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FACILITATOR'S TRAINING GUIDE FOR A STIGMA-FREE HEALTH FACILITY

Training Menus, Facilitation Tips, and Participatory Training Modules

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Training Menus, Facilitation Tips, and Participatory Training Modules

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Overview

Welcome! This training guide is designed to help facilitators promote "stigma-free" HIV services through training of health facility staff. The facilitator's guide is a set of educational exercises intended to raise awareness and promote advocacy and action to challenge HIV and key population stigma and discrimination (S&D). It will be used by facilitators to run training workshops that teach health facility staff about the issues people living with HIV (PLHIV) and key populations are facing in health facilities, and what might be done to change this situation.

Globally, many people living with or perceived to have HIV, as well as key populations, experience negative attitudes and harmful actions in health facilities that undermine their health and ability to lead a productive life. However, health facility staff actions worldwide demonstrate that S&D can be successfully addressed. Stigma-reduction efforts in settings as varied as Brazil, China, Ghana, India, Tanzania, and Vietnam have resulted in significant changes in health facility staff attitudes and practices, and better quality care for PLHIV and other key populations, such as men who have sex with men (MSM), people who use drugs, transgender people, and sex workers.

A stigma-free health facility is one in which PLHIV and other key populations are treated with respect and compassion and provided with high-quality care. In a stigma-free facility, staff also are able to protect themselves from HIV transmission in the workplace through the use of Standard Precautions, which the World Health Organization (WHO) defines as the basic level of infection control precautions for all patients. In a stigma-free facility, staff also feel confident about getting tested for HIV, living with HIV, and continuing to work.

The facilitator's guide is written for you—the facilitator. It provides detailed, step-by-step instructions on how you can plan and facilitate S&D-reduction sessions. The guide has two parts. Part One is a set of training menus that provide curricula options for different types of health facility staff (e.g., managers, doctors, nurses, support staff, trainers) using the participatory modules provided in Part Two.

Part Two begins with general guidelines and tips for facilitating the training modules. Modules A–E are the participatory training modules that provide core exercises to raise the awareness of health facility staff about S&D in the health facility and help them change their attitudes and behavior toward PLHIV and key populations. The modules also cover basic skills on Standard Precautions. These exercises use a participatory approach—one based on discussion, small group activities, case studies, and other participatory methods (e.g., role-playing, cardstorming) aimed at making the learning lively and fun. The aim is to get participants actively involved in thinking about the issues affecting PLHIV and key populations, rather than passively listening to a lecture. Participants learn through sharing ideas, discussing and analyzing issues, relating new concepts to their own experience, trying to find solutions to problems, and planning what they can do to challenge S&D. This approach fosters learners' sense of initiative and responsibility and reinforces their ability to think for themselves—a feature needed in building self-reliant action and advocacy.

PART 1

Training Menus: Curricula Options for Different Audiences and Timeframes

Introduction

This section provides a number of sample training programs, which combine the training modules or exercises from the following five participatory training modules:

A. Naming Stigma & Discrimination in Health Facilities

B. Judgments and Values: Breaking Down Stigma Toward Key Populations

C. HIV and AIDS Update

D. Standard Precautions and Overcoming Stigma

E. Developing a Code of Conduct and Action Plan for a Stigma-free Health Facility

The sample programs show how to combine the exercises into a single course. The programs are standardized courses of different lengths (e.g., half day, one day, four days) and for different health facility staff target groups (e.g., facility managers, doctors, other medical health workers, nonmedical health workers, trainers, health trainees, etc.). The modules include the best exercises on S&D and Standard Precautions, drawn from different training manuals (see Annex, p.142). The selection is deliberately tight—the aim is to provide the minimum needed to help health facility staff understand S&D and change their attitudes and behavior toward PLHIV and key populations. The modules cover the most important topics on S&D and Standard Precautions. The sample training programs can be introduced as a single event—for example, intensive training course over one to three days—or as a series of two-hour training events over several weeks or months (see below).

The modules include core exercises—those to which every health facility staff member should be exposed—and, in some cases, the following optional exercises:

- CORE EXERCISES are the most important exercises; they are included in all courses for health facility staff—e.g., A1, A2, A3, A4, A6, B1, B2, B4, C1, and D1, plus the Code of Conduct exercise (E).These are the minimum needed to understand S&D.
- OPTIONAL EXERCISES are those that can be added when health facility staff have more time to look at the stigma issue in depth; for example, looking at stigma directed toward health facility staff (A5) or key populations (B6, B7, B8, C2, and C3), or more in-depth information on Standard Precautions (D2, D3, D4, D5), or counseling skills and challenging stigma (B9, B10).

Packaging of Training

This is not a one-size-fits-all approach. It is a MODULAR curriculum—a set of modules that can be packaged in different ways for different audiences.

The modular approach allows each trainer to package the training to suit his/her audience, the workplace context, and the amount of time available. The set of modules can be used to organize the following:

- A complete course on stigma over two to three days—a course consisting of several modules and giving health facility staff an intensive exposure to stigma over a short period
- A series of short two-hour sessions over several weeks or months – training in smaller doses spread out over a longer period of time
- A short intensive course of one or two days, reinforced with one- to two-hour follow-up sessions
- A stigma component (two to three sessions) within a larger training course on HIV

The context for this training can also vary widely. The training could take a number of different forms:

- Stigma training within a single health facility for all of the staff in the facility—a stigma reduction program addressing the health facility staff as a team
- Stigma training modules as part of a continuing education program for health workers[1]
- Stigma sessions included within refresher training on HIV for health facility staff

The training kit can be used to organize intensive, standalone courses on stigma or to "mainstream" awareness on stigma—to integrate stigma sessions into other HIV training activities and workplace meetings, making it a regular part of all training activities for health workers.

The package of modules could also be used in pre-service training.

We also recommend that all courses be followed up with a half-day reinforcement course (see Course Q) to reflect on S&D after the original training and discuss how health workers are implementing the Code of Conduct they developed in the first course. This course would be conducted three to six months after the completion of the Code of Conduct.

Timing Issues

Each organization will determine how the training will be organized—either during a single time period (one to four days, depending on the time available) or spread out over several weeks. This will depend on the availability of health staff and what schedules can be agreed on locally for in-service training.

We recommend that the basic course on stigma for medical and nonmedical health workers be at least two days long. From our experience, one day is too short to cover the key topics, bring about a real change in attitudes and behavior, and have enough time to agree on a Code of Conduct for creating a stigma-free health facility.

If the course includes a more intensive training on Standard Precautions, then a longer course is needed.

The modules are roughly one hour in length, but the time for doing each activity may vary, depending on factors such as the number of participants or small groups.

The agendas or timetables described in this section are dense—there is very little extra time. Taking too long for one activity will affect the amount of time you have for other activities, so try to stick to the time suggested.

Given the tight timeframes, you may need to condense some of the activities or place greater or lesser emphasis on others, depending on your observation of the needs of the participants. Feel free to make the necessary adjustments to save time.

Who Should Attend the Training?

ALL staff employed in the health facility should be involved in the training, including people who provide health services directly (e.g., doctors, nurses, pharmacists, and lab technicians) and those who work indirectly to support the delivery of health services (e.g., managers, accountants, receptionists, cleaners, drivers, and security guards). All health facility staff have fears about HIV and may stigmatize clients, so the training should be provided for all of them. All staff members can contribute to building a stigma-free health facility.

1. In some Caribbean countries, a continuing education program is a requirement for certain categories of health workers. For example, in Barbados, every doctor is required to attend a number of continuing education sessions every year. Stigma training modules could be incorporated into this compulsory training program.

Mixed Groups or Single Cadre Groups?

In organizing the training, you may decide to bring together different cadres from different departments—for example, all of the health facility staff from different departments in a single training facility (both those providing direct medical care and those supporting them). This mixed approach helps to build better relations among staff, but it requires good facilitation skills to make sure that the more educated and powerful groups (e.g., doctors) do not dominate, and that other staff members develop the courage to talk. You will need to start off with activities that get everyone talking and interacting as peers—to help nurses and auxiliary staff talk as equals with doctors.

In some settings, the integration of different cadres and levels of staff within the training may be regarded as too radical a step. In such cases, an alternative might be to run the training for single groups (e.g., all of the doctors in one session) and then run an additional session near the end of the process, bringing all of the groups together, perhaps in developing the Code of Conduct.

Health Workers Living with HIV or from Other Key Populations

In planning your workshop, you should assume that some participants or trainers may be HIV positive or members of a key population. Participants or trainers may or may not have disclosed this information to other participants or choose to share it during the training.

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

PLHIV AND KEY POPULATIONS AS CO-FACILITATORS

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

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

PLHIV and members of key populations should be invited to help plan the training program, serve as co-facilitators, and monitor and evaluate the training program.

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

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

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

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

Sample S&D Training Programs

Introduction

This section provides sample timetables for the following workshops:

A. Half-day workshop for health facility managers
B. One-day workshop for health facility managers
C. Two-day workshop for medical health workers
D. Three-day workshop for medical health workers
E. Ten-week modular course for medical health workers—two hour sessions once a week over 10 weeks
F. Four-day workshop for medical staff, including full component of Standard Precautions
G. Three-hour introductory workshop for doctors
H. One-day workshop for doctors
I. Three-hour workshop for doctors on stigma toward key populations
J. One-day workshop for nonmedical health staff
K. Two-day workshop for nonmedical health staff
L. Three-day intensive workshop on stigma toward key populations (also includes basics on S&D)
M. Two-day workshop on stigma toward men who have sex with men (MSM) (also includes basics on S&D)
N. Two-day workshop on stigma toward people who use drugs (also includes basics on S&D)
O. Two-day workshop on stigma toward sex workers (also includes basics on S&D)
P. Four-day training-of-trainers (TOT) workshop for S&D reduction trainers
Q. Half-day reinforcement course—follow-up to all of the courses listed above
R. Pre-service course for health worker trainees—two-hour sessions once a week over 12 weeks

Assumptions:

Four sessions in the morning (one hour each) and two sessions in the afternoon (one hour each), producing a total of roughly six sessions per day and covering roughly six hours. Most sessions can be squeezed into one hour; however, some sessions may take longer.

Extra Notes:

- The workshops are described as full-day sessions, but you may choose to organize them as half-day sessions.
- The workshops are described as a block of continuous training over several days—ensuring that the modules are closely linked and the learning process is sustained. However, it is also possible to organize the training to take place for two to four hours every week (see sample timetable E). This depends on the local schedule and the availability of health workers for training.

A Vietnam stigma-reduction training program conducted in hospitals was scheduled as half-day or one-day blocks of training held every week over a four-week period. The training blocks included the following: Stigma Awareness (half day), HIV Knowledge Update (half day), Universal Precautions (one day), and Hospital Policy Development (one day). This scheduling fit into health workers' schedules and did not interfere with normal hospital services. Staff availability was negotiated with hospital managers. Target groups for training included doctors and nurses, auxiliary nurses (ward staff), and administration and support staff.

Oanh, Khuat Thi Hai, Kim Ashburn, Julie Pulerwitz, Jessica Ogden, and Laura Nyblade. 2008. "Improving Hospital-based Quality of Care in Vietnam by Reducing HIV-related Stigma and Discrimination." Horizons Final Report. Washington, DC: Population Council.

A. Half-day Workshop for Health Facility Managers

Description

The aim of this workshop is to provide an overview and general understanding of S&D in the health facility so that health facility managers can plan and manage the training of other staff in their facilities and lead the process of developing a Code of Conduct.

Target Group

Health facility managers

Objectives

By the end of the training, the health facility managers will have accomplished the following:

- Identified some of the common examples of stigma in their own health facilities
- Discussed the forms, effects, and causes of stigma in health facilities
- Agreed on an action plan to train health workers and develop a Code of Conduct

Modules

NUMBER	TITLE	TIME
A1 or A4	Naming Stigma in Health Facilities Through Pictures; or Naming Stigma in our Health Facility (Case Studies)	1 hour
A6	Analyzing Different Forms of Stigma in Health Facilities	1 hour
E	Planning a Program to Develop a Stigma-free Health Facility	1.5 hours

B. One-day Workshop for Health Facility Managers

Description

This is a longer workshop for health facility managers. The extra half day makes it possible to explore stigma toward key populations and cover the basics on Standard Precautions.

Target Group

Health facility managers

Objectives

By the end of the training, the health facility managers will have accomplished the following:

- Identified some of the common examples of stigma in their own health facilities
- Discussed the forms, effects, and causes of stigma in health facilities
- Developed skills and a better understanding of how to implement Standard Precautions
- Agreed on an action plan to train health workers and develop a Code of Conduct

Modules

NUMBER	TITLE	TIME
A1 or A4	Naming Stigma in Health Facilities Through Pictures; or Naming Stigma in Our Health Facility (Case Studies)	1 hour
A2	How Stigma Feels (Reflection Exercise)	0.5 hour
B4	Exploring Beliefs and Attitudes About PLHIV and Other Key Populations (Value Clarification Exercise)	1 hour
D1	What Are Standard Precautions?	1 hour
A6	Analyzing Different Forms of Stigma in Health Facilities	1 hour
E	Planning a Program to Develop a Stigma-free Health Facility	1 hour

C. Two-day Workshop for Medical Health Workers

Description

A two-day workshop for medical health staff that provides an overview and general understanding of S&D, including forms of stigma in the health facility, key populations, Standard Precautions, and developing a Code of Conduct. Two days is a brief time period for the course, so the facilitators will need to manage their time carefully.

Target Group

Medical health workers, including nurses and other health professionals

Objectives

By the end of the training, the health workers will have accomplished the following:

- Identified some of the common examples of stigma in their own health facilities
- Discussed the forms, effects, and causes of stigma in health facilities
- Demonstrated new attitudes of respect and tolerance toward PLHIV and other key populations
- Increased their understanding of HIV transmission and the reality of occupational risk
- Developed skills and a better understanding of how to implement Standard Precautions
- Written a Code of Conduct for a stigma-free health facility

Modules

NUMBER	TITLE	TIME
DAY ONE		
A1 or A4	Naming Stigma in Health Facilities Through Pictures; or Naming Stigma in Our Health Facility (Case Studies)	1 hour
A2	How Stigma Feels (Reflection Exercise)	0.5 hour
A3	Effects of Stigma on the HIV Epidemic	1 hour
B4 or B5	Exploring Beliefs and Attitudes About PLHIV and Other Key Populations; or The Blame Game—Things People Say About PLHIV and Other Key Populations	1 hour
C1	Fears About Getting HIV Through Nonsexual Casual Contact	1 hour
B1	Reflection Quiz on Key Populations (Homework)	Homework
DAY TWO		
B2	Panel Discussion on Key Populations; or Review of Answer Sheet	1 hour
D1	What Are Standard Precautions?	0.5 hour
A6	Analyzing Different Forms of Stigma in Health Facilities	1 hour
E	Developing a Code of Conduct for a Stigma-free Health Facility	2 hours

D. Three-day Workshop for Medical Health Workers

Description

This is a three-day intensive workshop for medical staff. The longer three-day program provides the opportunity to explore the topics in more depth. The workshop covers all of the basics on value- and fear-based stigma, and an introduction to key populations and Standard Precautions. The last step is to develop a Code of Conduct.

We consider three days an ideal length for a basic course on stigma reduction among health workers.

Target Group

Medical staff, including nurses and other health professionals

Objectives

By the end of the training, the health workers will have accomplished the following:

- Identified some of the most common examples of stigma in their own health facilities
- Discussed the forms, effects, and causes of stigma in health facilities
- Demonstrated new attitudes of respect and tolerance toward PLHIV and other key populations
- Increased their understanding of HIV transmission and the reality of occupational risk
- Written a Code of Conduct for a stigma-free health facility

Modules

NUMBER	TITLE	TIME
DAY ONE		
A1	Naming Stigma in Health Facilities Through Pictures	1 hour
A2	How Stigma Feels (Reflection Exercise)	1 hour
A4	Naming Stigma in Our Health Facility (Case Studies)	1 hour
A3	Effects of Stigma on the HIV Epidemic	1 hour
A2	How Stigma Feels (Reflection Exercise)	1 hour
B5	The Blame Game—Things People Say About PLHIV and Other Key Populations	1 hour
B1	Reflection Quiz on Key Populations (Homework)	Homework
DAY TWO		
B2	Panel Discussion on Key Populations; or Review of Answer Sheet	1 hour
D1	What Are Standard Precautions?	1 hour
B4	Exploring Beliefs and Attitudes About PLHIV and Other Key Populations (Value Clarification Exercise)	1 hour
C2 or C3	HIV Transmission and MSM; or HIV Transmission and People Who Use Drugs	1 hour

NUMBER	TITLE	TIME
DAY THREE		
A6	Analyzing Different Forms of Stigma in Health Facilities	1 hour
B9	Counseling Skills and Value Judgments	1 hour
B10	Challenge the Stigma—and Be the Change!	1 hour
E	Developing a Code of Conduct for a Stigma-free Health Facility	2 hours

E. Ten-week Course for Medical Health Workers—10 Weeks x Two-hour Sessions per Week

Description

This is a series of short, two-hour training sessions on stigma and Standard Precautions introduced over a period of 10 weeks. Trainees receive two hours of training once a week over the 10-week period.

Target Group

Medical staff, including nurses and other health professionals

Objectives

By the end of the training, the health workers will have accomplished the following:

- Identified some of the most common examples of stigma in their own health facilities
- Discussed the forms, effects, and causes of stigma in health facilities
- Demonstrated new attitudes of respect and tolerance toward PLHIV and other key populations
- Increased their understanding of HIV transmission and the reality of occupational risk
- Written a Code of Conduct for a stigma-free health facility

Modules

NUMBER	TITLE	TIME
WEEK 1		
A1	Counseling Skills and Value Judgments	1 hour
A3	Challenge the Stigma—and Be the Change!	1 hour
WEEK 2		
A2	How Stigma Feels (Reflection Exercises)	1 hour
A4	Naming Stigma in our Health Facility (Case Studies)	1 hour
WEEK 3		
B5	The Blame Game—Things People Say About PLHIV and Other Key Populations	1 hour
B4	Exploring Beliefs and Attitudes About PLHIV and Other Key Populations (Value Clarification Exercise)	1 hour
B1	Reflection Quiz on Key Populations (Homework)	Homework
WEEK 4		
B2	Review on Homework and Answer Sheet	1 hour
B6	Understanding the Different Identities of Sexual Minorities	1 hour

NUMBER	TITLE	TIME
WEEK 5		
C1	Fears About Getting HIV Through Nonsexual Casual Contact	1 hour
C2	HIV Transmission and MSM	1 hour
D1	What Are Standard Precautions?	0.5 hour
WEEK 6		
D2	Use of Protective Apparel and Stigma	1 hour
D3	Fear of Infection Through Use of Sharps	1 hour
WEEK 7		
D4	Health Facility Hygiene and Waste Disposal	1 hour
D5	Occupational Exposure, PEP, and Stigma	1 hour
WEEK 8		
A6	Analyzing Different Forms of Stigma in Health Facilities	1 hour
A5	Stigma Faced by Health Workers—Health Workers Living with HIV	1 hour
WEEK 9		
B9	Counseling Skills and Value Judgments	1 hour
B10	Challenge the Stigma—and Be the Change!	1 hour
WEEK 10		
A7	Human Rights—PLHIV and Key Populations	1 hour
E	Developing a Code of Conduct for a Stigma-free Health Facility	1 hour

F: Four-day Workshop for Health Workers (Including Standard Precautions)

Description

This is a four-day workshop for medical staff that allows time for both an in-depth understanding of stigma within the healthcare setting and Standard Precautions.

Target Group

Medical staff, including nurses and other health professionals

Objectives

By the end of the training, the health workers will have accomplished the following:

- Identified some of the most common examples of stigma in their own health facilities
- Discussed the forms, effects, and causes of stigma in health facilities
- Demonstrated new attitudes of respect and tolerance toward PLHIV and other key populations
- Increased their understanding of HIV transmission and the reality of occupational risk
- Developed skills and a better understanding of how to implement Standard Precautions
- Written a Code of Conduct for a stigma-free health facility

Modules

NUMBER	TITLE	TIME
DAY ONE		
A1	Naming Stigma in Health Facilities Through Pictures	1 hour
A4	Naming Stigma in our Health Facility (Case Studies)	1 hour
A3	Effects of Stigma on the HIV Epidemic	1 hour
A2	How Stigma Feels (Reflection Exercise)	0.5 hour
B5	The Blame Game—Things People Say About PLHIV and Other Key Populations	1 hour
B1	Reflection Quiz on Key Populations (Homework)	Homework
DAY TWO		
B2	Panel Discussion on Key Populations	1 hour
C1	Fears About Getting HIV Through Nonsexual Casual Contact	1 hour
D1	What Are Standard Precautions?	0.5 hour
C2 or C3	HIV Transmission and MSM; or HIV Transmission and People Who Use Drugs	1 hour
B4	Exploring Beliefs and Attitudes About PLHIV and Other Key Populations (Value Clarification Exercise)	1 hour

NUMBER	TITLE	TIME
DAY THREE		
D2	Use of Protective Apparel and Stigma	1 hour
D3	Fear of Infection Through Use of Sharps	1 hour
D4	Health Facility Hygiene and Waste Disposal	1 hour
A6	Analyzing Different Forms of Stigma in Health Facilities	1.5 hours
B9	Counseling Skills and Value Judgments	1.5 hours
DAY FOUR		
D5	Occupational Exposure, PEP, and Stigma	1 hour
A7	Human Rights—PLHIV and Key Populations	1 hour
B10	Challenge the Stigma—and Be the Change!	1 hour
E	Developing a Code of Conduct for a Stigma-free Health Facility	2 hours

G: Three-hour Introductory Workshop for Doctors

Description

This is a mini-workshop for doctors who may not have time for a full workshop. The three hours includes an introduction to stigma in health facilities; a reflection on personalizing stigma; and an opportunity to analyze stigma in health facilities, with a view to suggesting actions for change.

If possible, follow up this workshop with Workshop I, which focuses on key populations.

Target Group

Doctors

Objectives

By the end of the training, the doctors will have accomplished the following:

- Identified some of the most common examples of stigma in their own health facilities
- Discussed the forms, effects, and causes of stigma in health facilities
- Discussed further steps for helping to reduce stigma in their health facilities

Modules

NUMBER	TITLE	TIME
A1 or A4	Naming Stigma in Health Facilities Through Pictures; or Naming Stigma in our Health Facility (Case Studies)	1 hour
A3	Effects of Stigma on the HIV Epidemic	1 hour
A2	How Stigma Feels (Reflection Exercise)	0.75 hour
A6	Analyzing Different Forms of Stigma in Health Facilities	1 hour

H: One-day Workshop for Doctors

Description

The one-day workshop includes an introduction to stigma in health facilities; a reflection on personalizing stigma; and an opportunity to analyze stigma in health facilities, with a view to suggesting actions for change.

If possible, follow up this workshop with Workshop I, which focuses on key populations.

Target Group

Doctors

Objectives

By the end of the training, the doctors will have accomplished the following:

- Identified some of the most common examples of stigma in their own health facilities
- Discussed the forms, effects, and causes of stigma in health facilities
- Discussed further steps for helping to reduce stigma in their health facilities

Modules

NUMBER	TITLE	TIME
A1 or A4	Naming Stigma in Health Facilities Through Pictures; or Naming Stigma in our Health Facility (Case Studies)	1 hour
A2	How Stigma Feels (Reflection Exercise)	0.5 hour
A3	Effects of Stigma on the HIV Epidemic	1 hour
B4	Exploring Beliefs and Attitudes About PLHIV and Other Key Populations (Value Clarification Exercise)	1 hour
A6	Analyzing Different Forms of Stigma in Health Facilities	1 hour
E	Developing a Code of Conduct for a Stigma-free Health Facility	1 hour

I: Three-hour Workshop for Doctors (Focus on Key Populations)

Description

This is a mini-workshop for doctors that focuses on stigma toward key populations, with the aim of increasing understanding of the needs of key population groups and breaking down stigma in health facilities. This can be a stand-alone training or a follow-up from the introductory workshops (either G or H, described above).

Target Group

Doctors

Objectives

By the end of the training, the doctors will have accomplished the following:

- Explored their own attitudes toward key populations
- Discussed how HIV stigma increases the marginalization of key populations and results in their not accessing health services
- Increased their understanding of the experiences and needs of PLHIV and other key populations

Modules

NUMBER	TITLE	TIME
B1	Reflection Quiz on Key Populations (Homework)	0.75 hour
B5	The Blame Game—Things People Say About PLHIV and Other Key Populations	1 hour
B2 B1	Panel Discussion on Key Populations; or, if this is not possible, Review of the Answer Sheet for the Reflection Quiz	1 hour

J: One-day Workshop for Nonmedical Health Staff

Description

This is a one-day workshop that introduces participants to stigma through pictures and their own experiences. The topic of stigma toward key populations is tackled through a panel discussion with representatives of key populations to increase understanding and provide an opportunity for questions. The day ends with a chance to clarify fears about HIV transmission and explore the reality of risk at work.

Target Group

Nonmedical staff—administrative and clerical, ward attendants, security staff, cleaning staff, etc.

Objectives

By the end of the training, the staff will have accomplished the following:

- Identified some of the key forms and causes of stigma in health facilities
- Explored attitudes toward key populations and how stigma affects patients' access to health facilities
- Increased their understanding of HIV transmission and the reality of occupational risk

Modules

NUMBER	TITLE	TIME
A1	Naming Stigma in Health Facilities Through Pictures	1 hour
A2	How Stigma Feels (Reflection Exercise)	0.5 hour
B5	The Blame Game—Things People Say About PLHIV and Other Key Populations	1 hour
B2 B4	Panel Discussion on Key Populations; or Exploring Beliefs and Attitudes About PLHIV and Other Key Populations (Value Clarification Exercise)	1 hour
C1	Fears About Getting HIV Through Nonsexual Casual Contact (Parts A and C)	1 hour
D5	Occupational Exposure, PEP, and Stigma	1 hour

K: Two-day Workshop for Nonmedical Health Staff

Description

This is a two-day workshop for nonmedical staff that covers an introduction to understanding stigma—what it looks like, how it feels, and how it can affect service provision. The program also includes exercises to clarify how HIV is and is not transmitted, and to look at Standard Precautions. In addition, it includes exercises to increase staff awareness of the need to understand and address stigma toward key populations and health workers living with HIV.

Target Group

Nonmedical staff—administrative and clerical, ward attendants, security staff, cleaning staff, etc.

Objectives

By the end of the training, the staff will have accomplished the following:

- Identified some of the key forms and causes of stigma in health facilities
- Explored attitudes toward key populations and how stigma affects patients' access to health facilities
- Increased their understanding of HIV transmission and the reality of occupational risk
- Discussed Standard Precautions and procedures

Modules

NUMBER	TITLE	TIME
DAY ONE		
A1	Naming Stigma Through Pictures	1 hour
A2	How Stigma Feels (Reflection Exercise)	0.5 hour
A6	Analyzing Different Forms of Stigma in Health Facilities	1.5 hours
C1	Fears About Getting HIV Through Nonsexual Casual Contact (choose which parts according to time and needs)	1.5 hours
D1	What Are Standard Precautions?	0.75 hour
D4	Health Facility Hygiene and Waste Disposal	0.5 hour
B1	Reflection Quiz on Key Populations (Homework)	Homework
DAY TWO		
B5	The Blame Game—Things People Say About PLHIV and Other Key Populations	1 hour
B2	Panel Discussion on Key Populations	1 hour
A4	Naming Stigma in Our Health Facility	1 hour
E	Developing a Code of Conduct for a Stigma-free Health Facility	2 hours

L: Three-day Intensive Workshop on Stigma Toward Key Populations in Health Facilities

Description

This is a three-day workshop designed for health facilities that are trying to address stigma toward key populations. The longer program provides the opportunity to explore the topics in more depth. Apart from identifying stigma in the health facilities, the emphasis is on understanding the needs and experiences of members of key populations and understanding how stigma impedes their access to health services. Health staff also get a chance to enhance their counseling skills to improve services to key populations.

