

# Linkages Across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES)

**FACILITATORS' MANUAL**

**ON**

**ADDRESSING STIGMA AND DISCRIMINATION  
AMONG KEY POPULATION IN SRI LANKA**

**JANUARY 2019**



The Facilitators' Manual for Addressing Stigma and Discrimination Among Key Population in Sri Lanka was adapted from Understanding and Challenging HIV and Key Population Stigma and Discrimination-Caribbean Facilitator's Guide developed by Health Policy Project supported by USAID and PEPFAR.

*This document was made possible by the generous support of the American people through the United States Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The contents are the responsibility of the LINKAGES project and do not necessarily reflect the views of USAID, PEPFAR, or the United States Government. LINKAGES, a five-year cooperative agreement (AID-OAAA-14-00045), is the largest global project dedicated to key populations. LINKAGES is led by FHI 360 in partnership with IntraHealth International, Pact, and the University of North Carolina at Chapel Hill.*

## Foreword



The National STD & AIDS Control Program (NSACP) of the Government of Sri Lanka is well positioned to **End AIDS in Sri Lanka** by 2025, ahead of the global target of 2030. For this goal to be achieved, NSACP collaborates with several agencies and partners including - local civil society organizations; communities; United Nations (UN) agencies; and donor organizations including the Global Fund for AIDS, TB and Malaria (GFATM). With GFATM support, the NSACP has been implementing a nation-wide peer-led community outreach program in Sri Lanka in partnership with the Family Planning Association of Sri Lanka, other local CSOs, KP-led organizations and STD clinics. The community outreach interventions cover different key population groups i.e. female sex workers (FSW), men who have sex with men (MSM), injecting drug user (IDU) and transgender (TG) populations.

Since December 2017, FHI 360, the US-based NGO has been extending technical assistance to NSACP and the local CSO partners to build their technical and program implementation capacity in key population programming. FHI 360 has introduced several global good practices, tools and innovations to address emerging challenges to achieve optimal coverage and HIV testing among different key population groups. This technical assistance is supported by the United States Agency for International Development (USAID) India and USAID Sri Lanka and Maldives Missions as part of a two-year collaborative partnership with the Ministry of Health, Nutrition and Indigenous Medicine (MoH), Government of Sri Lanka.

NSACP have been using stigma related information associated with key population to improve the quality of services in both clinic and outreach settings. NSACP has conducted Integrated Bio-Behavioural Surveillance in 2018 and UNAIDS Stigma Survey in Sri Lanka to understand the magnitude, forms and possible solutions to address self-stigma and stigma from providers. FHI 360 has helped the program by adapting a standardized tool to sensitize service providers and outreach staff to understand their role in addressing key population related stigma. The three learning site partners under LINKAGES project for female sex workers (FSW), men who have sex with men (MSM) and people who use/inject drugs (PWU/ID) had used the **Facilitator's Manual on Addressing Stigma and Discrimination among Key Population** to sensitize their staff to address field level stigma issues and to develop policies to address stigma and discrimination for key population at the organizational level as well. These policies are being used by six CSOs working with key population. All CSOs working with key population in the country have been oriented on the need for addressing stigma and several community champions have taken lead to mobilize community in creating demand for HIV related services.

On behalf of NSACP, I extend my deep appreciation to USAID and FHI 360 for their contribution in introducing this Facilitator's Manual to the local CSOs, seeking technical advice from experts and guidance from their global office staff, and for working collaboratively with FPASL as well my colleagues from NSACP.

A handwritten signature in blue ink, appearing to read 'Rasanjalee Hettiarachchi'.

Dr. Rasanjalee Hettiarachchi  
Director, National STD & AIDS Control Programme  
Ministry of Health, Nutrition & Indigenous Medicine  
Sri Lanka  
December 2019

## Acknowledgement



FHI 360 has been providing technical assistance in key population programming in the sub-continent for the last two decades working collaboratively with local governments and civil society organizations (CSO) to support innovations at-scale and capacity strengthening in technical and program management areas with a focus on key populations (KP). The United States Agency for International Development (USAID)-funded LINKAGES Project was implemented by FHI 360-led consortium in Sri Lanka from December 2017-December 2019.

We wish to appreciate and acknowledge the leadership, support and guidance extended to FHI 360 LINKAGES Project by Director, National STD & AIDS Control Program (NSACP), Sri Lanka and other members of the senior management team especially Dr. G. Weerasinghe, Senior Consultant-Venereologist and Coordinator-Key Population Program in NSACP, who coordinated the different areas technical assistance seamlessly at the national level. As part of LINKAGES, FHI 360 developed three civil society partners as learning sites for HIV prevention for female sex workers (FSW), men who have sex with men (MSM) and people who use/inject drugs (PWU/ID). The CSO partners adopted tools and technical guidelines in KP programming to enhance coverage and quality of their HIV interventions. Further, their organizational systems were strengthened to improve program delivery at-scale. We acknowledge the leadership and collaborative partnership demonstrated by the three learning site partner organizations namely - Alcohol Drug Information Center (ADIC); Community Strength for Development Foundation (CSDF); and Saviya Development Foundation (SDF). Further, we appreciate and thank contributions made by the community champions and community members, peer educators and field staff, Global Fund for AIDS, Tuberculosis and Malaria (GFATM) supported CSOs implementing KP program in the country, peripheral STD clinics and all those who contributed in adapting the LINKAGES tools and guidelines.

We acknowledge the Ministry of Health (MoH), Government of Sri Lanka and the USAID India and USAID Sri Lanka and Maldives Missions for giving FHI 360 the opportunity to work in Sri Lanka and to contribute towards the national mission of Ending AIDS in Sri Lanka by 2025. FHI 360 received unstinting support and cooperation from other local stakeholders including – GFATM Country Coordination Mechanism (CCM); GFATM local fund agent; UN agencies; Family Planning Association of Sri Lanka. Last but not the least, the FHI 360 teams in headquarters, regional office, India Country Office and the local team of consultants and vendors for their tireless effort and exemplary commitment towards achieving the LINKAGES program results in Sri Lanka.

