

REDUCING STIGMA AND DISCRIMINATION IN **HIV** AND **SEXUAL HEALTH SERVICES**

A Facilitator's Training Guide



NATIONAL STD/AIDS CONTROL PROGRAMME

Ministry of Health, Sri Lanka

First Edition
July 2026

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Table of Content

How to Use This Facilitator's Guide	1
Icons used in this guide	1
Structure of each session	2
Preparing to deliver the module.....	2
Choosing the right format.....	2
Module Overview	4
Purpose of the module	4
Why this training matters.....	4
Target audience	4
Duration and delivery options.....	5
Overall learning objectives.....	5
Training methods used.....	5
Materials and equipment checklist	6
Facilitator qualifications.....	6
Pre-Training Assessment	7
Part A - True / False.....	7
Part B - Short answer / self-reflection.....	7
Session 1: Introduction and Setting the Context.....	8
Introducing the concept of stigma and discrimination	8
Create a safe and respectful learning environment	9
Clarify expectations of participants.....	10
Session 2: Understanding Stigma and Discrimination.....	11
Key concepts.....	11
Stigma	11
Discrimination.....	11
Types of stigmas.....	11

Common sources of stigma in health services.....	12
Impact of stigma on programmes	12
Activity: The Stigma Iceberg.....	12
Session 3: Case Scenarios in Health-Care Settings.....	14
Instructions for facilitators	14
Case 1: The Reception Desk.....	15
Case 2: The Laboratory	15
Case 3: The Antenatal Ward.....	16
Case 4: The Pharmacy Window	17
Case 5: Outreach in the Community	18
Case 6: The Inpatient Ward.....	19
Closing discussion for Session 3	20
Session 4: Role Play and Skills Practice	21
Method	21
Suggested role-play scenarios.....	21
Observer checklist	22
Session 5: Ethics, Rights and Professional Responsibility.....	23
Key content.....	23
Patient rights.....	23
Medical ethics principles	23
National HIV and STI policy context.....	23
Professional accountability.....	23
Activity: "Right or Wrong?".....	24
Session 6: Building Stigma-Free Services.....	26
Group exercise — Facility action planning.....	26
Facility action-planning worksheet	27
Session 7: Commitment and Closing.....	28

Activity - Personal commitment.....	28
Facilitator closing summary - key messages	28
Closing steps for the facilitator	29
Post-Training Assessment	30
Part A — True / False (repeat of pre-training questions).....	30
Part B — Reflection.....	30
Annexures.....	31
Annexure 1: Stigma-Free Service Checklist	32
Annexure 2: Sample Diagrams and Visual Aids	33
Diagram 1 — How Stigma Affects the Care Continuum	33
Diagram 2 — Stigma-Free Service Model.....	33
Diagram 3 — Types of Stigmas.....	33
Annexure 3: Practical Conversations and Dialogue Examples	34
Conversation 1 - HIV Testing Registration.....	34
Conversation 2 - Disclosure of HIV Result.....	35
Conversation 3 - MSM Client Requesting PrEP.....	36
Conversation 4 - Pregnant Woman Newly Diagnosed	37
Conversation 5 - Laboratory Staff and Occupational Fear	38
Annexure 4 - Visual Posters for Training Rooms and Clinics	39
Annexure 5 - Facilitator Preparation Checklist	40
Annexure 6 — Facility Action-Planning Worksheet (blank, for reproduction).....	41
Annexure 7 — Assessment Answer Key	42
Annexure 8 — Sample Training Agendas.....	43
Full-day workshop (6–7 hours)	43
Half-day workshop (3–4 hours)	43
Annexure 9 - Training Evaluation Form.....	44
Annexure 10 - Certificate of Participation (Template text)	45

Annexure 11 - Glossary of Key Terms.....	46
Annexure 12 - References and Further Reading.....	47

How to Use This Facilitator's Guide

This guide is designed for facilitators (including trainers, clinical supervisors, and programme officers) who will deliver this module to health workers and other participants. It is organized so that facilitators with little or no preparation time can still deliver consistent, high-quality sessions, while experienced facilitators have the flexibility to adapt the content to local needs.

Icons used in this guide

Throughout the module, coloured boxes are used to flag specific types of content. Look out for:



FACILITATOR TIP

Practical advice for delivering the session smoothly — timing suggestions, common pitfalls, and how to handle difficult questions or emotional reactions.



KEY MESSAGE

The core takeaway participants should remember from a section. Read these aloud or write them on a flipchart at the end of a topic.



HANDLE WITH CARE

Sensitive content that may raise strong emotions (disclosure, sexuality, past discrimination). Slow down, watch the room, and remind participants of the ground rules before proceeding.



LEARNING POINT

Highlights an important concept or insight that deepens participants' understanding of the topic. Use these points to reinforce learning and encourage reflection during the session.

Structure of each session

Each session in this guide follows the same structure, helping facilitators know what to expect and how to prepare:

- Session snapshot table - duration, learning objectives, methods, and materials at a glance.
- Step-by-step facilitator instructions - numbered steps with suggested time allocations.
- Core content - the technical information to be delivered or discussed.
- Activities - fully scripted, including instructions, guiding questions, and debrief points.
- Key messages and learning points - to reinforce and close each topic.

Preparing to deliver the module

Before the training day, the facilitator should:

1. Read the entire guide at least once, including the annexures.
2. Print or prepare all handouts, case scenarios, and role-play cards listed in Annexure 5 (Facilitator Preparation Checklist).
3. Confirm that the venue supports small-group work (e.g., movable seating, breakout spaces, or separate areas within the room).
4. Prepare flipchart papers, markers, name tags, and the pre/post-training assessment forms (Annexure 7).
5. Review the debrief questions for each activity so responses can be guided confidently.
6. Identify a co-facilitator where possible, especially for the full-day, 6–7-hour version of the module.

Choosing the right format

The module can be delivered as a half-day (condensed) or full-day (complete) workshop.

Select sessions for the half-day option based on the audience's role and prior exposure to stigma-reduction training.