Target Group

Any health staff (adapt exercises accordingly)

Objectives

By the end of the training, participants will have accomplished the following:

- Explored and understood stigma toward PLHIV and other key populations
- Learned more about the different identities of sexual minorities
- Developed a better understanding of HIV transmission, as related to key populations
- Practiced counseling skills to address the needs of key populations
- Developed a Code of Conduct related to services for key populations

Note: Trainees may have covered some of these exercises already if they have participated in other training events. If so, the trainer may decide to drop the general stigma exercises listed for the first day and focus on the exercises provided for the second day, which emphasize a specific stigma-targeted group.

Modules

NUMBER	TITLE	TIME
DAY ONE		
A1	Naming Stigma in Health Facilities Through Pictures	1 hour
A3	Effects of Stigma on the HIV Epidemic	1 hour
A2	How Stigma Feels (Reflection Exercise)	0.5 hour
A4	Naming Stigma in Our Health Facility	1.5 hours
B5	The Blame Game—Things People Say About PLHIV and Other Key Populations	1 hour
B1	Reflection Quiz on Key Populations (Homework)	Homework

NUMBER	TITLE	TIME
DAY TWO		
B2	Panel Discussion on Key Populations	1 hour
B3	Talking About Sex—Breaking the Sex Ice	1 hour
B6	Understanding the Different Identities of Sexual Minorities	2 hours
B4	Exploring Beliefs and Attitudes About PLHIV and Other Key Populations (Value Clarification Exercise)	1 hour
DAY THREE		
A7	Human Rights—PLHIV and Key Populations	1 hour
B9	Counseling Skills and Value Judgments	1 hour
B10	Challenge the Stigma—and Be the Change!	1 hour
E	Developing a Code of Conduct for a Stigma-free Health Facility	1 hour

M: Two-day Workshop on Stigma Reduction Toward Men Who Have Sex With Men

Description

This is a two-day program designed for health facilities that want staff to explore stigma toward MSM in more depth. Some of the exercises focus on all key populations but they can be adapted to include only MSM case studies or scenarios.

Target Group

All health staff (adapt accordingly)

Objectives

By the end of the training, the staff will have accomplished the following:

- Explored and understood how stigma toward MSM affects the HIV epidemic and impedes access to health services
- Learned more about the different identities of sexual minorities
- Developed a better understanding of HIV transmission related to MSM
- Practiced counseling skills to address the needs of MSM

Note: Trainees may have covered some of these exercises already if they have participated in other training events. If so, the trainer may decide to drop the general stigma exercises listed for the first day and focus on the exercises provided for the second day, which emphasize a specific stigma-targeted group.

Modules

NUMBER	TITLE	TIME
DAY ONE		
A1	Naming Stigma in Health Facilities Through Pictures	1 hour
A3	Effects of Stigma on the HIV Epidemic	1 hour
A2	How Stigma Feels (Reflection Exercise)	0.5 hour
A4	Naming Stigma in Our Health Facility	
B5	The Blame Game—Things People Say About PLHIV and Other Key Populations	1 hour
B1	Reflection Quiz on Key Populations (Homework)—Questions About MSM	Homework
DAY TWO		
B2	Panel Discussion on Key Populations (include MSM, male sex workers, and transgender people, if possible)	1 hour
C2	HIV Transmission and MSM	1 hours
B6	Understanding the Different Identities of Sexual Minorities	1 hour
B4	Exploring Beliefs and Attitudes Toward MSM	1 hour
B9	Counseling Skills Practice for Working with MSM	1 hour

N: Two-day Workshop on Reducing Stigma Toward People Who Use Drugs

Description

This is a short workshop that aims to increase health workers' knowledge and understanding of drug use, addiction, and harm reduction strategies to reduce stigma toward people who use drugs.

Target Group

Health workers

Objectives

By the end of the training, participants will have accomplished the following:

- Explored and discussed why people use drugs and how stigma toward people who use them can impede access to health services
- Developed a better understanding of HIV transmission related to people who use drugs
- Learned about harm reduction approaches to manage addiction
- Practiced some counseling skills to address the needs of people who use drugs

Note: Trainees may have covered some of these exercises already if they have participated in other training events. If so, the trainer may decide to drop the general stigma exercises listed for the first day and focus on the exercises provided for the second day, which focus on a specific stigma-targeted group.

Modules

NUMBER	TITLE	TIME
DAY ONE		
A6	Analyzing Different Forms of Stigma in Health Facilities	1 hour
A2	How Stigma Feels (Reflection Exercise)	0.5 hour
A3	Effects of Stigma on the HIV Epidemic	1 hour
B5	The Blame Game—Things People Say About PLHIV and Other Key Populations	1 hour
B7	Understanding Drug Addiction and Harm Reduction	1 hour
B1	Reflection Quiz on Key Populations (Homework)—Questions About People Who Use Drugs	Homework
DAY TWO		
C3	HIV Transmission and People Who Use Drugs	1 hour
B4	Exploring Beliefs and Attitudes Toward People Who Use Drugs	1 hour
B8	Harm Reduction, Drug Use, and HIV	1 hour
B9	Counseling Skills Practice for Working with People Who Use Drugs	1 hour

O: Two-day Workshop on Stigma Reduction Toward Sex Workers

Description

This is a two-day program designed for health facilities that want staff to explore stigma toward sex workers in more depth. Some of the exercises focus on all key populations but they can be adapted to include only sex worker case studies or scenarios.

Target Group

All health staff (adapt accordingly)

Objectives

By the end of the training, participants will have accomplished the following:

- Explored and understood how stigma toward sex workers affects the HIV epidemic and impedes access to health services
- Developed a better understanding of HIV transmission related to sex workers
- Practiced counseling skills to address the needs of sex workers

Modules

NUMBER	TITLE	TIME
DAY ONE		
A6	Analyzing Different Forms of Stigma in Health Facilities	1 hour
A2	How Stigma Feels (Reflection Exercise)	0.5 hour
A3	Effects of Stigma on the HIV Epidemic	1 hour
B5	The Blame Game—Things People Say About PLHIV and Other Key Populations	1 hour
B7	Understanding Drug Addiction and Harm Reduction	1 hour
B1	Reflection Quiz on Key Populations (Homework)—Questions About People Who Use Drugs	Homework
DAY TWO		
B2	Panel Discussion on Key Populations (including sex workers)	1 hour
B3	Talking about Sex—Breaking the Sex Ice	1 hour
B4	Exploring Beliefs and Attitudes Toward Sex Workers	1 hour
B9	Counseling Skills Practice for Working with Sex Workers	1 hour

P: Four-day Training-of-Trainers Workshop

Description

This is a four-day workshop to train health workers on how to facilitate the stigma reduction training exercises. The workshop includes demonstration sessions on some of the modules conducted by the workshop trainers, plus two afternoon sessions in which the trainees practice using the different modules and get feedback on their performance.

Target Group

Health worker trainers

Objectives

By the end of the training, participants will have accomplished the following:

- Become familiar with the exercises in the training kit
- Demonstrated an in-depth understanding of HIV and key population stigma
- Developed skills, experience, and confidence in using the various exercises in the training kit
- Learned how to select and adapt the exercises for use in their own context

Modules

NUMBER	TITLE	TIME
DAY ONE		
A1	Naming Stigma in Health Facilities Through Pictures	1 hour
A4	Naming Stigma in our Health Facility (Case Studies)	1 hour
A2	How Stigma Feels (Reflection Exercise)	1 hour
B5	The Blame Game—Things People Say About PLHIV and Other Key Populations	1 hour
	Facilitation Skills—Demonstration + Practice	1.5 hours
B1	Reflection Quiz on Key Populations (Homework)	Homework
DAY TWO		
	Review of Homework (B1)	1 hour
A3	Effects of Stigma on the HIV Epidemic	1 hour
C1	Fears About Getting HIV Through Nonsexual Casual Contact	1 hour
	Preparation—then Practice Teaching (in Pairs) with Feedback (Afternoon Session) – Focus on Chapters A and B	1 hour of prep + 3 hours of practice

NUMBER	TITLE	TIME
DAY THREE		
	Training Skills Review	1 hour
C2 or C3	HIV Transmission and MSM; or HIV Transmission and People Who Use Drugs	
D1	What Are Standard Precautions?	1 hour
	Preparation—then Practice Teaching (in pairs) with Feedback (Afternoon Session) – Focus on Chapters C and D	1 hour of prep + 3 hours of practice
DAY FOUR		
	Training Skills Review	
A6	Analyzing Different Forms of Stigma in Health Facilities	1 hour
A7	Human Rights—PLHIV and Key Populations	1 hour
B9	Counseling Skills and Value Judgments	1 hour
B10	Challenge the Stigma—and Be the Change!	1 hour
	Action Planning	1 hour

Q: Half-day Reinforcement Workshop

Description

This course is a series of short training sessions on stigma and Standard Precautions introduced into a pre-service course for health worker trainees. Trainees would receive two hours of training once a week over the 12-week period.

Target Group

Health worker trainees in a pre-service training course

Objectives

By the end of the training, the health worker trainees will have accomplished the following:

- Identified some of the most common examples of stigma in their own health facilities
- Discussed the forms, effects, and causes of stigma in health facilities
- Demonstrated new attitudes of respect and tolerance toward PLHIV and other key populations
- Increased their understanding of HIV transmission and the reality of occupational risk
- Developed skills and a better understanding of how to implement Standard Precautions
- Written a Code of Conduct for a stigma-free health facility

Modules

NUMBER	TITLE	TIME
A8	Review and Reinforcement Workshop	2–3 hours

R: Pre-service Course For Health Worker Trainees—Two-hour Sessions/Week Over 12 Weeks

Description

This course is a series of short training sessions on stigma and Standard Precautions introduced into a pre-service course for health worker trainees. Trainees would receive two hours of training once a week over the 12-week period.

Target Group

Health worker trainees in a pre-service training course

Objectives

By the end of the training, the health worker trainees will have accomplished the following:

- Identified some of the most common examples of stigma in their own health facilities
- Discussed the forms, effects, and causes of stigma in health facilities
- Demonstrated new attitudes of respect and tolerance toward PLHIV and other key populations
- Increased their understanding of HIV transmission and the reality of occupational risk
- Developed skills and a better understanding of how to implement Standard Precautions
- Written a Code of Conduct for a stigma-free health facility

Modules

NUMBER	TITLE	TIME
WEEK 1		
A1	Naming Stigma in Health Facilities Through Pictures	1 hour
A3	Effects of Stigma on the HIV Epidemic	1 hour
WEEK 2		
A2	How Stigma Feels (Reflection Exercises)	1 hour
A4	Naming Stigma in our Health Facility (Case Studies)	1 hour
WEEK 4		
B2	Review on Homework + Panel Discussion	1 hour
B3	Talking About Sex—Breaking the Sex Ice	1 hour
WEEK 5		
C1	Fears About Getting HIV Through Nonsexual Casual Contact	1 hour
D1	What Are Standard Precautions?	1 hour
WEEK 6		
B6	Understanding the Different Identities of Sexual Minorities	1 hour
C2	HIV Transmission and MSM	1 hour

NUMBER	TITLE	TIME
WEEK 7		
D2	Use of Protective Apparel and Stigma	1 hour
D3	Fear of Infection Through Use of Sharps	1 hour
WEEK 8		
D4	Health Facility Hygiene and Waste Disposal	1 hour
D5	Occupational Exposure, PEP, and Stigma	1 hour
WEEK 9		
A6	Analyzing Different Forms of Stigma in Health Facilities	1 hour
A5	Stigma Faced by Health Workers—Health Workers Living with HIV	1 hour
WEEK 10		
B9	Counseling Skills and Value Judgments	1 hour
B10	Challenge the Stigma—and Be the Change!	1 hour
WEEK 11		
A7	Human Rights—PLHIV and Key Populations	1 hour
C3	HIV Transmission and People Who Use Drugs	1 hour
WEEK 12		

PART 2

Training Tips and Participatory Training Modules

Tips for Facilitation (Source: Caribbean Facilitator's Guide)

Session Plans

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

Each session plan is divided into the following parts:

FACILITATOR'S NOTE

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

OBJECTIVES

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

TIME

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

MATERIALS

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

STEPS

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

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

Methods

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

Groups

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

Questions

Specific questions used to guide discussion.

Example Responses

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

Report Back

Procedures for groups giving reports after discussion.

Processing

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

Summary

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

Methods and Materials

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

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

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

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

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

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

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

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

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

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

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

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

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

General Facilitation Tips

Work as a Team

- If possible, plan and run the sessions with another facilitator—and take turns in the lead role.
- One facilitator can lead the session, while the other facilitator records on a flipchart and helps with the preparation of materials.
- Plan the training sessions together beforehand and decide who will lead each session.

At the start of the training, do the following:

Prepare the Room and Materials

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

Break the Ice and Introduce the Session

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

Give Clear Instructions for Exercises

- Keep your instructions simple and clear, and use examples to help with understanding.
- If participants have blank looks, check that they have understood. "What are you being asked to do—or discuss?"
- Write the instructions or discussion questions on a flipchart and use the same words that you plan to use in explaining the instructions or questions.
- After groups are formed, go around to each group to **check that they are clear about the task**. Ask them to explain what they are expected to do—to see if they understand.

Divide into Groups Quickly and Efficiently

- In dividing into groups, the aim is to mix participants up to get them working with different people. Keep changing the members in a group for each exercise.
- To achieve this objective, select groups on a random basis. You can use many ways to divide people into groups. Be creative in dividing them into groups and turn this process into an energizer if you need to get people moving.
- Some group work can be done in buzz groups (pairs)—everyone gets a chance to talk.

Record Discussions on a Flipchart

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

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

Give Effective Summaries

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

Manage Time

- In a short training program, there is not enough time to explore all the issues in depth. You will need to manage time carefully or your overall objective will be lost.
- Decide how much time you need for each session—and work to these time limits. Don't allow sessions to drag on too long! Tell participants in advance how long each session will be and explain your reasons if you subsequently decide to shorten or lengthen it.
- Remember—small group work takes more time than you expect. You also will need to allocate time for report backs.
- Give small groups enough time to do their work. Don't rush them.

Evaluation

- Organize an evaluation at the end of each day.
- Hand out a one-page questionnaire (e.g., likes, dislikes, what was learned, issues needing more discussion) and ask participants to complete it. This helps to identify problems or issues that need to be addressed—and helps you improve the training sessions.

Specific Facilitation Techniques

Introduction

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

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

Case Studies

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

Role-playing

- Role-playing is improvised drama in which participants take on roles and act out a real-life situation. There is no written script; the drama is created spontaneously. Role-playing is always followed by discussion—to draw out what was learned from the role-play.
- Techniques for organizing role-plays are as follows:
  - Divide into groups and ask each group to do a role-play based on the issue or problem.
  - The group can also create a role-play to show how the problem might be solved.
  - After the groups are ready, ask each to perform its play for the other groups.
  - At the end of each performance, ask questions to encourage the audience to analyze what happened—"What happened? Why did it happen? Was it realistic? Would the solution work? What else might be done? What does it mean for us?" and so on.

Cardstorm

- Prepare materials—cards (half sheets of paper), masking tape strips, and markers. Make sure you have enough cards and markers, and that the markers are not going dry.
- Put up topic cards along the upper wall—categories/questions for the cardstorm.
- Put up a few example cards showing what participants are expected to write.
- Divide into pairs and hand out cards and markers to each pair.
- Explain the task—"Write points on xxxxx—one point on each card. Check what others are writing so you don't repeat points that already are on the wall."
- Encourage participants to start writing. As the cards are written on, tape them on the wall.
- After enough cards are on the wall, ask a few participants to eliminate repetition and cluster common points (put common points together) under different categories.
- Ask people to clarify points—"What does this mean? Examples? Anything missing?"
- Prioritize the points and then focus on the most important points (processing).
- Processing—"What does it mean to you? What can we do to solve this problem?"

Rotational Brainstorm

- Prepare by putting up topic headings on different flipchart sheets and tape them on different walls of the room. Make sure there is enough room between each sheet. Put markers at each flipchart.
- Give clear instructions about the task, such as what the groups should discuss/write, the rotational system, and what direction to move in. Check that people understand the task.
- Divide into the number of groups for the number of topics and assign each group a topic.
- Ask groups to start discussing the topic and writing down their ideas immediately, rather than stand around talking.
- Check on the output of each group. When every group has been able to write at least one or two points, ring a bell or start a song to get groups rotating.
- Remind participants which direction to move and show them with your hands.
- Each group moves to a new sheet, reads what is already on it, and then adds new points that are not already written.
- Continue the process until the groups have contributed to all flipchart sheets.
- Organize a report back. Ask the group that started on the flipchart sheet to present the points on its sheet.

Individual Reflection

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

MODULE A

Naming Stigma & Discrimination in Health Facilities

A

Introduction

This chapter gets health workers to name and own the problem, so they can see the following:

- Stigma exists and takes two major forms—isolating/avoiding and blaming/shaming
- Stigma toward PLHIV has three major causes—(a) fear and lack of understanding of how HIV is transmitted, (b) judgmental attitudes, and (c) people's lack of awareness that they are stigmatizing
- Stigma toward other key populations has similar causes—lack of understanding of marginalized groups and moral judgment of their behavior
- Stigma has a number of effects, including self-stigma (PLHIV and key populations accepting the stigma, withdrawing from social contact, and not accessing health and other services)
- We all are involved in stigmatizing, even if we are not aware that we do it
- Stigma is harmful to our health practice, our families, and our communities
- Stigma and the fear of being stigmatized result in PLHIV and other key populations not getting full access to HIV-related health services and other forms of support
- We can make a difference by changing our own thinking and actions

This chapter also gets participants to name the problem in their own work context—to recognize how they, as health workers, stigmatize PLHIV and other key populations. The aim is to help health workers see that they are stigmatizing—often without realizing it—and decide how they want to change.

Some of the exercises focus on the stigma faced by health workers who are living with HIV or those stigmatized for working on HIV issues.

At the end of each exercise, ask participants to identify two to three changes they would like to make in their health facilities to reduce stigma toward patients. Keep a record of this list of changes. It can be used at the end of the workshop to develop a **Code of Conduct**.

Exercises

A1. Naming Stigma in Health Facilities Through Pictures

A2. How Stigma Feels—Individual Reflection Exercise

A3. Effects of Stigma on the HIV Epidemic

A4. Naming Stigma in Our Health Facility

A5. Stigma Faced by Health Workers—Health Workers Living with HIV

A6. Analyzing Different Forms of Stigma in Health Facilities

A7. Human Rights—PLHIV and Key Populations

A8. Review and Reinforcement Workshop

A1. Naming Stigma in Health Facilities Through Pictures

Facilitator's Note: In this activity, participants look at pictures showing stigma and discuss what each picture means to them. This exercise helps participants to "name" stigma in an objective rather than a personalized way. Participants identify different forms of stigma in the health facility.

This is a good activity to "break the ice" and get everyone interested in the issues around S&D, and build a common vocabulary around stigma. The use of pictures helps those health facility staff who cannot read to participate freely and equally.

Participants can use the pictures to discuss stigma with their colleagues, families, and friends—a form of follow-up—so make photocopies and hand them out to your participants.

Objectives: By the end of this session, health workers will be able to accomplish the following:

- Identify different forms of stigma in health facilities
- Explain why stigma happens
- Discuss examples of stigma from their own health facilities and communities

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

Time 1 hour

Materials Stigma pictures, displayed on the wall

Handouts F1: HIV AND KEY POPULATION STIGMA & DISCRIMINATION

Steps

Naming Stigma (Picture Discussion)

Divide into small groups of two or three people. Ask each group to walk around and look at as many pictures as possible. Then, when they have viewed all of the pictures, ask each group to select one. Ask them to discuss these points:

- What do you think is happening in the picture in relation to stigma?
- Why do you think it is happening?
- Does this happen in your health facility? If so, discuss some examples.

Report Back

Ask each group to hold up its picture for everyone to see (or tape it on the wall) and explain its contents. Use questions to probe more deeply, e.g., "Why do we stigmatize people who are known to be or suspected to be HIV-positive?" Record points on a flipchart.

EXAMPLE RESPONSES

Picture: Two health workers, wearing masks, gossip about PLHIV

- Health workers are wearing gloves and masks even though there is no medical procedure requiring the use of gloves. They are gossiping—not aware that they are stigmatizing.
- Why does this happen? They don't understand how HIV is transmitted—so they are afraid that they can get HIV through casual contact.

Does this happen in your health facility? Yes, some nurses use gloves even when feeding a client. The excessive use of gloves and masks makes the client feel bad.

Processing

Ask

- What are the major forms of stigma?
- What does this show us about stigma in health settings?

Report Back

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

- Stigma is a belief or attitude. The action resulting from stigma is discrimination—for example, PLHIV or other stigmatized groups being refused treatment in a health facility, or their HIV status or sexual identity being revealed publicly.
- As health workers, we sometimes automatically make judgments about people without realizing how these will affect them or the health services they receive. Heavy workloads and stress also affect how we treat our clients.
- There are different forms of stigma:
  - **Isolation and Rejection**—based on ignorance and fear about HIV transmission or the behaviors of a marginalized group. The person stigmatized is forced to sit alone, eat alone, live alone.
  - **Shaming and Blaming**—gossip, name calling, insulting, judging, shaming. Stigmatized people are "blamed and shamed" for assumed "bad behavior," for breaking social norms.
  - **Discrimination (Enacted Stigma)**—unfair treatment, such as refusing to operate on HIV-positive or marginalized clients, treating them last, or testing clients without their consent.
  - **Self-Stigma**—PLHIV and key populations sometimes stigmatize themselves in reaction to stigmatization from society. They accept the blame and rejection of society, and withdraw from social contact or exclude themselves from accessing health and other services out of fear of having their status revealed.
  - **Stigma by Association**—People associated with stigmatized groups often face stigma themselves. The family of a person living with HIV or a person from a key population may be stigmatized because of the stigma faced by their family member—the reputation of the family is affected. Some health workers are stigmatized for working with HIV clients or clients from marginalized groups.
  - **Layered Stigma**—Marginalized groups (e.g., MSM, sex workers, people who use drugs, prisoners, etc.) are already stigmatized. When they get HIV, they are doubly stigmatized—gaining another layer of stigma.

Developing a Code of Conduct:

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

A2. How Stigma Feels (Reflection Exercise)

Facilitator's Note: This is one of the most important exercises in the toolkit because it draws on personal experiences to bring out the feelings of being stigmatized. The exercise asks health workers to think about a time in their lives when they felt stigmatized and use this experience to help them empathize with stigmatized groups.

The exercise looks at stigma in general, not stigma toward PLHIV or key populations. This is why the instructions are to "Think of a time in your life when you felt isolated or rejected for being seen as different from other people."

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

Objectives: By the end of this session, health workers will be able to do the following:

- Describe some of their own personal experiences concerning stigma
- Identify some of the feelings associated with being stigmatized

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

Time 45 minutes

Handouts F1: HIV AND KEY POPULATION STIGMA & DISCRIMINATION

Steps

Individual Reflection

Ask participants to sit on their own. Then say, "Think about a time in your life when you felt lonely or rejected for being seen as different from others." Explain that this does not need to be an example of stigma toward PLHIV or other marginalized groups; it could be any form of stigmatization for being seen as different.

Sharing in pairs

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

Sharing in plenary

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

Processing:

Ask:

- What did you learn from the exercise about stigma?
- What feelings are associated with stigma?

Summarize:

Summarize the main points that participants have made during the exercise. In giving your summary you may use some of the following points if participants have not already mentioned them.

- This exercise helps us get an inside understanding of how it feels to be stigmatized—shamed or rejected. It helps put us into the shoes of PLHIV or marginalized groups. It helps us understand how painful it is to be stigmatized.
- Everybody has felt ostracized or treated like a minority at different times in their lives. We have all experienced a sense of social exclusion.

A3. Effects of Stigma on the HIV Epidemic

Facilitator's Note: This exercise helps participants understand how stigma toward PLHIV (or those suspected to have HIV) and other key populations fuels the HIV epidemic.

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

Objectives: By the end of the session, health workers will be able to see how stigma or the fear of being stigmatized affects PLHIV and other key populations, including their ability to access health services and practice safe sex.

Sources Understanding and Challenging Stigma Toward MSM: Toolkit for Action (Cambodia) – Exercise A12

Time 1 hour

Handouts F1: HIV AND KEY POPULATION STIGMA & DISCRIMINATION

Steps

Introduction

Explain the objective of this exercise. Then divide into groups and give each group one of the following case studies. Ask them to read the case study and answer the questions at the end.

Case Studies

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

Case Study A: Effects of stigma on MSM

Kiri started to have sex with men when he was a teenager but managed to hide it from his family. He knew that being a man who has sex with men was natural for him, but he was worried that his family would find out and make his life miserable.

When he grew older, he lived in the same town as his family but lived on his own. His family suspected he might be gay, but they didn't bother him until he was 30, when they started to pressure him to get married. He agreed to marry, feeling that he had no choice.

Soon after getting married, he found out that one of his previous male partners had tested HIV positive, so he started to worry about his own status. What would people think if he was HIV positive? Would his wife find out that he has sex with men? How would he be treated?

He went to the health facility to take an HIV test, but the counselor made him feel very uncomfortable. He asked lots of questions about Kiri's sex life. When Kiri mentioned having had sex with men, the counselor said, "No, you are not one of those! You seem different!" Kiri left the health facility without taking the test and told himself he would never go back.

He was so worried that his wife would find out about his male partner that he just continued to have sex with her without using condoms.

Discussion

- What happened in the story? Why is Kiri behaving this way?
- How does stigma affect disclosure to his partners and his use of health services?

Case Study B: Effects of stigma on PLHIV

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

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

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

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

Discussion

- What happened in the story? Why did Mohammed not tell his wife?
- What are the consequences of Mohammed not disclosing his HIV status to his wife?

Case Study C: Effects of stigma on people who use drugs

Nam finished university and started his own business selling computer equipment. He also got married. After the birth of his first son, he decided to expand his business. He traveled around the country to get customers, and in the evenings he spent a lot of time in bars. In one bar, he met Ly, a sex worker. He fell in love with Ly, began to see her on a regular basis, and stopped using condoms. Ly introduced him to drugs, saying it would make sex more enjoyable—and he agreed. After a while, he became addicted. He used drugs by injection, sharing needles with Ly and two other sex workers.

One day, Nam started to have a lot of pain when urinating. He went to a health facility to get tested for a sexually transmitted infection (STI). The doctor gave Nam a funny look, asked if he was using drugs, and told him he was ruining his life with drugs. Nam got very upset and left the health facility. He bought some penicillin from a friend and treated himself.

Nam's life started to fall apart. Some of his clients suspected he was using drugs and stopped doing business with him. His wife suspected he was using drugs and refused to sleep with him.

When Nam saw Ly again, he told her about the STI. Ly said they should be more careful, but Nam said he didn't need to use condoms with her. They continued to have sex without using condoms and to use drugs together.

Nam's friend told him to check his HIV status. Nam took the HIV test and found out he was positive. Nam was shocked and confused and didn't know how to tell Ly and his wife. He became very depressed and worried about what to do next.

Discussion

- What happened in the story? Why is Nam behaving this way?
- How does stigma affect his use of injecting drugs, condoms, and health services?

Report Back and Processing

Organize a report back. Ask each group to report on what they discussed. Then discuss the following:

- How does stigma result in the continuing spread of HIV?
- What can we do to change this?

Summarize

Summarize the main points that participants have made during the exercise. In giving your summary you may use some of the following points if participants have not already mentioned them.

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

- **Accessing health services**—getting tested for HIV and STIs, getting information on how to avoid HIV transmission, and getting condoms and lubricant
- **Openly discussing their sexuality with health workers** and providing complete information about their sexual practices
- **Accessing treatment** (antiretroviral therapy [ART] or treatment of opportunistic infections [OIs])
- **Using other services**—for example, a pregnant woman living with HIV is discouraged from HIV testing and making use of the prevention of mother-to-child transmission (PMTCT) program
- **Disclosing to their partners**
- **Protecting their own health and the health of their sexual partners**—for example, by insisting on condom use with partners, using clean needles and syringes for drug use, and accessing treatment to reduce viral load
- **Disclosing their HIV status and getting counseling care and support**. Because of stigma, PLHIV and other key populations are afraid to tell others about their HIV status. As a result, they may have difficulty in negotiating condom use; accessing services, support, and treatment for HIV; and so may be at increased risk for transmitting HIV to their partners.