Dr. Bitra George  
Country Director  
FHI 360 India and Sri Lanka Offices

## **ABBREVIATIONS AND ACRONYMS**

ART	Antiretroviral Treatment (or therapy)
ARV	Antiretroviral
LGBTI	Lesbian, Gay, Bisexual, Transgender, and Intersex people
MSM	Men who have Sex with Men
NGO	Non-Governmental Organisation
PLHIV	People Living With HIV
PWID	People Who Inject Drugs
QQR	Quantity, Quality, and Route of transmission
STI	Sexually Transmitted Infection
TOF	Training of Facilitators
VCT	Voluntary Counselling and Testing

## **What Is the Facilitator’s Guide?**

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

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

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

To use these exercises, you will need basic facilitation skills—the skills needed to facilitate large and small group sessions, use different participatory methods, summarize key points, manage conflict and challenging questions, and involve all participants.

### **Who Is the Facilitator’s Guide for?**

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

### **How Is the Facilitator’s Guide Organised?**

The facilitator’s guide consists of seven chapters for a two-day workshop including Introduction

- Chapter A: Naming HIV and Key Population Stigma
- Chapter B: Sex, Morality, Shame, and Blame
- Chapter C: Understanding Key Populations and Stigma
- Chapter D: HIV Transmission and Fear-based Stigma

- Chapter E: Coping with Stigma and Discrimination
- Chapter F: Moving to Action

Chapters A, B, C, D, and F are written for mixed audiences, including people living with HIV, key populations, health workers, teachers, media workers, and faith-based and community leaders.

Chapter E is written specifically for use by groups of people living with HIV or key populations, or people who work with these groups.

## **Why a Facilitator’s Guide on HIV and Key Population Stigma and Discrimination?**

### **HIV-related Stigma and Discrimination**

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

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

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

### **Key Populations**

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

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

- Blamed and shamed at home, and in some cases forced to leave home
- Isolated and made fun of by their peers at school
- Subjected to verbal and physical abuse and social isolation in the community

- Denied work opportunities and access to accommodation
- Given poor treatment by health workers and find it difficult to access health services
- Subjected to discriminatory laws and unable to exercise their human rights

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

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

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

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

The facilitator's role is to engage and build skills to support these efforts – in particular to:

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



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

**Special Note on Stigma and Discrimination:**

In the toolkit, we are going to use the word 'stigma' to indicate both stigma and discrimination because we think of discrimination as an end of the process of stigma. Stigma remains the single most important barrier to public action. It is the main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world.

Not only is it unethical not to protect [most at-risk population - MARP] groups, it makes no sense from a health perspective. It hurts us all!

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

## How to Use the Facilitator's Manual?

### Use the Contents Selectively

There is a collection of individual training exercises, organized into different topics/chapters. It is designed for Sri Lankan context to use as a completed package. **You can even select those topics and exercises which best suit your target groups/participants, your objectives, and the time you have for your training sessions or meetings.** However, **there are some core exercises that are recommended to be included in any session.**

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

### *Examples of Workshop Plans:*

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

### *Case Studies:*

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

### *Handouts:*

The Fact Sheets are designed as handouts and would be distributed at the end of sessions for reference after the training. The Fact Sheets are linked to specific exercises in the toolkit. All these material needs to be photocopied in advance of the training session.

### **Use the manual for Participatory and Collective Learning**

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

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

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

### **Some participants may be living with HIV or from other key populations**

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

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

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

### **Dealing with Disclosure**

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

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

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

### **Consideration about Literacy**

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

## **PLHIV and Key Populations as Co-facilitators**

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

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

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

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

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

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

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

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

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

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

## Session Plans

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

Each session plan is divided into the following parts:

### **Facilitator’s Note**

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

### **Objectives**

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

### **Time**

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

### **Target Group**

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

### **Materials**

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

### **Steps**

The learning activities used in the exercise, described “step by step,” and the learning content “**Steps**” are the core of each session plan. This section includes information on:

### **Methods**

Discussion, rotational brainstorm, card-storming, role plays, etc.

### **Groups**

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

### **Questions**

Specific questions used to guide discussion.

### **Example Responses**

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

### **Report Back**

Procedures for groups giving reports after discussion.

### **Processing**

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

### **Summary**

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

## **Methods and Materials**

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

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

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

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

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

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

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

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

**Pictures:** The guide includes pictures for use in different exercises.

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

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

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

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

## Tips for Facilitating Participatory Learning

### Part A: Planning

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

### *Planning for Action*

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

### Part B: General Facilitation Tips

#### *Work as a Team*

- If possible, plan and run the sessions with another facilitator – and take turns in the lead role.

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

**At the start of the training, do the following:**

*Prepare the room and materials*

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

*Break the ice and introduce the session*

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

**Examples of Ground Rules:**

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



## Brief overview of the sessions – DAY 1

### 1.1 Set goals for the workshop:

- Raise awareness of key population stigma and discrimination
- Advocate for a more inclusive environment
- Develop action plans to reduce stigma and discrimination in different settings  
– self stigma, family, workplace, facilities, media, society in general

Go through the Agenda for the workshop

### 1.2 Define participant expectations

Activity/Method	Resources Needed	Time
Exercise 1.2: distribute sticky notes to the participants to write down their expectations	Note cards or sticky notes	10 minutes

### 1.3 Power Flower

Activity/Method	Resources Needed	Time
Exercise 1.3: Ask participants to judge who the trainer is from the outward appearance		20 minutes

### 1.4 Naming HIV and Key Population Stigma in Different Contexts

Activity/Method	Resources Needed	Time
Exercise 1.4: labelling – interactive exercise	Flip chart/markers	40 minutes

## Stigma defined

### 2.1 How Key Population Stigma Fuels the HIV Epidemic

Activity/Method	Resources Needed	Time
See how stigma or the fear of being stigmatized stops key populations and PLHIV from getting health services and practicing safe sex, which increases their risk of getting HIV and passing HIV to their partners	Interactive discussion	40 minutes

## Activity 01

Identifying and Addressing Key Populations Stigma in Health Facilities  
What People Say, Fear, and Do About Key Populations  
Review & Wrap-up