Format	Duration	Recommended sessions
Half-day workshop	3 – 4 hours	Session 1, Session 2, Session 3 (2 cases only), Session 7
Full-day workshop	6 – 7 hours	All seven sessions, in sequence, with a lunch break after Session 3
Refresher / short session	90 minutes	Session 2 and Session 4 (role play) only

Module Overview

Purpose of the module

This module is designed to strengthen the capacity of health-care workers, counsellors, laboratory staff, outreach workers, and programme managers to recognize, prevent, and respond to stigma and discrimination in HIV and sexual health services. It uses participatory learning, case scenarios, and role plays to promote attitude change and improve the quality and equity of services offered to clients, particularly people living with HIV and key populations.

Why this training matters

Stigma and discrimination remain among the most persistent barriers to HIV prevention, testing, and treatment worldwide. When people fear being judged, blamed, or mistreated at a health facility, they are more likely to delay testing, avoid disclosing risk behaviour to their provider, default from treatment, or avoid services altogether. Health workers are often unaware of how their words, tone, or routine practices (such as labelling files or discussing a client's status where others can hear) are experienced as discriminatory by clients. Addressing stigma at the level of individual practice, service organisation, and institutional policy is therefore essential to national goals such as the Elimination of Mother-to-Child Transmission (EMTCT)/Triple Elimination (HIV, syphilis, and Hepatitis B), and broader epidemic control targets.



KEY MESSAGE

A single negative experience with a health worker can be enough to keep a person away from care for years. Respectful, non-judgemental service is a clinical intervention, not simply good manners.

Target audience

- Health care workers (doctors, nurses, midwives, medical officers)
- Counsellors and psychologists

- Laboratory staff and phlebotomists
- Outreach workers and peer educators
- Pharmacy and records staff
- Programme managers and supervisors

Duration and delivery options

- Half-day workshop (3–4 hours) - selected sessions, see "How to Use This Guide" for recommended combination.
- Full-day workshop (6–7 hours) - the complete module, delivered in sequence.

Overall learning objectives

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

1. Define stigma and discrimination and describe their different forms.
2. Identify how stigma occurs in healthcare and programme settings.
3. Explain the impact of stigma on HIV prevention, EMTCT, treatment, PrEP, and retention in care.
4. Demonstrate stigma-free communication and professional behaviour.
5. Apply practical strategies to reduce stigma at individual, service, and institutional levels.
6. Develop an action plan to improve stigma-free services in their own facilities.

Training methods used

- Facilitated large-group discussion
- Small-group case-study analysis
- Role play with structured debrief
- Individual reflection and action planning
- Short input/presentation segments (kept brief to maximize participation)

Materials and equipment checklist

Item	Quantity / Notes
Flipchart stand and paper	1–2 per training room
Markers (assorted colors)	1 set per small group
Name tags / tent cards	1 per participant
Printed case scenario handouts (Session 3)	1 set per group of 6–8
Printed role-play cards (Session 4)	1 set per triad
Pre- and post-training assessment forms	1 per participant, x2
Training evaluation form	1 per participant
Sticky notes / index cards	3–5 per participant
Projector / screen (optional)	For diagrams and slides
Certificates of participation	1 per participant (Annexure 10)

Facilitator qualifications

This training should be delivered by a facilitator or co-facilitator(s) with:

- Prior clinical or programme experience in HIV/STI services;
- Training or experience in adult learning and facilitation; and
- The ability to discuss sexuality, gender, HIV status, and related issues sensitively and without judgment in a diverse professional setting.

Where possible, consider pairing a clinical facilitator with a counsellor or a trained person living with HIV who is willing to co-facilitate. Lived-experience perspectives can greatly strengthen the training and promote more meaningful learning.

Pre-Training Assessment

Administer this short assessment before Session 1 begins. It is not a competitive or graded assessment; its purpose is to establish a baseline of participants' knowledge and attitudes. The facilitator can then compare the results with the post-training assessment (administered after Session 7) to evaluate the impact of the training. Allow approximately 10 minutes for completion. Assure participants that their responses are anonymous.



FACILITATOR TIP

Collect forms before introductions begin. Do not discuss the correct answers at this stage - this is a baseline measure, not a test.

Part A - True / False

1. Stigma and discrimination mean the same thing. **[True / False]**
2. A person can legally be denied a health service because they are HIV-positive. **[True / False]**
3. Discussing a client's HIV status with colleagues who are not involved in their care is acceptable if it is 'for their safety'.. **[True / False]**
4. Internalised stigma can prevent care-seeking even when no one else is present. **[True / False]**
5. Universal precautions make it unnecessary to treat any patient differently based on HIV status. **[True / False]**

Part B - Short answer / self-reflection

1. In your own words, describe one example of stigma that you have observed or experienced in a healthcare setting.
2. On a scale of 1 (not confident) to 5 (very confident), how confident are you in responding professionally when a client discloses their HIV status or sexual orientation to you?
3. What is one thing you hope to learn from this training?

(An answer key for Part A is provided in Annexure 7)

Session 1: Introduction and Setting the Context

 Duration	30 minutes
 Objectives	Introduce the topic of stigma; establish a safe learning environment; clarify expectations
 Methods	Facilitated discussion, ground-rule setting
 Materials	Flipchart, markers, prepared ground-rules poster

Introducing the concept of stigma and discrimination

Facilitator steps

- 1. (5 min)** Begin by asking participants what comes to mind when they hear the word stigma. Write responses on a flipchart without commenting - this helps you understand the group's current perceptions.
- 2. (5 min)** Explain that stigma refers to negative attitudes, beliefs, or judgments directed toward a person or group because of a particular characteristic, condition, or behaviour.
- 3. (3 min)** Clarify that discrimination is the action that results from stigma - unfair treatment, exclusion, denial of services, or differential treatment.
- 4. (5 min)** Ask participants to identify examples of HIV-related stigma and discrimination, and add examples such as avoiding physical contact with PLHIV, refusing or providing unequal care, breaching confidentiality, and blaming or judging individuals based on assumptions about their behaviour.
- 5. (2 min)** Mention that stigma can occur in communities, families, workplaces, schools, and even healthcare settings - nowhere is automatically exempt.
- 6. (5 min)** Emphasize that stigma affects health-seeking behaviour, testing uptake, treatment adherence, mental well-being, and overall quality of life.
- 7. (5 min)** Briefly connect this to national efforts such as the National STD/AIDS Control Programme and elimination programmes, where reducing stigma is essential for service access and achieving programme targets.

