Post-Test Support Services (PTSS)
Stigma Reduction Training
STIGMA REDUCTION USING THE STIGMA REDUCTION TOOLKIT FOR ACTION

1.0. PREAMBLE
HIV epidemic has been accompanied by ignorance, fear and denial and associated with stigma and discrimination. This has in turn impeded preventive efforts such as participation in voluntary counseling and testing and disclosure of sero-status to significant others. This recognition that HIV related stigma impacts negatively on prevention efforts and service delivery led to a study involving Ethiopia, Zambia and Tanzania. The broad objective of the study was to understand the underlying meanings and motivations for HIV related stigma and discrimination and their implications for activities designed to inform future interventions.

The study employed qualitative methods of community mapping, key informant interviews, focus group discussions, in-depth interviews and content analysis of newspapers. The study was carried out in an urban communities as well as rural communities, a cohort study of individuals who tested positive at an HIV voluntary counseling and testing centre was done as well as interviews with health personnel at teaching hospital and People living with HIV and AIDS and antenatal clinic attendees at a prevention of mother to child transmission intervention. The key findings distilled from this research project were:

- Knowledge on HIV and AIDS needs to be enhanced with an opportunity to process, discuss, and reflect on the information provided;
- Opportunities for values clarification and a safe space for sharing personal experiences and emotions allows staff to break down their own stigmatizing attitudes, language and behaviors and be aware of how these may influence the objectivity of the work that they are involved in.
- Language used to describe HIV and PLHA in the community reflected that employed by the media and was scaring, derogatory, judgmental, condemnatory and at times vengeful and vicious. It employed scaring tactics that have an effect of displacing the fear of HIV to PLHA.
- Community members appeared to be aware that risk of infection through casual contacts, such as sharing eating utensils, is very low. Yet there is disconnect between this awareness and emotional response to an infected person. An elder in the urban community observed: “even though it is said that HIV is not transmitted through eating, people will still avoid you”. Ignorance is generally recognized as an important factor that contributes to stigma. Once a person is known to be infected, he is perceived as promiscuous and sinful. It is paradoxical that in an urban community that has had to deal directly with AIDS patients is less tolerant in comparison with the rural community that has in the main only heard about the disease. People in the rural community appeared to be understanding and tolerant of PLHA although they had no personal experience of seeing or caring for PLHA. They freely expressed their ignorance and said they wished to learn more. They indicated that a patient with AIDS should be cared for just like any other patient: “it is not right to treat them differently”.
- With regard to provision of care, ignorance and fear of casual infection leads to neglect and poor care of patients. It is surprising that health personnel do not escape share of blame in this. Patients and relatives quickly learn that they do not obtain attention from doctors and nurses because their conditions are considered to be hopeless. Often health care providers offer differential care for patients with AIDS and often unintentionally stigmatize patients. The belief that HIV infection means immediate death fosters an atmosphere in which persons who are HIV infected are perceived to be non-productive members of society. Some religious leaders deny PLHA spiritual service including last rites (burial service).
Incomplete knowledge appears to contribute to misconceptions about PLHA including attributing to them ill motives and negative attributes. Incomplete knowledge may also contribute to the blaming of others as well as finger pointing to groups of people as cause of HIV transmission. Other than small children, no group of people appeared to be spared of blame.

Fear of stigma and discrimination is an impediment to positive sero-status disclosure. Stigma arises from perception of deviant sexual behaviors causing HIV and shame. Stigma is contagious to those who are associated or related to persons who have HIV or AIDS.

