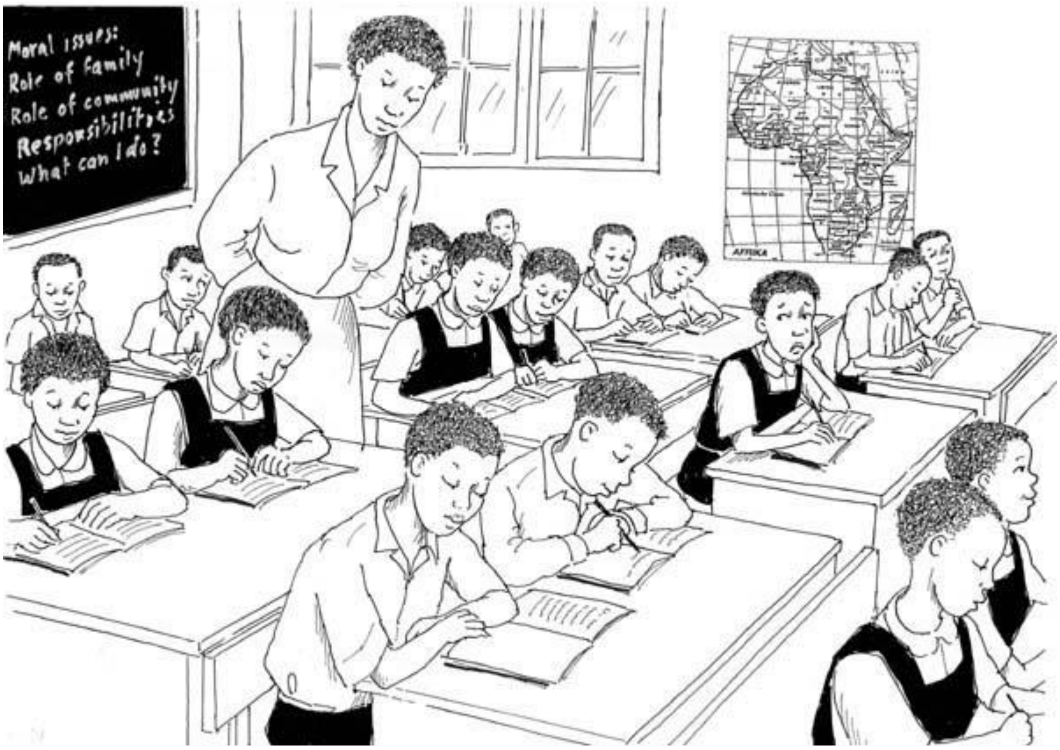
Moral issues:
Role of family
Role of community
Responsibilities
What can I do?
AFRICA

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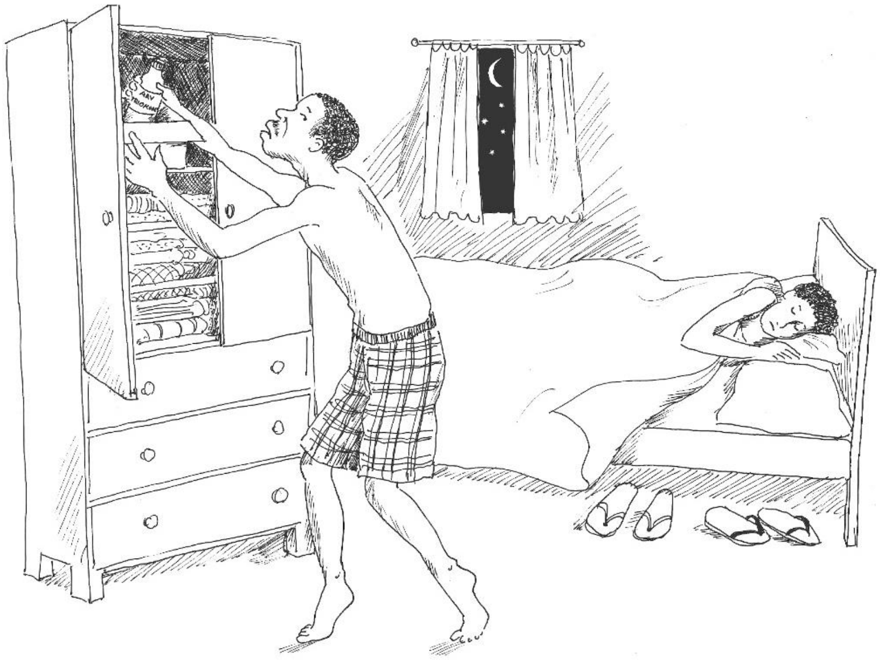

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APPENDIX 2: TIMETABLE TEMPLATE FOR TRAINING

Time	Day 1	Day 2
09:00–10:30	Opening session (Welcome, warm-up, introductions, objectives) Naming stigma through pictures	
10:30–10:45	Break	Break
10:45–1:00		
1:00–2:00	Lunch	Lunch
2:00–3:15		
3.15–3.30	Break	Break
3.30–4.30		Developing a code of practice Evaluation

Include 10–11 stigma exercises, including all the core exercises.

APPENDIX 3: POST-TRAINING DEBRIEF

It is important that facilitators come together as a group at the end of a training session to debrief and reflect on how the session went and make plans for next steps or any adjustments needed. Below is a checklist that can be used for this post-training debrief.

These are only prompts, and can be added or changed to suit the needs of the training team.

- What went well during today's session?
    - One way build confidence and unity among the training team is to have each trainer share one or two things they felt their co-facilitators did well.
- What can be improved?
- Did participants seem clear about all the topics discussed? Were there any topics or issues that participants seemed confused about that may need to be addressed in future training sessions?
    - If so, how will these be incorporated into the next day/session?
- Emotional state of the training team:
    - Stigma-reduction trainings can be emotionally challenging, not only for participants, but also for facilitators. It's good to check in with each other during the debrief about the team is doing emotionally. Does anyone need additional support? What will trainers do to care for themselves in preparation for the next day/session, or to continue supporting each other after the session?
- Plan for the next day:
    - Any changes of timing or content needed?
    - Any logistical issues to address?
- Quick "round" to close
    - Have each member of the team summarize one positive point/something they liked about how the session/day went, and one thing they want to focus on or improve during the next day/session.

For more information, contact:

Health Policy Plus
Palladium
1331 Pennsylvania Ave NW, Suite 600
Washington, DC 20004
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@thepalladiumgroup.com
www.healthpolicyplus.com