**KEY MESSAGE**

Stigma is an attitude; discrimination is that attitude put into action. Reducing one without addressing the other leaves services only partly improved.

Create a safe and respectful learning environment

Facilitator steps

- Set ground rules at the beginning of the session and write them on a flipchart to keep visible all day.
- Encourage mutual respect: all opinions should be heard without interruption or judgment.
- Reinforce confidentiality: personal stories or examples shared during the session should not be discussed outside the group.
- Encourage open discussion and honest reflection, including admitting to attitudes participants may now recognise as unhelpful.
- Remind participants that sensitive topics such as sexuality, gender, HIV status, and personal experiences may arise, and all discussions should remain respectful.
- Use inclusive language and encourage participants to avoid labelling or blaming terms.
- Facilitate by acknowledging different experiences and perspectives rather than dismissing them.
- Assure participants that the session is intended for learning and improvement, not criticism or blame.

Suggested ground rules (write on flipchart)

- Speak from your own experience - use "I" statements.
- One person speaks at a time; no side conversations.
- What is shared in the room stays in the room.
- It is safe to disagree, but not to be disrespectful.

- Mobile phones on silent.
- Full participation is expected - there are no "observers only"



HANDLE WITH CARE

Sensitive personal disclosures may occur during this session. Do not press a participant to share more than they are comfortable with, and thank them for their contribution before moving on.

Clarify expectations of participants

Facilitator steps

- Explain the purpose of the session: to build understanding of stigma, recognize its impact, and identify ways to reduce discriminatory practices.
- Ask participants what they hope to gain from the training.
- Invite them to share challenges they have observed in healthcare settings, community work, or service delivery.
- Clarify that active participation is expected - sharing ideas, engaging in discussions, and reflecting on attitudes.
- Encourage participants to think about how the learning can be applied in their own workplace.
- Highlight that the session is interactive and their experiences are valuable learning resources.
- Set expectations on time management, participation in group activities, and respectful engagement.
- Conclude by linking participant involvement to improving person-centred care and reducing barriers for key populations and people living with HIV.



LEARNING POINT

Training on stigma can only succeed if the room itself is free of judgement. The ground rules set in this session protect every later activity.

Session 2: Understanding Stigma and Discrimination

 Duration	45 minutes
 Objectives	Define key concepts; distinguish types and sources of stigma; explain the programmatic impact of stigma
 Methods	Short input session, facilitated discussion, small-group activity
 Materials	Flipchart, markers, sticky notes or index cards

Key concepts

Stigma

A social process in which individuals or groups are labelled, stereotyped, and devalued because of a particular characteristic such as HIV status, sexual orientation, gender identity, occupation, or behaviour.

Discrimination

Unfair or unequal treatment that results from stigma and leads to denial of services, poor-quality care, exclusion, or violation of rights.

Types of stigmas

Type	Description	Example in a health setting
Enacted stigma	Direct discrimination, refusal of services, verbal abuse	A nurse refuses to draw blood from a client known to be HIV-positive
Perceived stigma	The fear of being judged or rejected, even if it has not yet happened	<i>"If people at the clinic know I have HIV, they may treat me differently"</i> – So delaying coming to treatment
Internalized stigma	Shame, guilt, or low self-esteem experienced by the client themselves	<i>"Having HIV makes me less worthy than other people"</i> – A PLHIV avoids disclosing their status to a partner out of shame
Institutional stigma	Policies, systems, or practices that disadvantage certain groups	Files of HIV-positive patients are marked with a special-colored sticker

Common sources of stigma in health services

- Fear of infection (often based on outdated or incorrect information)
- Moral judgement about sexual behaviour, drug use, etc
- Cultural and religious beliefs
- Lack of training on, stigma, discrimination and its effect
- Lack of training on key populations, specific groups and their specific needs
- Work overload and stress, which reduce patience and empathy

Impact of stigma on the programme

- Reduced testing uptake
- Late presentation to care
- Poor adherence and retention in treatment
- Low PrEP uptake among people who would benefit from it
- Failure to achieve EMTCT and Triple Elimination targets



KEY MESSAGE

Every point in the care continuum (from the reception desk to follow-up) is a point where stigma can interrupt a person's care. Reducing stigma is a technical requirement for programme success, not an optional extra.

Activity: The Stigma Iceberg

Purpose	Help participants see that visible discriminatory acts (enacted stigma) are only the tip of a much larger set of underlying attitudes, fears, and institutional practices
Time	20 minutes
Materials	Flipchart with a large iceberg drawn (a triangle above a horizontal waterline, with a larger triangle below it), sticky notes or markers
Group size	Whole group, or small groups of 4–6 if numbers are large

Instructions

1. Draw (or display) a large iceberg on the flipchart: a small visible tip above the waterline and a much larger mass hidden below it.
2. Ask participants to call out or write on sticky notes examples of visible, enacted stigma they have seen or heard of in health services (for example: refusing to treat a patient, public questioning, marking a file). Place these above the waterline.
3. Ask participants to now think about what lies beneath the surface - the fears, beliefs, workplace pressures, and institutional gaps that drive those visible actions (for example: fear of infection, lack of training, moral judgement, unclear policies, staff shortages). Place these below the waterline.
4. Facilitate discussion: Why is it easier to notice the tip of the iceberg than what lies beneath it? What would it take to address the hidden part, not just the visible acts?
5. Summarize that lasting change requires addressing attitudes and systems, not only correcting individual incidents after they happen.