The trajectory evident from cohort study of individuals who tested positive at the voluntary counseling and testing centre suggest that HIV infected persons come to terms with their sero-status many months after post test counseling. Internalizing and integrating the full implications of a HIV positive status is a prolonged process worked through meaningful self-reflection. Initial self-reflection appears to center around what it means to be HIV infected and what may happen to them when they disclose their sero-status. Due to the limited disclosure of status to a small select support network, PLHA without visible symptoms continue to be protected from direct stigmatizing and discriminating experiences. PLHA perception that stigmatization happens more with visibility of symptoms than on disclosure of sero-status in a healthy person living with HIV also reflect that of the community. Posttest counseling’s focus on staying physically healthy appears to have a list of do’s and don’ts for fighting the infection … being hyper vigilant. Counseling may inadvertently reinforce anxiety that for the HIV infected person any deterioration in health making their status visible is paramount to saying you are not living positively. It is not so much the visibility of HIV positive status that is most feared but rather the fear of being stigmatized and discriminated against. From follow-up interviews with PLHA a pattern seems to emerge that as they continue to reflect on their HIV positive status a depressive cognitive bias of helplessness and fear for the future becomes more deeply ingrained overtime. Long term counseling about what positive living really means needs to focus more on dynamic issues such as integrating the fact of being, HIV positive and working towards a stage of being positive and comfortable with their status.

People’s attitude towards PLHA is stigmatizing whether due to ignorance, lack of knowledge, fear and denial. This stigmatizing attitude has engendered serious and often tragic consequences, denying people living with HIV and AIDS access to treatments, services and support.

Findings of this study lend support to the observation that “the epidemic of fear, stigmatization and discrimination has undermined the ability of individuals, families and societies to protect themselves and provide support and reassurance to those infected.

There is stigma in health care settings associated, with ignorance, shortage of protective supplies and post exposure prophylaxis (among other factors). This is in the background of environments where resources (financial, human, materials and time) for health care in general are limited. As a result of this, there is selective universal precautions and differential treatment of patients infected or perceived to be HIV infected. Health care providers would like to test for HIV or know the HIV status of their patients as protection from getting accidentally infected in the workplace, as they fear if they become HIV infected their community will view them as promiscuous and immoral. Health care providers hold the same judgmental and stigmatizing attitudes towards those who are HIV infected or have AIDS. They gossip about them and inadvertently disclose their sero-status, subjecting their patients to negative consequences associated with being HIV infected. Health care providers report families are reluctant to spend resources on care if they learn their relative is HIV infected. Health care providers feel that treating persons infected with HIV takes time, extra care, but there is little they can do to really help persons infected with HIV. They experience physical and emotional fatigue.
The above mentioned results have programmatic implications especially in as far as combating stigma and discrimination is concerned:

- There is a need to provide safe opportunities and spaces for individuals and groups to not only receive HIV and AIDS related information and knowledge but to also process and discuss it. This should include research and intervention program personnel.
- There is a need to develop programs that focus on reducing stigma as a primary goal and offer direct, structured opportunities for individuals, groups and communities to reflect and discuss HIV related stigma and resulting discrimination.
- It is recommended that participatory educational activities such as village or town meetings guided by facilitators will increase both knowledge and awareness sufficiently to dispel misconceptions and negative attitudes towards PLHA.
- Mechanisms need to be developed that allow for those who are secondarily stigmatized to work with counselors with the aim of changing the family and health care dynamics of cognitive attributions of self-blame and guilt.
- Reduction of parental and familial self-blame and guilt may help PLHA disclose HIV sero-status early and access the HIV prevention, care and support continuum. Intervention programs should also directly address the issue of blame and create an understanding that using blame as a way of dealing with HIV and AIDS deflects and misdirects energy and attention away from coming to terms with the reality of the epidemic and what needs to be done to stem the spread of HIV.
- Encouragement of public disclosure of positive sero-status should be done with care and due consideration together with appropriate preparation of PLHA in view of the amount of stigma and discrimination they are likely to be challenged with

1.1. THE STIGMA REDUCTION TOOLKIT

The toolkit has a participatory, interactive feel that comes from the development process. It was developed through a series of interactive materials design workshops conducted in Ethiopia, Zambia and Tanzania. These workshops built on each other to test the activities and materials developed in the previous and to design new exercise. The toolkit helps in making stigma “visible”, even to the stigmatizer. It does this through activities that are intended to help close the gap between good intentions and the unintended consequences of behavior. It helps people to see and recognize stigma in different contexts, with different kinds of people and situations.