Developing a Code of Conduct

Ask participants, based on this discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

A4. Naming Stigma in Our Health Facility

Facilitator's Notes: This exercise helps health workers name the problem of stigma in their own workplace. It includes case studies based on the real experiences of PLHIV and other key populations. Select the case studies suited to your own context.

Objectives: By the end of this session, health workers will be able to accomplish the following:

- Identify stigmatizing attitudes and discriminatory practices within the healthcare setting
- Explain the causes of those attitudes and practices, and how these affect their clients
- Identify practical things they can do to change the way they relate to their clients

Sources Understanding and Challenging Stigma Toward MSM: Toolkit for Action (Cambodia) – Exercise A13

Time 2 hours

Handouts Copies of case studies for participants

Steps

Case Study Analysis

Select the case studies most suited to your own context. Divide the participants into groups and give each group a case study to read. Have each group then discuss the following questions:

- What happened in the case study? Is the situation realistic?
- What other forms of stigma have you observed happening in health facilities?

Report Back and Processing

Ask each group to report back on what they have learned from discussing the case study. Then ask the following questions:

- What are the effects of stigma on PLHIV and other key populations?
- Why is stigma happening in the health facility?
- What can we do to make our health facilities more user friendly and challenge stigma?

Case Studies – Select Those That Fit Your Situation

HIV-positive Client Case Studies

Case Study A: Sarah

Sarah is a 30-year-old woman. She went to a health facility for the delivery of her baby. The nurse looked at her health facility card, which read "PMTCT," and knew immediately that she was HIV positive. While waiting, Sarah saw this nurse and other nurses looking at her and whispering, which made her upset and nervous. She waited a long time for someone to help her; when the baby started to come, she shouted for help, but the nurses kept doing whatever else they were doing, pretending to be busy. One doctor took pity on her and came and assisted with the delivery. Afterward, she was left all alone. Sarah saw other women being helped, but she was left to do everything on her own.

Case Study B: Victor

Victor is a 40-year-old man. He started to have rashes and diarrhea, which did not respond well to treatment. The health staff bullied him into taking an HIV test and he was diagnosed as HIV positive. He was admitted to a health facility and his health worsened. He stayed in the health facility for four days without receiving any treatment. During the

ward rounds, he complained to the doctor but the nurses told the doctor not to pay attention to him, saying that he was confused. Victor's condition became so bad that he could no longer get himself to the toilet and started to soil his bed. The nurses would not give him a bed pan no matter how often he requested one and they scolded him for soiling the bed. He finally asked to be discharged so that he could go home and die peacefully.

Case Study C: Mary

Mary is a 35-year-old nurse who is married with two children. After noticing some symptoms of HIV in her husband, she decided to be tested and found out she was HIV positive. Mary accepted the situation. She asked her husband to take a test but he refused and accused her of being unfaithful. He started to drink on a daily basis and each time he came home drunk, he would beat her and call her names. When it became known that Mary was HIV positive, other nurses refused to work with her. She felt excluded and heard the other nurses gossiping about her. Eventually, they assigned her to the ward that deals with HIV-related diseases. Mary started to feel demoralized by her rejection by the other nurses and began to take her anger out on her clients. She often forced them to be tested for HIV, using harsh words to scold them and make them feel guilty.

Case Study D: Sick Child

Two women arrived at a health facility with a nine-year-old boy who looked very sick. The nurse read on his card that the boy was HIV positive and, thinking that there was not much she could do, began to feel angry and said to the women, "Can't you see that this child is almost dead anyway? Are you not aware of your child's condition?" Then she added, saying these words in the middle of a busy waiting room, "Maybe you should take an HIV test yourself!" The mother kept quiet, but her friend said, "Nurse, all we are asking is for you to treat this child." The nurse left the room, returned with a prescription for the pharmacy, and told them to go home, saying there was nothing else she could do.

Case Study E: Judith

Judith is a 35-year-old nurse who has worked for more than 10 years in a health facility. She has not received any training since leaving medical college. When doing her tasks in the facility, including serving food to clients and taking their temperature, she puts on gloves, a gown, and a mask.

Key Population Case Studies

Case Study A: MSM

Juan is a 30-year-old gay man. One day, he began getting painful sores around his anus, so he went to the health facility to be tested and get treatment. Because of his fear of stigma, he told the nurse that he was constipated and it was very painful. The nurse didn't say anything but left the room; a few minutes later, she returned with two other nurses. The nurses looked at Juan, whispered to each other, and then left.

The nurse returned 20 minutes later. Juan said, "I've been waiting a long time. Could you help me?" The nurse laughed and said, "Who are you to tell me what I should do? You'll just have to wait. We know you people…." She said this in the presence of other clients and then left.

After a long delay, a doctor entered and, without even examining him, said, "What have you been doing? How did you get this STI? It must be your disgusting behavior!" He told Juan to remove his pants and examined his bum from a long distance.

He then began to ask Juan a lot of questions about his sex life: "When was the last time you had sex? When was the last time you had sex with a woman? How do you have sex with a man?" Juan told him that he just wanted to be treated, not asked about his sex life. The doctor told him he only treated "real men."

As soon as the doctor went into the next room, Juan got dressed and left the health facility. He told himself he would never go back. "All I wanted was treatment," he said, "but all I got was insults and blame!"

Case Study B: Sex Workers

Sara is a 30-year-old sex worker. One day she went to a health facility for an STI check and a supply of condoms. When she arrived at the health facility, she was kept waiting for a long time. Clients who arrived after her were treated before her. When she asked one nurse for help, the nurse said, "You'll just have to wait. We know you—ladies of the night! You wait all night for men, so why can't you wait a few more minutes?" The nurse said this in the presence of all of the other clients; Sara felt humiliated.

Eventually, Sara was called in to see the doctor. The doctor gave her a funny look and said, "What is your problem?" She explained the symptoms and the doctor said, "I don't know why we are wasting our time on you. You are just a virus collector. I don't care if you die. It's your own fault, sleeping with all of these men!" Then he told Sara to take off her dress, and made a quick examination of her private parts.

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

As soon as the doctor left, Sara got dressed and left the health facility—without medicine or condoms. She never went back.

Case Study C: People Who Use Drugs

Nam is a young man who uses drugs. One day, he went to a health facility for an STI check. The nurses watched him closely, observing the scars on his arm. Nam could hear them gossiping about him. "That one looks dangerous! If you are not careful, he might attack you!" He asked one nurse to help him, but she turned around and walked out of the room.

Finally, one nurse called him and told him that he had to take an HIV test. There was no counseling—they simply gave him the test without his consent.

After the test, he was called in to see the doctor. The doctor looked at him and said, "I can tell you are a drug user. You must have HIV. You are ruining your life with drugs and sex workers!" Nam said, "All I want is to get treatment for this STI. Could you please help me?" The doctor got angry and did a rushed examination. Nam left the clinic without getting any medication for his STI. He bought some penicillin from a friend and treated himself.

When Nam got the results of the HIV test, he learned that he was HIV positive. He went to another health facility to register for ART. One nurse scolded him, telling him that he had come on the wrong day. When he returned on the right day he was told, "You don't look reliable enough to adhere to ART. We need someone who is responsible. I'm sorry, we can't help you."

Summarize

Summarize the main points that participants have made during the exercise. In giving your summary, you may use some of the following points if participants have not already mentioned them.

- Stigma in the health setting takes a number of common forms, including delaying or refusing services, providing differential treatment, verbal abuse, breaking confidentiality, forcing clients to take an HIV test without their consent, isolating clients in separate wards, or excessive use of barrier precautions (e.g., gloves and masks) for routine tasks.
- Stigma may be based on judgmental attitudes toward clients or fears about getting HIV through casual contact with HIV-positive clients.
- Stigma toward PLHIV or other key populations defeats our mandate as health workers. PLHIV or key populations may stop using our health services. If so, we are failing in our role as health workers.
- Health workers' code of conduct requires us to treat all clients without exception. Every client has the right to be free from discrimination and access the highest attainable level of physical and mental healthcare.

- Make your health facility a warm, welcoming, and nonjudgmental environment that is open to and respectful of all clients—a place where clients can seek services without fearing discrimination from health workers or that community members will learn about their situation. This means establishing systems that ensure client privacy and confidentiality.

Developing a Code of Conduct

Ask participants, based on this discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

A5. Stigma Faced by Health Workers and Health Workers Living with HIV

Facilitator's Note: This exercise explores the stigma faced by health workers living with HIV. Health workers often report that they are afraid of going for an HIV test in a health facility where they are known—they fear the judgments of their colleagues and clients. Some health workers fear that their HIV status may put their jobs at risk. In many health institutions, health workers are dying because of this kind of stigma—they are not even accessing the ART available in their own health facilities.

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

Objectives: By the end of this session, health workers will be able to do the following:

- Explore some of the stigma issues facing health workers
- Discuss ideas on how to reduce stigma in health facilities and increase the uptake of antiretrovirals (ARVs) among health workers living with HIV

Sources Understanding and Challenging HIV Stigma: Toolkit for Action (G7)

Time 1 hour

Materials Copies of health worker case studies

Handouts F2: STIGMA TOWARD HEALTH WORKERS

Steps

Introduction (Buzz Groups)

Divide into pairs and ask: "What are some of the examples of stigma facing health workers living with HIV?" Record answers on a flipchart.

Case Studies

Divide into five groups; give each group a case study to read and ask them to discuss the questions listed at the end of their case studies and write their answers on a flipchart.

Report Back

Ask each group to read the case study and present its report. Then, with the help of the groups, make a list on a flipchart summarizing the actions to address the stigma toward health workers. (What can you do to support someone, such as_____?)

Case Studies

Case Study A: Mrs. Aquino

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

Recently, when she went to the private health facility to collect her monthly prescription, Mrs. Aquino met a colleague from her own facility. The colleague guessed that she was HIV positive and told others at work. Mrs. Aquino is aware that there is a lot of gossip about her, especially among junior colleagues, and has begun to hate going to work.

Discussion

- Why do you think Mrs. Aquino went to the private health facility for her treatment?
- Why do you think colleagues are gossiping about her at work?
- What can you do to support someone like Mrs. Aquino in your workplace and address the problem of stigma in the health facility?

Case Study B: Viola Gaspar

Viola Gaspar is an HIV counselor at a local health facility. She is 27 years old and engaged to be married. She has a good reputation as a hard worker and gets on well with her colleagues at work.

Viola tested herself last year and found out that she was HIV positive. She knows about ARVs but does not know whether she wants to start treatment yet. She feels well but has begun to lose weight. She overheard some colleagues talking about her, saying that they suspect she is HIV positive and that "she should know better!" She has not talked to anyone at work about her situation.

Discussion

- Why do you think Viola has not talked to anyone at work yet?
- Why do you think colleagues are gossiping about her at work?
- What can you do to support someone like Viola in your workplace and address the problem of stigma in the health facility?

Case Study C: Faruque Ahmed

Faruque Ahmed is a nurse on a surgical ward. He is 30 years old and married with two children. Faruque is HIV positive and was getting his ARVs from a clinic in another town. He did not want anyone at work to know about his status. Last month, his clinic ran out of his prescribed ARVs so he went to the clinic at his hospital. Since then, nearly all of his colleagues have avoided him; they now whisper bad names about him and no longer ask him to go out for a drink after work. Faruque feels depressed and is now on sick leave because he cannot face his situation at work.

Discussion

- Why do you think Faruque was going to another town to get his ARVs?
- Why do you think Faruque's colleagues are treating him this way at work?
- What can you do to support someone like Faruque in your workplace and address the problem of stigma in the clinic?

Case Study D: Dr. Arnando

Dr. Arnando is 40 years old and works in a health facility. He has a good reputation and is well respected. His wife died two years ago; he has four children. For the last two years Dr. Arnando has known that he is HIV positive and has been taking ARVs he obtains secretly from the health facility. Sometimes the supply of ARVs does not come through and he has to go to a private health facility where a friend of his works to buy them. Dr. Arnando has not told anyone at work about his status and lives in fear of other health workers finding out.

Discussion

- Why do you think Dr. Arnando does not want people to know his status?
- What can you do to support someone like Dr. Arnando in your workplace and address the problem of stigma in the health facility?

Case Study E: Mrs. Felicia Nunes

Mrs. Felicia Nunes is a home-based caregiver in one of the squatter areas outside of her town. She got involved by volunteering through her church and looks after a lot of people who have AIDS-related illnesses. Mrs. Nunes also helps community members set up support groups for PLHIV.

Mrs. Nunes is HIV positive herself but travels to the health facility in town to get her ARVs so that no one will see her. She has told her family but they have told her not to tell anyone else, especially people on the home-based care team. Recently, her husband lost his job and there is a shortage of money. Her family is putting pressure on her to access the free ARVs at the local health facility nearby.

Discussion

- Why do you think that Mrs. Nunes has been getting her ARVs in town?
- Why do you think that her family does not want her to tell others about her status?
- What can you do to support someone like Mrs. Nunes in your workplace and address the problem of stigma among home-based care team members?

Case Study F: Mr. Samson Banda

Samson Banda is 32 years old and works as a ward attendant in a large teaching hospital. Samson is married and has two young sons. Samson's main duties are to clean the wards and the sluice rooms, take the clinical waste to the incinerator, and help the medical staff and patients when needed. Samson has been working at the hospital for five years and enjoys his work. Samson is HIV positive and has been taking ARVs for the last two years. He is healthy and has accepted his HIV status, although he has not discussed it with anyone at work.

Last week, a new group of student nurses started their practicals at the hospital and Samson overheard them talking about the "AIDS ward" and how they dreaded working there. They were talking about "those kind of people" and acting as though HIV was nothing to do with them. Samson wants to have a talk with them about their attitudes, but is worried that everyone then will know he is HIV positive.

Discussion

- Why do you think Samson has not told any colleagues at work about his HIV status?
- Do you think Samson should talk to the student nurses to try and open their minds?
- What would you do if you were in Samson's position? What would help to challenge stigma among student nurses?

Case Study G: Ms. Aisha Manzor

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

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

Aisha asked one of her colleagues who works in the lab if she would test her, and the result came back positive for HIV. She was shocked, as she has had sex only with her fiancé and could not believe the result. After a confirmation test, she knew that it must be true.

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

Discussion

- Why do you think Aisha feels she cannot tell her family or colleagues about the test?
- What can help Aisha in this situation?
- What would you do if you were Aisha's friend who conducted the test?

Summarize

Summarize the main points that participants have made during the exercise. In giving your summary, you may use some of the following points if participants have not already mentioned them.

- As health workers, we can all take responsibility for reducing stigma in our facilities.
- We can use our staff meetings to talk about stigma and emphasize the importance of respect, teamwork, and mutual support.
- We can change our personal attitudes and behavior—e.g., stop gossiping.
- We can challenge others if they stigmatize.
- We can use meetings to develop and implement an anti-stigma policy.

Developing a Code of Conduct

Ask participants, based on this discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

A6. Analyzing Different Forms of Stigma in Health Facilities

Facilitator's Note: In this session, health workers analyze different forms of stigma that occur in health facilities, including health workers' stigma toward HIV-positive clients, clients' stigma toward other clients, and health workers' stigma toward other health workers living with HIV. The aim is to examine the root causes and effects, and then look at what they can do to solve these problems.

This exercise uses a PROBLEM TREE ANALYSIS—a method for analyzing the effects and root causes of a problem. Each group will analyze a different type of stigma. Explain the technique before splitting into groups.

The technique uses the following steps:

- Draw a picture of a tree on a flipchart paper.
- On the trunk, write the name of the problem—e.g., "Stigma toward clients by health workers."
- Then, on the trunk, using cards, add more details on the FORMS of stigma, e.g., "shouting and scolding the client, making the client wait, using gloves to do non-invasive tasks, etc."
- Then, at the roots at the bottom of the picture, write the CAUSES, e.g., "fear of getting HIV through casual contact, judgmental attitudes, heavy workloads and stress, etc." Ask participants to dig deeper—to look for the causes of some of the causes they list.
- Then, on the branches of the tree, write the EFFECTS on cards, e.g., "feeling isolated and ashamed, feeling angry and depressed, self-blame, wanting to leave the health facility, etc."
- Then, underneath the flipchart paper, write POSSIBLE SOLUTIONS on cards, e.g., "remind health workers of their code of conduct, improve health workers' knowledge about HIV transmission so they no longer fear getting HIV through contact with HIV-positive clients."

Objectives: By the end of this session, health workers will be able to identify the following:

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

Sources Draft exercises from Alliance Regional Stigma Team (#4)

Time 1 hour

Handouts F1: HIV AND KEY POPULATION STIGMA & DISCRIMINATION

Steps

Analyzing Different Forms of Stigma (Task Groups)

On cards, write down the different categories of stigma that occur in health settings. (Select those that apply.)

A. Stigma toward HIV-positive clients by health workers
B. Stigma toward people who use drugs by other clients
C. Stigma toward HIV-positive health workers by other health workers
D. Stigma toward women living with HIV who get pregnant
E. Stigma toward sex workers by health workers
F. Stigma toward adolescent clients living with HIV by health workers

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

- Clarify the problem—what are the FORMS of stigma; what actually happens?
- Identify the CAUSES (roots) and EFFECTS (branches), and work out POSSIBLE SOLUTIONS (write on cards)

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

EXAMPLE RESPONSES

A: Stigma Toward HIV-Positive Clients by Health Workers

Forms: Shaming and blaming clients for getting HIV; making clients wait; using gloves for non-invasive tasks; moving away from clients assumed to be HIV positive.

Causes: Fear of getting HIV through casual contact; judgmental, moralizing attitudes; heavy workloads and stress.

Effects: Feeling isolated, ashamed, angry, and depressed; self-blame; some may transfer to another health facility or stop treatment.

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

Report Back (Gallery Walk)

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

Summarize

Summarize the main points that participants have made during the exercise. In giving your summary, you may use some of the following points if participants have not already mentioned them.

- The three main causes or drivers of HIV-related stigma are (1) lack of awareness that they are stigmatizing, (2) inadequate knowledge of HIV transmission and fear of getting HIV through casual contact, and (3) judgmental attitudes.
- Judgmental attitudes toward other key populations bring up some of the following issues:
  - Gender (e.g., the common perception that "MSM and transgender people are not real men")
  - Culture (e.g., the perception that "homosexuality, sex work, or use of drugs is 'abnormal,' breaking social norms")
  - Religion (e.g., the perception that "same-sex relationships, sex work, or use of drugs is immoral, against the teachings of our faith")
- Health workers alone cannot solve many of the root causes of stigma. However, general awareness of the root causes will help health workers better understand the needs and concerns of PLHIV and marginalized groups so health workers can provide better services and refer PLHIV to other appropriate services.
- Stigma leads to low uptake of health services by PLHIV. Reducing stigma is key to increasing the uptake of HIV prevention and services; improving HIV disclosure; and improving client follow-up for treatment, care, and support services.

Developing a Code of Conduct

Ask participants, based on this discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

A7. Human Rights—People Living with HIV and Key Populations

Facilitator's Note: This exercise looks at how the rights of PLHIV and key populations are violated—and what might be done to address these human rights violations.

During the initial brainstorm, when participants are naming the rights being violated, probe further on how the rights are being violated. During the second activity in which groups are working on solutions, push them to come up with realistic solutions.

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

- Identified different rights that could be violated in the case of PLHIV and key populations
- Developed realistic strategies for protecting the rights of PLHIV and key populations

Source Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide (Exercise F4)

Time 1 hour

Materials Photocopies of the scenarios

Handouts F3: HUMAN RIGHTS AND STIGMA

Steps

What Are Human Rights? (Buzz Groups)

Ask pairs to discuss two questions:

1. What are human rights?
2. What are examples of human rights?

Report back

Take each question, one at a time, and ask pairs of participants to present one point each. Record the first discussion on a flipchart and the second discussion on individual cards (so the rights cards can be used in the following exercise that explores which rights get violated).

EXAMPLE RESPONSES

What are human rights?

- Fundamental things that every person must have because they are human
- To be treated fairly by everyone, regardless of who they are and what they do, i.e., regardless of gender, age, occupation, sexual orientation, etc.
- Practices that protect human beings against ill-treatment or violence
- Examples of human rights

Right to life, food, water, work, shelter, clothing, health, freedom, education, protection, dignity and respect, privacy (confidentiality), religion, sex, have children, get married, own land and property, vote, freedom of movement, freedom from discrimination.

Violation of Human Rights (Small Group Activity)

Divide into groups of three to four people and ask each group to select one human right listed during the previous step. Group task:

- Decide on how the right might be violated if the person is HIV positive or a key population.
- Discuss "How could this violation be challenged?"

Report Back

Ask each group to describe how the right might be violated—and what could be done to address this violation.

EXAMPLE RESPONSES

Right to High-quality Healthcare

Example of Violation: Denying treatment, rushed treatment, or being kept waiting; no confidentiality of test results; poor services (e.g., no cleaning of rooms)

Solution: Training of health workers, discipline, and suspension; review and update policies and enforce them; ensure that policies include key populations

Right to Privacy (Confidentiality)

Example of Violation: Revealing someone's HIV status or sexual orientation to other health staff or family members without the client's consent

Solution: Adopting a policy in the clinic related to confidentiality and checking that it is observed by all staff

Right to Autonomy (Make Decisions)

Example of Violation: Forcing clients to be tested without their consent; i.e., they have no control over what happens to them and are prevented from exercising the right to make their own decision about testing

Solution: Supervision and controls to stop health workers from forcing clients to take HIV tests

Right to have children

Example of Violation: Health workers discouraging HIV-positive women from having children; tubal ligation of HIV-positive women to prevent them from having any more children

Solution: Educating and empowering women so they know they have the right to say "no," speak out, and get support

Finding Solutions (Case Studies)

Divide the class into small groups and give each group one of the case studies (below). Ask them to read the case study and discuss the following:

- Which rights have been violated?
- How well do you think the character in the story is able to stand up for his or her rights in the situation given? What could you do if you were the person whose rights were violated?
- As a health worker, what do you think should have been done to empower people to stand up for their rights?
- What do you think should have been done to protect the person's rights? What examples can you give from your own experience?

Report Back and Processing

Ask groups to present the key points from their discussions, providing the main strategies to challenge the violation.

Case Studies

Case Study A: Susan

Susan is a sex worker. People in her community suspect that she is a sex worker and do not respect her because they think such work is wrong. She tries at all times to practice safer sex with her clients, but her boyfriend refuses to use condoms. She knows that he has other girlfriends in their community and suspects that he is not using condoms with them because she keeps getting the same STI. The first time she went to a clinic to get treatment for the STI, the nurse treated her only reluctantly and told her that she needed to use condoms "doing what you do." Knowing that she got the STI from her boyfriend, she tried to convince him to get treatment and use condoms, but he became angry and beat her up. He continued to demand unprotected sex from her and she became infected with the STI again. When she returned to the clinic, the same nurse saw her, but refused to treat her, saying "You are wasting precious resources by what you are doing on the streets. There is no point in treating you because you will just come back again."

Case Study B: Linda

Linda is a sex worker who prides herself on her professionalism in her work: she insists on condoms with her clients, even when they offer her more money for unprotected sex; she does not even give oral sex without a condom; she makes sure she has regular health check-ups; and she is able to take care of her children and other family members with her earnings. One day, when she refused to have unprotected sex, a client raped her. Afraid that she would be arrested by telling the police that she had been raped by a client, she did not report the incident, but rushed to the clinic to get post-exposure prophylaxis (PEP). The nurse refused to give her PEP, stating that a police report was needed to give it to her. Afraid to tell the nurse her story, she went home and prayed that she had not been infected with HIV.

Case Study C: Terry

Terry is a gay man who is HIV positive. When his CD4 count fell below 250, he enrolled in an ART program. When he went to the first meeting, he was told to bring his "girlfriend" as his adherence supporter. At the next appointment, he came with his male lover and told the nurse that this man was his treatment supporter. The nurse said "Is this your partner? I'm sorry, but I told you to bring your girlfriend, not your boyfriend. He doesn't look like a dependable guy. We need someone who can be responsible. Looking at you guys, I don't think you can be reliable enough to adhere to the medication."

Case Study D: James

James is a gay man who went to a clinic for an STI check-up. The nurse said "If you have an STI, then you must be given an HIV test." The nurse bullied James to take the test. When the results were revealed, the nurse said "I'm sorry, you are HIV positive. You need to stop this gay thing! That's where it all started." There was no post-test counseling, and the staff sent him away from the clinic without even treating him for the STI. He felt totally humiliated.

Case Study E: Barbara

Barbara, a nurse, dislikes MSM—they make her uncomfortable and she thinks they are immoral. When they come to get help from her, she gives them dirty looks, rushes through medical examinations, and does not provide the information and condoms they need to avoid getting or transmitting HIV. These clients don't say anything, but they do notice they are not being treated as well as other clients. The hospital manager has noticed that clients are reluctant to be treated by Barbara, and that many of them leave her consultation room looking dejected.

Closing activity

Hand out cards with a human right written on each. Ask each person to read his/her card, going around the circle: Each person then stands up in turn and says—"I am human and I have a right to…" "be loved," "get married," "have a family,"

Case A: Refusal to Treat a Sex Worker Who Returns for STI Treatment

HR Violations: Right to health. Right to treatment. Right to dignity.

Solution: Challenge the health worker—"It is your duty to provide healthcare."

Case B: Refusal to Provide PEP Without a Police Report

HR Violations: Right to health. Right to freedom from inhumane treatment.

Solution: Explain the circumstances to the health worker—that PEP needs to be administered quickly and getting a police report takes a long time.

Case C: Discrimination at a Clinic—told to bring "girlfriend" as treatment supporter

HR Violations: Right to health. Freedom of choice (to choose his own treatment supporter).

Solution: Clarify the procedure: a treatment supporter is not just one's partner; it could be a family member and could be male or female.

Case D: Discrimination at a Clinic—no consent, no counseling, and no results

HR Violations: Right to counseling, confidentiality, and consent (3 Cs). Right to treatment.

Solution: The problem here is not the policy—it is the attitudes of the health worker—she is not doing her job; performance and attitude.

Case E: Discrimination at a Clinic—rushed treatment and no provision of information

HR Violations: Right to healthcare. Right to freedom from discrimination.

Solution: The manager has a responsibility to ensure she protects the rights of clients and that they receive proper care and treatment. She should investigate and if she finds that Barbara has been acting unprofessionally, should remedy the situation through negotiation or discipline/punishment, and prevent this behavior from continuing.

"good quality healthcare," "be treated with confidentiality," "food and shelter," "a job of my choice," "education," "safety from violence," "equal justice," and "right to vote."

Summarize

- PLHIV and key populations have human rights like anyone else and should be able to access those rights, but their rights are abused because of stigma and fear.
- Because of criminalization and stigma, key populations are forced to operate in a climate of secrecy and find it difficult to get information and advice on safe sex practices. As a result, they are more vulnerable to getting HIV and may be more likely to pass it to others.
- The fear of being arrested prevents key populations from asserting their rights—in fact, they accept the violation of their rights as part of their stressful lives as key populations. As a result, they find it difficult to complain to the police for fear of being arrested, or to challenge the stigma they face in health facilities and other public services.
- Key populations are more at risk of HIV infection because of their limited access to human rights. Because they lack rights and have limited power, it is difficult for them to control sexual decision making and other choices that will lead to a healthy lifestyle. For example, it is difficult for them to access and use condoms and lubricant, and to negotiate safe sex with partners. This makes them vulnerable to getting HIV.

Developing a Code of Conduct

Ask participants, based on this discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

A8. Review and Reinforcement Workshop

Facilitator's Note: This is a short reinforcement workshop (half day) to support follow-up action by the trainees who attended the other training courses. This half-day workshop allows them to reflect on S&D in their health facilities after the original training and discuss how health workers are implementing the Code of Conduct that they developed in the first course, what they are doing well, and what might need strengthening. When finding a half day is not possible, the last part of this module takes only one hour and could be implemented on its own—for example, as part of a routine departmental or facility staff meeting.