Debrief questions

- Which items below the waterline were most familiar to you from your own workplace?
- What is one item below the waterline that your facility could realistically address in the next six months?



LEARNING POINT

Punishing a single discriminatory incident treat only the tip of the iceberg. Preventing stigma requires changing attitudes, training gaps, and policies that sit beneath the surface.

Session 3: Case Scenarios in Health Care Settings

 Duration	120 minutes
 Objectives	Recognize stigma and discrimination as they occur across different points of the care pathway; practice identifying corrective action
 Methods	Small-group case analysis and presentation
 Materials	Printed case handouts (one case per group), flipchart paper for group presentations

Instructions for facilitators

1. Divide participants into small groups of 6–8.
2. Assign one case to each group (six cases are provided below; if there are fewer than six groups, choose the cases most relevant to the audience present).
3. Give each group 25 minutes to read the case, discuss the guided questions, and prepare a 3–4-minute summary on flipchart paper.
4. Each group presents their case and conclusions to the full room (5 minutes presentation + 5 minutes discussion per group).
5. After all groups have presented, facilitate a closing discussion using the cross-cutting question: "What is one pattern you noticed across several of today's cases?"



FACILITATOR TIP

If time is limited (half-day workshop), select two or three cases most relevant to the audience rather than rushing through all six.

Keep an eye on groups discussing Case 3 or Case 5 - these touch on disclosure and confidentiality and can raise strong reactions.

Case 1: The Reception Desk

Setting: Outpatient reception area of a district hospital, mid-morning, several other patients waiting within hearing distance.

A 24-year-old man arrives at the reception desk and asks quietly for an HIV test. The receptionist, without lowering her voice, asks: "Why do you want this test? What have you been doing?" The man looks around at the other patients, hesitates, and says he will come back another day. He does not return for three months.

Guided discussion questions

1. What specific actions by the receptionist constitute stigma or discrimination?
2. What impact did this interaction have on the client's health-seeking behaviour?
3. What could the receptionist have said or done differently?
4. What changes to the physical space or facility procedures could prevent this situation from happening again?

Facilitator notes / key learning points

- Public questioning about risk behaviour, even without hostile intent, discourages testing.
- A private area or simple, neutral registration script ("All clients are offered this test") protects dignity and confidentiality.
- The three-month delay illustrates how a single poor interaction can have a lasting effect on care-seeking.

Case 2: The Laboratory

Setting: Hospital laboratory/ sample collection point.

A phlebotomist notices that a sample request form is marked with a red sticker used informally by some staff to indicate a patient is HIV-positive. She asks a colleague to draw the blood instead, saying she "doesn't want to take the risk today". The colleague draws the blood but complains to other staff afterwards, and the patient overhears part of the conversation while leaving the room.

Guided discussion questions

1. What forms of stigma are present in this scenario (consider both the sticker system and the phlebotomist's behaviour)?
2. What are the infection-control facts that make this refusal unnecessary?
3. What institutional practice needs to change, beyond addressing the individual technician's behaviour?
4. How might the patient feel after overhearing the conversation, and what could restore their trust?

Facilitator notes / key learning points

- Universal precautions are designed to protect staff from all bloodborne pathogens for all patients, regardless of known status - there is no additional risk that justifies differential treatment.
- Informal marking systems (coloured stickers, symbols, coded notes) are a form of institutional stigma and should be discontinued in favour of standard universal-precaution practice for everyone.
- Staff conversations about a patient's status, even after the patient has left the room, are a confidentiality breach if the patient or others can overhear.

Case 3: The Antenatal Ward

Setting: Antenatal clinic.

A pregnant woman is newly diagnosed with HIV during a routine antenatal visit. The attending midwife, wanting to "make sure the rest of the team is careful", mentions the diagnosis to two other staff members within the clinic, where two other pregnant women are also present and overhear part of the conversation. The woman later confides to a counsellor that she is now afraid to return for her next appointment.

Guided discussion questions

1. Was there a legitimate clinical reason to inform other staff? If so, how should that information have been shared??
2. What was the effect of the disclosure being overheard by other patients?

3. How does this scenario connect to EMTCT (Elimination of Mother-to-Child Transmission) outcomes?
4. What facility-level changes (space, handover procedures) would prevent this from recurring?

Facilitator notes / key learning points

- Relevant clinical information should be shared only with staff directly involved in the client's care, and through private channels (written handover, private conversation) - not verbally in a shared ward.
- Fear of further exposure can cause a woman to disengage from antenatal care, directly undermining EMTCT goals.
- Private counselling spaces and clear handover protocols protect both confidentiality and continuity of care.

Case 4: The Pharmacy Window

Setting: Hospital pharmacy, dispensing window, queue of approximately 15 patients.

A client comes to collect antiretroviral therapy (ART). The pharmacist places the client's prescription at the bottom of the pile, serves several other clients first, and then, when finally serving the client, says loudly enough for others to hear: "This is the HIV medicine, isn't it? Make sure you take it properly." The client leaves without making eye contact with anyone in the queue.

Guided discussion questions

1. What two separate discriminatory practices occurred in this scenario?
2. Why might a client experience this kind of treatment as worse than a single rude comment?
3. What simple system changes could prevent both problems (queue order and confidentiality at the window)?
4. How would you raise this issue with a colleague without shaming them, consistent with the training's ground rules?

Facilitator notes / key learning points

- Deprioritizing a prescription based on the medicine type is a form of enacted, institutional discrimination and should never occur — all clients should be served in the order they arrive, or according to clinical urgency, not diagnosis.
- Announcing the nature of medication aloud breaches confidentiality even without naming the diagnosis directly, since ART is widely recognized.
- Simple systems - numbered queue tickets, private counters, discreet packaging - remove the opportunity for this kind of unintentional disclosure.

Case 5: Outreach in the Community

Setting: A client's place of work, during a routine follow-up visit by an outreach worker.

An outreach worker, trying to remind a client (a man who has sex with men, enrolled in a PrEP programme) about his follow-up appointment, visits him at his workplace without prior arrangement. He asks the receptionist where to find him, mentioning he is "from the HIV clinic". The client is deeply embarrassed in front of his colleagues and later asks to be discharged from the programme.