The research told us that incomplete, partial or incorrect knowledge played a role and that fear was an important underlying driver of stigma. The toolkit has exercises to help people get a deeper level of knowing – a practical grasp of issues that are of concern – to explore these concerns and resolve them with facts, rather than myths and misperceptions.

In order to get underneath stigma means opening up discussion about commonly held beliefs and attitudes regarding issues such as morality prejudice, sex, and death. The toolkit allows for the discussion of sensitive topics such as sex, death, morality, judgment and blame.

In some languages, Kiswahili, for instance, the word stigma did not exist until very recently, so the toolkit instead used a number of indirect approaches – using pictures, stories, role plays and drama which allow participants to use their own words, to develop a common vocabulary to describe stigma. By describing the issue in their own terms, the toolkit enables communities and people to design their own responses.

Persons with HIV and AIDS have had a prominent role in the design of the toolkit and it is intended to strengthen their role in developing interventions to combat stigma.

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1 A preliminary draft that focuses on the Southern Asia epidemic is now available in Vietnamese.
As the subtitle suggests, the purpose of the toolkit is to enhance knowledge and understanding of HIV-related stigma and provide communities with the resources they need to create effective responses. Specifically:

- To create awareness within individuals that stigma exists, that they themselves have a role to play, and that by changing their own perspectives and actions they can make a difference.
- To improve the depth and quality of peoples understanding of HIV and AIDS in order to address fears and beliefs about casual transmission. And provide the space in which individuals can discuss and debate the values and beliefs that underlie stigma, and to take steps to challenge stigma in a variety of settings in their lives and in their communities.
- To strengthen PLHA by helping them deal with the HIV diagnosis, overcome the self-stigma and associated shame, rebuild their self-esteem, and develop appropriate skills to contribute to the fight against stigma.
- To provide communities and individuals with an opportunity to come together to discuss the issues confronting them and collaboratively decide on community – led responses.

Toolkit is a general resource collection of materials, which different groups can select from and adapt to suit different target groups. Modules are not a complete package for a single course; meant to be used as a set of optional activities which can be used as single activities or in different combinations for different target groups. Select from and adapt for use with different groups. It is not to be used as a complete package for a single course but a continuing package.

1.2.1. Resource for Participatory Learning
The toolkit is a learner-centered, participatory approach built around discussion and small group activities. The idea is for individuals and groups to build from and onto their own experiences, correcting misinformation, exploring their own fears, concerns, values and beliefs about AIDS and stigma, and then begin to talk and plan about what they can do practically to help reduce stigma.

1.2.2. Problem-Based Curriculum
The toolkit activities focus on problems or concerns, rather than theories or information bas topics of discussion. Problem based curriculum links learning directly to behavior change and focuses learning around study of real, not theoretical problems, builds practical knowledge, and applies it – working on practical and immediate solutions.

1.2.3. Target Groups
Major target audiences are the front-line staff--AIDS educators and counselors. The secondary target audiences are community groups which AIDS educators work with. Many of the same exercises (developed for AIDS educators and counselors) can be used with community groups. The third target audience--People living with HIV and AIDS (PLHA) and families living with HIV and AIDS. The toolkit will help PLHA and families play an important role in anti-stigma education. It will help them cope with stigma and self-stigma, and prepare them as educational facilitators.

As an entry point the toolkit starts by raising and challenging stigma among the front-line workers -- getting them to reflect on their own values, language, and relations with PLHA, before they try to educate others on stigma. It tackles stigma from two perspectives – the “stigmatizers” and the “stigmatized”. This allows for everyone to see how they stigmatize – often unknowingly and gives an opportunity for people to see what stigma feels like and for people living with HIV and AIDS to look at stigma and develop the skills and strategies to deal with it.

1.2.4. Community Ownership and Management
Anti-stigma education from which the toolkit draws from is rooted in a process of getting communities to take ownership and management of AIDS. Stigma needs to be addressed not only on an individual but a collective basis. Working as a community makes it possible for people to compare ideas and experience on stigma, learn from each other, set group or community norms for changed
attitudes and behavior, address the issue of how the community supports AIDS affected households, and work together to change things.