This workshop would be conducted three to six months after completing the Code of Conduct.

Objectives: By the end of this workshop, the health workers will have accomplished the following:

- Identified some of the continuing examples of S&D in their own health facilities and developed strategies to stop or challenge these forms of stigma
- Reviewed new practices in the health facility based on the new Code of Conduct
- Agreed on an action plan to strengthen the new Code of Conduct

Time 2–3 hours

Steps

Continuing Examples of Stigma in the Health Facility (1.5 hours)

1. Put up blank sheets of flipchart paper on different walls of the room:
   A. Stigma and discrimination toward PLHIV
   B. Stigma and discrimination toward sex workers
   C. Stigma and discrimination toward MSM
   D. Stigma and discrimination toward people who use drugs
   E. Stigma and discrimination toward HIV-positive health workers

   Option: The topics on the flipcharts could cite S&D in specific health facility locations, e.g., a waiting area, doctor's room, operating room, lab, patients' ward, counseling area.
2. **Divide into five groups**: If appropriate, get participants to work in the same groups in which they work at their health facility.
3. **Rotational brainstorm:** Assign each group to a flipchart. Ask them to write forms of stigma and discrimination toward the assigned target group. After a few minutes, ask the groups to rotate and add points. Continue until the groups have contributed to all of the flipcharts.
4. **Review the flipcharts:** Identify the forms of stigma that should be given priority attention—"Which forms of stigma need to be solved immediately?"
   - Some patients are kept waiting for a long time or treated last.
   - Patients receive bureaucratic and unfriendly treatment, and insulting or scolding language.
   - Staff refuse to do anal examinations for MSM clients.
   - Staff break confidentiality—revealing the HIV status or other marginalized identities to other health staff or family members without clients' consent.

- Staff use gloves and masks for routine tasks that don't involve the handling of blood and bodily fluids.

5. Assign one of these forms of stigma to each group and ask them to discuss what they can do as health workers to tackle this particular form.

The above assessment could also be done using the facility questionnaire (see http://www.healthpolicyproject.com/index.cfm?id=StigmaPackage).

Reviewing The Code of Conduct and Action Plans (1 hour)

Hand out copies of the **Code of Conduct** and the **Action Plans** (see Section E). Assess the following:

A. Which of the best practices (Code of Conduct) are being applied on a regular basis?

B. Which tasks in the action plan have been done and which have not?

Ask the group to make a list of the practices that are working well and need to be maintained, and those that need to be improved. Develop at least two key recommendations for making these improvements.

MODULE B

Judgments and Values: Breaking Down Stigma Toward Key Populations

Some of the key influences on stigma are the values and beliefs we hold that affect the way we relate to other people. Our values regarding what we think is "normal" behavior can lead us to judge those who seem to live or behave differently.

For example, we may believe that sex between two men is not normal or that sex workers are immoral. These beliefs inevitably affect the way we treat members of key populations.

Much HIV stigma is related to our values and attitudes around sex and morality. Because HIV is generally transmitted through unprotected sex, PLHIV have been judged to be "promiscuous," "immoral," or to have engaged in sex outside of "normal" behavior.

For key populations, HIV stigma simply adds to the existing negative attitudes that people might have toward them. On top of this, countries often have laws that criminalize their behaviors and make it difficult for them to exercise their human rights, including accessing health services. Thus, key populations face overt discrimination.

Many other key populations are particularly vulnerable to HIV and experience multilayered stigma, depending on the nature of the epidemic and the sociocultural context. These key populations may include the following: children and orphans, women and girls, young people, prisoners, migrants and mobile workers, refugees and internally displaced people, and people with disabilities.

Our values and beliefs link closely to our cultural and social upbringing—we learn them from our families, communities, leaders, history, and traditions. Yet culture is continually changing, and so our beliefs and values also can change.

Often we have not been exposed to people who have different lifestyles—maybe we think we have never met someone who is gay or a sex worker. We may never have talked to them, listened to their stories, or tried to understand them.

Health workers may lack information about key populations—for example, how they live; why they sell sex, use drugs, or have sex with men; what is appropriate treatment or advice to offer; or what other services are available for referral. Some health workers may not even understand the link between the behaviors of marginalized groups and their vulnerability to HIV.

As a trainer, you need to help health workers understand the importance of exploring their own attitudes and beliefs to help change the stigma that members of key populations face in health facilities. Health workers may hold judgmental attitudes toward PLHIV or toward the behaviors of key populations, such as selling sex, having sex with a member of the same sex, or using drugs. These attitudes affect the services received by clients and act as barriers to accessing treatment and care.

Some health workers may assume that certain key populations, e.g., MSM, are not stigmatized or relevant to the HIV epidemic in their setting just because they have not heard about this issue before. Explain how generalized epidemics can have concentrated epidemics within them, and that some key populations are so heavily stigmatized that there is little recognition by society that they actually exist, e.g., MSM in some countries.

This lack of information can result in health workers creating barriers to health services, such as the following:

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

This section will help teach some of the basics so that health workers have the right information and greater understanding needed to overcome fears and misconceptions about key populations. It will also help them learn the best practices used by other health workers to support key populations in overcoming stigma and accessing high-quality health services.

At the end of each exercise, ask participants to identify two to three changes they would like to make in their health facilities to reduce stigma toward patients who are members of key populations. Keep a record of this list of changes. It can be used at the end of the workshop to develop a Code of Conduct.

Exercises

B1. Reflection Quiz on Key Populations

B2. Panel Discussion on Key Populations

B3. Talking About Sex—Breaking the Sex Ice

B4. Exploring Beliefs and Attitudes About PLHIV and Other Key Populations (Value Clarification Exercise)

B5. The Blame Game—Things People Say About PLHIV and Other Key Populations

B6. Understanding the Different Identities of Sexual Minorities

B7. Understanding Drug Addiction and Harm Reduction

B8. Harm Reduction, Drug Use, and HIV

B9. Counseling Skills and Value Judgments

B10. Challenge the Stigma—and Be the Change!

B1. Reflection Quiz on Key Populations

Facilitator's Note: This exercise consists of an individual reflection quiz about beliefs, knowledge, and feelings toward key populations. Then participants discuss their thoughts with a partner and share them in the large group. The quiz may also be done individually as a form of homework.

Ideally, this exercise should be done in conjunction with exercise B2 (Panel Discussion). Participants complete the reflection quiz individually before the discussion. Then they listen to a panel of resource persons drawn from different key populations. However, if it is not possible to organize members of key population groups to participate, the Reflection Quiz is a good introduction to the topic.

The quiz consists of questions on each of the different key populations. It helps health workers assess what they know, believe, and feel about key populations, and trigger other questions. Select the quiz questions suited to your context. You might, for example, ask the group, "Which key populations would you like to know more about?" and then hand out the quiz about those key populations.

Objectives: By the end of this session, health workers will be able to accomplish the following:

- State their own values and beliefs, and identify gaps in their knowledge about key populations
- Explain some of the basic facts and issues affecting key populations

Sources

Understanding and Challenging Stigma Towards Men Who Have Sex with Men: Toolkit for Action (Cambodia)—Exercise B2

Understanding and Challenging Stigma Towards Entertainment Workers: Toolkit for Action (Cambodia)—Exercise B2

Understanding and Challenging Stigma Towards Injecting Drug Users and HIV in Vietnam: Toolkit for Action—Exercise A3

Time 1 hour

Materials Reflection Quiz + Answer Sheets

Handouts F4: TRUE/FALSE QUESTIONS RE: KEY POPULATIONS

Steps

Reflection Quiz

Hand out the quiz (choose sections suited to your context and group) and ask participants to spend time alone thinking about the questions and writing any notes if they wish. Allow at least 15 minutes for this process.

Sharing Thoughts

Ask participants to pair up and share their thoughts about the reflection. If you are NOT doing the panel discussion, hand out the answer sheet and ask pairs to read it through together.

Group Discussion

Ask if anyone wants to discuss their thoughts or has any other questions about key populations. Ask "What did you learn from this exercise?"

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

Reflection Quiz Questions

Men who have sex with men

1. Some people believe that gay men are born to be gay; some believe that they can be influenced by others or choose to be gay. What do you think?
2. Some people believe that being gay is a sign of mental illness, and that MSM can be "cured." What do you think?
3. Some people say that being gay is against religion, but others say that religions teach us to love one another and accept everyone, regardless of their behavior. What do you think?
4. Is homosexuality a new thing to our culture? Have MSM been too influenced by Western values or have they always been here but we have not talked openly about it?
5. Do you think it is true that MSM are at increased risk of HIV because of unprotected anal sex? Is it possible that some gay men also have sex with women?
6. Do you feel that you would be able to offer welcoming and safe service to a client who is a gay man, so that he could talk openly about his health concerns?
7. What other questions do you have about MSM?

Sex workers

1. Some say that sex work is the quickest way for poor women (and men) to make money. Others think that sex workers are too lazy to find other jobs. Some people think that there are often no other work opportunities because of high unemployment everywhere. What do you think are the reasons that people sell sex to earn money?
2. What kind of problems do you think sex workers face?
3. Some sex workers use alcohol and/or drugs as a way of coping with the job. What impact do you think this could have on their health and their use of health services?
4. Do you think HIV is a serious problem that sex workers face? Do you think that most sex workers use condoms? What do you think are some of the barriers to preventing HIV and other STIs that sex workers face?
5. Why do you think selling sex is illegal in many countries? Do you think this is a good thing? What impact might this have on the needs of people who sell sex?
6. How would you feel if a client told you that they sell sex? Would you treat them the same way that you treat other clients?
7. What else would you like to know about sex workers?

People who use drugs

1. How do you feel about drugs? Some say that cigarettes and alcohol are addictive, like heroin, but they are legal substances. Not everyone who starts using illegal drugs, such as heroin, becomes addicted. What do you think? Do you have any experience of using drugs or of family members who have had an addiction problem?
2. Why do you think people start using drugs? Some say it is to try to forget their problems. Others say it is just for fun—to feel good. Some say that once people who use drugs become addicted, their main motivation for continuing to take drugs is to get that feeling of pleasure induced by the drug. What do you think?
3. People who have quit drugs often start using drugs again, for a number of reasons. Just stopping is not easy. Why do you think it is difficult to quit drug use?

4. What do you know about injecting drug use? Why do people inject drugs instead of smoking or inhaling? Do you think that most people who inject drugs inject on their own—doing this quietly, without anyone knowing?
5. Why is HIV a risk for people who inject drugs? Do you think HIV is the main health problem for people who use drugs? What other problems could they face?
6. What do you know about treating drug addiction? Do you know about any specialist services for people who use drugs in your locality? Would you be able to ensure that a client who uses drugs would be treated well and given good service at your health facility?
7. What else would you like to know about people who use drugs?

Prisoners

1. What do you know about prisoners? Have you ever talked to someone who has been in prison? Have you ever visited a prison? Do you think that prisoners have the same rights as everyone else?
2. What risks do you think prisoners face in terms of HIV? Do you think prisoners should be tested for HIV? Do you know if prisoners have access to ARVs in your country?
3. What do know about sex in prisons? Do you think that male prisoners should be given condoms or do you think this would encourage sex between men in prison? Do you think that only gay men have sex in prison?
4. Do you think prisoners with HIV receive adequate healthcare because they are being cared for in prison? How would you treat a client who told you they had recently been released from prison?
5. What else would you like to know about prisoners?

Migrants

1. What do you think about people who migrate to a different country? Why do you think migrants move to new countries? Do you know anyone who has come to your country from abroad?
2. What problems do you think migrants might face in accessing health services? Do you think people with HIV should be stopped from traveling to other countries? Do you think migrants who are HIV positive should be able to access HIV services wherever they go?
3. How are migrants treated at your health facility? Do you treat clients from other countries in the same way you treat other clients?
4. Is there anything else you would like to know about migrants?

B2. Panel Discussion on Key Populations

Facilitator's Note: This exercise can have a big impact on changing participants' understanding and attitudes toward key populations.

The personal stories from key population resource persons have a powerful impact—it is often the first time that health workers have listened to key populations talk about their lives and their experiences of being stigmatized.

If possible, do the Reflection Quiz before a break and organize the Panel Discussion after the break to allow time to organize the discussion, and give the participants a chance to absorb the topic.

Organize a panel discussion with resource persons from key populations as the guest speakers (e.g., a gay man or man who has sex with men, a male and/or female sex worker, a person living with HIV). Your job as facilitator is to guide this panel discussion, asking questions and ensuring that everyone on the panel gets a chance to talk.

Make sure that the resource persons are well prepared. Give them copies of the reflection quiz and an outline of any questions that the participants want to ask before the discussion starts.

Ask them also to talk about their own experiences in using health facilities and how they were treated.

Objectives: By the end of this session, health workers will be able to do the following:

- State their own values and beliefs, and identify gaps in their knowledge about key populations
- Understand some of the main challenges facing members of key populations
- Explain some of the basic facts and issues affecting the health of key populations

Sources Draft exercises from Alliance Regional Stigma Team (Exercise 11)

Time 1 hour

Materials Answer Sheet to the Quiz Questions

Handouts F4: TRUE/FALSE QUESTIONS RE: KEY POPULATIONS

Preparation

Approach support groups or organizations for key populations in your area to identify people who are willing to talk about their lives. Find out in advance the needs of the resource persons and make sure that these can be met in the training environment. You may need to provide financial support for travel and other costs.

Give the resource persons the following briefing on how to present their stories and information:

- Respond to participants' questions and give examples drawn from your own life.
- Talk about how you have been treated in health facilities—and how it made you feel.
- Tell your stories in a factual way, without blaming or criticizing health workers. This approach will ensure that the health workers don't become defensive.

Steps

Reflection Quiz

Do Exercise B1 before the panel discussion.

Preparation for Panel Discussion

Ask participants:

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

Write down the questions. You might rephrase any questions that could be offensive or judgmental. Use this set of questions to guide the panel discussion.

Panel Discussion

Go through each of the questions and invite the resource persons to respond. Make sure to allow time for the resource persons to talk about their experiences in using health facilities and any stigma they have faced. At the end of the session, hand out the Answer Sheet to the Quiz Questions.

Summarize

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

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

B3. Talking About Sex—Breaking the Sex Ice

Facilitator's Note: In our role as health workers, we often find it difficult to talk to our clients about sex. Talking about sex that is considered "immoral" or "abnormal" may increase our discomfort. Our views as health workers about what is "appropriate" sex may lead to a lack of acceptance of people who do not conform to our own or society's views about what is proper sexual behavior. These views about sex fuel stigma against MSM, transgender people, sex workers, and other marginalized groups. Our attitudes and beliefs about sex can lead to stigma against key populations, so we need to help participants talk more openly about sex. These exercises can help to achieve this objective.

The exercises below are optional. Choose the exercise or exercises suited to your group.

Objectives: By the end of this session, health workers will be able to accomplish the following:

- Talk more openly about sex and their feelings about different types of sex
- Recognize that beliefs about what is "acceptable" or "proper" sex is one of the root causes of stigma toward key populations, such as MSM, sex workers, and transgender people

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

Time 1 hour

Activity A: First Thoughts About Sex

Steps

Cardstorm

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

Then divide into four groups and give each group one of the following questions to discuss:

- Why is it difficult to talk about sex?
- What are the social norms around sex?
- What is the link between sex and stigma?
- Why is it important as health workers to be able to talk about sex?

Activity B: Secret Vote—Anonymous Participatory Sex Survey

Steps

1. At least two facilitators are needed to run this exercise: one facilitator at the front of the room to read the questions, the other facilitator at the back of the room to collect the answer slips and quickly record the results on a flipchart.
2. Explain that the survey is anonymous—"no one will know how you respond."
3. Hand out 10 slips of paper to each participant.
4. Ask each question and tell participants to record their answers on a slip of paper and fold it up. Collect the slips after each question and record the results on a flipchart. Do not present these results until all of the questions have been asked.
5. Present and discuss the results. Then ask, "How did you feel answering the questions? What did you learn from the exercise?"

Example Questions and Example Results

NUMBER	QUESTION	YES	NO	TOTAL
1	Can you talk openly about sex to close friends?	16	8	24
2	Do you enjoy sex?	20	4	24
3	Have you ever masturbated?	22	2	24
4	Have you ever participated in vaginal sex?	22	2	24
5	Have you ever participated in oral sex?	14	10	24
6	Have you ever participated in anal sex?	6	18	24
7	Have you ever had a sexually transmitted infection (STI)?	12	12	24
8	Have you ever taken an HIV test?	18	6	24
9	Did you use a condom the last time you had sex?	20	4	24
10	Have you ever paid for sex?	8	16	24
11	Have you ever been paid for sex?	3	21	24
12	Have you ever been attracted to someone of the same sex?	5	19	24

Activity C: Why Do People Have Sex?

Steps

Split into gender groups. Give the women a flipchart with the question: "WHY DO WOMEN HAVE SEX?" Give the men a flipchart with the question, "WHY DO MEN HAVE SEX?" Bring the groups together and share the answers. Once participants have finished, discuss, "What did we learn from this exercise?" "Why do gay men, lesbians, bisexuals, and transgender persons have sex?"

Activity D: What Have You Always Wanted to Ask Men/Women About Sex?

Steps

Divide into two groups—a men's group and a women's group. Ask each group to make a list of questions about sex to be asked to the other group. Then swap the lists and ask the men and women to discuss the questions in their groups. Ask the men's group and then the women's group to present their answers. Then ask, "What did we learn from this exercise?"

EXAMPLE RESPONSES

Questions asked by WOMEN to MEN

How can you tell that a woman has reached orgasm? How can men help women reach orgasm? Why are men selfish in sex (i.e., thinking only of their own pleasure)?

Why do men feel the need to sleep with different women at the same time?

Questions asked by MEN to WOMEN

Why do women fake orgasm sometimes? Why don't women like sex sometimes?

How can a man help a woman get aroused for sex? What is your favorite sexual position?

Summarize:

Summarize the main points that participants have made during the exercise. In giving your summary, you may use some of the following points if participants have not already mentioned them.

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

B4. Exploring Beliefs and Attitudes About People Living with HIV and Other Key Populations (Value Clarification Exercise)

Facilitator's Note: This is a value clarification exercise—health workers review a number of statements about PLHIV and other key populations and decide if they agree or disagree.

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

- Remain neutral throughout the exercise. You may, however, provide factual information to clarify matters, as needed.
- If a participant expresses extreme views that reinforce stigma, allow other participants to challenge these statements or, if no one responds, do it yourself.
- Emphasize that there are no "right" or "wrong" answers. The aim of the exercise is to explore different views when they exist.

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

- Explored their attitudes and values about PLHIV and other key populations
- Recognized how their own attitudes regarding PLHIV and other key populations might affect their work as health workers

Sources Understanding and Challenging HIV Stigma: Toolkit for Action (C6)

Draft exercises from Alliance Regional Stigma Team (Exercise 7)

Time 1 hour

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

Steps

Divide into groups, give each group three to four statement cards, and ask them to discuss, "Do you agree or disagree, and why?" Explain to the groups that there are no "right" or "wrong" answers. We all respond to the statements based on our beliefs and values, and the purpose of this activity is to explore these differences when they exist.

Report Back

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

Processing

Ask

- Which statements were the most controversial, and why?
- How do our attitudes toward PLHIV and other key populations affect the way we behave toward these clients?
- How can we keep our own values from influencing our work in a negative way?

Summarize

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

- Some of the statements involve stereotypes—negative things we say and believe about PLHIV and other key

populations. Often we believe that these misconceptions are facts about other people, when actually they are false. This belief or assumption leads to S&D.

- We are socialized to judge other people based on assumptions about their behavior. PLHIV, MSM, transgender people, sex workers, people who use drugs, prisoners, and migrants are regarded as breaking social norms—so some people think they deserve to be condemned and punished.
- We are not saying that the moral values are wrong, we are saying that the "judging" is wrong. We have no right to judge others—and the judging ends up hurting people.
- We need to be aware that our opinions have effects on other people. Some of these opinions are very judgmental toward PLHIV and other key populations. As a result, they may feel hurt, humiliated, and depressed; this affects their access to health services and how they protect their sexual health.
- As health workers, we have a professional obligation to remain objective and nonjudgmental with clients and avoid letting our personal beliefs and attitudes become barriers to providing compassionate and high-quality care to clients.

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

Statements for Value Clarification Exercise

Select the statements suited to your context and training group.

Statements on PLHIV

1. Health workers have a right to know which of their clients are HIV positive.
2. Clients who are HIV positive should be treated the same as other clients.
3. HIV-positive clients should be treated at a separate facility, rather than in the same facility as other clients.
4. Health workers have a duty to inform the spouse and family of a person who is HIV positive.
5. Women living with HIV should not be allowed to have babies.
6. People who get HIV through sex deserve it because of their bad behavior.
7. People who get HIV through injecting drugs deserve it because of their bad behavior.
8. A health worker living with HIV should not be allowed to treat clients.
9. Clients have a right to know if a health worker has HIV.
10. PLHIV should be monitored closely by health workers.

Statements on Men Who Have Sex with Men

1. MSM can easily seduce or convert young men to become MSM.
2. MSM cause harm to society and to families, so they should all be locked up in prison.
3. MSM are victims of social stigma and discrimination, not criminals or deviants.
4. Preventing an HIV epidemic is more important than condemning MSM.
5. MSM deserve to get HIV because of their immoral behavior.
6. Men don't decide they want to love men. It just happens to them.
7. Being a man who has sex with men is a mental illness, so MSM should be given treatment.

8. MSM couples should be allowed to get married.
9. MSM do not want long-term partners, they only want casual sex.
10. A family with MSM is paying for the sins of its ancestors.

Statements on Sex Workers (male, female, and transgender)

1. Sex workers love money and are too lazy to work. They could easily get other jobs.
2. Sex workers have a right to say "no" to sex. No one can force them to have sex, even a client who has already paid them.
3. Sex workers deserve to get HIV because of their immoral behavior.
4. Sex workers are sex maniacs—they love to have sex with anyone.
5. Sex workers steal the partners of other women/men.
6. Sex workers are like other people—they have long-term, loving relationships with their regular partners.
7. All sex workers are HIV positive.
8. Sex workers should be allowed to get married and continue their work as sex workers.
9. Sex workers cause harm to society, so they should all be locked up in prison.
10. Sex workers show off and sell their bodies, so they deserve to be raped.

Statements on People Who Use Drugs

1. Drug addiction should be considered a disease, not a crime.
2. People who use drugs cause harm to society, so they should all be locked up.
3. Preventing an HIV epidemic is more important than stamping out drug use.
4. Young people take drugs because their parents did not educate them properly.
5. You kill a snake by cutting off its head, not the tail. Public security efforts should be directed against drug traffickers and pushers, not the people who use drugs.
6. People who use drugs deserve to get HIV because of their immoral behavior.
7. People who use drugs should be allowed to get married.
8. People who use drugs should be closely monitored by the community authority.
9. Needle and syringe programs (NSPs) that provide sterile needles and syringes to people who use drugs will result in more drug use and more people who use drugs.
10. People who use drugs are unreliable and won't adhere to ARVs, so don't give them ARVs.

B5. The Blame Game—Things People Say About People Living with HIV and Other Key Populations

Facilitator's Note: This exercise helps participants verbalize stigma toward different types of people. The language can be very strong, so people need to understand why they are being asked to make lists of stigmatizing words for PLHIV and other marginalized groups.

The title of this exercise, "Things people say about people living with HIV and other marginalized groups," allows participants to express their own stigmatizing labels for other groups under the cover of attributing them to "the people." So whereas some words are those commonly used by the community, other words are those actually used by participants themselves.

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

Extra Tips for Facilitators:

- The rotational brainstorm is fun, but the real learning comes in the debriefing—so make sure you allow enough time/energy for this part.
- In debriefing this exercise, it is important to focus on "how participants feel about these names," rather than focusing on the words themselves. This approach helps to avoid the embarrassed laughter that can often occur. The whole point of this exercise is to help participants recognize how these words can hurt.
- Challenge the laughter. Often participants will laugh out of embarrassment, providing a good opportunity to ask, "How do you feel about the laughter?"

Objectives: By the end of this session, health workers will be able to do the following:

- Identify labels used to stigmatize PLHIV and other marginalized groups
- Recognize that these words hurt

Preparation

Make a list of groups that experience stigma in your context e.g., PLHIV, MSM, transgender people, sex workers, people who use drugs, migrants, prisoners, and health workers living with HIV. Then, using this list, prepare the flipchart stations—blank sheets of flipchart paper on different walls of the room, with the name of one of the groups written at the top of each sheet.

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

Time 1 hour

Steps

Warm-up—Switching Chairs Game

Set up the chairs in a circle beforehand. Allocate roles to each person, going around the circle; base the roles on the groups listed on the flipcharts: a person living with HIV, a man who has sex with other men, a transgender person, a sex worker, a person who uses drugs, a migrant, and a prisoner. Continue until everyone has been assigned a role. Then explain how the game works:

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

Then shout—"PLHIV and MSM"—and get people having those roles to run to a new chair. The game starts at this point.

Debriefing

Ask, "How did it feel to be called a PLHIV, an MSM, a sex worker, or a drug user?"

Things People Say About… (Rotational Brainstorm)

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

Report Back

Bring everyone back together into a large circle. Ask one person from each group to read out the names on their flipchart, starting with "I am a _____ (e.g., sex worker) and this is what you say about me …."

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

- What do you think about these names?
- Why do we use such hurtful language?

Summarize

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

- We are socialized or conditioned to judge other people. We judge people based on assumptions about their sexual and other behavior.
- Sex is a taboo—it is regarded as something shameful that we should not talk about, so we often shame and blame people whose sexual behavior is different from ours.
- Key populations are already stigmatized even if they are not HIV positive. They are stigmatized because they are seen as being different, and it can be difficult for them to challenge the stigma.
- All of these labels show that when we stigmatize, we stop dealing with people as human beings. Using mocking or belittling words gives us a feeling of power and superiority over them, and we forget people's humanity.
- Stigmatizing words are very strong and insulting—they have tremendous power to hurt, humiliate, and destroy people's self-esteem. When we "shame and blame" people for their characteristics or behavior, it is like stabbing them with a knife—it hurts!
- So how should we treat PLHIV and other key populations? We should give them (a) respect and affection; (b) support and encouragement; and (c) space, place, and recognition. If we treat them well, they will keep their self-esteem, feel empowered, and take charge of their lives, accessing health services and taking care of their sexual health.

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

B6. Understanding the Different Identities of Sexual Minorities

Facilitator's Notes: This exercise provides information on MSM and transgender people, and then looks at the stigma both groups face.

The first part of this exercise will help to build understanding about different terminologies used in relation to sexuality. These include biological sex, gender identity, gender expression, and sexual orientation. It is important to recognize that these identities are held by everyone, not just sexual minorities such as MSM or transgender people.

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

Objectives: By the end of the activity, health workers will be able to do the following:

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

Sources Engaging Boys and Men in Gender Transformation (EngenderHealth)

Understanding and Challenging Stigma Towards Men who have Sex with Men: Toolkit for Action (Cambodia)—Exercise B5

Time 2 hours

Handouts F5: MEN WHO HAVE SEX WITH MEN AND STIGMA

Steps

Introduction

Explain that MSM and transgender people have many different identities; we need to be able to understand the differences if we are to respond to their needs effectively. This exercise will help to explain these different identities.

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

Part A: Introduction to Concepts (40 minutes)

1. Write "BIOLOGICAL SEX" at the top of a flipchart sheet and draw a line immediately below it.

   Ask the group, "What do you understand by biological sex?"

   Label one side of the line "Man," the other side "Woman," and place "Intersex" in the middle. (See the diagram on p. 83.) Then explain: "Most children are born male or female, but some people are born with full or partial genitalia of both sexes, or with underdeveloped genitalia, or with unusual hormone combinations. We say these people are 'intersex.'"