Activity/Method	Resources Needed	Time
Case study: get groups to discuss case studies and analyse what happened why it happened and what could change	Pre-prepared case studies per group	40 minutes

### Also have available the following:

- Overheads or PowerPoint slides for this Module (in Presentation Booklet)
- Overhead or LCD projector, extra extension cord/lead
- Flipchart or whiteboard and markers or blackboard and chalk
- Pencil or pen for each participant

Relevant Policies for Inclusion in National Curriculum
<b>Session 1</b> <ul style="list-style-type: none"><li>▪ National policies on discrimination, equal rights, and human rights</li><li>▪ National policies on discrimination, equal rights, and human rights relevant to people with HIV</li><li>▪ Local or national policies regarding patient rights within PMTCT and ANC services</li></ul>

### Wrap up session

## Brief overview of the sessions – DAY 02

Review Day 01

2.1 Beliefs about PLHIV and Key Populations

**2.1 Explore their attitudes and values about PLHIV and key populations.**

Activity/Method	Resources Needed	Time
Statements for Value Clarification exercise	Select pre-prepared statements suited for your context and training group	20 minutes

**2.2 How to Challenge Stigma assertively**

Activity/Method	Resources Needed	Time
Participants practice this skill through a series of paired role plays	Real life situations where KPs are discriminated	20 minutes

Relations within the PLHIV and key populations community

Explaining how KPs can benefit from networking with different KP groups

2.3 Ten Steps for Moving to Action

Activity/Method	Resources Needed	Time
Explain 10 steps for moving to Action plan. Each group will be given three different categories to work on their action plan.	Flip charts/markers	1.30 hours

## Curriculum Map

The sessions can be used for specific objective or a group of sessions can be used for focused training of specific target audience.

Sessions	Duration	Target Audience					
		PLHIV	Key Population	KP program staff	Health care providers	Other stakeholders	Media
Power Flower <b>Objective:</b> <ul style="list-style-type: none"> <li>Recognize that humans have many social identities</li> <li>See that stigma and discrimination are part of a process of imposing dominant identities</li> </ul>	1 hour	X	X	X	X	X	X
Naming HIV and Key Population Stigma in Different Contexts <b>Objective:</b> <ul style="list-style-type: none"> <li>Identify stigma and discrimination faced by PLHIV and key populations in different contexts</li> <li>Identify some of the effects of stigma</li> </ul>	1 hour	X	X	X	X	X	x
What is the meaning of 'Stigma'	20 mins	X	X	X	X	X	X
How HIV and Key population stigma fuels the epidemic	1 hour	X	X	X	X	X	X
Naming Stigma and Discrimination towards key population in the health facility	1 hour	X	X	X	X	X	X
The Blame Game – What people say about PLHIV, MSM, Sex workers, Drug users	1 hour	X	X	X	X	X	X
Beliefs about PLHIV and key population (value clarification)	1 hour	X	X	X	X	X	X
How to challenge stigma assertively	1 hour	X	X				
Relations within PLHIV and LGBTI Community	1 hour	X	X				
Ten steps for moving action	3 hours	X	X				

### 1.1 Setting the expectations

### 1.2 Brief introduction of the training and the goals of the training

### 1.3 The Power Flower

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

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

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

**Target Groups:** All groups

**Time:** 1 hour

**Handout:** C-FS4: OUR MULTIPLE SOCIAL IDENTITIES

**Preparation:**

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

POWER FLOWER (Introduction):

Put up a picture of the trainer or a third party who is not known to the participants and ask them to define the person on the screen. This activity can be done as a verbal activity or a written one.

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

After they finish this exercise you can start a conversation about how/where/why people get stigmatized and discriminated.

**Why do we stigmatise?**

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

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

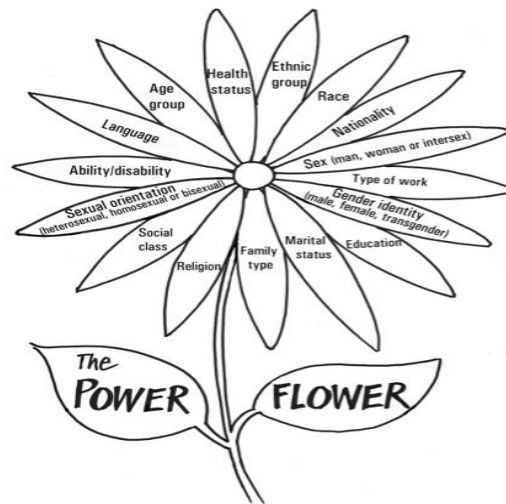
- Increases the level of stigma
- Forces the person to hide all their stigmatised identities or selectively hide identities

**SUMMARISE:**

Include some of the following points in your summary:

- All of us have many social identities—nationality, race, class, ethnicity, biological sex, age, marital status, gender identity, gender expression, sexual orientation, language, religion, education, occupation, children or no children, ability/disability, or health status.
- Key populations are marginalized and stigmatized based on some of these identities or characteristics. They are forced to live within a world dominated by identities which exclude them. As marginalized groups, they are expected to conform to those identities, and when they don't, they become targets for stigma and discrimination.
- In thinking about key populations, we often limit ourselves to thinking about one of their characteristics, e.g., sexual orientation, occupation (in the case of sex workers), disability, etc. In other words, we don't treat them as whole people, with a full set of identities. We treat them as having only one identity—their stigmatized identity. We make this single feature the basis for their entire identity.
- In focusing on this single identity, we stop treating key populations as human beings—we forget their humanity, and this gives us a feeling of power and superiority over them. We focus on one aspect of a person's identity and we become blinded and rob ourselves of the entire rich package of a human being.

- So, we need to change our ways of thinking about key populations as having a single identity and look at them as people with a full set of identities—they are our children, our brothers or sisters, our friends, workmates, church members, and community members, and not just MSM or sex workers or PWID. We need to respect members of key populations by treating them like anyone else.