2.0. FACTS ABOUT HIV
(Refer to module 101)
3.0. NAMING THE PROBLEM

3.1. NAMING STIGMA THROUGH PICTURES

3.1.1. Objectives:
Participants will be able to:
(1) To identify different forms of stigma in different contexts
(2) To identify how stigma affects people with HIV
1 hour

In order to be able to “spot stigma” the discussion will take the form of a Picture-Discussion. The picture selection will be from pictures A1 to A41 in the picture book
• Instructions: Divide into groups of 2-3 people. Ask each group to select one of the pictures. Ask them to discuss—“What do you see in the picture? How does this picture show stigma?”
• Report back: Put up one picture at a time and ask the group to present their analysis. Record points on flipchart sheets. One other recorder should make a running list of common issues, which should be presented at the end.

3.2. PROBLEM TREE ANALYSIS: (root causes, consequences and effects of stigma)

3.2.1. Objectives
1. Identify different forms of stigma and how stigma affects people
2. Identify some of the root causes of stigma
1-2 hours

3.2.2. Activity
• Participants write points on cards and tape them on a wall diagram to make a “problem tree”, showing forms of stigma (main trunk), effects (branches) and causes (roots).
• Then points are reviewed—and more analysis is done on the causes.

3.2.3. Card-Storming
• Divide into pairs. Hand out cards and markers.
• Ask pairs to record each point on a different card and tape at the appropriate level of the diagram.
• Cluster common points and eliminate repetition.

3.2.4. Debriefing
• Review one level at a time. Cluster similar points and add extra points.
• Help participants see the two levels of effects—immediate impact on PLHA (isolation) and spin-off effects (loss of jobs).

3.2.5. Extra Analysis on Causes
• Identify a list of key causes of stigma: morality, low knowledge, fear of disease, poor health care, poverty, fatalism, media, gender, government policy.
• Set up a topic group for each cause.
• Ask groups to do a detailed analysis.
3.3. OUR EXPERIENCE AS STIGMATIZER AND STIGMATIZED

3.3.1. Objectives
Participants will be able to:
1. Describe some of their own personal experiences concerning stigma.
2. Identify some of the feelings involved in being stigmatized or stigmatizing others

1-2 hours

This exercise is used to get people to think about their own experience of “being isolated or rejected for being seen to be different” helped them see how it really feels to be stigmatized. People could see how HIV stigma hurts people.

3.3.2. Individual reflection on our own experience of being stigmatized

- Ask participants to sit on their own at a distance from other participants.
- Then say: “Think about a time in your life when you felt isolated or rejected for being seen to be different from others—or when you saw other people treated this way.”
- Explain that this does not need to be examples of HIV stigma—it could be any form of “isolation or rejection for being seen to be different.”
- Ask them to think about:
  - What happened?
  - How did it feel?
  - What impact did it have on you?”
- Sharing in Pairs Say—“Share with someone with whom you feel comfortable.”
- Report Back: invite participants to share their stories in the large group. There is no compulsion—people will share if they feel comfortable.
- Stop-Start Drama: invite some of the story tellers to act out their stories in short role plays (with other participants playing the other roles). This activity helps to make the stories come alive and to see the feelings involved—the pain in being rejected, isolated, or condemned. At the end of each scene ask the role players - “How did you feel to be stigmatized?”

3.3.3. Individual reflection our own experience of stigmatizing others

Ask participants to sit on their own. Then say—“Think about a time in your life when you isolated or rejected other people
- Sharing in Pairs: Say—“Share with someone with whom you feel comfortable.”
- Report Back: Invite participants to share their stories in the large group. There is no compulsion—people will share if they feel comfortable.
- Stop-Start Drama: Invite some of the story tellers to act out their stories in short role plays (with other participants playing the other roles). This activity helps to make the stories come alive and to see the feelings involved—the pain in being rejected, isolated, or condemned. At the end of each scene ask the role players - “How did you think the other person felt about being stigmatized?”