2. Draw a second line and title it "GENDER IDENTITY."

   Ask the group, "What do you understand by gender identity?"

   Label one side "Male," the other side "Female," and the midpoint "Transgender." Explain that a person's GENDER IDENTITY is not always the same as their biological sex. When a person feels that their personality, their inner self, is different from their biological sex, we say that the person is "transgender." A transgender person may decide to wear clothing of another gender, decide to change his or her biological sex (called "gender reassignment surgery"), or do nothing at all. Explain that a "transwoman" is a person whose biological sex is male, but who feels that she is a woman; a "transman" is a person whose biological sex is female, but who feels that he is a man.

3. Draw a third line and title it "GENDER ROLES/EXPRESSION."

   Ask the group, "What do you understand by gender roles or gender expression?"

   Label one side "Masculine" and the other "Feminine." Explain that GENDER ROLES are society's expectations of how men and women should act. Often, when a man acts in a feminine manner, he is assumed to be homosexual, but this may not be true because gender roles and sexual orientation are different. Explain that a person's gender roles can also move across the continuum over time or change in a given situation.

4. Draw a fourth line and title it "SEXUAL ORIENTATION."

   Ask the group, "What do you understand by the term sexual orientation?"

   Label one side "Homosexual," the other side "Heterosexual," and the midpoint "Bisexual." Explain that SEXUAL ORIENTATION can be seen as a continuum, from homosexuality to heterosexuality, and that most individuals' sexual orientation falls somewhere along this continuum. Although individuals cannot change their sexual orientation at will, sexual orientation might change throughout a person's lifetime, so a person's orientation can move along the continuum as time passes. Most people, however, do not change much during their lifetimes.

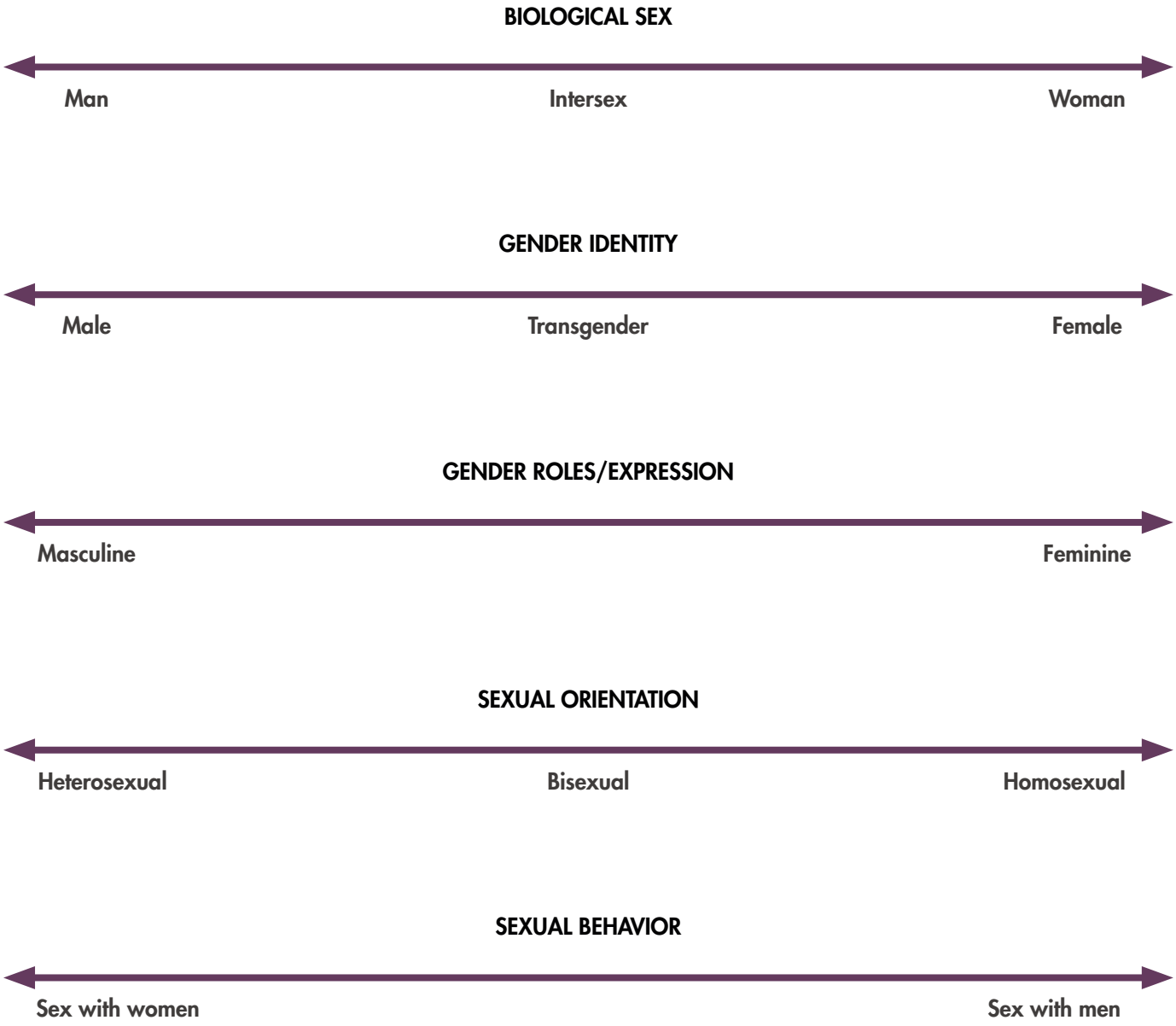
5. Draw a fifth line and title it "SEXUAL BEHAVIOR."

   Label one side "Sex with Men" and the other side "Sex with Women." Explain that a person's sexual behavior does not always indicate his or her sexual orientation. Not all individuals who have had sexual experiences with members of their own sex define themselves as homosexual. For example, some men who have sex with other men in isolated settings, e.g., prisons, do not consider themselves to be homosexual. In addition, individuals who engage in same-sex sexual activity might not be exclusively attracted to members of their own sex and might not wish to engage in sex only with members of their own sex. Some married persons, for example, engage in same-sex sexual activity outside of marriage and still consider themselves to be heterosexual. People who have sex with both men and women might consider themselves to be bisexual, homosexual, or heterosexual.

6. In summary, our human sexuality and gender identity includes five elements:

Biological Sex	based on our physical status of being either male or female
Gender Identity	how we feel about being male or female
Gender Roles	society's expectations of us, based on our sex
Sexual Orientation	the sex to which we are attracted to sexually
Sexual Behavior	the kind of sex we have

Sexuality Continuum Diagram



Part B: Practice Using the Concepts (30 minutes)

Group Work

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

Case Studies

Sam is a 25-year-old transman. He was born in a woman's body but from an early age began to think of himself as a male and would dress in boys' clothing. After trying to change Sam, his parents gave up and kicked him out of the house. Sam moved to the city, where he had a sex change operation.

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

Issa is a gay man who works as a mechanic. He loves to play football and drink with the boys, and no one has ever suspected that he is gay or has sex with men.

Sulimana is a 40-year-old married businessman. He uses a few effeminate gestures, but everyone sees him as a happily married man. In reality, he loves to have sex with men and sends his assistant out to arrange these encounters with male sex workers.

Coleman makes his living as a sex worker. Coleman only has sex with men for money. He is sexually attracted to women and in the future hopes to marry his girlfriend.

Report Back

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

EXAMPLE RESPONSES

What can we do to make health facilities friendlier and challenge stigma?

- Provide a friendly, welcoming environment—friendly face, body language, and voices.
- Ensure that the confidentiality of the medical information of MSM and transgender people is guaranteed, and their HIV status is not disclosed.
- Train health workers how to provide counseling and services to MSM and transgender people, e.g., nonjudgmental, neutral, or supportive language and appropriate body language.
- Ensure that MSM and transgender people have access to HIV prevention services, STI management, provision of male and female condoms, and voluntary HIV counseling and testing.

MSM	EXAMPLE ANALYSIS
Sam	Biological sex – woman (before sex change) Gender identity – transman Gender expression – masculine Sexual orientation – gay (sexually attracted to men)
Makara	Biological sex – man Gender identity – male Gender role/expression – primarily masculine, but some effeminate gestures Sexual orientation – gay (sexually attracted to men)
Issa	Biological sex – man Gender identity – male Gender role/expression – masculine Sexual orientation – gay (sexually attracted to men)
Sulimana	Biological sex – man Gender identity – male Gender role/expression – slightly effeminate Sexual orientation – bisexual (sex with both his wife and with men)
Coleman	Biological sex – man Gender identity – male Gender role/expression – masculine Sexual orientation – heterosexual (sexually attracted to women)

Part C: Stigma Toward MSM and Transgender People (45 minutes)

Case Study

Divide into groups and give each group a case study. Ask them to read the case study and discuss the questions included with each.

Report Back and Processing

Ask each group to report. Then ask:

- What can we do to make our health facilities more user friendly and challenge stigma?

MSM Case Studies

Case Study A: Dray and Isaac

Dray and Isaac have been living together as a couple for the last year. They decided to go together to the health facility for couples counseling. When they asked to be tested together and receive couples counseling, the nurse looked shocked and told them she wasn't sure this was allowed in the health facility. She went to talk to other staff, and lots of whispering and finger-pointing followed.

- What examples of stigma are in the case study?
- Do you think this could happen in your health facility?
- What other forms of stigma have you observed toward MSM and transgender people in health facilities?

Case Study B: Tim

Tim has been working as a nurse in a clinic for the last three years. He is single and often gets offers from some of the younger female staff to go out on dates. However, Tim is gay and, although he keeps this a secret at work, he is open in his life outside and has a wide circle of gay friends. One night, as he was dancing with a friend in a gay bar, he saw two staff members from work staring at him. The next day, his colleagues at the clinic seemed to be avoiding him, and he worried about what might happen.

- What examples of stigma are in the case study?
- Do you think this could happen in your health facility?
- What other forms of stigma have you observed toward MSM and transgender people in health facilities?

Case Study C: Margaret

Margaret is a nurse in a prison clinic. One of the prisoners came in for some tests and as he chatted, he told her that he was having a relationship with one of the prison wardens. The warden made sure that he got enough food and was not mistreated by other prisoners. Margaret was shocked because she knew the warden—and his wife—well. She felt that she should report what she had been told.

- What would you do in Margaret's situation?

Case Study D: Cathy and Kennedy

Cathy is a student nurse in a busy hospital ward and has been looking after a client named Kennedy for the last two days. During visiting hours, a crowd of Kennedy's male friends came to visit—they were very loud, and some were dressed in feminine-looking clothes. The friends greeted Cathy in a friendly way, but some of the other clients started complaining. The man in the next bed called her and said, "Those kind of people should not be allowed in here." Cathy wanted to defend Kennedy but was not sure what to say.

- What examples of stigma are in the case study?
- Do you think this could happen in your health facility?
- What could Cathy say to help challenge the stigma faced by Kennedy?

Transgender People Case Studies

Case Study A: Aisha

Aisha, who is transgender, was admitted to a male ward. She felt that she should be in the female ward, but the nurses refused to put her there. In the male ward, she wore female clothes; a lot of people stopped and stared at her, thinking she was a woman. Some doctors suggested that Aisha should be sent to the department of psychiatry and mental health.

- What do you think about this case study?
- Could this happen in your health facility?

Case Study B: Sarah

Sarah is a 30-year-old transwoman. She was born with the body of a man but has always felt that she was female. She lives as a woman but has not had any reassignment surgery. Sarah has relationships with men and goes to a clinic to get a supply of condoms. Every time she comes, she hears health staff whispering loudly, "Is he a man or a woman?"

- What do you think about this case study?
- Could this happen in your health facility?

Case Study C: Dan

Dan is 19 years old and went to a clinic to see if the doctor had any information about hormone treatment. Dan was born with a girl's body but knows he was meant to be male. He heard that there were hormones available that would change his voice and body hair—some of his friends are taking them. He wanted to know if they are safe. The doctor looked completely blank when Dan told him why he had come.

- What do you think about this case study?
- Could this happen in your health facility?

Summarize

Summarize the main points participants have made during the exercise. In giving your summary, you may use some of the following points if participants have not already mentioned them.

- Common forms of stigma and discrimination toward MSM and transgender people include: delaying or refusing services or providing poor-quality treatment, gossip and verbal abuse, breaking confidentiality, invasive questioning, etc.
- Sex between men is often criminalized; as a result, MSM are forced to operate in a climate of secrecy. This leaves them open to being exploited, stigmatized, and subject to violence.
- Stigma fuels the HIV epidemic—it may prevent MSM and transgender people from accessing information and services needed for prevention and accessing treatment. Stigma results in the loss of self-esteem; as a result, MSM and transgender people may take more risks in their sexual behavior (e.g., not using condoms or clean needles), which may lead to HIV infection.
- Our Code of Conduct requires us to treat all clients without exception. Every client has the right to be free from discrimination and access the highest attainable level of physical and mental health.
- Make your health facility a warm, welcoming, and nonjudgmental environment that is open to and respectful of all

clients, and where clients can seek services without fearing discrimination from health workers or that community members will learn about their situation. This means establishing systems that ensure client privacy and confidentiality.

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

B7. Understanding Drug Addiction and Harm Reduction

Facilitator's Note: This exercise will teach some of the basics of drug addiction—why people start taking drugs, how they get addicted, and why it is difficult to overcome addiction. The aim is to help health workers obtain accurate information and full understanding needed to overcome the fears and misconceptions about people who use drugs. At the same time, it will help health workers see that a lack of understanding often leads to stigmatizing responses to people who use drugs and poor strategies for solving the problem.

Often health workers have some information about drugs but not enough to help them deal with their fears about drugs in a rational way. They don't understand the following, for example:

- The difference between drug use and drug addiction: They are often lumped together.
- The power of addiction: They assume, for example, that it is easy for people who use drugs to stop—that it is only a matter of will. They don't see that drug addiction is beyond the control of people who use drugs—painful feelings of withdrawal make it very difficult to quit.
- The nature of addiction: What pushes the addict to find more drugs is fear of the painful feelings of withdrawal, not the pleasure of the drug (which was the main attraction when they started taking drugs).
- The different options for HIV prevention and/or treatment: These include voluntary or compulsory detoxification, needle and syringe exchange programs, drug substitution programs.

Objectives: By the end of this session, health workers will be able to accomplish the following:

- Describe why and how people start using drugs and why it is difficult for them to quit drugs
- Identify stigmatizing practices toward people who use drugs
- Explain how stigma affects the health of their clients
- Identify practical things to change the way they relate to their clients who use drugs.

Sources Understanding and Challenging Stigma Towards Injecting Drug Users and HIV in Vietnam: Toolkit for Action—Exercises A4, A5, and A6

Time 1 hour

Handouts F7: UNDERSTANDING DRUG ABUSE

Steps

Part A: The Dynamics of Drug Addiction

Group Discussion

Divide into five small groups and assign each group one of the following questions:

- Why do people start taking drugs?
- Which groups of people get involved in drugs, e.g., rich or poor people?
- How do people get addicted to drugs?
- Why is it difficult for people to quit drugs once they are addicted?
- Why do some people who use drugs inject them, rather than use them in other ways?

Report Back and Processing

Responses to the above questions and those below are included in Fact Sheet F7, UNDERSTANDING DRUG ABUSE. Discuss any areas that may not have been covered.

Processing

Ask

- Why do some people think that all people addicted to drugs do not have a strong will?
- What can help people who are addicted to drugs to quit?

Part B: Stigma Toward People Who Use Drugs

Stigma Toward People Who Use Drugs (Case Studies)

Divide into groups and give each group one of the case studies (below). Ask them to read the case study and discuss the questions.

Report Back and Processing

Ask each group to give a report on its case study. Ask the group:

- Why do we stigmatize people who use drugs?
- What are the effects of stigma on people who use drugs?

Case Studies

Case Study A: Van

Van, a drug user, went to the health facility for an HIV test. The health workers watched him closely and kept him waiting. Everyone seemed afraid of him, fearing he might stab them with a syringe, so they kept their distance. Van asked one health worker to help him, but she walked out of the room. When Van appealed to another health worker, she said: "I don't care if you die. It's your own fault—your disgusting and filthy habits!" Van left—and never went back.

- What happened in the case study?
- Could this happen in your health facility?
- What other forms of stigma have you observed in your health facilities toward people who use drugs?

Case Study B: Sally

Sally, a drug user and sex worker, went to a clinic for an STI check-up. When she took off her clothes, the nurse noticed that she had a tattoo. The nurse asked her many questions: "Are you a sex worker? Are you a drug user? Have you quit drugs?" Then she forced Sally to take an HIV test. Sally felt humiliated, so she said nothing. When the results came out, the nurse said, "I'm sorry, but you are HIV positive. You need to stop using drugs! That's where it all started." There was no post-test counseling; the health workers rushed her out of the facility without even treating her for her STI.

- What happened in the case study?
- Could this happen in your health facility?
- What other forms of stigma have you observed toward people who use drugs in your health facilities?

Case Study C: Hong

Hong is a 30-year-old nurse working in a clinic. She has been hearing lots of stories and gossip from other nurses about the patients using the center, especially those who are people who use drugs. She has heard about patients attacking nurses

and also about things being stolen. As a result, she has become very frightened of patients who use drugs. She is afraid that if she says something wrong, they may attack her when she is checking their weight or doing other checks. She doesn't want her patients to see that she is afraid, but they begin to notice that she keeps her distance and limits contact with them. She always locks up her purse and, when she moves around the clinic, she always looks in every direction, worried that something bad might happen to her. She has become a nervous wreck.

- What happened in the case study?
- Could this happen in your health facility?
- What would help in this situation?

Case Study D: Tony

Tony has been trying to quit drugs for the last two years and has not used drugs for two months. He is well known at the local clinic because he used to collect condoms to sell to some of his friends who sell sex on the streets.

Tony is HIV positive and went to collect his ARV drugs. There was a long queue in the waiting room and he asked one of the nurses if he could just collect his prescription without waiting. The nurse looked at him disapprovingly and said, "What's the point of people like you taking ARVs when you don't even care about what you do to your body!" Tony left the clinic without his ARVs, feeling angry and upset.

- What happened in the case study?
- Could this happen in your health facility?
- What would help in this situation?

Case Study E: Noleen

Noleen has been using drugs since she started living on the streets when she was 16 years old. She is now 24 and lives with her boyfriend in a small township. Noleen thinks that she might be pregnant and decided to get checked at the antenatal clinic.

Many people were waiting at the clinic, so Noleen started to feel anxious about how long she would have to wait. She talked to a student nurse who was kind and who took her to the Sister in Charge. The Sister did a pregnancy test and told Noleen that she was two months pregnant.

Noleen had a lot of questions but she overheard the Sister talking to her colleague, saying, "Some people should not be allowed to be parents!" Noleen thought they were talking about her and she quickly left the clinic.

- What happened in the case study?
- Could this happen in your health facility?
- What would help in this situation?

Challenging Stigma (Buzz Groups)

Discuss in pairs: "What can we do to make our health facilities more user friendly and challenge stigma?"

Summarize:

- Common forms of stigma and discrimination toward people who use drugs include delaying or refusing services or providing poor-quality treatment, gossip and verbal abuse, breaking confidentiality, invasive questioning, etc.
- Drug use is criminalized, so people who use drugs are forced to operate in a climate of secrecy. This leaves them open to being stigmatized, harassed by the police, and forced to hide their activities.

- People who use drugs have rights—e.g., the right to healthcare, the right to humane treatment, etc.—and they should be able to access those rights. The fear of being reported to the police prevents people who use drugs from asserting their rights. As a result, they find it difficult to challenge the stigma and discrimination they face in health facilities.
- Stigma against people who use drugs causes them to have even greater difficulty quitting drugs, as services and support are lacking. It also causes many to avoid using health services for fear of being reported. Because people who use drugs operate in a climate of secrecy, it is difficult for them to use safe injection practices, and this makes them vulnerable to getting HIV.
- As health workers, we need to be aware of our attitudes about drugs and people who use drugs. If we do not address our personal reactions and attitudes, we may, without thinking, stigmatize our clients who are using drugs. It is our professional duty to ensure that our personal feelings and attitudes do not affect our work performance.

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

B8. Harm Reduction, Drug Use, and HIV

Facilitator's Note: In this session, participants will learn more about harm reduction, a strategy closely related to stigma reduction. In fact, harm reduction adopts a destigmatizing approach, taking a morally neutral stance to drug use, rather than blaming people for using drugs. The aim is to put aside our attitudes toward people who use drugs and look at what we can do to protect their right to health and reduce their vulnerability to HIV infection.

The World Health Organization and many governments have adopted a harm reduction approach to reduce HIV infection among people who use drugs. The idea is that once people who use drugs become addicted, it is very difficult to help them quit. Because drug use is a criminal offense in many countries, people who use drugs hide their use of injecting drugs and, as a result, do not take care when drug taking and often end up getting HIV. Harm reduction does not condone drug use but it gets people who use drugs to do so in a safe and responsible way so they do not get HIV or transmit it to others.

In this exercise, health workers will learn how to help people who use drugs (a) deal with their drug addiction; (b) prevent contracting or transmitting HIV; and (c) live healthier, more stable lives.

Objectives: By the end of this session, health workers will be able to do the following:

- Describe what is involved in a harm-reduction approach
- Explain how they can help people who use drugs (a) deal with their drug addiction; (b) prevent contracting or transmitting HIV; and (c) live healthier, more stable lives
- Demonstrate skills for counseling people who use injecting drugs

Sources Fact Sheet on Drug Addiction and HIV

Time 1 hour

Handouts F7: UNDERSTANDING DRUG ABUSE

F8: HARM REDUCTION

Steps

Introduction to Harm Reduction (Small Groups)

Divide into four groups and assign each group one of the following questions to discuss:

- What do you know about harm-reduction programing?
- Are there any harm-reduction strategies that you use or exist in your country?
- What are the principles underlying harm-reduction programs?
- Why is harm-reduction for injecting drug use important in the context of HIV?

Report Back

Ask each group to report. Responses to the questions above are included in Fact Sheet F8 HARM REDUCTION. Discuss areas that may have not been covered.

Practice Giving Advice to Clients Who Are Using Drugs (Paired Role-playing)

Divide into pairs and hand out a scenario to each pair. Ask them to try out the scenario as a role-play—one of the partners playing the health worker, the other partner playing the client.

Ask all pairs to try out the role-play at the same time—this gives everyone a chance to practice. Then invite one or two pairs to show their role-play to the whole group. After each role-play, debrief—ask the group to identify the harm reduction advice given by the health worker to the client.

Option: Stop-Start Role Play

Choose one scenario and ask for volunteers to start the role-play. After a while, "freeze" the actors and get feedback from the group about the harm-reduction approach. Then invite others to play the role of the health worker or try a new scenario.

Scenarios

- Health worker—your client is a young person who you suspect may just be starting to use drugs. You have met this client on his/her previous visits to the clinic and would like to help him/her think about the disadvantages of using drugs.
- Health worker—you are already familiar with the client, who has informed you that s/he is sharing the use of injecting equipment with his/her friends. Advise and encourage him/her to (a) stop sharing injecting equipment; (b) use clean injecting equipment, and (c) inform him/her about where s/he can access clean injecting equipment.
- Health worker—your client (sex worker), who uses drugs, is already accessing clean injection equipment. Encourage him/her to talk about how s/he can practice safe sex and access condoms and lubricant.
- Health worker—your client, whom you know is using drugs, comes to the health facility and asks for an HIV test. You advise him/her on the issues around HIV testing.
- Health worker—your client comes to the clinic looking very anxious and explains that s/he is going through withdrawal. Help him/her to deal with this situation.
- Health worker—your client would like to join a methadone substitution program. Discuss the benefits of this program with him/her.
- Health worker—your client, who uses drugs, has been attending your clinic regularly and you already have provided advice to him/her about accessing clean injecting equipment and stopping the sharing of needles. Discuss with the client some of the other health issues s/he needs to think about.

Summarize

- A harm-reduction approach does not stop or condone drug use. It is not necessary to condone people's drug use to be able to help them.
- Harm reduction reduces the harm toward people who use drugs—their vulnerability to HIV.
- The aim of a harm-reduction approach is to help people who use drugs move out of the margins of society as "stigmatized groups," stabilize their lives, and reintegrate with the community.
- The harm-reduction approach recognizes that stigmatizing people who use drugs makes them feel despised and rejected, and drives them "underground." people who use drugs feel that people don't respect them and are left wondering why they should live responsible lives. They stop accessing HIV and health services and safe injection practices, which puts them at risk.
- A harm-reduction approach encourages people who use drugs to take responsibility for their own health.
- Health workers should stop judging, saying "these people are bad," and instead focus on what they can do practically to help people who use drugs—to live up to their code of providing healthcare to all people, without exception.
- This approach encourages health workers to fulfill their mandate. Health workers are obligated to provide services to all patients equally without distinction, and to put their attitudes (judging) aside. Health workers cannot refuse to

serve people because they don't like them. They are obligated as health professionals to provide these services to everyone, without discrimination.

- In many countries, drug use is not well understood and is criminalized. This has led to stigma against and, in the context of HIV, to less-adequate healthcare, treatment, and support. Many health workers believe that people who use drugs are less than human and thus deserve less-adequate health treatment than other people.
- Some health workers do not understand that people addicted to drugs cannot quit easily. Many people who use drugs would like to quit, but the craving for drugs makes it difficult for them to break the addiction.
- In treating people who use drugs, we need to treat each person as an individual with unique needs and strengths. Health workers need to take each person "where that person is" rather than create unrealistic expectations of people who use drugs.
- In treating people who use drugs, we must accept that drug use exists in the world, and that ignoring or condemning it will not deal with the harm that can occur as a result of the failure to provide harm reduction options for people who use drugs.
- Stigmatizing people who use drugs does not help us to fight drug abuse or HIV. Instead of stigmatizing those who use drugs, we should help people to stay away from drugs and provide voluntary and safe services for people who wish to stop using them (e.g., opiate substitution therapy, etc.).
- There is a debate about whether the criminal law or other punitive measures should be allowed to undermine public health needs. For instance, some countries have implemented harm-reduction programs to help People Who Inject Drugs access clean needles and seek out treatment without the fear of repercussions so the risk of transmission of HIV and other blood-borne conditions can be reduced.

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

B9. Counseling Skills and Value Judgments

Facilitator's Note: This exercise helps health workers explore how their value judgments about certain types of behavior or groups of people could affect the quality of their counseling in an HIV clinic. Sometimes these judgments lead to stigma: e.g., clients may be "rushed through" a session, given inappropriate advice, avoided, or referred to other counselors because a health worker refuses to see them.

In countries where the HIV epidemic is concentrated and particularly affects key populations, such as sex workers, MSM, or people who use drugs, it is important that health workers have the skills to counsel these groups and are willing to ensure equal access to services for all clients.

The exercise provides counseling skills practice. The main focus of the practice sessions is to make health workers aware of the ways in which they may judge clients, and how their judgments affect the quality of the counseling.

Explain that pairs will practice the first part of the counseling session, in which the counselor is trying to establish rapport and find out about the client's concerns.

Objectives: By the end of this session, health workers will be able to do the following:

- Describe counseling situations that challenge their value judgments
- Demonstrate how to use counseling skills to counsel clients from different backgrounds
- Explain how their own value judgments could affect their counseling sessions

Sources Draft exercises from Alliance Regional Stigma Team

Time 1 hour

Materials Scenarios listed at end of exercise—give one to each group

Steps

Buzz and Brainstorm

Divide into pairs and ask, "What situations might make us feel less comfortable in dealing with them as counselors?" Give an example if needed; e.g., a man talking about his male partner or a sex worker who has been beaten by a client. Record responses on the flipchart—then select a few scenarios for the practice described below.

Counseling Practice

Divide participants into groups of three. Explain that in each group, one person will play the counselor, one person the client, and one person the observer. You are going to give the client in each group a role to play (without letting the counselor know what that role is). Explain that all of the role-plays will focus on the start of the counseling session. The role of the counselor is to build rapport with the client, ensure confidentiality, and identify the client's concerns. The role of the observer is to note whenever questions or statements from the counselor contain a value judgment.