Guided discussion questions

1. What assumptions or planning failures led to this breach of confidentiality?
2. What agreement should be made with clients in advance regarding outreach contact?
3. What does this case suggest about the risks outreach and peer-support programmes carry, even when the outreach worker's intentions are good?
4. How should the outreach worker and his supervisor respond after this incident to rebuild the client's trust?

Facilitator notes / key learning points

- Outreach contact methods, locations, and the language used to identify the service should always be agreed with the client in advance, and an alternative discreet method (e.g. a private phone call, a generic clinic name) should be used by default.
- Good intentions do not prevent harm - the impact on the client is what matters, and it should be acknowledged directly and without defensiveness.

- A single breach can undo months of trust-building in a peer-support relationship; Respect the client's decision, acknowledge the breach of confidentiality, and offer a sincere apology and appropriate support without pressuring him to continue the programme. Review the incident. Offer alternative follow-up arrangements if the client wishes to continue care.

Case 6: The Inpatient Ward

Setting: General medical ward, four days after admission.

A patient admitted for an unrelated illness during routine testing, is found to be HIV-positive. Following this, his medical file is marked with a red symbol, and nursing staff begin double-gloving and wearing additional protective equipment only for his care, which they do not do for other patients. Other patients on the ward notice this and begin to avoid him. He asks to be discharged early.

Guided discussion questions

1. Which elements of this case reflect institutional stigma, and which reflect enacted stigma by individual staff?
2. Is additional personal protective equipment (PPE) clinically justified in this situation? Why or why not?
3. What message did the visible change in staff behaviour send to other patients on the ward, and what was the effect?
4. What would a stigma-free version of this scenario look like, from admission to discharge?

Facilitator notes / key learning points

- Marking files with visible symbols is an institutional practice that should be replaced with confidential, standardized documentation accessible only to the care team.
- Universal precautions are applied consistently to all patients regardless of known infection status; visibly different PPE use for one patient is not clinically justified and signals stigma to everyone on the ward.

- Visible differential treatment by staff can trigger exclusion by other patients, compounding harm - staff behaviour sets the tone for the whole ward.

Closing discussion for Session 3

After all groups have presented, ask the full group:

- Which of these six cases felt the most familiar to your own workplace?
- What single change, if made today, would have prevented the situation in that case?



KEY MESSAGE

Stigma rarely appears as one dramatic act. It usually shows up as a series of small decisions - where a file is marked, who is served first, where a conversation happens - that are each individually 'minor' but cumulatively drive people away from care.

Session 4: Role Play and Skills Practice

 Duration	60 minutes
 Objectives	Practice stigma-free communication skills in realistic clinical interactions; give and receive constructive feedback
 Methods	Triad role play (client, provider, observer) with structured debrief
 Materials	Printed role-play cards, observer checklist (below)

Method

Participants work in triads. One person plays the client, one plays the health-care provider, and one is the observer. Each triad is assigned one scenario. After 8 minutes of role play, the triad spends 7 minutes debriefing using the questions below, then triads rotate roles if time allows.

Facilitator steps

- (5 min)** Explain the exercise and assign roles within each triad.
- (3 min)** Distribute role-play cards: one scenario per triad, drawn from the list below or from the case studies used in Session 3.
- (8 min)** Triads act out the scenario. Circulate to observe, but do not interrupt.
- (7 min)** Each triad debriefs using the observer checklist and debrief questions.
- (5–10 min)** If time allows, rotate roles and repeat with a new scenario.
- (10 min)** Bring the full group together for a shared debrief and key messages.

Suggested role-play scenarios

- Disclosure of a positive HIV result to a newly diagnosed adult
- A man who has sex with men (MSM) requesting PrEP for the first time
- A sex worker attending the clinic for a routine STI screening
- A pregnant woman newly diagnosed with HIV during an antenatal visit
- A young person requesting confidential STI testing without a parent present
- A client returning after defaulting from ART for several months

Observer checklist

Behaviour to observe	Yes / No / Partly	Notes
Provider ensured privacy before discussing sensitive information		
Provider used neutral, non-judgemental language		
Provider explained confidentiality to the client		
Provider's tone and body language were respectful and calm		
Client's concerns were acknowledged before moving to next steps		
Provider avoided assumptions about the client's behaviour or lifestyle		

Debrief questions

- What went well in this interaction?
- What caused discomfort, for either the client or the provider?
- How could communication be improved?
- What would you do differently if this were a real client?



FACILITATOR TIP

Some participants may find playing the "client" role uncomfortable, particularly for disclosure scenarios. Allow participants to opt out of a specific role if it is too close to a personal experience, and offer an alternative scenario.

During the full-group debrief, avoid singling out any triad's performance as "wrong" in front of the room - focus feedback on skills to build, not mistakes made.



LEARNING POINT

Skills used in role play - privacy, neutral language, checking understanding - are the same skills that determine whether a real client returns for their next appointment.

Session 5: Ethics, Rights and Professional Responsibility

 Duration	45 minutes
 Objectives	Link stigma reduction to patient rights, medical ethics, and professional accountability
 Methods	Short input, "Right or Wrong?" structured debate activity
 Materials	Flipchart, prepared statement cards

Key content

Patient rights

- Dignity
- Confidentiality
- Privacy
- Informed consent

Medical ethics principles

- Beneficence - acting in the client's best interest
- Non-maleficence - doing no harm, including psychological or social harm
- Autonomy - respecting the client's right to make informed decisions about their own care
- Justice - providing fair and equal treatment regardless of diagnosis, behaviour, or identity

National HIV and STI policy context

Health workers are guided by national HIV/STI policies and professional codes of conduct that uphold confidentiality, non-discrimination, and informed consent. Facilitators should include relevant Sri Lankan policies, circulars, guidelines, and professional codes in this section.

Professional accountability

Breaches of confidentiality or discriminatory refusal of care are not simply ethical lapses - they may also constitute professional misconduct with disciplinary consequences and can undermine public trust in the health system more broadly.