4.0. THINGS PEOPLE SAY: Sex, Morality, Shame and Blame

4.1. Objectives:
Participants will be able to:
1. Identify labels used by people to stigmatize PLHA and other stigmatized groups.
2. See that these words hurt

2 hours
4.1.1 Wearing labeled banners on the forehead

- Write on pieces of paper different roles and make the participants wear on their foreheads. Allocate roles to each person going round the circle—“PLHA, Sex Worker, Teenage Girl, Gay Man, Street Child, Widows, Famous person” Continue until everyone has been assigned a role.
- Then explain how the game works. You will walk around and act out what you feel about the role assigned to each of the group member
- Debriefing Ask: “How did it feel about the behavior portrayed by the other group members?
- Synthesize: Discuss what this means for stigma and stigma reduction activities

4.1.2 Rotational Brainstorm

- Things people say about: Stick on the wall six flip charts with roles assigned for the each flip chart—PLHA, sex workers, intravenous drugs users, women, street children, truck drivers, men who have sex with men.
- Activity Hand out markers. Ask each member to go in a rotational manner to a flipchart station and to write on the flipchart all the things people about the group.
- Synthesis: what is the meaning of these names, why are the people called such names, what does this mean to the person assigned these names

4.2. WHERE DID YOU GET IT FROM? Sex, Morality, Shame and Blame

4.2.1. Game and Song

<table>
<thead>
<tr>
<th>Participants will be able to:</th>
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<tbody>
<tr>
<td>1. See that asking PLHA &quot;where did you get it&quot; can be judging or stigmatizing</td>
</tr>
<tr>
<td>2. Analyze why people always ask this question when they meet PLHA</td>
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<tr>
<td>3. Explain how this question makes PLHA feel</td>
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<tr>
<td>4. Formulate arguments to counter this type of question when it occurs</td>
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30 minutes

4.2.2. Character Cards: Finger Pointing Pictures (A2 & A3)

- Explain that this session will look at why the first thing people always ask PLHA is “Where did you get it!”
- Pass the object (masking tape) around the circle. When the leader claps, the person holding the object at that time has to step into the center of the circle. The whole group points their fingers at him/her and chants 3 times, “Where did you get it?”
- The person in the centre responds to the same beat as the chant— for instance “I got it from my husband.” Record on flipchart and continue the game.

Buzz Groups

WHY DO WE ASK THIS QUESTION?
How did you feel when asked this question with everyone pointing fingers?
Why do we ask this question: "Where did you get it?"
Does the answer make a difference to how we respond to that person?

Report back

Help the group to see that:
1. This question is judging—we want to know how people have “sinned.”
2. The question makes PLHA feel bad or condemned.

5.0. FEARS ABOUT NON-SEXUAL (CASUAL) CONTACT
5.1. More Understanding and Less Fear

5.1.1. Objectives
Participants will be able to:
1. Name their fears in relation to specific forms of nonsexual contact with PLHA
2. Identify why they think that HIV can be transmitted through those activities

1 hour

5.1.2. Divide into pairs and ask
1. “What fears do you think people have about non-sexual casual contact with PLHA at home or at work?”
2. Ask pairs to write single points on cards and tape on the wall. Our aim is to find out indirectly what participants’ own fears are.

Please make reference to rooms in the house below where the point you have suggested may occur
Ask participants to prioritize—“What do you think are the biggest fears?”

1. Accidents—PLHA getting cut; coming into contact with PLHA blood
2. Contact with PLHA blood when I am helping to wash him at home
3. While preparing food, PLHA cuts herself by accident—blood gets on food
4. Helping to lift the PLHA when s/he has deep sores
5. Carrying the body of a dead PLHA to the church, mosque or cemetery
6. Eating a communal meal in a common pot with PLHA family member
7. PLHA holding or playing with children
8. Sharing toilets—virus from inside the toilet
9. Shaking hands—HIV in sweat
10. Sharing utensils—spoons, cups hold HIV virus from infected person
11. Kissing when the PLHA has cuts in his mouth or on his lips

Role Play
Then ask each pair to select one of the high priority fears and make a role play to show how people stigmatize because of fear of this form of contact.