Then hand out the scenarios (one to each group) and ask the groups to role-play the counseling session.

Large Group Discussion

Bring the group back together and ask:

- Clients—How were you treated? Do you feel you were being heard?
- Counselors— How did the session go?
- Observers—What happened? Did the counselor make any value judgments?

Emphasize that the aim of the session is not to assess counseling skills but to help everyone become more aware of the ways in which we might make judgments about clients when we are counseling.

Stop-Start Counseling Practice

Invite one pair to show the group a few minutes of their session in the center of the circle. After a few minutes, shout "stop!" and ask—"How did it go? Did the counselor make any value judgments?" Then invite other participants to take over the counselor's role and continue the role-play. Explain that you or other participants will shout "STOP" when the counselor makes a value judgment.

Processing

Ask

- What have we learned from this?
- How might our own value judgments interfere with the counseling process?
- What can we do if we find that our own judgments or inexperience are affecting the service we offer to a particular client?

Summarize

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

- We need to be aware of how our values and judgments can affect our counseling practice.
- We need to accept and respect clients as they are, since this is one of the cornerstones of counseling.
- We should treat each client as an individual and be open to what they need to discuss. We need to respect each client's issues and explore the context in which they live to help frame good decisions.
- All clients have a right to access our counseling service and receive the same quality.
- Remember the key counseling principles—we need to accept everyone and be nonjudgmental.

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

Roles for Clients—Counseling Role-plays

- You are a man and have been with your male partner for two years. Two days ago, he told you that he had fallen in love with someone else and was leaving you. He also said that you should get checked for HIV. You are feeling very sad and start crying in the counseling session.
- You sell sex as a way of surviving but you hate what you do and worry all the time about HIV. You are scared to tell the counselor what you do, but you want to find out if s/he can help you find a way to get out of sex work.
- You are a sex worker and really enjoy meeting different people and earning money. There are some sexual practices, e.g., anal sex, that you want to ask the counselor about, to see if there is a risk of HIV and get some advice—but you are not sure how the counselor will react.
- You have been given a positive result for HIV and are feeling very angry. All you can talk about to the counselor is how it is all your wife's fault, and that you will make sure she is "punished" when you get home.
- You are a young person who has been using drugs for the last few years but only recently started injecting drugs. You want to find out about HIV risks and where you can get clean needles.
- You are a woman and have come to find out information about HIV risks. Your husband has started insisting on anal sex and you are feeling embarrassed to ask, but you need to know how to protect yourself.

- You are a young woman and have realized that you are pregnant. You are not ready to have a baby, and your relationship with your boyfriend is not going well. You want to find out how to have an abortion.
- You are a prisoner and have been brought to the health facility because you are sick. You want to tell the counselor that you have been forced to have anal sex with other prisoners and find out what to do.
- You are a young man and have realized that you are more attracted to other men than to women. You want to talk to the counselor about how you are feeling, and where to meet other gay men.
- You have returned to the clinic after telling your husband about testing HIV positive last week. Your husband has left you and the children, and is threatening to tell the whole family.

B10. Challenge the Stigma—and Be the Change!

Facilitator's Note: This exercise looks at how to challenge stigma toward marginalized groups in your day-to-day work as a health worker. Participants learn how to be assertive and then practice this skill in a series of paired role-plays. The aim is to help people see that acting against stigma can be done whenever it happens.

Objectives: By the end of the session, health workers will have the skills to challenge stigma and change the situation using an assertive approach.

Sources Understanding and Challenging Stigma Towards Men Who Have Sex with Men: Toolkit for Action (Cambodia)—Exercise E3

Time 1 hour

Steps

Introduction

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

Paired Role-playing

Explain that we will now practice how to challenge stigma and discrimination in different common work situations by taking one issue at a time. Then give the following instructions:

> Everyone stand up, find a partner, and face that partner. You are both health workers. Make a role-play about the following situation: A complains to B about a client, saying that the client (who is assumed to be a gay man) is disgusting and immoral. Health worker B should respond in a strong and confident way. Play!

EXAMPLE ROLE-PLAY

A. I don't know why we are wasting our time on this man who has sex with men. He is mentally sick and a danger to everyone.

B. He is no different from anyone else. He just happens to love men, not women.

A. But he is having sex with men, which is against our culture and religion.

B. There is nothing in our religion that says men cannot have sex with men.

A. Okay, but I don't know why we have to treat him. He should go somewhere else.

B. As health professionals, we have a Code of Conduct. We need to treat all of our clients equally. We cannot stop serving a person because we don't like him. It is part of our responsibility as professionals to provide medical care to everyone.

> After two minutes, ask a few pairs to show their role-plays (one at a time) in the center of the circle. After each role-play, ask, "How did the 'challenger' do? What approach was used by the challenger? Did it work? What other approaches might be used?"

EXAMPLE COMMENTS ON ROLE-PLAYS

Good eye contact—looked health worker in the face. Strong voice. Spoke with confidence.

Didn't criticize the stigmatizer; simply explained her responsibility as a health worker.

Good arguments: "He is no different from anyone else." "There is nothing in our religion…"

She was not afraid to disagree with her colleague. Did not back down, apologize, or allow the first health worker to dominate her. She quietly insisted that the health worker do her job.

After each performance, ask other participants if they have a better way of challenging the stigmatizer and let them take over the challenger's role in the play and show their approach. After each new attempt, ask, "What made a difference?" (Examples: good arguments, strong voice level, body language, confidence, etc.)

Repeat the paired role-playing for other scenarios. For each new scenario, the partners should take turns playing the "stigmatizer" and "challenger" roles.

Other scenarios

- A health worker refuses to examine a client who is a man who has sex with men, saying he is disgusted with the person's sexual behavior. Try to challenge the stigmatizer.
- The manager of the health facility is enforcing a stigmatizing policy (e.g., forcing key populations to get HIV testing without their consent). The health worker approaches the manager to explain the effect of the policy on clients and discuss changing it.
- One health worker refuses to treat a sex worker who is waiting in line. Try to challenge the stigmatizer.
- Two men enter the clinic and say they are a couple and have come for an HIV test. The counselor says they should go to another clinic. Try to challenge the stigmatizer.
- One health worker refuses to treat a client who is an immigrant, saying that "the government cannot provide health services to foreigners." Try to challenge the stigmatizer.
- Two health workers are discussing the use of condoms in prisons. One health worker insists that prisoners should not be given condoms, saying that sex in prison is disgusting. The other health worker challenges him/her.

Processing

Ask, "What have you learned about the best ways to challenge stigma?"

EXAMPLE RESPONSES

- Avoid getting upset—stay calm. Don't raise your voice.
- The best approach is to say it honestly, clearly, and simply: "This is wrong."
- When I challenged her politely but firmly, she denied that she was stigmatizing. Avoid condemning this person and telling him/her he is wrong.
- Ask questions to help clarify why this person is stigmatizing the client.
- Help the person think about her behavior and how it affects the client.
- Urge the stigmatizer to think about her own experience of being stigmatized—and how it felt.
- Help the person deal with her fears toward the client.
- Explain your argument for treating the client in the same way as other clients.
- Encourage the person to take responsibility for caring for the client.

Summarize

- We can all challenge stigma on an individual level, using an assertive approach.
- When stigma leads to discrimination, you may need to develop policies or a Code of Conduct to protect clients. Involve senior managers in this process.
- The most powerful responses to people who are stigmatizing are those that make the stigmatizer stop and think, rather than attacking responses, which can make the stigmatizer defensive. These are examples of strong responses:
  - You are probably not aware that you are stigmatizing.
  - MSM did not choose to become MSM. This just happens; it is natural.
  - We have a Code of Conduct as professionals to serve everyone.

Explain and discuss the following list of assertiveness techniques:

- Tell people what you think, feel, and want—clearly and forcefully.
- Say "I" feel, think, or would like.
- Don't apologize for saying what you think, or put yourself down.
- Stand or sit straight in a relaxed way.
- Hold your head up and look the other person in the eye.
- Speak so that people can hear you clearly.
- Stick with your own ideas and stand up for yourself.
- Don't be afraid to disagree with people.
- Accept other people's right to say "no" and learn how to say "no" yourself.

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

MODULE C

HIV and AIDS Update

C

Introduction

This section provides an update for health facility staff on the basic facts around HIV, especially the information on HIV transmission, which is needed to do the following:

- Overcome fears about getting HIV through casual contact
- Understand the basic issues underlying the procedures involved in Standard Precautions
- Understand HIV transmission as it relates to key populations, especially MSM and people who use drugs

Its aim is to update health facility staff on HIV transmission, prevention, treatment, and care—and show the links between this knowledge and reducing stigma.

Health facility staff all over the world have received basic information on HIV and AIDS over the past two decades, but gaps still exist in understanding; this lack of knowledge fuels fear about contact with HIV-positive patients in health facilities. In addition, most health facility staff have very little information on HIV as it applies to MSM and people who use drugs.

There is also a need to raise health facility staff awareness about the risk of hepatitis C virus (HCV) infection among people who use drugs and some groups of HIV-positive MSM.

Exercises

C1. Fears About Getting HIV Through Nonsexual Casual Contact

C2. HIV Transmission and MSM

C3. HIV Transmission and People Who Use Drugs

C1. Fears About Getting HIV Through Nonsexual Casual Contact

Facilitator's Note: In this exercise, health facility staff identify specific forms of contact with PLHIV that they fear might result in their becoming infected with HIV. Then they explain the reasons behind their fear, and the trainer provides information to counter these fears.

Fear of HIV transmission is one of the main drivers of stigma; it is important to allow health facility staff, especially those who have little training on HIV issues (e.g., clerical workers, guards), time to explore how HIV is—and is not—transmitted. Being able to provide clear information about HIV transmission is an important tool in eradicating stigma.

The exercise is divided into three parts. Part A explores common fears about HIV transmission. Part B gives participants a chance to try and explain transmission in a clear and simple way, so that they can help to challenge misinformation in their own health facilities. Part C explores fears of those risks specific to health facilities and then introduces the concept of Standard Precautions, which is explained more fully in Part D.

Objectives: By the end of this session, health facility staff will be able to do the following:

- Describe some of the fears they have about HIV transmission
- Explain how HIV is, and is not, transmitted
- Explain why HIV cannot be transmitted through nonsexual casual contact

Sources Understanding and Challenging HIV Stigma: Toolkit for Action (B4)

We Are All in the Same Boat: Using Art and Creative Approaches with Young People to Tackle HIV-related Stigma (UNESCO)—Exercise 18

Time 1 hour

Materials FEARS PICTURE CARDS

Quantity, Quality, and Route of Transmission (QQR) Fact Sheet—copy for each participant

Handouts F9: QQR—Quantity, Quality, and Route of Transmission

Steps

Part A: Naming and Analyzing Fears, and Providing Correct Information

Naming the Fears (Pictures Cards)

Divide into pairs and hand out one picture card to each pair (randomly). Ask each pair to discuss the form of casual contact shown in the picture and the reasons why some people might fear that this form of contact could lead to getting HIV.

Analyzing the Fear

Go around the circle quickly, asking each pair to present their picture and explain why people think this form of contact will lead to HIV infection.

EXAMPLE RESPONSES

Contact through food: A woman living with HIV cooks food in the canteen and cuts her finger. The blood gets into the food, then through the food into the mouths of her staff, who then get HIV.

Providing Correct Information:

Explain Quantity, Quality, and Route of Transmission (QQR). Then respond to two or three of the pictures, using information from the QQR Fact Sheet to show how transmission is not possible. Hand out the fact sheet.

EXAMPLE RESPONSES

Contact through food: HIV cannot survive outside the body, so even if the blood gets into the food, the HIV would die as soon as it is exposed to air. In addition, the heat of the cooking would kill the HIV.

Part B: Practicing Giving Clear Information

Margolis Wheel

Arrange the Margolis Wheel—two concentric circles of chairs—an inner circle and an outer circle—with the two circles facing each other. Ask the more confident participants to sit in the inner circle. Give those in the outer circle the first four questions listed below (questions for the Margolis Wheel). Ask them to ask the first question to their partner seated in the inner circle. Those in the inner circle should try to give clear information and reasons to explain the transmission question.

Ring a bell, and ask the outside row to rotate to the next seat, ask the second question to their new partners, and so on.

After the first four questions, ask the two circles to change places and continue with questions 5–8, so that both sets of participants have a chance to practice.

Questions for the Margolis Wheel

1. Can you tell me why you cannot get HIV from shaking hands?
2. Can you tell me why there is no risk of getting HIV from a mosquito bite?
3. Can you tell me why you cannot get HIV from a person living with HIV who is cooking?
4. Can you tell me why sharing utensils or blankets with someone who has HIV is not risky?
5. Can you tell me why you cannot get HIV from sharing a toilet?
6. Can you tell me why there is no risk of getting HIV from a barber's machine?
7. Can you tell me why there is no risk of getting HIV from changing a patient's bedding?
8. Can you tell me why there is no risk of getting HIV from a pedicure or manicure?

Plenary

Come back together and ask if anyone has any other questions about transmission. Ask participants to read through the QQR Fact Sheet and be ready to share the information with as many colleagues as possible.

QQR – Quantity, Quality, and Route of Transmission

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

- There must be a large enough Quantity of the virus in body fluids. HIV is found in large quantities in blood, semen, vaginal fluids, and breast milk—so there is a risk of transmission from these fluids. HIV is found in small quantities in saliva, vomit, feces, and urine, and not at all in sweat or tears. In these cases, there is no risk. HIV is transmitted only through infected blood, sexual fluid, or breast milk entering the body.
- There must be sufficient Quality—the virus must be strong enough. HIV does not live on the surface of the skin; it lives inside the body. HIV is a fragile organism and does not survive for long outside of the body. It starts to die as soon as it is exposed to air.

- HIV must have a Route of Transmission or entry through the skin and into the bloodstream of the uninfected person:
  - Through a vein (e.g., a needle injection, which puts infected blood directly into the blood of the uninfected person)
  - Through lining of the anus or vagina, or sores on the penis, anus, or vagina
  - Through open cuts in the skin, although HIV cannot pass through these very easily
  - Mother-to-child transmission—HIV-positive mothers passing HIV to their babies before or during birth (through blood) or after birth through breast milk

Additional notes on HIV transmission:

- Our bodies are closed systems. Healthy skin is an excellent barrier against HIV. HIV cannot pass through unbroken skin.
- To become infected with HIV, the virus has to get inside your body. When we have sex, sexual fluid can get into the bloodstream through small cuts on the penis, vagina, or anus. When we inject drugs, the infected blood on needles or syringes can go directly into the bloodstream.
- It is natural to fear HIV because there is no cure. This is a human reaction to a disease that can lead to people dying. Now that ARVs are available, however, HIV should be treated as a manageable disease, like cancer or hepatitis.
- Some fears are rooted in lack of knowledge about how HIV is transmitted—some people still believe they can get HIV through having casual contact with a person living with HIV. As a result of this fear, they try to protect themselves by minimizing contact with people who have, or are suspected to have, HIV. These practices are stigmatizing—they make the person feel unwanted, despised, and rejected.
- As health facility staff, we need to understand the behaviors and situations that can lead to HIV infection. This information will help us (a) better serve our clients, and (b) better understand the risk for HIV infection in a health facility and in our own lives.
- Standard Precautions should be in place to reduce the risk. (Standard Precautions are covered in Chapter E.)
- Sex without a condom and unsafe sexual practices carry a significantly higher risk of HIV transmission than accidental exposure to blood and body fluids in a health facility.

C2. HIV Transmission and Men Who Have Sex with Men

Facilitator's Notes: This exercise is designed to deepen health facility staff's understanding of HIV transmission as it applies to MSM.

Ideally, this exercise should be done with the involvement of an MSM resource person who is free to talk openly about his sexuality and skilled in explaining these basic facts.

This exercise uses "BODY MAPPING." Using two body maps—a man and a woman—helps to make it easier to talk about all forms of sexual activity, and about sex between people of the same sex.

Participants may be shy at first about naming the sexual body parts. As the facilitator, you should let them do it, rather than doing it for them. Encourage them, even to the point of pointing a finger to a sexual body part and asking, "What do we have here?" Once people get past the initial embarrassment of naming the body parts, the process usually goes smoothly. Some words for sexual body parts in the local language may sound like insults, so ask participants to use the words that they feel comfortable using. Out of embarrassment, some participants may not list the anus in naming sexual body parts. If so, remind them to add it to the list.

Objective: By the end of this session, health facility staff will be able to identify the risks of getting HIV through different forms of sex involving MSM.

Sources Understanding and Challenging Stigma Towards Men Who Have Sex with Men: Toolkit for Action (Cambodia)—Exercise D2

Time 1 hour

Handout F10: HIV TRANSMISSION AND MSM—RISK CONTINUUM

Steps

Divide into Single-sex Groups

Ask one group to draw the outline of a woman on the flipchart and the other to draw an outline of a man.

Sexual Body Parts

Ask participants to label the sexual body parts of the bodies. They can agree together on which language/words to use.

Male: penis, testicles, buttocks, anus, breasts, nipples, mouth, neck

Female: vagina, clitoris, breasts, nipples, belly, buttocks, anus, mouth, neck

Sexual Activities

Ask participants to write different sexual activities on cards—sexual activities between a man and a woman, between a man and a man, and between a woman and a woman—and stick these cards around the body map. Help the group if needed; ask probing questions to make sure participants understand each sexual activity.

Vaginal sex. Oral sex. Anal sex. Kissing. Mutual masturbation. Fingering. Thigh sex.

Report Back

Ask the groups to look at each other's body maps and ask any questions to the group, if needed.

If necessary, explain in more detail the sexual activities practiced by MSM, making some of the following points:

- Oral sex and anal sex are practiced by both heterosexuals and homosexuals.
- Not all MSM have anal sex.

Risks of Getting HIV (Brainstorm)

In the large group, ask, "Which of the sexual activities do you think are most risky in terms of HIV, and why?" Record points on a flipchart. Ask, "What advice can we give to clients to make these activities safer?"

Ensure that all participants know about lubricant as well as condoms.

Hand out the Fact Sheet (D-FS6) for further reading.

Summarize

As a summary, present the following basic messages on HIV transmission in relation to sex between men:

- HIV has to penetrate your body for you to get infected. When we have anal sex without a condom, sexual fluid can get into the body through small cuts in the rectum or penis.
- Receptive anal sex is much more risky than insertive anal sex. The rectum has a large surface area and the skin in the rectum can easily get torn during anal sex, especially if the insertive partner is not using a water-based lubricant. Once the skin is broken, HIV in the semen, or in blood from cuts on the penis of the insertive partner, can easily get into the body and the bloodstream of the receptive partner if that person is not using a condom.
- Younger men, whose skin in the rectum is not fully mature, are more likely to develop cuts during anal sex and thus are at higher risk of getting HIV.
- Insertive anal intercourse is not as risky as receptive anal sex. Why? The skin of the penis is stronger than the skin of the anus. It is less prone to cuts, so it is less vulnerable to penetration by HIV. However, HIV contained in blood and rectal fluids can pass through the urethra of the penis or under the foreskin of someone who is uncircumcised.
- Water- or silicone-based lubrication is a must for anal sex. With a condom and lubricant, anal sex can be practiced and enjoyed safely.
- Oral sex is a low risk for HIV infection but a high risk for other STIs, such as gonorrhea.
- Some untreated STIs greatly increase one's risk of getting HIV. Many STIs cause sores, which make it easier for HIV to enter the body. MSM may not have symptoms of STIs or cannot see the sores because they are inside the anus or mouth, which puts them at greater risk of HIV infection or transmission.

C3. HIV Transmission and People Who Use Drugs

Facilitator's Notes: This exercise is designed to review and update participants' understanding of HIV transmission as it applies to people who use drugs.

Try to find a resource person with local knowledge about drug use patterns in your country.

Objectives: By the end of this session, health facility staff will be able to do the following:

- Describe global and current information on injecting drug use and HIV
- Explain how HIV is transmitted through injecting drug use and other associated health risks
- Discuss the extent to which drug use contributes to the HIV epidemic worldwide

Sources Fact Sheet on Drug Addiction and HIV (ICRW/ISDS)

Time 1 hour

Handout F11: DRUG USE AND HIV

Preparation Write one of the questions from the next page at the top of each flipchart and paste them on different walls of the room.

Steps

Rotational Brainstorm

Divide into four groups and assign each group one of the following questions.

- How is HIV transmitted through the use of injecting drugs?
- Apart from HIV, what other health problems are caused by injecting drugs?
- How can an injecting drug user prevent HIV infection?
- To what extent does drug use contribute to the global HIV epidemic?

Report Back

Ask participants to read through the answers and allow for additions or clarifications, or clarify points yourself.

Local Expert (Presentation)

Ask a local expert on drug use to give a presentation or facilitate a discussion on drug use and HIV in the local context. Ask the local expert to produce handouts to be given to participants. It may be helpful to provide the expert with some questions with which to prepare the presentation. These could include the following:

- What is the nature and extent of drug use locally?
- What is known about the impact of drug use on the HIV epidemic and other serious health risks?
- Who is at risk of contracting HIV through drug use (e.g., general use, or concentrated in the prison population and the urban poor) or by association with someone using drugs (e.g., children, partners of people who use drugs, etc.)?
- What are the local policies, practices, laws, and programs targeting drug use and/or HIV program interventions?

EXAMPLE RESPONSES

Question A: How is HIV transmitted through the use of injecting drugs?

Answer: Drug use itself does not transmit HIV (e.g., inhaling drugs does not transmit HIV), nor does injecting drugs if you are using your own sterile equipment. The problem is that HIV can spread among people who inject drugs if they share or reuse needles and syringes that have become contaminated with HIV-infected blood. Small amounts of blood, which are invisible, can remain on the needle and syringes after they have been used. HIV could survive up to one week in the blood left on the syringe or needle. If the equipment is reused, this blood will be injected directly into the bloodstream of the next person who uses the equipment. If the blood is infected with HIV, then HIV can be passed on to that person.

Question B: Apart from HIV, what other health problems are caused by injecting drugs?

Answer: Injecting can also lead to drug overdose, abscesses, septicemia, thrombosis, scarring, circulatory problems, collapsed veins, poor healing of wounds, and other blood-borne infections, such as hepatitis B and C.

Question C: How can a drug user prevent HIV infection?

Answer: People who inject drugs can prevent HIV infection by not sharing injecting equipment and using sterile injecting equipment.

Question D: To what extent does drug use contribute to the global epidemic?

Answer: Although on average there has been a decline in HIV infections globally, in some areas, including Eastern Europe and Central Asia, the number of PLHIV has almost tripled since the start of the 21st century; it reached an estimated total of 1.4 million in 2009 compared with 760,000 in 2001. A rapid rise in HIV infections among people who inject drugs between 2001 and 2009 caused the epidemic in this region to surge. New epidemics also are beginning to emerge from high drug use in Asia, where it is estimated that at least 4.5 million people inject drugs; more than half of these people live in China, although India, Pakistan, and Vietnam also have large numbers of people who inject drugs. In Africa, Kenya, South Africa, and Tanzania also are showing newly emerging drug use activity. For instance, in Kenya, an estimated 3.8 percent of new infections derive from injecting drug use. Unique to sub-Saharan Africa, which has a general epidemic, drug use is the main driver of HIV in Mauritius.

MODULE D

Standard Precautions and Overcoming Stigma

D

Introduction

This section introduces the concepts, principles, procedures, and skills involved in implementing Standard Precautions.

According to the World Health Organization, of the 35 million health workers worldwide, about 3 million are occupationally exposed to blood-borne microorganisms each year—and of these, about 170, 000 are exposed to HIV. These exposures to HIV through occupational injury may result in about 1,000 HIV infections each year. More than 90 percent of these infections occur in developing countries. Although a far less significant risk than sexual intercourse and injecting drug use, occupational risk to HIV is an issue of concern for health workers as well as others who work in a health facility.

Most blood exposure in health facilities is preventable. Two of the major strategies to protect health facility staff in a health facility are implementing Standard Precautions and managing possible HIV exposure through Post-exposure Prophylaxis (PEP).

Standard Precautions are practiced in many settings across the world. They are used to protect health facility staff, clients, and visitors from exposure to blood-borne microorganisms. "Standard" means that these precautions should be applied with all clients, irrespective of whether health facility staff know the HIV status of their clients or not.

Standard Precautions are one of the best methods to protect health facility staff. They provide a set of skills and procedures for health facility staff to protect themselves from infection in their health facility. They make the use of forced HIV testing as a means of protecting health facility staff totally unnecessary. Using these precautions is also one way of ensuring that clients are not inappropriately treated—shunned and isolated, for instance—by separating "real" risk from fear-associated risk.

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

This chapter aims to do the following:

- Address health facility staff fears of getting HIV through casual contact
- Make health facility staff aware that fear-based practices (e.g., forcing clients to take the HIV test) make clients feel stigmatized and fail to provide real protection
- Help health facility staff replace stigmatizing practices with Standard Precautions that will improve their safety, and the safety of clients and others, from exposure to microorganisms found in blood and other body fluids

Exercises

D1. What Are Standard Precautions?

D2. Use of Protective Apparel and Stigma

D3. Fear of Infection Through Use of Sharps

D4. Health Facility Hygiene and Waste Disposal

D5. Occupational Exposure, PEP, and Stigma

Sources

- Reducing Stigma and Discrimination in Health Care Settings: Trainer's Guide.
- Infection Prevention: A Reference Booklet for Health Care Providers.
- Safe & Friendly Health Facility: Trainer's Guide (Vietnam).

D1. What Are Standard Precautions?

Facilitator's Notes: This exercise is a short introduction to Standard Precautions.

Objectives: By the end of this session, health facility staff will be able to do the following:

- Explain what "Standard Precautions" means
- Describe what Standard Precautions have been adopted in their own health facilities

Sources	Safe & Friendly Health Facility: Trainer's Guide (Vietnam)
	Reducing Stigma and Discrimination in Health Care Settings: Trainer's Guide
Time	45 minutes
Handout	F12: INTRODUCTION TO STANDARD PRECAUTIONS
	F13: FEARS OF GETTING HIV & HOW TO OVERCOME FEAR THROUGH STANDARD PRECAUTIONS

Steps

Part A: What Are the Standard Precautions?

Principles (Buzz and Brainstorm)

Ask

- What is the meaning of "Standard Precautions"?
- What is the difference between Universal Precautions and Standard Precautions?
- Why have "Standard Precautions" replaced "Universal Precautions"?

Then provide a summary, using the points below.

Standard Precautions Practiced in Health Facilities (Group Work)

Divide into small groups and ask groups to discuss:

- What are some Standard Precautions used in your facility?
- What are the barriers to the use of Standard Precautions?

EXAMPLE RESPONSES

What are the barriers to using Standard Precautions?

- Individual attitude—and not being aware of the importance of Standard Precautions
- We want to do things in a hurry, so we don't give it enough attention
- Some health facility staff use the same pair of gloves all day long as their form of hygiene, not realizing they may be infecting everyone with whom they come into contact
- Water is not available or located a long distance away from the work area
- Lack of resources (e.g., gloves) to support Standard Precautions

Summarize

Present and discuss the following points in Fact Sheet F12 Introduction to Standard Precautions.

- "Universal Precautions" refer to practices performed to protect health facility staff from exposure to blood-borne microorganisms. "Universal" means that these precautions should be applied universally—that is, with all clients, regardless of whether health facility staff know their health status or not.
- "Standard Precautions" has replaced the term "Universal Precautions." It is a broader term that includes not only safety for health facility staff but for clients and visitors as well. It is also a broader term that covers safety from exposure not only to blood and bodily fluids, but also to other infections occurring in health facilities.
- Standard Precautions constitute a system for infection control used to make health facilities safe for health facility staff and clients. It involves the use of precautions designed to help minimize the risk of exposure to HIV and other infectious diseases by health facility staff and clients.
- The first principle of Standard Precautions is that health facility staff apply them to ALL clients, regardless of whether or not they think the client may be HIV positive or have any other infectious disease. It is important to emphasize, however, that Standard Precautions deal with all healthcare-associated infections, not just HIV.
- The second principle is that Standard Precautions are designed to protect both health facility staff and clients from infection.
- The general topic areas of Standard Precautions include the following:
  - Hand hygiene
  - Using barriers (surgical attire—including gloves, masks, etc.)
  - Aseptic techniques
  - Use and disposal of sharps
  - Instrument processing
  - Housekeeping and waste disposal
  - Respiratory hygiene and cough etiquette

Part B: Risks in Health Facilities and How These Fears Lead to Stigma

Risk-clarification Exercise (Individual Exercise)

Hand out the risk-clarification exercise below and ask participants to complete it individually (5 minutes).