#### 1.4 Naming HIV and Key Population Stigma in Different Contexts

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

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

#### Extra Tips for Facilitators:

- The number of flipchart stations/categories depends on the number of participants and the amount of time you have. With a large group, you will need many stations/categories so that the groups are not too large. (For this activity, it is good to keep the group size to four or less. Example: 24 participants—eight groups of three people.)
- In introducing this exercise, tell groups which direction to move—so there is no confusion when you blow the whistle to ask groups to move to the next station.
- The rotational brainstorm is fun, but the real learning comes in the debriefing—so make sure you allow enough time/energy for this.

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

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

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

**Time:** 1 hour

**Preparation:**

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

**Steps:**

*Setting Up Rotational Brainstorm:*

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

*Report Back and Processing:*

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

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

**SUMMARISE:**

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

- Stigma towards PLHIV and key populations takes place **everywhere**—homes, schools, communities, clinics, workplaces, churches, public places, and in the media.
- PLHIV and key populations are often shamed and rejected by families and forced to leave home; isolated and made fun of by their peers at school and in the media; mistreated at health facilities; harassed by the police; and banned from religious and social gatherings.
- There are **few places where PLHIV and key populations feel completely safe**. They often feel watched and face stigma and hostility in many places they go.
- **Stigma at home is particularly painful**. This is the place of last resort. If your own family stigmatizes you, you may feel you have nowhere else to go. You are all alone.
- Stigma has several common features across these contexts:



- People make fun of or gossip about MSM or sex workers who dress or act differently from other people. Even if someone is not openly MSM, people will make assumptions based on his clothing and body language and discriminate against him. The same is true for sex workers: people will abuse them if they dress ‘inappropriately.’

a) People ‘shame and blame’ sex workers, MSM, and PWID—condemning them for their sexual practices or use of drugs—practices viewed as breaking ‘traditional’ norms.

b) People may isolate or exclude people who are assumed to be HIV positive or from a key population, trying to keep them at a distance, e.g., not allowing them to attend social events.

c) Families and friends of PLHIV and key populations may also be stigmatized.

d) PLHIV and key populations face different forms of discrimination, e.g., health workers treat them unfairly, police officers harass them, and they are turned down for jobs.

e) MSM and sex workers also face violence—sex workers are attacked by clients and MSM may be attacked if people suspect they are MSM.

- **Stopping Stigma** will take a huge effort by everyone. **The starting point is to change ourselves**—the way we think, talk, and act towards PLHIV and key populations. We have to personalize the issue for ourselves, to see that we have to do something to change things. We first need to change our attitudes—the way we feel towards PLHIV and key populations

- After we have changed ourselves, **we can start to educate and challenge others**. It takes courage to stand up and challenge others when they are stigmatizing PLHIV or key populations— but this is one of the ways to stop stigma. Breaking the silence and getting people talking openly is the first big step.

- **Talk with your family and friends, get community leaders** to speak out against stigma and discrimination. Help everyone make these problems visible and unacceptable.

- **Reach out to and support PLHIV and key populations**. Once PLHIV and key populations feel accepted, they will be more open to discussing their situation with others, seeking support, and accessing services.

**Example Responses:**

**Home**

- Name calling, scolding, belittling, and shaming – *“Why have you brought shame on the family?”*

- Shunned, isolated, and neglected. Forced to stay alone. Not sharing utensils, food, or clothing.
- Some PLHIV or key populations are kicked out of the home and forced to move to another place. Exclusion from family activities. Disowned—no longer can access family property.
- Parents try to hide the behaviour of their gay children, fearing what the neighbors will say.

### **Community**

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

### **Health Facility**

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

### **School**

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

- Some MSM students accept the shame (self-stigma) and drop out of school because of stigma.

### **Workplace**

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

### **Religious Places**

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

## **1.4 What Is the Meaning of ‘Stigma’?**

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

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

**Time:** 20 minutes

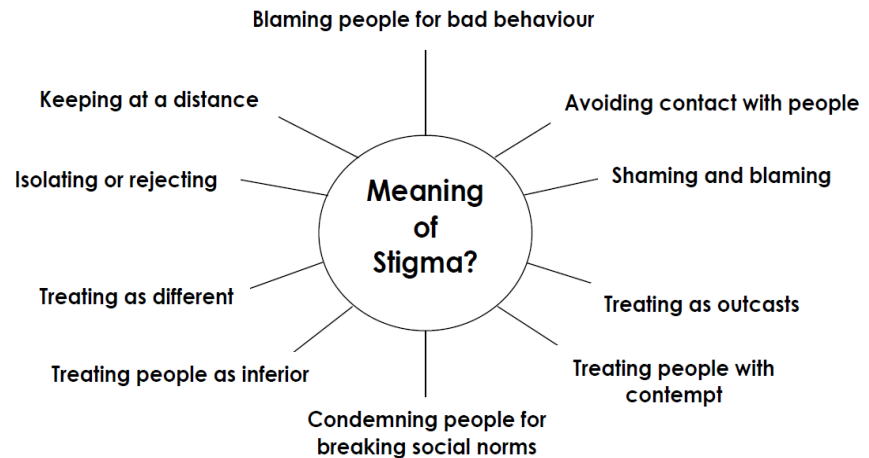
**Target Group – All Groups**

**Steps:**

**Participants' Ideas about Stigma? (Brainstorm):** Ask,

“What do you think is the meaning of ‘stigma’?”

Record participants’ responses in a circle diagram. An example of what this diagram might look like.