6.0. DISCLOSING HIV SERO-STATUS

6.1. Objectives
1. Describe some of the issues involved in supporting PLHA to disclose their status to other family members
2. Understand some of the difficulties involved in disclosure

Materials: Pictures A29 and A42

6.1.1. Brainstorm: Why is it important for PLHA to disclose their status to other family members?

6.1.2. Picture-Discussion: How to disclose
Show picture A29 and A42 and discuss in pairs:
- What do you think is happening in the picture?
- What are the difficulties in disclosing to other family members?
If one of your family has told you/were to tell you about having HIV, how did/will you react?
Have/Would you told/tell anyone else in your family?

6.1.3. Paired Role Playing: Practice
- The aim is to help participants practice how to disclose the status of a loved one to other family members or friends.
- Divide into small groups and read the scenario.

Scenario: Georgina is a widow and a mother of five children. Last month her son returned from university and told her that he was HIV positive. He is still healthy, but he wanted his mother to know so that he can talk openly about it. He asked his mother if she would tell his brothers and sisters. His older sister is visiting today and Georgina has decided that she will try to tell her.

- Take turns in the different roles.
- Debriefing
  - Georgina: How did you feel about telling your daughter?
  - Daughter: How did you feel?
  - What techniques worked to tell the story?

6.1.4. Summary
- A strong feeling of unity in some families makes disclosure slightly easier
- If your relationship with someone is strong, it will probably withstand the disclosure
- Old conflicts within families are reinforced with HIV.
- Due to past relationships HIV gives people an excuse to confirm their prejudices
- Always check with the PLHA before informing third person of HIV status

6.2. Objectives
- Share experiences about telling family members about their status
- Describe some basic strategies for disclosing to members of the family
- Know when to keep quiet and not disclose one’s HIV status

2 hours

Hand out scenario from Naledi of Botswana (see Appendix 1) and then follow through with the discussions below

6.2.1. Discuss
- What happened to Naledi when she told her results to her husband?
- What are your own biggest fears about sharing your status with partners, family members, or friends?

6.2.2. Who did you tell first?

Option 1
Draw concentric circles on the flipchart. Write “ME” at the center of the inner circle. Then in the next circle write for example, my older sister, mother—the closer relationships are located closer to the center of the circle. Use this to show how to disclose your status on a gradual basis, starting with close family members (siblings) and then gradually moving out to other people. Use the first supportive person to help you talk to the rest of the family.
Distribute note cards and markers to participants and have them complete this exercise for themselves.
6.2.3. **In Pairs:** Disclosing to different family members
Discuss
- Who in your family have you told about being HIV positive?
- How did you do it?
- What happened?

6.2.4. **Paired role-play:** Deciding about disclosure
This exercise is designed to give people practice in disclosing to family members. Discuss in pairs:
- Who would you like to tell?
- What are some of your concerns about telling them?

6.2.5. **Role-play:**
Practice telling the person (take the role of the person you want to tell first of all, then swap)
After 5 minutes, ask one or two pairs to volunteer to come into the centre and show their role plays to the whole group.

6.2.6. **Debriefing**
Partner A - How did you feel about disclosing your status?
Partner B - How did you feel about your role as the listener?
Partner A - What techniques did you use to tell your story?

6.2.7 **When to Keep Quiet**
- Inform participants that there will be occasions when “keeping quiet” is a good coping mechanism to deal with stigma.
- As a large group, discuss situations where you might choose to keep quiet about your status, and about stigma etc. Record these situations on the flipchart paper.

6.2.8 **When to Keep Quiet Role Play**
- In small groups (3-4 people) choose one of the situations and practice a role-play the situation to show the effects of keeping quiet.
- Have each group perform the role play in front of the entire group. Then, in a large group, discuss
- Debrief (Record key concepts and points raised by the group on the flip chart):
  - What happened in the role-play
  - How did the strategy of keeping quiet work?
  - How do the characters feel?
  - Are there any other strategies you could use in this situation?

6.3.1 **Summary**
Who, when and where to tell someone about your status is a personal decision. You should never be put under pressure to tell someone you do not want to.