Please put an "x" in the appropriate column to show your response to the following statements.

STATEMENT	AGREE	DISAGREE	NOT SURE
1. Clients who are HIV positive should be placed in a separate room.			
2. The linens of HIV-positive clients should be separated from the linens of other clients and washed separately.			
3. All clients should be given an HIV test before surgery.			
4. Appropriate protective barriers, e.g., wearing gloves, are needed when coming into contact with the blood of HIV-positive clients.			
5. Special care should be taken in cleaning up the blood spills of HIV-positive clients.			
6. After giving an injection to HIV-positive clients, the needle should be separated and treated differently than needles of other clients.			
7. Gloves must be used at all times when touching HIV-positive clients.			
8. The risk of getting HIV in the healthcare setting is the biggest occupational risk facing health facility staff.			
9. Health facility staff should treat the blood of all clients as having the potential for transmitting HIV, hepatitis B virus, and hepatitis C virus.			
10. The main goal of Standard Precautions is to protect health facility staff only.			

Review the responses for each statement and make the following points:

Statement 1: FALSE. There is no need to isolate HIV-positive clients in a separate room because HIV is not transmitted through casual contact.

Statement 2: FALSE. Linen used by clients with HIV does not need to be treated separately from the linen of other clients.

Statement 3: FALSE. There is no need to test all clients before surgery because surgeons and their teams should apply Standard Precautions in dealing with blood and bodily fluids from all clients. During surgery, they should put on gloves and masks to protect themselves.

Statements 4 & 5: FALSE. Health facility staff should always wear appropriate protective barriers whenever they come into contact with the blood or bodily fluids of ALL CLIENTS.

Statement 6: FALSE. Health facility staff should treat ALL NEEDLES in the same way. All used needles should be discarded appropriately.

Statement 7: FALSE. When coming into contact with the skin of all clients, health facility staff need to wear gloves only if the client's or health worker's skin is not intact. There is no need to use gloves when feeding a client or taking his/her temperature, however.

Statement 8: FALSE. Contact with HIV-positive clients is NOT the biggest occupational risk facing health facility staff. The biggest occupational risk depends on the context.

Statement 9: TRUE. Health facility staff should regard the blood of every client as a potential source for transmission of hepatitis B virus, hepatitis C virus, and HIV because it is impossible to test every client; even if it could be done, a negative test result does not guarantee the HIV-free status of a client (some clients may be in the window period).

Statement 10: FALSE. Standard Precautions are designed to protect everybody in a health facility, including nurses, doctors, cleaners, clients, and visitors.

Stigmatizing Practices that Do Not Protect Health Facility Staff (Small Groups)

Divide into groups and ask them to discuss the questions below. Then organize a round-robin report (one question at a time—groups taking turns reporting).

Questions

- What are some unnecessary safety practices performed by health facility staff?
- Which of these practices may be perceived by clients living with HIV as stigmatizing?
- Why are these practices used?
- What can be done to ensure that people are adequately protected from infection and feel less stigmatized?

Summarize

Present and discuss the following points:

- Knowing how HIV is actually transmitted is an important first step in preventing HIV infection in a health facility. It is equally important to learn how HIV is NOT transmitted, so that health facility staff know how to properly protect themselves and others.
- Some health facility staff insist that it is their right to be told which clients are HIV positive so they can protect themselves against HIV. They claim that not knowing who has HIV puts them at risk. They identify who has HIV by isolating such clients in separate rooms, marking HIV clients' files, or simply telling other health facility staff. These practices are wrong—they stigmatize HIV-positive clients and create a climate of fear around them; they do not decrease the risk of HIV transmission in the health facility.
- Standard Precautions provide a non-stigmatizing method for protecting health facility staff and their clients. Standard Precautions are based on the assumption that all blood and bodily fluids are potentially infectious—whether they are from a client or health facility staff and regardless of their known HIV status—and should be applied to all clients. Standard Precautions give health facility staff more control over ensuring their own safety within the health setting while also ensuring the safety of their clients.
- We often assume that we, as health facility staff, are the ones who may be getting the infection, but in some cases, we may be the ones who are passing the infection. Thus, Standard Precautions protect both health facility staff and clients—and health facility staff should realize that they can potentially pass on infections to clients.

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

D2. Use of Protective Apparel and Stigma

Facilitator's Note: This exercise introduces the use of protective apparel, such as gloves and masks—one form of Standard Precautions. Health facility staff should know how to use them properly so they do not pose an infection risk to themselves or others.

In the case of gloves, health facility staff need to know which gloves to use for which procedures, and how to put gloves on and take them off. Often health facility staff use the wrong type of glove for a certain task. For example, they may use sterile gloves when that is unnecessary, or use exam gloves to wash instruments or clean up. Sometimes there are no gloves available, or only one type.

Some health facility staff use gloves when it is unnecessary—for example, for feeding a client or taking a client's temperature. This makes clients feel they are a risk or threat to the health worker—a form of stigma.

Objectives: By the end of this session, health facility staff will be able to do the following:

- Describe the use of different protective apparel and when they should be used
- Describe when protective apparel should be discarded or decontaminated

Sources Safe & Friendly Health Facility: Trainer's Guide (Vietnam)—Exercise B3

Reducing Stigma and Discrimination in Health Care Settings: Trainer's Guide

Time 1 hour

Materials Case studies

Handouts F14: WHEN TO USE DIFFERENT PROTECTIVE APPAREL

Steps

Introduction (Role-play)

Organize, with participants' help, a role-play of a nurse putting on gloves to feed a client because she knows the client is HIV positive. Then discuss the following:

- What happened in the role-play?
- Was the use of gloves appropriate?

Buzz and Brainstorm

- What protective apparel is used in your health facility—and for what purpose?
- Why do we use gloves?

EXAMPLE RESPONSES

What types of apparel are used in your health facility—and for what purpose?

- Gloves, masks, goggles, face shields, gowns, caps, aprons, and covers for shoes
- They are used to prevent health facility staff from direct contact with pathogenic agents on the skin, or in the blood, bodily fluids, or respiratory tracts of clients, and vice versa
- Clients are protected from pathogens present on the skin, in saliva, or in the respiratory tracts of health facility staff

Why do we use gloves?

- To protect clients and health facility staff by using them as a barrier against infectious microorganisms

Participant Questionnaire

Hand out copies of the following questionnaire and ask participants to work with a partner and complete it.

STATEMENT	GLOVES NEEDED? (YES/NO)	PREFERRED TYPE OF GLOVES? (SURGICAL/UTILITY/ EXAMINATION)
Taking blood pressure		
Drawing blood		
Performing a pelvic examination		
Serving food to a client		
Handling contaminated waste		
Handling and cleaning instruments and other items		
Taking someone's temperature		
Cleaning blood or other body fluid spills		

Participant Questionnaire

Hand out copies of the following questionnaire and ask participants to work with a partner and complete it.

STATEMENT	GLOVES NEEDED? (YES/NO)	PREFERRED TYPE OF GLOVES? (SURGICAL/UTILITY/ EXAMINATION)
Taking blood pressure		
Drawing blood		
Performing a pelvic examination		
Serving food to a client		
Handling contaminated waste		
Handling and cleaning instruments and other items		
Taking someone's temperature		
Cleaning blood or other body fluid spills		

Handout: Fact Sheet F14– WHEN TO USE PROTECTIVE APPAREL

Use of Protective Barriers and Stigma (Case Studies)

Divide into six groups and give each group a case study. Ask the groups to discuss the following:

- Why did this situation result in stigma?
- What are some possible bad effects of situations like these?
- How can situations like these be corrected?

Case studies

Case Study A: Maria

Maria is a nurse working in an antenatal clinic. Her tasks include taking clients' pulse, temperature, weight, and blood from the finger tip for the hematocrit test. She usually does not wear gloves while doing these tasks. She puts on gloves only when working with women who look sick.

Case Study B: Gomez

Gomez works in the surgery department of a hospital. He is going to change a bandage for an HIV-positive client who had an appendectomy. He puts on a mask, cap, gloves, and apron. He doesn't wear this apparel when changing the bandages of other clients.

Case Study C: Beatrice

Beatrice has had three days' leave and is returning to work. She is now working on the night shift. She has been told that one of her new clients has cervical cancer. She also has been told that this client does not have tuberculosis or another airborne disease. She suspects this woman has HIV, so she puts on a mask when she takes medicine to her.

Case Study D: Samson

Samson is a nurse working in the pediatric department. This department is taking care of a number of children living with HIV. One of the children develops a high fever. Before going to take his temperature, Samson puts on a double pair of gloves.

Case Study E: Luisa

Luisa is a young nurse who has just graduated from nursing college. She has heard lots of stories about HIV and AIDS, and is really worried she will get HIV. To protect herself, she always wears a mask and gloves when she walks through wards that have HIV clients and takes them off when she is in other wards.

Case Study F: Dr. Nzimande

Dr. Nzimande is 55 years old. He has been involved in HIV work since the start of the AIDS epidemic. His theory on protecting himself from HIV is to wear the same pair of gloves and a doctor's gown all day long, whether visiting clients or doing operations. He never takes them off. He takes them off only when he goes home at night.

Processing

Ask, "What can be done to improve the way in which protective barriers are used in your facility?"

Summarize

Present and discuss the following points:

- Protective apparel is worn to protect both health facility staff and clients—to prevent exposure to blood or bodily fluids. This apparel should be used with all clients, not just when the client is known or suspected to have HIV.
- Protective apparel should be used only when there is a realistic chance of a splash or contact with your body, skin, or mucous membranes from the following:
  - Blood or other body fluids
  - Blood- or other body fluid–contaminated items and surfaces
  - Broken skin and mucous membranes
- Protective apparel should protect only the area of the body likely to be contaminated or spattered.
- Although health facility staff need to protect themselves and others by wearing protective apparel, the feelings of clients should be considered. When necessary, the health facility staff should explain to a client why certain apparel is being worn, emphasizing mutual safety.
- Gloves should be discarded after working with each client. Wearing one pair of gloves to provide care for many clients increases their risk of infection.
- Protective apparel should be strategically placed throughout client care, cleaning, and waste management areas for rapid and emergency access. It should be available on trolleys for procedures, or at the bedside if contamination is anticipated.

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

D3. Fear of Infection Through Use of Sharps

Facilitator's Note: In this exercise, health facility staff discuss their fear of getting HIV through tasks involving blood, e.g., giving injections or taking blood. This fear leads them to stigmatize clients known or suspected to be HIV positive. Because of this fear, health facility staff may avoid giving injections or taking blood by pretending they are busy, saying they can't find a vein, or delegating the task to other staff. They might also wear extra gloves and masks or stand at a distance—stigmatizing the client with their body language.

Thus, it is important to help health facility staff understand the following: (1) how to use and dispose of needles and other sharps safely, (2) the risks of injection from needle-stick injuries, and (3) what to do if a needle-stick injury occurs.

This exercise looks at the techniques involved in giving injections safely and handling sharp instruments.

To demonstrate sharps disposal, you should use both kinds of puncture-proof containers (PPC): (a) those that are re-usable, because many health facilities cannot afford the disposable kind; and (b) disposable, single use containers.

In health facilities unable to afford disposable sharps containers, get participants to discuss what they can use as alternatives—e.g., plastic bottles or jugs in which antiseptics come, or heavy cardboard boxes.

Objectives: By the end of this session, health facility staff will be able to do the following:

- Describe how the fear of getting HIV while using sharps results in health facility staff avoiding this job or using excessive precautions (e.g., double gloves)—resulting in clients feeling stigmatized
- Demonstrate how to give injections safely and safely discard used needles
- Agree on a safe method to dispose of used needles

Sources Safe & Friendly Health Facility: Trainer's Guide (Vietnam)—Exercise B4

Reducing Stigma and Discrimination in Health Care Settings: Trainer's Guide

Time 30 minutes

Materials

- 10 disposable needles and syringes
- 4 puncture-proof containers (reuseable)
- 4 puncture-proof containers (disposable)

Handout F15: USE AND DISPOSAL OF SHARPS

Steps

Introduction (Role-play)

With participants' help, organize a role-play of a nurse at first refusing to draw blood from a client for a CD4 count. When she realizes there are no other health facility staff around to do this task, she puts on extra gloves and tries to take the blood while standing at a distance from the client. She keeps missing the vein and hurts the client, who becomes very upset.

Then discuss:

- What happened in the role-play?
- Does this happen in your health facility? Why?

Summarize

Fear of occupational exposure to HIV while giving injections or taking blood results in health facility staff avoiding this job or using excessive precautions (e.g., double gloves)—resulting in clients feeling stigmatized and also risking disclosure of the client's HIV status to other health facility staff and clients.

It is important for health facility staff to understand how to use and dispose of needles, syringes, and other sharps safely to help reduce their fears.

Task Groups

Divide into four groups and give each group a different task:

Group A	Make a list of activities that might lead to accidents related to the use of sharps while considering everyone who might be at risk, including clients and visitors
Group B	Make a list of safety practices to be used by health facility staff when handling sharps
Group C	Make a list of practical steps to dispose of needles and syringes—how to do it—given the resources and practical conditions in a health facility
Group C	Practice how to use puncture-proof containers to isolate and dispose of used needles and then prepare to give a demonstration to the group

Report Back

Groups A, B, and C present their reports on a flipchart—Group D then gives a demonstration. Invite comments after each presentation. Hand out copies of the Fact Sheet F15 USE AND DISPOSAL OF SHARPS.

Summarize

- Needle-stick injuries are the main cause of occupational exposure to blood-borne pathogens. Sharps injuries may occur for various reasons, but unsafe or careless practices while using or discarding them is the main reason for most accidents—and most are avoidable.
- Fear of occupational exposure to HIV while giving injections or taking blood results in health facility staff avoiding this job or using excessive precautions (e.g., double gloves) when dealing with clients who are known or assumed to be HIV positive; this results in clients feeling stigmatized. It also risks disclosure of the client's HIV status to other health facility staff and clients.
- It is important for health facility staff to understand how to use and dispose of needles, syringes, and other sharps safely to help reduce their fears.

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

D4. Health Facility Hygiene and Waste Disposal

Facilitator's Note: This exercise looks at the hygienic condition of health facilities and how to dispose of waste. It includes instruction on how to clean up blood spills on the floor so that cleaning staff do not panic when they have to perform this task.

Objectives: By the end of this session, health facility staff will be able to do the following:

- Describe how to develop a hygienic environment
- Describe how to manage the disposal of contaminated waste
- Explain how proper hygiene and waste disposal are linked to stigma

Sources Safe & Friendly Health Facility: Trainer's Guide (Vietnam)—Exercises B7 and B8

Reducing Stigma and Discrimination in Health Care Settings: Trainer's Guide

Time 30 minutes

Handout F16: FACILITY HYGIENE AND WASTE MANAGEMENT

Steps

Cleaning Up Spills (Scenario and Discussion)

Divide into groups and ask them to read the following scenario and answer the questions.

During a busy period in the morning, a container of blood spills on the floor in one ward. The health staff are overloaded so they leave the pool of blood and move on to other wards in the health facility. The spill remains on the floor all day. On the night shift, a senior nurse orders cleaning staff to clean up the spill.

- What happened?
- Would something like this happen in your health facility?
- How can the cleaning up of spills be improved at your facility?

Waste Management (Cardstorm)

Put two title cards on the wall—DANGEROUS WASTE and REGULAR WASTE. Then divide into pairs and hand out cards and markers. Ask the pairs to write examples of different types of health facility waste on the cards—one example per card. Then ask them to tape the examples under one of the two title cards.

Discussion

Ask:

- Is there any waste that is misplaced (in the wrong category)? Which type, and why?
- What is waste management and why is it done?
- Who is at risk? Give examples of situations.
- Who is involved in waste management, and in what ways?
- What are the risks to health facility staff if dangerous waste is mixed with other waste?

EXAMPLE RESPONSES

Who is at risk from contaminated waste?

- Contaminated waste, when not disposed of correctly, poses a risk of infection to health facility staff, clients, and the community.
- Anyone who handles medical waste—from the time it is thrown out by a service provider until it reaches the site of final disposal—is at risk of infection or injury.
- Proper handling of medical waste minimizes the spread of infections and reduces the risk of accidental injury to staff, clients, and the community.
- Many health facility staff often do not know what happens to the waste generated from their facilities, nor do they know who handles it after it is put in a trash container.

Examples of dangerous waste

Needles and sharps. Blood and bodily fluids. Bandages and dressings from clients.

What are the risks involved in mixing waste?

Someone handling regular waste could get a needle injury. For example, if a cleaner sees a bag normally used for non-dangerous waste, assumes that it is regular waste, and touches it, he may be injured by a needle inside.

Hand out Fact Sheet F16 FACILITY HYGIENE & WASTE MANAGEMENT.

Summarize

Present and discuss the following points:

- We are all responsible for maintaining a hygienic facility because
  - Health facility staff and clients are at risk of infection from an unhygienic environment.
  - It is part of professional and personal courtesy—we are all adults and should clean up after ourselves.
  - It is a waste of resources to hire people to clean up after us all the time.
- We should train and empower the cleaners and other staff responsible for housekeeping with Standard Precautions.
- Contaminated medical waste, when not disposed of correctly, poses a risk of infection to health facility staff, clients, and the community. Anyone who handles medical waste—from the time it is thrown out by a service provider until it reaches the site of final disposal—is at risk of infection or injury. Proper handling of medical waste minimizes the spread of infections and reduces the risk of accidental injury to staff, clients, and the community.

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

D5. Occupational Exposure, PEP, and Stigma

Facilitator's Notes: This exercise explores the link between the low uptake of Post-Exposure Prophylaxis (PEP) by health facility staff and the stigma related to taking PEP (i.e., one's HIV status may become known, thus making them a target for HIV-related stigma). PEP is now widely available in most health facilities, but many health facility staff may not be aware of how and why to access it, or be afraid to do so because of the stigma that might follow.

Objectives: By the end of this exercise, health facility staff will have accomplished the following:

- Reflected on their own knowledge and feelings about PEP
- Shared experiences of PEP and explored its complexities
- Identified issues that block them from accessing PEP
- Developed the knowledge and confidence to speak out and access PEP

Sources Draft exercises from Alliance Regional Stigma Team (#6)

Time 1 hour

Materials Copies of case studies for all participants

Handout F17: PEP MANAGEMENT PROCEDURES

Steps

Introduction Buzz and Brainstorm

Ask: "What is occupational exposure?"

> **EXAMPLE RESPONSES**
>
> Occupational exposure is any situation that exposes or puts a health facility staff member at risk of either infection or injury. Health facility staff exposed to blood and bodily fluids on the job are entitled to certain forms of support.

Individual Quiz

Ask participants to respond to a quiz involving eight questions about PEP. Explain beforehand that this is not a test. Each person should make notes for themselves about the answers, but they will not be asked to hand anything in! The quiz is an informal way of introducing PEP.

Read out the questions below and give the participants time to record their answers.

Questions

- What does PEP stand for?
- How does it work?
- Name three different examples of when you might need PEP.
- Have you ever been on PEP or do you know anyone who has been on PEP?
- What is your greatest concern about going for PEP?
- If exposure has taken place, who qualifies for PEP?

- What are the advantages of PEP?
- Do you know of any disadvantages? What are they?
- What other precautions should you take if you receive a needle-stick injury?
- Is PEP available in your health facility? Are you familiar with its protocol?

Then ask, "How was the exercise?" and read through the questions, asking for volunteers to answer. Allow for additions and clarifications or clarify points yourself.

EXAMPLE RESPONSES

Question: What does PEP stand for?

Answer: PEP stands for Post-Exposure Prophylaxis.

Question: How does it work?

Answer: PEP's main function is to stop HIV from infecting the exposed health facility staff member by blocking its entry into the CD4 cells.

Question: Have you ever been on PEP or do you know anyone who has been on PEP?

Question: Name three different examples of when you might need PEP.

Answer: A person needs PEP in the following situations:

- After an accidental prick with a needle previously used on any client
- After cutting the skin with a used surgical blade while operating on a client
- After being raped
- After splashing of blood or body fluids in the eyes, nose, or mouth

Question: What is your biggest fear about going for PEP?

Answer: The biggest fears about going for PEP are the following:

- Other colleagues might find out that we are HIV positive
- Side effects of the drugs, as some people get nausea and diarrhea

Question: What are the advantages of PEP?

Answer: If a person is HIV negative, using PEP will stop the virus from invading his/her body.

Question: What are some disadvantages of PEP?

Answer: Some disadvantages include the following:

- You have to go on drugs, which may have side effects
- Some people who go on PEP do not complete the full treatment due to side effects

Question: What other precautions should you take if you receive a needle-stick injury?

Answer: Wash the injured area thoroughly with running water—use soap and water. When there is bleeding, allow the site to bleed briefly. There is no scientific evidence that squeezing the wound decreases the risk of HIV transmission. In the absence of water, an antiseptic solution can be used to flush the area.

Question: Do you know if PEP is available in your health facility and who the responsible health officer is?

How to Handle Workplace Exposure to HIV (Case Studies)

Divide into four groups, hand out the case studies, and assign each group one of the studies. Ask them to read their case studies, discuss the questions, and write their answers on a flipchart.

Report Back

Ask each group to present its report.

Processing

Ask, "How can we ensure that HIV stigma or fear of stigma do not prevent health facility staff from accessing PEP when it is needed? What recommendations can we make to ensure that PEP is more accessible?"

EXAMPLE RESPONSES

How can we ensure that stigma does not prevent health facility staff from accessing PEP?

- PEP can result in inadvertent disclosure of a health facility staff member's status. If the health facility staff member knows she is HIV negative, she will move quickly to get PEP. If she knows she is HIV positive, she may be less worried about getting PEP. These different responses can expose health facility staff to stigma from their colleagues. Colleagues will ask, "Why did she not rush for PEP?" Because of this stigma issue, it is difficult for colleagues to counsel the health facility staff member.
- Educate all staff on PEP and emphasize that the WHO has recommended PEP as safe and effective.
- Encourage all health facility staff to know their HIV status and, if positive, to get access to ARVs.

Developing a Code of Conduct

Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

Case Studies

Case Study A: Janet

Janet is a 42-year-old midwife working in the antenatal clinic at a hospital. Janet tested herself for HIV two years ago when her husband died. She tested positive. She has not told anyone at work. One day Janet was taking a blood sample from a young mother when she splashed some blood on her face and in her eyes. She went to wash it immediately but her colleague saw her and started panicking. She told Janet that she must report the incident to the Sister in Charge and go for PEP. Now Janet is worried that her HIV status will be exposed.

Discussion

- What are the issues facing Janet in this situation?
- What advice would you offer to Janet?
- Are there guidelines or policies that would help someone in Janet's situation?

Case Study B: Serena

Serena is a student nurse in her third year of studies. She has a boyfriend. They have been dating for a year so he no longer uses condoms, even though she doesn't know his HIV status and believes he might be seeing other women. Although Serena loves nursing, she fears that she might get HIV from her work with the clients in the wards. She hates taking blood or giving injections. Serena has read all about PEP and tests herself for HIV every three months in case she has been exposed.

Discussion

- What are the issues facing Serena in this situation?
- Would you advise health facility staff to test themselves regularly for HIV?
- Are there guidelines or policies that would help someone in Serena's situation?

Case Study C: Wilfred

Wilfred is a nurse on the surgical ward. Last week he was involved in a procedure that resulted in possible exposure to HIV transmission and he was advised to go for PEP. When he was tested for HIV before going for PEP, he tested positive. Wilfred has not returned to work since then and is feeling angry and confused.

Discussion

- What are the issues facing Wilfred in this situation?
- What assistance do you think Wilfred needs?
- Are there guidelines or policies that would help someone in Wilfred's situation?

Case Study D: Maria

Maria is a 38-year-old married woman who works as a nurse at a district hospital. One day, as she was trying to inject a client, she accidentally pricked herself. Maria did not inform any of her colleagues at work but as soon as she got home, she cleaned her wound with alcohol. Maria knows about PEP but does not want to access it.

Discussion

- What are the issues facing Maria in this situation?
- Should Maria seek PEP? If so, why?
- Are there guidelines or policies that would help someone in Maria's situation?

MODULE E

Developing a Code of Conduct and Action Plan for a Stigma-free Health Facility

Introduction

The aim of this section is to show you how to support:

- Health facility staff and facility managers in writing their own Code of Conduct for a stigma-free and safe facility
- Health facility staff and facility managers in writing an Action Plan to turn the health facility into a stigma-free service

A stigma-free and safe health facility is one in which the rights of PLHIV and other key populations are supported, they receive high-quality care, and health facility staff are able to protect themselves from HIV in the workplace through the use of Standard Precautions.

A brief description of each of these documents is given below.

DOCUMENT	DESCRIPTION
Code of Conduct	List of practices describing how health facility staff can provide care and treatment to PLHIV and other key populations in a stigma-free way. The list of practices will be brainstormed by health facility staff during the training course or soon afterward. Examples: ■ Care for all clients is not denied, delayed, or referred elsewhere. ■ Medical information of clients is treated confidentially. ■ Health services are provided free of judgmental attitudes. ■ Health facility staff speak to clients in a respectful and dignified manner. ■ Clients' complaints about stigma and discrimination are dealt with effectively.
Action Plan	List of suggested actions to make the health facility stigma-free: ■ Two to three actions that can be taken by the health facility staff themselves ■ Two to three actions that they recommend be taken by the managers Examples of actions: ■ Extra training on counseling skills ■ Extra training on how to conduct anal STI examinations ■ Changing the way patients' records are filed to ensure confidentiality ■ Improving the ordering of supplies for Standard Precautions ■ Monitoring healthcare/service to check that it is delivered in a stigma-free way Health facility staff would make these two lists and give them to the managers, who then would write up an Action Plan for the facility.

The Code of Conduct should be written collaboratively by health facility staff and facility managers, rather than being developed and imposed by the managers. This will help to facilitate a sense of ownership by everyone—and health facility staff will be more likely to implement the new practices.

The Code of Conduct may be compiled on a gradual basis during the training program. After each session, participants would be asked to agree on two to three practices to address the topic discussed. For example, after module A6 (Analyzing Different Forms of Stigma in Health Facilities), the group would agree that all patients, regardless of their sexual orientation or occupation, should be treated equally and with respect—e.g., not kept waiting, treated in a friendly manner, not be subjected to abusive language, etc. At the end of the training program, the group would review and finalize this list as a Code of Conduct. The group would also prepare an Action Plan—two to three things they would do and two to three things the managers would do to improve healthcare services in the health facility.

Alternatively, participants could write the Code of Conduct and Action Plan at the end of the training. Working in groups, they would discuss S&D in their own facility and agree on the following:

- What a stigma-free facility would look like (Code of Conduct)
- What changes are needed to create and sustain a stigma-free health facility (Action Plan)

The facility managers would then take this output and develop an institutional Action Plan to support the implementation of the new Code of Conduct.

In summary, writing the Code of Conduct and Action Plan can be done in different ways, depending on the amount of time available and the number of institutions involved.

- **At the end of each training session, ask participants to identify practices to make their facility stigma free—and keep a list.** At the end of the workshop, review and finalize this list as a Code of Conduct and then develop an Action Plan.
- **At the end of the workshop, organize a session** to develop the **Code of Conduct and Action Plan**; this session is described below.
- **After the training, hold a separate workshop** to develop the Code of Conduct and Action Plan, involving representatives from different departments or facilities who attended the training workshop. This workshop could use the process described in the following exercise. The results of the workshop should be sent to all of the participating departments or facilities so they can give their feedback. A joint Code of Conduct and Action Plan then can be finalized, based on the feedback. This process was used in St. Kitts & Nevis to develop a joint Code of Conduct and Action Plan for all health facilities.