*Presentation:*

Next, explain and discuss the following:

- Stigma is a process where we create a ‘spoiled identity’ for an individual or a group of individuals that attributes a lower value to the person or group. We identify a difference in a person or group—for example a behavioural (e.g., same-sex relationships), physical (e.g., physical disfigurement), or social difference (e.g., poor or a migrant) and then assign negative connotations to that difference, thereby marking it as something negative—as a sign of disgrace. In identifying and marking differences as ‘bad,’ we create an ‘us’ and ‘them’ to distance ourselves from a person or group, and this allows and justifies our mistreatment of and discrimination against the person or group. The end result is that stigmatized people often lose status and access to basic human rights, resources, and services because of these assigned ‘signs of shame,’ which other people view as showing they have done something wrong (sinful or immoral behaviour).
- To stigmatize is to believe that people are different from us in a negative way, to assume that they have done something bad or wrong. When we stigmatize, we judge people, saying they have broken social norms and should be shamed or condemned, or we isolate people, saying they are dangerous or a threat to us.
- Stigma is a powerful social process of devaluing a person or group that often ends in the action of discrimination—unfair and unjust treatment, e.g., PLHIV or MSM not being hired, a sex worker kicked out of the house, key populations refused treatment at the clinic, or their HIV status or sexual behaviour being publicly revealed.
- Stigma and discrimination result in great suffering. People get hurt.

- Applying these terms to HIV:
  1. HIV stigma takes two major forms: isolation or rejection, and shaming and blaming
  2. HIV stigma has three major causes:
- Lack of awareness about stigma—what it looks like, what it does—and lack of awareness that we are stigmatizing others
- Fear and ignorance: People do not know how HIV is or is not transmitted, so, fearing they might get infected through contact with persons living with HIV, they isolate them; and
- Moral judgements: People know that HIV is transmitted mainly through sex or injecting drugs, so they assume that people living with HIV got HIV through these activities. Therefore, they condemn people living with HIV for immoral behaviour.
- Stigmatization is a process:
  - We identify and name the differences in someone suspected to have HIV.
  - We make negative judgements about the person (e.g., promiscuity).
  - We isolate or judge/ridicule the person, thereby separating ‘her/him’ from ‘us.’
  - The person who is stigmatized (isolated and judged) loses status and faces discrimination.
- Stigma is often viewed as something right, as a tool to ‘control’ behaviour and people. People think that it is acceptable to isolate and shame people. People are not aware of how stigma affects people living with HIV and how it affects the HIV epidemic.
- HIV stigma is wrong and unacceptable! HIV stigma hurts people living with HIV and drives the HIV epidemic underground. Those stigmatized may become silent and, out of fear of stigma and discrimination, not disclose their status to their sexual partners, which may lead to an increased risk for HIV transmission.
- People living with HIV have the right to be protected from stigma and discrimination.
- We need to support people living with HIV, not blame them.

## **2.1 How HIV and Key Population Stigma Fuels the HIV Epidemic**

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

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

**Time:** 1 hour

**Target Groups –** All Groups

**Materials:** Copies of the case studies for participants

**Steps:**

**Story and Discussion:**

Ask the group to read the following stories.

Story and Discussion:

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

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

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

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

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

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

Eventually he went to get tested, but the voluntary testing and counselling (VCT) counsellor made him feel very uncomfortable. She asked lots of questions about Vimal’s sex life—and when Vimal mentioned having had sex with men, the counsellor said, *“No, you are not one of those! You seem different!”* Vimal left the VCT without taking the test—and told himself he would never go back. He started to worry about infecting his wife and his male lover. He insisted on using condoms with his wife, but she got angry and said he must be having an affair. He was so worried about losing his male lover that he agreed to have sex without a condom—to please his partner. He became very depressed and worried about what he would do next.

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

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

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

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

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

*Plenary Discussion:*

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

**SUMMARISE:**

Stigma or the fear of stigma stops PLHIV and key populations MSM from:

- **Accessing health services**—getting tested for HIV and STIs, getting information on how to avoid HIV transmission, and getting condoms and lubricant;
- **Openly discussing their sexual behaviour with health workers** and providing complete information about their sexual practices, which is necessary to receive appropriate screening and care;

**Accessing treatment** (ARV therapy or treatment of opportunistic infections);

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

#### **1.4 Naming Stigma and Discrimination towards Key Populations in the Health Facility**

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

Use this exercise only after a general exercise to introduce the idea of stigma and discrimination. This exercise will help to prepare health workers to name stigma and discrimination in their own work setting. The aim is to help health workers make a frank and open assessment about stigma in their own workplace.

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

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

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

**Target Group:** Health workers

**Source:** Draft Toolkit on Stigma Reduction in Health Care Settings

**Time:** 1 hour

**Materials:** Case studies

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



## Steps:

### Case Studies:

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

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

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

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

When the first nurse returned, I challenged her and said, *"I've been waiting a long time. Could you examine me and give me some treatment?"* She laughed and said, *"Who are you to tell me what I should do? You'll just have to wait. We know you people!"* She said this in the presence of the other patients and then left. I was told that she and the other nurses had gone off for tea break. I could imagine them gossiping about me over their tea. I wondered who they would tell about me.

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

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

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

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

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

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

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

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

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

### **EXAMPLE RESPONSES—MSM CASE STUDY**

#### **Forms of stigma in the health facility:**

- The MSM client is kept waiting a long time. Other clients are served first.
- Bureaucratic and unfriendly treatment and insulting language.
- Clinic staff gossip about the MSM client and show their disapproval/judging—body language.
- Break confidentiality—one nurse tells the other nurses and other clients about him.
- Blaming and shaming – *"You deserve to get this because of your disgusting behaviour."*
- Poorly done, rushed examination—doctor inspects client's bum from a long distance.
- Invasive questioning, e.g., *"Where did you get this STI? What kind of sex do you do?"*
- Doctor is more concerned about the client's sexual orientation than dealing with the illness.
- No information is provided on safe sex for MSM.

- Some MSM are afraid to access health services because they do not want to reveal their sexuality, for fear they will be discriminated against and others will be told.

### **Effects**

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

### **Why are these problems happening?**

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

### **Solutions**

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

### *Discuss:*

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

### **What happens if we stigmatize key population clients?**

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

### **Why are stigmatizing clients wrong?**

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

### **SUMMARISE:**

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

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

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

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

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

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

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

Stigmatizing MSM and sex workers does not help us to fight HIV. Instead of stigmatizing MSM and sex workers, **we need to show care, compassion, and acceptance**—so that MSM and sex workers can lead a healthy life and act in their own and other people’s interest. So that they can be responsible for their health and take informed decisions.

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

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

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

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

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

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

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

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

**Target Groups:** All groups including key population and PLHIV groups since often one group of key population feels they are more stigmatized than other group.