Most of the above exercises define disclosure as disclosure of HIV status. Sometimes, telling others that you had an HIV without telling them the results can be just as effective. Remind participant that disclosure can refer to the results of the HIV test or the act of getting an HIV test.

Practicing telling someone can be a useful way to develop personal strategies.

Avoid telling people who might use it against you.

Fear of stigma and blame are the main reasons that stop people from telling others about their HIV status.

7.0. PLHA COPING WITH STIGMA-ASSERTIVENESS

6.1. Objectives
1. Define and understand assertiveness
2. Practice some assertiveness skills

1-2 hours

7.1.1. What is assertiveness?

One reason why PLHA are treated as “victims” is that they allow themselves to be treated as “victims.” They remain passive, allow others to think and decide for them and keep their own feelings and ideas hidden. PLHA need to be more assertive if they are to gain more control over their lives and defend their rights.

Discuss in small groups:
- What do think about this view?
- What does it mean to be assertive?
- Why does being assertive help?

7.1.2. Paired Role Playing: Practicing assertiveness

- Divide into pairs and ask pairs to stand facing each other.
- Ask each pair to decide who the PLHA is and who the other person is.
- Give out the case studies

Scene 1: The PLHA has found a new friend—a neighbor. A family member objects to this friendship and wants to stop it.

Scene 2: The PLHA is sweeping the yard when her mother returns from the market.

Then explain the PLHA role—Your role is to (1) decide what you want to say and to say it clearly, (2) stick to this statement, repeating it over and over, if necessary and (3) brush off the other person’s excuses—and then repeat your demand.

Then ask all the pairs to play (at the same time).

After a few minutes, shout “stop” and ask to see a few of the plays.

After a few demonstration plays, stop and ask:
- What happened?
- How did you feel?
- How can you assert your rights to contribute in different settings and keep control over your life?
- When people suggest solutions, ask one of the pairs to play it out.
- Then discuss what made a difference
7.2. How to be assertive?

- Saying what you think, feel, and want in a clear and honest way that is good for yourself and others.
- It is not being aggressive or showing anger.
- It is repeating one self several times to stand for you rights
- It is simply telling people in a clear and honest way what you
  - think
  - feel and
  - want

7.3. Why be assertive?

- Increase your confidence.
- Stand up for your rights.
- Gain more respect from others.
- Improve your relationships.
- Gain more control over your life.

8.0. CHALLENGING STIGMA

**8.1. Objectives:**
1. Identify statements which are stigmatizing
2. Develop arguments for challenging stigma when it occurs

**1 hour**

Invite participants to take turns sitting in the "HOT SEAT". The person in the hot seat is expected to improvise challenges to stigmatizing statements presented one at a time from other members of the group. The person in the HOT SEAT should quickly respond with short, assertive, and strong rebuttals. See the stigmatizing statements below:

- Use any common statements relevant to the group/community/language
- Don’t stand too close to someone with TB
- People who sleep around deserve what they get
- I feel sorry for the children who get HIV
- If I got AIDS I’d kill myself
- You deserve to get sick if you behave badly
- I don’t want my children to go to school with a child who is HIV positive
- She looked so thin, I said “Go and say goodbye to your mother.”
- If you have TB you must have slept with a woman who had an abortion
- I do not want a house help who is HIV positive to care for my child

**Discussion:** “What methods work best for challenging stigma? Be specific. What could individuals in the HOT SEAT said or done differently in response to the stigmatizing statements?”

**Summary:** The most powerful responses are those which make people stop and think, rather than attacking responses which make the stigmatizer defensive. Examples of strong responses:

- You only need to sleep with one person to get HIV.
- My sister had TB and she is fine now.
You may be in the same boat in a year's time so you should be more compassionate to PLHA now.

9.0. ACTION PLANNING

9.1. Finding solutions in context

9.1.1. OBJECTIVES
Participants will be able to:
1. Develop practical strategies for overcoming stigma in their own context

1 hour

Put up signs (in different parts of the room) for meeting spaces for different task groups. For instance: PLHA, home based care, youth, counseling, health care, workplace, schools, faith groups and media.