Activity: "Right or Wrong?"

Purpose	Test and discuss participants' understanding of professional and ethical boundaries in a low-pressure format
Time	20 minutes
Materials	Read each statement aloud; ask participants to move to one side of the room (or raise a card) for "Right", the other for "Wrong"; discuss briefly before revealing the recommended answer

Statements for discussion

Statement	Recommended answer	Rationale
It is acceptable to mark HIV patient files with special symbols.	Wrong	This is a confidentiality breach and a form of institutional stigma. Standard, confidential documentation should be used for all.
Health workers can refuse services if they feel uncomfortable treating a patient.	Wrong	Refusing care based on a client's status or identity violates justice and may constitute unlawful discrimination. Discomfort should be addressed through training and support.
Informing colleagues of a client's status without consent is justified for staff safety.	Wrong	Universal precautions protect staff for all patients. Sharing a diagnosis without consent breaches confidentiality and is unnecessary for safety.
A client has the right to decline a recommended test or treatment after receiving full information.	Right	Informed consent means the client's decision must be respected, even if the provider disagrees, provided the client has the relevant information to decide.
Health workers can discuss a case with a colleague directly involved in the client's care, using a private channel.	Right	Sharing clinically relevant information through appropriate, private channels with those directly involved in care is both necessary and ethical.



FACILITATOR TIP

If the group is small, this can be run as a hands-up vote instead of a room-movement exercise. Keep the discussion after each statement to 2–3 minutes so all statements are covered within the allocated time.



KEY MESSAGE

Professional ethics protect both clients and health workers. Confidentiality, consent, and equal treatment are not optional courtesies - they are the standard of care.

Session 6: Building Stigma-Free Services

 Duration	45 minutes
 Objectives	Identify where stigma occurs within participants' own facilities; generate practical, actionable improvements
 Methods	Small-group facility action planning exercise
 Materials	Flipchart paper, markers, facility action-planning worksheet (Annexure 6)

Group exercise - Facility action planning

Facilitator steps

- (5 min)** Introduce the exercise: participants will map where stigma occurs in their own facility and identify realistic changes.
- (20 min)** In groups of 5–6 (ideally grouped by facility or facility type), each group identifies:
 - Where stigma occurs in their facility (physical spaces, procedures, interactions)
 - Immediate changes possible - low-cost, achievable within weeks
 - Long-term institutional changes needed - policy, training, infrastructure
- (15 min)** Each group presents a 2-minute summary of their top three action points.
- (5 min)** Facilitator captures common themes across groups on a flipchart for the closing session.

Examples to prompt discussion

- Private counselling rooms with soundproofing or adequate separation from waiting areas
- Staff sensitization and refresher training programmes, including for non-clinical staff (security records, cleaners)
- Non-discrimination posters and visible commitment statements in waiting areas (see Annexure 4)
- Complaint and feedback systems that clients can use without fear of reprisal

- Standardized, confidential documentation systems (removing informal marking practices)
- Queue and scheduling systems that do not single out particular services or medications

Facility action-planning worksheet

Area of concern	Immediate action (within 1 month)	Long-term action (within 1 year)	Person responsible



FACILITATOR TIP

Encourage each group to be specific - "improve privacy" is too vague; "install a curtain at the counselling desk by [date]" is actionable and easy to follow up on

Session 7: Commitment and Closing

 Duration	30 minutes
 Objectives	Consolidate learning into a personal commitment; close the training with key messages
 Methods	Individual reflection, sharing (optional), facilitator summary
 Materials	Index cards or the personal commitment slip (below), post-training assessment forms

Activity - Personal commitment

Distribute an index card or the personal commitment slip to each participant. Ask them to write, silently:

- One attitude I will change
- One practice I will improve

Invite (do not require) two or three volunteers to share their commitment aloud. Collect the cards if the facility plans to follow up with participants after the training, or allow participants to keep them as a personal reminder.

Facilitator closing summary - key messages



KEY MESSAGE

Stigma reduction is essential for EMTCT/Triple Elimination, and epidemic control. Every health worker influences client trust and outcomes, in ways both large and small. Respect, confidentiality, and professionalism are core to quality care - not optional extras.

Closing steps for the facilitator

- 1.** Administer the post-training assessment (next page) - allow 10 minutes.
- 2.** Distribute the training evaluation form (Annexure 9) and allow 5 minutes to complete it.
- 3.** Thank participants and distribute certificates of participation, if applicable (Annexure 10).
- 4.** Share contact details for follow-up support, supervision, or further training.

Post-Training Assessment

Administer at the end of Session 7. Use the same Part A questions as the pre-training assessment to allow direct comparison, plus the additional questions below.

Part A — True / False (repeat of pre-training questions)

1. Stigma and discrimination mean the same thing. (True / False)
2. A person can be legally denied a health service because they are HIV-positive. (True / False)
3. Discussing a client's HIV status with colleagues who are not involved in their care is acceptable if it is 'for their safety'. (True / False)
4. Internalised stigma can prevent care-seeking even when no one else is present. (True / False)
5. Universal precautions make it unnecessary to treat any patient differently based on their HIV status. (True / False)

Part B — Reflection

1. What is one thing from today's training that changed how you think about your own practice?
2. What is one barrier you anticipate in applying what you learned today, and how might you address it?
3. On a scale of 1 (not confident) to 5 (very confident), how confident are you now in responding professionally when a client discloses their HIV status or sexual orientation to you?



FACILITATOR TIP

Compare aggregate Part A scores and the confidence rating (question 3) with the pre-training assessment to demonstrate the training's impact in your post-training report.

Annexures

The following annexures provide ready-to-use tools, scripts, and reference material to support delivery of this module.

Annexure 1: Stigma-Free Service Checklist

Facilitators can use this checklist for self-assessment, supervision visits, or as a discussion tool in Session 6.