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

**Time:** 1 hour

## Handout: BLAMING AND SHAMING

### Preparation:

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

### Steps:

#### *Warmup: Switching Chairs Game*

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

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

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

#### *Debriefing:*

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

#### *Things People Say About \_\_\_\_\_ (Rotational Brainstorm):*

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

### EXAMPLE RESPONSES

**PLHIV:** Nasty. Immoral. Promiscuous. Sinners. Whores. Disgusting. Abomination. Loose. Paying for their sins. They deserve it. Sex crazy. Irresponsible. Careless. Unhappy. Unlucky. Disease

carriers. Have de plague. Outcasts. Lepers. Dead man/woman walking. Cursed. Should be quarantined. Should be sent to a special place.

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

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

**PWID or People Who Use Drugs:** Druggies. Crack heads. Junkies. Drug pushers. Dirty. Thieves. Criminals. Homeless. Orphans. Vagrants. Beggars. Stupid. Lazy. Useless. Lost cause. Parasites. Do anything for drugs. Good for nothing. Sex for drugs/money. Outcasts. Deserve to die.  
(these words are based on various terminologies used in countries. There may be other local terms being used in Sri Lanka, include them while summarizing)

*Report Back:*

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

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

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

**How would you feel if you were called these names?**

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

## SUMMARISE:

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

- We are socialized or conditioned to judge other people. We judge people based on assumptions about their sexual and other behaviour, country of origin, or other features which are different.
- Sex is a taboo—something shameful that we should not talk about. So, we often shame and blame people whose sexual behaviour is different from ours.
- PLHIV, MSM, and sex workers were all labeled as sexually immoral on the flipcharts. They were called “sex crazy,” “irresponsible,” and “disease carriers.” The judgements in this case are based on sexual morality.
- These are disadvantaged/vulnerable groups who are lacking in power—they are stigmatized partly because they have limited power to resist these labels. They are often isolated and try to hide from being open in society.
- These labels show that when we stigmatize, we stop dealing with people as human beings—we forget their humanity (by using mocking or belittling words) and this gives us a feeling of power and superiority over them.
- These labels are based on assumptions in which we have insufficient information. They are based on generalizations which have no validity—we simply assume that “the other people” are “dirty, disgusting, sex crazy, etc.”
- Stigmatizing words can be very strong and insulting—they have tremendous power to hurt, to humiliate, and to destroy people’s self-esteem. When we “shame and blame” PLHIV and key populations, it is like stabbing them with a knife—it hurts! And the shaming has consequences in the way people lead their lives.
- We often attribute characteristics to a group and to everyone who belongs to that group. We assume that all members of that group have the same characteristics—e.g., all PLHIV are promiscuous, all MSM are mentally sick.
- So how should we treat PLHIV and key populations? We should give them a) respect and affection; b) support and encouragement; c) space, place, and recognition. If we treat PLHIV and key populations well—giving them love and respect, they will keep their self-esteem, feel



empowered, and take charge of their lives, including being more able to access health services and take care of their sexual health. But if we treat PLHIV and key populations badly, because of the feelings of hurt, shame, and rejection, they may hide from society, avoid using clinics, and may not protect themselves during sex. All of which puts them at higher risk of getting HIV – and this may result in HIV being passed to others.

- Why do we condemn some groups and accept others? We are not saying that PLHIV and key populations are right or wrong. Whether or not you agree with someone, you don't have the right to belittle him. You must look at a human being as a human being and empathize as though the person is your son or daughter. Try to put yourself in the shoes of the other person—how would you feel if you were called these names? Even if you don't like the person, understand him or her.

Review and wrap up for the day.

## **2.1 Beliefs about PLHIV and Key Populations (Value Clarification)**

**Facilitator's Note:** This exercise explores the beliefs and attitudes which result in stigmatizing judgements towards people living with HIV and key populations. Often, we are not aware that we are judging. These exercises help participants think about the judgements they make and why they make them, and the impact they have on people living with HIV and key populations. This is a value clarification exercise—participants review several statements about people living with HIV and key populations and decide if they agree or disagree.

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

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

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

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

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

**Target Groups:** All groups

**Source:** Draft Toolkit on Stigma Reduction in Health Care Settings

**Time:** 1 hour

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

**Steps:**

*Gather all participants in the middle of the room:*

Read out statements and ask them to discuss—“*Do you agree or disagree, and why?*” Explain to the groups that there are no “right” or “wrong” answers. We all respond to the statements based on our beliefs and values, and the purpose of this activity is to explore these differences where they exist. You can mark right side of the room as ‘agree’ and left as ‘disagree’ explain that if they do not agree or disagree they can remain in the middle. Participants can move to the predesignated areas as per their response. (ex: if you agree you move to right side of the room etc.)

*Report Back:*

Then ask participants to comment on why they chose to agree/disagree or neutral.

*Processing:*

Ask:

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

## SUMMARISE:

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

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

## **STATEMENTS FOR VALUE CLARIFICATION EXERCISE**

Select the statements suited to your context and training group.

### **Statements on People Living with HIV**

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

### **Statements on Men who have Sex with Men**

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

### **Statements on Sex Workers**

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

### **Statements on People Who Use Drugs**

- People who use drugs deserve to get HIV because of their immoral behaviour.
- Drug addiction should be considered a disease, not a crime.
- People who use drugs cause harm to society, so they should all be locked up.

- People who use drugs should be registered so that their use of drugs can be closely monitored by health workers.
- People living with HIV who use drugs are unreliable and won't adhere to ARVs, so don't give them ARVs.

### **Mixed Statements**

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

## **2.2 How to Challenge Stigma Assertively**

**Facilitator's Notes:** This exercise helps PLHIV and key populations learn how to challenge stigma and discrimination in an assertive way—saying what they think, feel, and want in a clear, forceful, and confident way. Participants practice this skill through a series of paired role plays.

**Objectives:** By the end of this session, participants will be able to challenge stigma and discrimination in an assertive way.