This exercise can be used in large workshops at the national or district or regional levels where there are participants from different NGOs or agencies. The exercise is built around task groups formed around different interests: PLHA support work, home based care, youth work, counseling, health work, workplace education, schools, and media depending on those present. This exercise can support the development of anti-stigma policies and practice.

Group division
Ask participants to “vote with their feet”—to join the group of their own choice.

Task Group Discussion
Ask groups to develop concrete action plans:
1. What forms of stigma do you see in your organization or community?
2. What is the biggest stigma problem in your organization or community?
3. What is the source of this problem?
   Option: Use problem tree or fishbone, if appropriate.
4. What are some possible solutions to this problem?
5. Identify 2-3 specific new things you would like to do to stamp out stigma in this context
6. Push groups to be concrete, “Think big. Start small. Act now!”

Report back
Ask each group to give a report on this discussion then quick comments.

9.2. Moving to action
Divide into small groups (2-4 members) for this exercise. After each step get a quick report back and then move to the next step.
9.2.1. Situation analysis

Ask “What is the current situation in the community regarding HIV stigma? What forms of stigma are common in the community?

What are some of the background factors?“-
- Lots of secrecy and silence around sex and AIDS – people find it difficult to talk
- Denial that AIDS is a problem
- AIDS affected households are the target for insults, exclusion and discrimination
- Lots of hidden conflicts between different households
- High levels of fear, fatalism and hopelessness
- Low knowledge and belief and fear of infection through casual contact
- Huge workload for women in AIDS affected households, including care of PLHA
- High levels of poverty and unemployment - impact on AIDS and on stigma
- Young women at high risk - coercion, poverty and limited control over sexuality
- Poorly run and equipped health services and lack of trust in health services

9.2.2. Moving to Action

OBJECTIVES
Participants will be able to:
1. Work out a detailed strategy for taking action against stigma

2 hours

9.2.2.1. Changing attitudes and behavior

Exercise: select specific context
This can either be done as a single large group exercise, or participants can be split into groups to work on specific contexts.
1. Strategy for changing attitudes
2. Explain that this exercise will look at a strategy for changing attitudes in a specific context faith based organizations (FBO).
3. Ask “What are the attitudes of faith based organizations towards PLHA?”
4. Two types of attitudes which are contradictory:
   5. Caring and compassion towards PLHA and their families
   6. Judging and condemnation—“You are promiscuous. You are a sinner.”

Ask “What strategies can we use to help the faith based organizations become less judgmental and more caring?”

Suggestions for change
1. Build on their strengths—their capacity for care and support to PLHA and families
2. Help churches/mosques analyze their own approach to PLHA and decide themselves they want to change their judging and stigmatizing habits
3. Bring FBO together to create a common message concerning stigma
4. Participatory workshop in which they can talk about their concerns and fears
Appendix 1: Naledi of Botswana Scenario

The funeral took place a week after her husband’s death, followed by a week of being insulted by her in-laws for bewitching their only son brother. As she watched the coffin being lowered into the grave, she whispered to herself, “If you had only listened to me, you would be alive. I would not have to take so many insults from your family.” As she tried to stand up to throw soil into the grave, she fainted. Her husband’s family would say that it was her guilty conscience for killing her husband so that she could inherit the big house he had just finished building. While she knew her husband had died of AIDS, Naledi decided to keep it to herself. Even if she told them they would never believe her. If anything they would say she had infected him with it. Her problem started two years earlier when she decided to go for an HIV test. Her husband refused to go with her. When her test results were positive, her husband would not accept it. “He kept denying the fact that I had the virus and that he might also have it. He even insisted that we should not use condoms, until it reached a point where we fought over condom use. He still refused to go for a test when he started to lose eight, claiming that he was on a diet. He finally agreed on his deathbed that he could be tested for AIDS. He dies knowing that he had the virus. But he was my husband, and I will love him always. That is why I will keep his secret.”

Source of Case Study: Article “Me Go for a Test? No Way!” by Gregory Kelebonye in mmegi Monitor (Botswana) 29 April to 5 May 2003.