Checklist item	Yes	No	Action needed
Private space available for counselling and disclosure conversations			
Confidentiality maintained in records, verbal handovers, and queuing			
Equal treatment given to all clients regardless of diagnosis or identity			
Non-judgemental language used by all staff, including non-clinical staff			
Universal precautions applied consistently to every patient			
No informal marking/coding of files by diagnosis			
Complaint and feedback mechanism available and known to clients			
Non-discrimination statement visibly displayed			
Staff have received stigma-reduction training in the past 12 months			

Annexure 2: Sample Diagrams and Visual Aids

These simple diagrams can be redrawn by a designer or recreated directly in presentation slides and handouts.

Diagram 1 — How Stigma Affects the Care Continuum

Client → Fear / Shame → Avoids Testing → Late Diagnosis → Poor Outcomes

This arrow diagram shows how stigma interrupts each stage of prevention, testing, treatment, and retention.

Diagram 2 — Stigma-Free Service Model

**Reception → Private Counselling → Testing → Results → Treatment/Prevention
→ Follow-up**



KEY MESSAGE

Respect at every step improves outcomes.

Diagram 3 — Types of Stigmas

Enacted	Perceived	Internalised	Institutional
Direct discriminatory acts	Fear of being judged	Shame and self-blame	Policies and systems that disadvantage

(Presented here as a table for clarity; in slides this can be recreated as a spoke diagram with 'Stigma' at the centre and the four types radiating outward.)

Annexure 3: Practical Conversations and Dialogue Examples

These scripted conversations can be used for demonstration, role play, and group practice.

Conversation 1 - HIV Testing Registration

WRONG PRACTICE

Nurse: *Why do you need this HIV test? What kind of behaviour do you have?*

Client: *(looks down, silent) I... I just want to check.*

Nurse: *You young girls nowadays are very careless.*

Key problems: Public questioning, Judgmental tone, Stigmatizing, Undermines the client's dignity

CORRECT / SUPPORTIVE PRACTICE

Nurse: *Please come inside, we will talk privately.*

Nurse: *All our clients are offered HIV testing. Do you have any questions before we proceed?*

Client: *No, thank you.*

Nurse: *Your information will be kept completely confidential.*



LEARNING POINT

Privacy and neutral language encourage trust and uptake of testing.

Conversation 2 - Disclosure of HIV Result

WRONG PRACTICE

Counsellor: *Your HIV test is positive. You should have been more careful.*

Client: *What will happen to me now?*

Counsellor: *You will have to live with this for the rest of your life. You should have thought about the consequences before.*

Key problems: Blaming, Lack of empathy, Creating fear, Failing to provide accurate information

CORRECT / SUPPORTIVE PRACTICE

Counsellor: *Your test result is positive for HIV. I know this may be difficult to hear.*

Client: *What will happen to me now?*

Counsellor: *With treatment, people with HIV live long and healthy lives. We will support you through every step.*

Client: *Will others know?*

Counsellor: *No. Your result is confidential. Only those you choose to tell will know.*



LEARNING POINT

Empathy, reassurance, and confidentiality reduce fear and internalised stigma.

Conversation 3 - MSM Client Requesting PrEP

WRONG PRACTICE

Client: *Doctor, I would like to start PrEP.*

Doctor: *If you take PrEP, you will become immoral and careless.*

Client: *Then maybe I should not take it.*

Key problems: Provider bias, Discouraging an effective prevention method.

CORRECT / SUPPORTIVE PRACTICE

Client: *Doctor, I would like to start PrEP.*

Doctor: *PrEP is a very good prevention option for people at higher risk. Let us discuss how to take it correctly and continue other safer practices.*

Client: *Thank you, I feel relieved.*



LEARNING POINT

Positive, factual messaging promotes responsible prevention behaviour.

Conversation 4 - Pregnant Woman Newly Diagnosed

WRONG PRACTICE

Midwife: *Your test shows HIV infection. There is a risk your baby could also get HIV.*

Woman: *Will my child be safe?*

Midwife: *You should have thought about this before becoming pregnant. You will have to be very careful now.*

Woman: *Will others know?*

Midwife: *People may find out because you will need special treatment.*

Key problems: Fear-inducing communication, Blaming, Lack of reassurance,

CORRECT / SUPPORTIVE PRACTICE

Midwife: *Your test shows HIV infection. This does not mean your baby will be infected.*

Woman: *Will my child be safe?*

Midwife: *Yes. With proper treatment, we can almost completely prevent transmission.*

Woman: *Will others know?*

Midwife: *No. Your result is confidential and only the care team will know.*



LEARNING POINT

Supportive counselling strengthens EMTCT outcomes.

Conversation 5 - Laboratory Staff and Occupational Fear

WRONG PRACTICE

Technician: *I'm afraid to handle this blood sample from that patient. What if I get infected?*

Colleague: *You should ask someone else to do it.*

Technician: *Yes, I should not risk my life.*

Key problems: Fear and stigma toward the patient, Unprofessional behavior, Holds misconceptions.

CORRECT / SUPPORTIVE PRACTICE

Technician: *I'm a little concerned about handling this patient's blood.*

Supervisor: *Follow the same universal precautions we use for every patient.*

Technician: *Okay, I will follow the standard procedure and handle the sample safely.*



LEARNING POINT

Knowledge and supportive supervision reduce fear-based discrimination.