**Target Groups:** PLHIV and key populations

**Source:** Understanding & Challenging HIV Stigma: Toolkit for Action

BONELA Sexual Minorities, Human Rights, and HIV/AIDS: Trainer's Guide

Cambodia Toolkit on Understanding and Challenging Stigma towards MSM

**Time:** 1 hour

### **Steps:**

#### *Introduction:*

Explain that the session is aimed at practicing how to challenge stigma in an assertive way, i.e., looking the stigmatizer in the eye and saying what we think, feel, and want in a clear, forceful, and confident way—without being aggressive or showing anger.

Ask participants—in the large group – to brainstorm a list of specific situations in which key populations are stigmatized. Record the list of stigmatizing situations on the flipchart.

## EXAMPLE RESPONSES

Stigmatizing situations faced by key populations:

- Family tells you that you have to be a ‘real man’
- Health workers make fun of MSM or sex workers at the clinic
- Family tries to force a gay man to marry a woman

*Paired role playing:*

Explain that we will now practice how to challenge these forms of stigma and discrimination—taking one issue at a time.

A quick pairing exercise:

Write HIV/Key pop related words or funny words, two from each word on a small piece of paper, fold it and put all in a bowl. Ask each participant to draw out a paper, instruct them not to reveal their word to others. Ask all participants to describe/act the meaning of the word they got to others and find their match. This activity is a great ice breaker as well.

Then move on to the role playing. Give the following instructions:

*“Everyone stand up and face your partner. A is the father and B is the gay son. In each pair, agree on who is A and who is B. (Wait until they decide.) The situation is: A ‘Policeman questioning a transgender person without reason’ a passerby intervenes to say it is unjust to harass someone for their gender identity. The passerby should speak in a strong and confident way. Act out the situation—PLAY!” (Ask pairs to start their role plays.) The role-playing situation can be changed in to a different topic as applicable to the participants.*

## EXAMPLE ROLE PLAY

This is an example of what the role play might look like –

**Passerby:** “officer, what seems to be the problem, why are you questioning this person”

**Police officer:** “**This person is dressed as a woman when he is a man. These social deviants should be taken off the street**”

**Passerby:** “Are you arresting him just because he is dressed like a woman?”

**Police officer:** “**yes. I am, why do you care?**”

**Passerby:** “**Is dressing is deviant, it is what makes oneself comfortable**”

**Victim:** “**Maybe no one will marry me, but this is the way I am, and I’m proud of it.**”

## EXAMPLE ROLE PLAY

This is an example of what the role play might look like –

**Father:** “You should change—I want you to be a real man!”

**Son:** “**I am a real man. I’m just attracted to other men. This is who I am. I can’t change.**”

**Father:** “Don’t you care about your future?”

**Son: “I do care. If you want me to get married to a woman, that’s impossible. I don’t have feelings for women.”**

**Father: “If you don’t have interest in women, who is going to marry you?”**

**Son: “Maybe no one will marry me, but this is the way I am, and I’m proud of it.”**

After two minutes, ask a few pairs to show their role plays (one at a time) in the center of the circle. After each role play, **ask: “How did the Passerby do? Was he convincing and effective? What made a difference in the way he challenged the police officer?”**

*Examples of types of comments on this role play from participants:*

- Good eye contact—looked directly at the police officer. Strong voice. Spoke with confidence.
- Didn’t criticize the stigmatiser—simply asserted his rights clearly and simply.
- Good arguments— “I like myself the way I am.” “I can’t change.”
- Did not apologize for his behaviour. Did not allow the police officer to dominate or bully him.
- Was not afraid to disagree with the police officer. Did not give up—insisted on being treated fairly.
- Helped the policer officer (stigmatiser) get a sense of how it feels to be treated like this. ask – “What made a difference?” [Examples—good arguments, strong voice level, body language, confidence, etc.].

Then repeat the same process for other stigmatising situations raised in the Step 1 brainstorm.

**PROCESSING:**

Ask— “What have you learned from the practice role plays?”

**EXAMPLE RESPONSES:**

*What did you learn?*

- I now see that I can do something. I never realised I could challenge the stigmatiser.
- It’s difficult at first. I felt shy. But after a while I began to feel confident.
- The best approach is to say it honestly and simply, it works.
- When I challenged him politely but firmly, he denied that he was stigmatising.
- Don’t be afraid to disagree with the person—to say “No.”

**SUMMARISE:**

Explain and discuss the following list of assertiveness techniques:

- Tell people what you think, feel, and want clearly and forcefully.
- Say ‘I’ feel, think, or would like.
- Don’t 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.
- Some people are full of prejudice—don't let them make their problems yours.

## **2.2 Relations within the PLHIV & LGBTI Community**

**Facilitator's Note:** One of the biggest problems facing PLHIV and LGBTI people in the Sri Lanka is the lack of trust within their community. There are examples of PLHIV or LGBTI people disclosing sexual orientation of other people. As a result, there is very little trust among LGBTI people. There are also examples of divisions and tensions between different types of LGBTI people—some transgender people or MSM who are effeminate are shunned by other MSM, for fear of being exposed themselves.

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

- Recognize the factors, including stigma and lack of confidentiality, which create tensions within the PLHIV and LGBTI communities
- Develop strategies to strengthen relationships within the PLHIV and LGBTI communities

**Target Groups:** PLHIV and key populations

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

**Time:** 1 hour

### **Steps:**

*RELATIONS WITHIN THE PLHIV AND LGBTI COMMUNITIES? (Plenary Discussion):*

Ask: "What are the relationships within the PLHIV and LGBTI communities?" Record the responses on the flipchart.

### **EXAMPLE RESPONSES**

- This is a small country, lots of gossip, and everyone knows what others are doing. Sometimes one PLHIV will reveal the status of another PLHIV. As a result, there is very little trust among PLHIV. They won't share their secret with anyone.
- Everyone is scared of their secret leaking out—and sometimes it is another PLHIV who reveals this information. So, disclosure among PLHIV is a huge issue.
- If I tell anyone, 10 other people will know within a short time. This is why we go to other islands for testing services and medical treatment.
- I don't discriminate against transgender people, but when I walk with one, I feel ashamed and am afraid people might see us together and mock me for being with them.



- Some gay men stigmatize transgender people—they want to hide their identity and be seen as ‘real men,’ so they avoid contact with transgender people, who are more exposed to stigma.
- Some gay men want to hide their sexual orientation, so they won’t be seen with other gay men who are more effeminate. They are still in the closet or have difficult issues. Everyone has to find his or her own process.
- We have a strong confidentiality rule within our group that members have to agree to.
- Our support group members are comfortable with each other, but they are afraid to let new members join the group. It’s a matter of trust.

### **STRATEGIES TO STRENGTHEN RELATIONSHIPS**

Ask—“What can we do to strengthen relationships within the PLHIV and LGBTI communities, so together we can fight for our rights?” Record responses on flipchart.

### **EXAMPLE RESPONSES**

- More joint workshops like this one, where we can work together to analyse stigma and discrimination and develop joint strategies for fighting it.
- Learn more about each other by spending more time together and asking questions openly.
- Educate and learn about the diversity within our own community.
- Learn the terminology for all the different identities and different types of gender expression and sexualities that exist.
- Don’t stigmatize each other and don’t be ashamed of spending time with other LGBTI people.
- With rights come responsibility—we have a right to identify as we choose, but we have to respect others in our community.
- Service providers should encourage all LGBTI people to work together.

Then agree on one or two things that the group can put into action immediately.

### **SUMMARISE:**

- Some LGBTI people stigmatize other LGBTI people—they avoid contact with them and even join in calling them names and keeping them from attending social events.
- This is a coping strategy by some LGBTI people—to avoid being stigmatized themselves through association with the others, they avoid them and join in stigma and discrimination towards the more exposed LGBTI people.
- In doing this, these LGBTI individuals have accepted the stigmatizing practices of the community.
- We need to work together if we are going to break the stigma and discrimination towards our community.

## 2.3 Ten Steps for Moving to Action

**Facilitator’s Note:** This exercise provides a structured process of action planning.

**Objectives:** By the end of the session, participants will be able to work out a detailed strategy for taking action against stigma towards PLHIV or key populations.

**Target Groups:** Key populations

**Source:** Understanding and Challenging HIV Stigma: Toolkit for Action

**Time:** 3 hours

**Handout:** F-FS11: TEN STEPS FOR MOVING TO ACTION

### **Steps:**

#### *ACTION PLANNING:*

Divide into small groups (four or five members) for this exercise. After each step, get a quick report back and then move to the next step.

#### *SITUATION ANALYSIS:*

Ask: “What forms of HIV and key population stigma are common in your community? What are some of the underlying causes of stigma and discrimination?” Record the responses on a flipchart.

#### **EXAMPLES—Forms of Stigma and Causes**

- Many faith groups preach that PLHIV and LGBTI are sinners.
- Homophobia—people have very little understanding about MSM and other LGBTI.
- Lots of secrecy and silence around sex—people find it difficult to talk.
- LGBTI are shamed by their families; pressured to become ‘real men’ and ‘real women’ and often forced to leave home; made fun of by the public; mistreated at clinics; harassed by police; fired at work when their identity becomes known; kicked out of churches.
- High levels of fear and hopelessness among PLHIV and key populations.
- Service providers have no training on how to provide services to key populations.
- Lack of trust in public health facilities by PLHIV and key populations.
- In the face of stigma (homophobia), LGBTI hide their sexual activities.
- Being forced to hide puts their health at risk.

**VISION:**

Ask: “What will the situation in our community look like in two years after our anti-stigma programme?”

**EXAMPLES—VISION**

- Key populations will not feel persecuted by the rest of the society and will no longer have to hide their sexual orientation.
- More support and closeness from parents and family—no rejection from family.
- Less gossip and name calling towards PLHIV and key populations.
- Key populations will be able to access medical, legal, and social services.
- MSM and sex workers will be included in the national HIV prevention strategy.
- People will be able to talk about LGBTI people without condemning them for immorality or treating homosexuality as a taboo topic.
- Health workers will have the skills to diagnose and treat STIs in gay men and MSM.
- More hope and more self-esteem by PLHIV and key populations.

**ACTIVITIES:**

Ask: “What activities will you carry out to reach that goal?”

**EXAMPLES—ACTIVITIES**

- Advocacy to get political commitment to the change process
- Training workshops for LGBTI groups, service providers, and community leaders
- Community and peer group meetings and awareness raising in schools
- Community participatory education on LGBTI and their rights
- Formation and operation of PLHIV and key population support groups
- Participatory assessments, data gathering, and analysis on stigma
- Mini-campaigns on specific issues, e.g., change in the penal code
- Production of information, education, and communication (IEC) materials to inform people about LGBTI
- Use of media as an advocacy and mobilisation tool
- Legal test cases to give some visibility to the issue

**PRIORITY ACTIVITIES:**

Ask: “Which activities are the most important?”

**RESOURCES:**

Ask: “What resources do we need to do these activities?”

- Funds and materials for the training workshops
- Skilled and committed personnel

**OBSTACLES:**

Ask: “What things might block our activities?”

**EXAMPLES—OBSTACLES**

- Religious and cultural beliefs
- Legal context, i.e., no change in penal code
- Lack of empowerment of LGBTI community
- Denial, homophobia, and lack of commitment
- Apathy and sense of fatalism—people feeling they cannot do anything
- Poverty—people too busy just trying to survive

**INDICATORS:**

Ask: “What things will show that we have been successful?”

**EXAMPLES—INDICATORS**

- Social, medical, and legal interventions—people are doing things
- More education around prevention methods for LGBTI and sex workers
- Increased use of government health services by key populations
- Key populations having more say in defining the national strategy for HIV prevention
- Lower number of STIs and lower HIV prevalence in the LGBTI community
- Fewer hate crimes directed towards LGBTI people
- Media—less homophobic language in their articles, and more understanding and support in the way they report about LGBTI issues, e.g., without sensationalizing
- Sex education in schools includes LGBTI issues—so children learn about these issues
- Lower statistics re: suicide