Annexure 4 - Visual Posters for Training Rooms and Clinics

Suggested poster messages for display in waiting areas and training rooms:

- "Respect is the first step of treatment"
- "Confidentiality builds trust"
- "No stigma. No discrimination. Quality care for all"
- "Universal precautions protect everyone"
- "Every client deserves privacy, dignity, and respect"

Suggested poster messages with Sri Lankan service context

- "Sexual health is health. Talk about it without shame"
- "HIV is a health condition - not a reason for discrimination"
- "Every person deserves care without judgment"
- "Different lives. Equal dignity. Equal care"
- "Treat the condition. Never judge the person"
- "Ask, don't assume. Listen, don't judge"

Annexure 5 - Facilitator Preparation Checklist

Task	Done
Read the full guide, including all annexures	
Confirm venue layout supports small-group and role-play work	
Print case scenario handouts (Session 3) - one set per group	
Print role-play cards (Session 4)	
Print pre- and post-training assessment forms	
Print training evaluation forms	
Prepare flipchart, markers, name tags, sticky notes	
Prepare or confirm certificates of participation	
Identify and brief a co-facilitator, if available	
Review debrief questions for each activity	

Annexure 6 — Facility Action-Planning Worksheet (blank, for reproduction)

Area of concern	Immediate action (1 month)	Long-term action (1 year)	Responsible person

Annexure 7 — Assessment Answer Key

Answer key for Part A of the Pre and Post Training Assessments [True/False]

#	Statement	Answer	Rationale
1	Stigma and discrimination mean the same thing.	FALSE	Stigma is an attitude; discrimination is the resulting action.
2	A person can be legally denied a health service because they are HIV-positive.	FALSE	Denial of care on this basis is a violation of patient rights and professional ethics.
3	Discussing a client's HIV status with colleagues who are not involved in their care is acceptable if it is 'for their safety'.	FALSE	Universal precautions make this unnecessary; it is a confidentiality breach.
4	Internalised stigma can prevent care-seeking even when no one else is present.	TRUE	Shame and self-blame operate independently of others' actions.
5	Universal precautions make it unnecessary to treat any patient differently based on their HIV status..	TRUE	Universal precautions apply equally to every patient, regardless of known status.

Annexure 8 — Sample Training Agendas

Full-day workshop (6–7 hours)

Time	Session
08:30 – 09:00	Registration
09:00 – 09:30	Session 1 — Introduction and Setting the Context
09:30 – 10:15	Session 2 — Understanding Stigma and Discrimination
10:15 – 10:30	Break
10:30 – 12:30	Session 3 — Case Scenarios in Health-Care Settings
12:30 – 13:30	Lunch
13:30 – 14:30	Session 4 — Role Play and Skills Practice
14:30 – 15:15	Session 5 — Ethics, Rights and Professional Responsibility
15:15 – 15:30	Break
15:30 – 16:15	Session 6 — Building Stigma-Free Services
16:15 – 16:45	Session 7 — Commitment and Closing

Half-day workshop (3–4 hours)

Time	Session
08:30 – 09:00	Registration
09:00 – 09:30	Session 1 — Introduction and Setting the Context
09:30 – 10:15	Session 2 — Understanding Stigma and Discrimination
10:15 – 10:30	Break
10:30 – 11:45	Session 3 — Case Scenarios (2 cases only)
11:45 – 12:15	Session 7 — Commitment and Closing

Annexure 9 - Training Evaluation Form

Please rate the following on a scale of 1 (poor) to 5 (excellent):

Item	1	2	3	4	5
Relevance of content to my work					
Clarity of facilitation					
Usefulness of case scenarios and role plays					
Opportunity to participate and ask questions					
Overall quality of the training					

What was most useful about this training?

.....

What would you improve for future trainings?

.....

Annexure 10 - Certificate of Participation (Template text)

CERTIFICATE OF PARTICIPATION

This is to certify that

has successfully participated in the training programme entitled
“Reducing Stigma and Discrimination in HIV and Sexual Health Services”
conducted by the **National STD/AIDS Control Programme, Ministry of Health,**
Sri Lanka

Venue: _____

Date: _____

Facilitator: _____

Programme Coordinator: _____

Annexure 11 - Glossary of Key Terms

Term	Definition
Stigma	A social process of labelling, stereotyping, and devaluing a person or group due to a characteristic, condition, or behavior.
Discrimination	Unfair or unequal treatment resulting from stigma, leading to denial of services, poor care, or violation of rights.
Enacted stigma	Direct, observable acts of discrimination, such as refusal of care or verbal abuse.
Perceived stigma	The anticipation or fear of being judged or discriminated against.
Internalized stigma	Shame, guilt, or reduced self-worth experienced by a person because of their own status or identity.
Institutional stigma	Policies, systems, or practices within an organization that disadvantage a particular group.
Key populations	Groups at higher risk of HIV, often facing additional social and legal barriers to care (for example, men who have sex with men, sex workers, and people who inject drugs).
PrEP	Pre-Exposure Prophylaxis: medication taken by HIV-negative individuals to reduce the risk of acquiring HIV.
EMTCT	Elimination of Mother-to-Child Transmission of HIV.
Universal precautions	Infection-control practices applied consistently to every patient, regardless of known or suspected infection status.
Confidentiality	The professional and ethical obligation to protect a client's personal health information from unauthorized disclosure.
Informed consent	A client's voluntary agreement to a test or treatment, given after receiving clear and adequate information.

Annexure 12 - References and Further Reading

- National STD/AIDS Control Programme, Ministry of Health, Sri Lanka - National HIV and STI guidelines and policy circulars
- World Health Organization (WHO) - Guidance on HIV testing services and stigma reduction in health-care settings
- Joint United Nations Programme on HIV/AIDS (UNAIDS) - Global guidance on stigma and discrimination reduction
- People Living with HIV (PLHIV) Stigma Index – Sri Lanka (2010)

REDUCING STIGMA AND DISCRIMINATION IN **HIV** AND **SEXUAL HEALTH SERVICES**

A Facilitator's Training Guide

Stigma and discrimination continue to be major barriers to equitable access to HIV and sexual health services. This facilitator's training guide provides practical tools, evidence-based insights, and interactive strategies to help healthcare providers, peer educators, and community facilitators create supportive, respectful, and inclusive environments.

Together, we can foster empathy, promote dignity, and ensure that everyone—without fear or judgment—can access the care and support they need.



THIS GUIDE WILL HELP YOU:



Understand stigma and discrimination in the context of HIV and sexual health



Develop skills to reduce stigma and promote respectful, person-centred care



Facilitate engaging discussions and activities in training sessions



Create inclusive services that leave no one behind

“

*Health services are stronger
when they are inclusive.
People are healthier when
they are treated with respect.*

”

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