Exercise or Mini-Workshop to Write a Code of Conduct and Action Plan

Facilitator's Note: The Code of Conduct could be developed on a gradual basis over the training or at the end of the workshop as a single activity. This exercise describes how to develop the Code of Conduct (and Action Plan) as a single activity at the end of the workshop or as a separate workshop.

Objectives: By the end of this session, health facility staff will have accomplished the following:

- Described what a stigma-free health facility would look like (Code of Conduct)
- Identified actions health facility staff and managers can take to create a stigma-free facility (Action Plan)

Time 1–2 hours

Steps

Existing Forms of Stigma in Health Facilities (Buzz Groups)

Divide into pairs and ask, "What are some of the key forms of stigma that we have identified during the training that occur in our own health facilities?" Record the answers on a flipchart.

EXAMPLE RESPONSES

Some of the common forms of S&D practiced by health facility staff in our health facility are_____

- Taking less time with clients, keeping them waiting, treating them last, referring them to other providers, and providing poor or no services
- Using gloves and masks for routine tasks that don't involve the handling of blood and bodily fluids, e.g., feeding or taking temperature
- Bureaucratic and unfriendly treatment, and insulting or scolding language
- Breaking confidentiality—revealing clients' HIV status or other marginalized identities to other health staff or family members without the consent of the clients
- Refusing to do anal examinations of MSM clients
- Forcing clients to be tested for HIV without their consent and adequate counseling
- Forcing clients to sit in a separate area or on a separate bench

Effects (Brainstorm)

Ask participants to brainstorm the effects of these forms of S&D on clients.

EXAMPLE RESPONSES

- Clients feel insulted and humiliated, and they do not recieve solutions for their health problems.
- Patients may stop using the health facility and then do not get treated.
- Patients have to find other forms of treatment—e.g., private doctors who treat them with more confidentiality and less stigma—or patients may try self-treatment.
- It may affect clients' self-esteem/self-confidence; they may deny their sexual risk and take more risks in their sexual behavior (e.g., not using condoms).

Code of Conduct for a Stigma-free Health Facility (Group Work)

Divide into groups (from the same department or facility or from similar jobs).

Write the phrase, *"A stigma-free health facility is one in which …"* on the flipchart and ask groups to make a list of practices for creating a stigma-free health facility.

Give them one or two examples to help them get started. If necessary, ask the questions, "What if your sister/brother/child is a person living with HIV or a member of a key population? How would you want them to be treated in a health facility?"

Report Back

Ask the groups to report on an alternating basis—one point per group. Make a list of the points and then discuss the full list, combine similar answers, and agree on any changes or additions.

EXAMPLE RESPONSES

"A stigma-free health facility is one in which…"

- Clients are treated equally and with respect and dignity, regardless of who they are.
- All clients receive the same high-quality medical care without discrimination, regardless of their HIV status, sexual orientation, gender, or other characteristics.
- No clients are denied care, kept waiting, or referred unnecessarily to other providers.
- Services are provided to clients known to be HIV positive without separating them from other patients, e.g., no use of separate rooms.
- Clients' medical information is treated confidentially.
- Health services are provided free of judgmental attitudes.
- Health facility staff speak to clients in a respectful and dignified manner.
- Clients are able to give their informed consent to the services available to them.
- Clients' circumstances (e.g., their criminalized situation) do not act as a barrier to their accessing healthcare and treatment.
- Clients' complaints about S&D are dealt with effectively.

Action Plan (Groups)

Ask the same groups to do the following tasks:

- Make a list of two to three changes you will make to create a stigma-free health facility
- Make a list of two to three things you would like your managers to do to create a stigma-free facility

EXAMPLE RESPONSES

Health Facility Staff List

- We need to take more care in keeping HIV test results confidential.
- We need to stop telling the families of patients the HIV test results without the patients' knowledge.
- We should listen, interact better, and be more patient with MSM and sex worker clients.

Health Facility Staff List

- Train all doctors how to do anal STI examinations.
- Train all health facility staff on the needs of sex workers and how to provide appropriate services and information.
- Establish a counseling program/service for health facility staff.
- Set up procedures for reporting on breaches of confidentiality.
- Use supervision and performance appraisals to ensure stigma-free care and treatment.
- Establish a register to record S&D complaints and a team to deal with complaints.
- Organize training on Standard Precautions for all levels and types of health facility staff.
- Set up a procedure to ensure regular ordering of supplies for Standard Precautions.

Extra Activity – Departmental Plans

If there is time, ask participants from the same department to prepare a Code of Conduct and Action Plan for their own department or specialization.

EXAMPLE DEPARTMENTAL PLANS

ADMISSION, CARE, AND TREATMENT

Code of Conduct

- All clients are treated equally and with respect and dignity, regardless of who they are.
- No clients are denied care or kept waiting.
- Services are provided to clients known to be HIV positive without separating them from the general population (e.g., no use of separate rooms).

Action Plan

- Train all health facility staff on stigma-free client care and service; those health facility staff who missed the training should also be trained.
- Train all nurses and doctors how to do anal examinations.
- Train all health facility staff on the needs of sex workers and how to provide appropriate services and information.
- Establish a register and procedure for S&D complaints from clients and an Action Team to deal with complaints.

HIV COUNSELING AND TESTING

Code of Conduct

- All HIV testing is voluntary.
- Health facility staff are not allowed to test clients without the clients' knowledge and consent.
- All HIV tests require pre- and post-test counseling by a trained health professional.

Action Plan

- Establish a counseling program/service for health facility staff.

PROTECTING CONFIDENTIALITY OF HIV TEST RESULTS

Code of Conduct

- Information on a positive HIV test result can be communicated only to health facility staff who directly provide care and treatment to a client.
- Health staff should not inform others about a client's HIV test result.

Action Plan

- Keep confidential documents locked away.
- Set up procedures for reporting on breaches of confidentiality.

STANDARD PRECAUTIONS

Code of Conduct

- Health facility staff should apply Standard Precautions to all clients, regardless of whether or not they think the client may be HIV positive or have any other infectious disease.
- Health facility staff do not have a right to be told which clients are HIV positive so they can protect themselves against HIV.
- Health facility staff should not wear gloves or masks inappropriately when dealing with people who are HIV positive or presumed to be HIV positive.
- Health facility staff should use and dispose of needles, syringes, and other sharps safely.

Action Plan

- Organize training on Standard Precautions for all levels and types of health facility staff.
- Set up a procedure to ensure regular ordering of supplies for Standard Precautions.

Applying the New Code of Conduct on the Job

Each health facility can plan and implement various activities to build a stigma-free health facility. Here are some ideas.

1. **Set up and identify your Stigma Action Group:** Include representatives from senior managers, health facility staff, non-clinical staff, and service-users. The group will be responsible for implementing the Action Plan and then monitoring its progress.
2. **Assess your facility:** If possible, carry out an assessment of the levels of stigma within your health facility. This can be done by using a facility questionnaire (see http://www.healthpolicyproject.com/index.cfm?id=StigmaPackage), which is a component of the toolkit. The assessment will serve two purposes: to give you a snapshot of the kind of stigma that exists in your health facility and to raise awareness about the plan to move toward a stigma-free health facility. Be sure to include staff and service users in the assessment, and share the results.
3. **Review current policies and practices:** This review has been started in the stigma-reduction training, so use the outputs from the training as a starting point. Use existing structures (e.g., staff meetings, senior management meetings, departmental meetings, etc.) to discuss the outputs and encourage further discussion and ideas from staff who were not at the training. One way of doing this is to get each department to develop its own ideas on new policies to counteract stigma and then bring representatives of all departments together to agree on a Code of Conduct. This has been done successfully in hospitals in Vietnam and the health sector in St. Kitts & Nevis.
4. **Solicit ideas from the community and other local organizations, including key population organizations:** Encourage these groups to come up with their own ideas and then meet with them to document their suggestions to stop stigma in their health facility.
5. **Launch the Code of Conduct:** Make sure as many people as possible (staff, clients, the public) are aware of your Code of Conduct. Display it in service areas and staff rooms. Use meetings to ensure that staff know what it means for their work. Ask for feedback from clients. Celebrate the fact that you are aiming to provide a stigma-free health facility!
6. **Monitor progress:** Carry out regular assessments of stigma, record success stories, discuss progress with staff, and review the Code of Conduct to see if new points need to be included. Share lessons with other health facilities and plan further stigma-reduction training.

MODULE F

Annex: Fact Sheets

F

ANNEX – Fact Sheets

F1. HIV and Key Population Stigma & Discrimination

F2. Stigma Faced by Health Workers

F3. Human Rights and Stigma

F4. True/False Questions re: Key Populations

F5. Men Who Have Sex with Men and Stigma

F6. Sex Workers and Stigma

F7. Understanding Drug Abuse

F8. Harm Reduction

F9. QQR—Quantity, Quality, and Route of Transmission

F10. HIV Transmission and MSM—Risk Continuum

F11. Drug Use and HIV

F12. Introduction to Standard Precautions

F13. Fears of Getting HIV & How to Overcome Fear Through Standard Precautions

F14. When to Use Different Protective Apparel

F15. Use and Disposal of Sharps

F16. Facility Hygiene and Waste Management

F17. PEP Management Procedures

F18. Examples of Codes of Conduct

- A. Code of Conduct from St. Kitts & Nevis (2014)
- B. Code of Practice developed for hospitals in Vietnam (2008)
- C. An Example Code of Conduct for Health Workers Working with Sexual Minorities
- D. The PLHA-Friendly Achievement Checklist—Reducing AIDS-related Stigma and Discrimination in Indian Hospitals Horizons Program, Sharan, Institute of Economic Growth (2006)

F1. HIV and Key Population Stigma & Discrimination

Handout for Exercises A1, A2, and A3

What is stigma?

Sometimes we treat people badly because of how they look or what we suspect they do. We isolate them, e.g., refusing to sit beside a person living with HIV in a clinic; or we gossip about PLHIV and call them names because of the way they look. When we isolate or make fun of other people, this is called "STIGMA." It makes the person feel ashamed or disgraced.

Stigma is a process through which we (society) create a **"spoiled identity"** for an individual or group of individuals. We **identify a difference** in a person or group—for example, a physical difference (e.g., physical disfiguration) or a behavioral difference (e.g., people assumed to be promiscuous)—and then **mark that difference as something negative**—as a sign of disgrace. Identifying and marking differences as "bad" allows us to stigmatize the person or group. **Stigmatized people lose status** because of these assigned "signs of shame," which other people regard as showing they have done something wrong or bad (sinful or immoral behavior).

Stigma is the belief or attitude that leads to discrimination. The action resulting from stigma is **discrimination**—unfair treatment, e.g., PLHIV being kicked out of the house or given poor treatment in health facilities. When we stigmatize PLHIV, we **judge** them, saying they have broken social norms and should be shamed or condemned, or we **isolate** them, saying they are a danger or threat to us (because of our fear of getting HIV through physical contact with them).

Sometimes as health workers we automatically make judgments about people without realizing how it will affect them, or the health services they receive. Heavy workloads and stress also affect how we treat our clients.

How do people stigmatize?

The main **FORMS** of stigma include the following:

- **ISOLATION AND REJECTION**—Based on ignorance and fear about HIV transmission or the behaviors of a marginalized group. The person stigmatized is forced to sit alone and others avoid contact with them.
- **SHAMING AND BLAMING**—Gossip, name calling, insulting, judging, shaming. Stigmatized people are "blamed and shamed" for assumed "bad behavior," i.e., for breaking social norms.
- **DISCRIMINATION (ENACTED STIGMA)**—Unfair treatment, such as refusing to provide health services to HIV-positive or key population clients, treating them last, or testing clients without their consent.
- **SELF-STIGMA**—PLHIV or those from key populations may stigmatize themselves in reaction to stigmatization from society. They may accept the blame and rejection of society, and withdraw from social contact or exclude themselves from accessing health and other services out of fear of having their status revealed.
- **STIGMA BY ASSOCIATION**—The families of PLHIV or key populations may be stigmatized by others in the community. Some health workers are also stigmatized for working with HIV clients or clients from key populations.
- **LAYERED STIGMA**—Key populations (e.g., sex workers, MSM, transgender persons, people who use drugs, prisoners) are already stigmatized. When they get HIV they are doubly stigmatized—adding another layer of stigma.

Common forms of stigma in health facilities

- Unfriendly looks. Gossip. Name calling. Blaming clients for "immoral behavior."
- Keeping clients waiting longer—other clients are treated first.
- Some health workers refuse to treat clients or refer them to other staff.

- Poorly done, rushed examinations, with minimal contact.
- Breaking confidentiality—revealing the status of HIV-positive clients or the identity of key populations to other health staff and clients—without the person's consent.
- Using gloves and masks for routine tasks that don't involve the handling of bodily fluids.
- Forcing clients to be tested without their consent and adequate counseling—and not providing the results of the HIV test to the client.
- Giving rushed instructions and not allowing the clients to ask questions.

What are some EFFECTS of stigma on HIV-positive clients or key populations?

- Feelings of sadness, loneliness, rejection, hopelessness, and self-doubt.
- Shame, loss of self-esteem, and feeling they are no longer accepted by others.
- Self-blame. Guilt. Denial. Self-hatred. Stress. Depression. Suicide. Alcoholism.
- No longer going to the health facility and looking for other, less-stigmatizing health facilities (e.g., private doctors who provide more confidentiality) or doing self-treatment.
- Hiding or stopping their use of medication.
- Losing self-esteem and as a result, not disclosing to their partners and taking more risks in their sexual behavior (e.g., not using condoms or clean needles).
- Hiding their sexual orientation, sex work, or drug use—as a result, they may have sex or use drugs in hidden places where it is difficult to obtain protection (e.g., condoms or clean needles) or negotiate for safer sex.

What are the EFFECTS of stigma on the HIV epidemic?

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

- Accessing health services—getting tested for HIV and STIs, accessing treatment (e.g., ART or treatment of OIs), getting information on how to avoid HIV transmission, and getting condoms and lubricant.
- Openly discussing their sexuality with health workers and providing complete information about their sexual practices.
- Protecting their own health and the health of their sexual partners—for example, by insisting on condom use with partners, using clean needles and syringes for drug use, or accessing treatment to reduce viral load.
- Disclosing their HIV status and getting counseling, care, and support. Because of stigma, PLHIV and other key populations are often afraid to tell others about their HIV status. As a result, they may have difficulty in negotiating condom use; accessing services, support, and treatment for HIV; and thus possibly passing HIV to their partners.

What are the CAUSES of stigma?

The three main causes or drivers of HIV-related stigma are:

- **LACK OF AWARENESS THAT WE ARE STIGMATIZING—**People are often unaware that their attitudes, words, and actions are stigmatizing toward other people, and of the resulting negative consequences. Some health workers may not be aware they are stigmatizing.
- **MORAL JUDGEMENTS—**People make judgments about others. They say that PLHIV or other key populations have done something bad or wrong (sinful or immoral behavior) so they should be shamed or condemned.
- **FEAR AND IGNORANCE—**Lack of knowledge and misconceptions about HIV transmission lead to fear about getting HIV through casual contact; as a result, we may isolate or reject people we assume are HIV positive. The fear

and ignorance may also be rooted in lack of understanding about the lives and sexuality of key populations—so, out of ignorance, we may judge key populations unfairly. We are often prejudiced toward people who are seen as behaving differently.

What can we do to challenge stigma?

STOPPING STIGMA will take a huge effort by everyone. **The starting point is to change ourselves**—the way we think and act toward PLHIV or other key populations.

After we have changed ourselves, **we can start to educate others**. It takes courage to stand up and challenge others when they are stigmatizing, but this is one of the ways to stop stigma. Breaking the silence and getting people talking openly is the first big step. Make stigma a visible problem that is viewed as unacceptable.

Make our health facilities stigma free through the following practices:

- Ensure that PLHIV and other key populations receive the same standard of care as other patients.
- Provide a friendly and welcoming environment—friendly faces, body language, and voices.
- Avoid stigmatizing or coded language for HIV-positive patients.
- Avoid unnecessary, excessive use of masks and gloves for doing routine tasks.
- Ensure confidentiality—don't let others know the status of HIV-positive patients.
- Speak up and challenge, in a polite but firm way, those health workers who are stigmatizing.
- Train health workers on patients' rights and the right of PLHIV and key populations to equal care and confidentiality.
- Train health workers on how to counsel HIV-positive clients and other key populations—e.g., using nonjudgmental, neutral, or supportive language, and appropriate body language.

Health workers alone cannot solve many of the root causes of stigma. However, general awareness of these root causes will help health workers better understand the needs and concerns of PLHIV and other key populations so they can provide better services and refer clients to other appropriate services.

F2. Stigma Faced by Health Facility Staff

Handout for Exercise A5

What forms of stigma are commonly faced by health facility staff living with HIV?

Health workers living with HIV face some of the following forms of stigma:

- Gossip and name calling, e.g., "You should know better."
- Loss of respect from other health facility staff.
- Exclusion from social interaction with other health facility staff.
- Separation of cups used by health facility staff suspected to be HIV positive.
- Self-stigma—hiding ARVs so no one knows.
- Transferring health facility staff living with HIV to the night shift or to work with HIV-positive clients.

What are the possible effects of stigma on health facility staff?

- Health facility staff may fear getting tested for HIV or accessing PEP after possible HIV exposure at work.
- Health facility staff may feel very isolated and lack the support of their colleagues.
- Health facility staff may hide from colleagues that they are taking ARVs.
- Health facility staff may travel to other health centers to access ARVs, thus increasing their costs.
- Some health facility staff may not access health services or, out of fear of being discovered taking ARVs, not practice full adherence.

Why do health facility staff not receive priority healthcare and treatment?

Health workers should receive priority healthcare, treatment, and support for HIV, but this does not often take place, for a number of reasons:

- There is a perception that giving health workers priority in healthcare services is unethical and that they should instead serve others first.
- Health workers living with HIV may fear stigma from colleagues once they are known to have HIV—possibly leading them to avoid accessing the healthcare they need and to self-medicate.

As the dual epidemics of HIV and tuberculosis place an increasing burden on healthcare systems, prioritizing the healthcare of health workers contributes significantly to the strengthening of healthcare systems.

What can we do to reduce the stigma toward health facility staff?

- As health facility staff, we can all take responsibility for reducing stigma in our facilities.
- We can use our staff meetings to talk about stigma and emphasize the importance of respect, teamwork, and mutual support.
- We can change our personal attitudes and behavior—e.g., stop gossiping.
- We can challenge others if they stigmatize.
- We can use meetings to develop and implement an anti-stigma policy.

F3. Human Rights and Stigma

Handout for Exercise A7

What are human rights?

- Human rights are rights inherent to all human beings, whatever your nationality, place of residence, sex, national or ethnic origin, color, religion, language, sexual orientation, gender identity, or any other status.
- Rights are basic and universal, and everyone needs them to live happy, meaningful lives.

What are some examples of human rights?

All individuals have rights to dignity, life, privacy (confidentiality), health, property, legal representation, religious expression, self-determination (autonomy), freedom from discrimination, freedom of speech, freedom of movement, and freedom of association.

What major rights are affected by HIV stigma in the health setting?

- Freedom from inhumane treatment: PLHIV and other key populations are sometimes treated badly by some health workers.
- Right to Healthcare: Some key populations are discouraged from using health facilities through unfriendly treatment and lack of confidentiality.
- Right to Liberty: Some PLHIV and key populations are forced to take an HIV test without their consent.
- Right to Privacy: Some health facilities disclose medical information about HIV-positive clients and conduct HIV testing without counseling and consent. Key populations have the right to keep facts about themselves confidential, but their sexual orientation, occupation, or drug use is often disclosed to others without their consent. This disclosure violates their right to privacy.
- Right to Information: Some key populations are not given enough/correct information about HIV—as a result, they lack the knowledge they need to prevent acquiring or transmitting HIV.

Why is HIV stigma a human rights issue?

- Stigma violates the human rights of the person who is stigmatized because he or she is, or is perceived to be, living with HIV. As stigma is a negative belief or judgment or attitude about that person, it directly affects that person's right to dignity and equality.
- Stigma makes people more vulnerable to getting HIV. When their rights are denied, people find it more difficult to protect themselves from getting HIV. For example, when a gay man is refused treatment in a health facility, he will find it more difficult to access condoms and lubricant to protect himself from HIV.
- Violations of human rights block an effective response to the HIV epidemic. Stigma against PLHIV and other key populations makes it difficult to provide them with HIV-related prevention, treatment, and care services.

What will happen if the rights of people living with HIV and key populations are respected?

- Their vulnerability to HIV will be reduced and they will be able to live a life of dignity without discrimination. They will feel that their rights are being protected.
- Feeling safe, they will access their right to health services and take more responsibility for their own health and the health of others.

F4. True/False Questions re: Key Populations

Handout for Exercises B1 and B2

What Do You Know About Men Who Have Sex with Men?

- Becoming gay does not just happen. Rather, men decide or learn that they want to be gay.
- MSM are mentally ill but they can be cured.
- Sex between two men is against religion.
- MSM have been too influenced by Western values.
- MSM are all the same. You can identify them by the way they dress and behave.
- In many countries, it is illegal for men to have sex with men.
- MSM have an increased risk of getting HIV and other STIs because of having unprotected anal sex.
- MSM engage in the same sexual practices as other couples.
- MSM do not want long-term partners; they want only casual sex.
- MSM may also have sex with women.

ANSWERS

Becoming gay does not just happen. Rather, men decide or learn that they want to be gay.

FALSE. Wanting to have sex with other men is part of some men's nature. It is like being right-handed or left-handed. It is natural or inborn and cannot be explained, predicted, or changed by individual will. It is not known what makes some men desire men, whereas other men desire women. Some studies suggest there are genetic influences, whereas other people believe it is a mixture of genetics and social influences. A man who has sex with men cannot simply be taught to be sexually attracted to women. There is no scientific evidence to prove that people can change their sexual orientation by exerting their will.

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

Men who have sex with men are mentally ill but they can be cured.

FALSE. Being gay is not a mental illness. In the past, psychiatrists tried to show that men desiring sex with other men was a mental illness, but they failed. Starting in 1973, the medical profession no longer treated being a man who has sex with men as an illness. However, some parents still wrongly send their gay sons to clinics, psychologists, or traditional doctors to be "cured." If being gay was accepted by everyone, no one would feel the need to "cure" it.

Sex between two men is against religion.

TRUE/FALSE. Religions have different views and interpretations of men having sex with men. Islam and some Christian churches consider it a sin, whereas other religions consider it a weakness that can be cured, and some feel it is an acceptable and normal sexual orientation.

In all religions, there is a difference between their texts and daily practice. Some people read their holy books literally and use such texts to condemn MSM. Others use the texts as a source of inspiration, but in daily life they accept MSM as

human beings. Others emphasize that religious teachings mention compassion and tolerance of other people. There are many MSM who find ways to keep their faith and still be who they are. Many religious people are faithful to their religions and also accepting of MSM.

Men who have sex with men have been too influenced by Western values.

FALSE. Historical research shows that homosexuality existed in Asia and Africa long before Europeans arrived in these regions. Research has shown that 5–10 percent of people in every community in the world are attracted to the same sex. In all countries of the world, MSM existed in the past—they kept it secret, but they existed. Today, it is relatively more open; it is estimated that people who have sex with people of the same sex live in every community, although because of stigma and discrimination, many keep it hidden.

Men who have sex with men are all the same. You can identify them by the way they dress and behave.

FALSE. As with all people, MSM are individuals who look and behave in different ways. Some MSM wear their hair longer and dress in a feminine way, whereas others may wear their hair short and dress and act like other men. In some cases, MSM are married and have families, or act one way in public and another way in private. Many MSM dress and act no differently from men who do not have sex with men. It is impossible to tell whether someone is a man who has sex with men just by the way he looks and behaves.

In many countries, it is illegal for men to have sex with men.

TRUE. In many countries, the penal code prohibits men from having sex with other men.

Men who have sex with men have an increased risk of getting HIV and other STIs because of having unprotected anal sex.

TRUE. At least 5–10 percent of all HIV infections worldwide are due to anal intercourse between men. Unprotected anal intercourse carries a higher risk for contracting STIs, including HIV, than vaginal intercourse. This is because the rectum tears very easily, leaving openings for HIV to be transmitted. Anal sex also requires a lot of lubrication and a condom to be practiced safely. Water-based lubricant, e.g., KY Jelly, which is safe to use with condoms, is often not accessible. Oil-based lubricant, e.g., Vaseline, will cause the condom to deteriorate and break. However, MSM can reduce the risk of contracting HIV by practicing safe sex.

Men who have sex with men engage in the same sexual practices as other couples.

TRUE. MSM use many of the same sexual practices as heterosexual couples, including kissing, masturbation, touching, anal sex, and oral sex. These sexual activities are not restricted to sex between a man and woman or sex between two men, but are commonly practiced by both groups. Some of us, for example, assume that all MSM practice anal sex; in fact, many do not, and many heterosexual couples practice anal sex. Some MSM also have sex with women, so they practice vaginal sex as well.

Men who have sex with men do not want long-term partners; they want only casual sex.

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

Men who have sex with men may also have sex with women.

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

What Do You Know About Sex Workers?

- Sex workers love money and are too lazy to work. They could easily get other jobs.
- Sex work is the quickest way for poor women to make money.
- HIV is the only serious problem sex workers face.
- Some sex workers use alcohol and/or drugs as a mechanism to cope with the hardship of their job.
- Sex workers hide their work to avoid being stigmatized by their families and the community.
- Sex workers are promiscuous; their relationships never last.
- Sex workers are highly vulnerable to HIV because they find it difficult to negotiate for safe sex with clients and their full-time partners.
- When sex workers come to a clinic, they receive the same treatment as everyone else.
- In many countries, sex work is illegal.
- Sex workers are afraid to report to the police those cases in which they have been beaten or raped by their clients because their work is illegal and they think they have no rights.

ANSWERS

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

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

Sex work is the quickest way for poor women to make money.

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

HIV is the only serious problem sex workers face.

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

Some sex workers use alcohol and/or drugs as a mechanism to cope with the job's hardship.

TRUE. Many sex workers drink because they are forced to do so as part of the job, to make them more relaxed in doing the work, and to forget their troubles with their job or family hardships. In some cases, this use leads to an addiction.

Sex workers hide their work to avoid being stigmatized by their families and the community.

TRUE. Sex workers often do everything possible to ensure that while they are working, family members or family friends

do not find out what they are doing. Although family members may know that they are supported by money from sex work, it is still heavily stigmatized by families and the community. Sometimes the community stigmatizes the entire family if one member is known to be a sex worker. The stigma associated with this work is so painful that it forces these individuals to carry the burden of their secret life alone, and usually away from home.

Sex workers are promiscuous and their relationships never last.

FALSE. Sex workers have sex with many people—this is the nature of their work—but most do have lasting relationships with their regular partners or spouses.

Sex workers are highly vulnerable to HIV because they find it difficult to negotiate for safe sex with clients and their own partners.

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

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

FALSE. Sex workers are sometimes stigmatized by health workers because of their work. Sex workers often wait longer, even when they arrive at a clinic early, and they may receive an incomplete diagnosis or inadequate counseling for their health problems.

In many countries, sex work is illegal.

TRUE. The penal code in many countries prohibits the selling of sex. Sex workers can be arrested for charging for sex. In some countries, selling sex itself is not criminalized but some other aspects of sex work, such as "pimping" and running a brothel, may be criminalized. In addition, in some countries, sex workers may be arrested for other offenses, e.g., loitering, public nuisance, offenses against public morality, etc.

Sex workers are afraid to report to the police those cases in which they have been beaten or raped by clients because their work is illegal.

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

What Do You Know About People Who Use Drugs?

Drug Use and Drug Addiction

- Not everyone who starts using illegal drugs, such as heroin, becomes addicted.
- Cigarettes and alcohol are as addictive as heroin but they are legal substances.
- Once people who use drugs become addicted, their main motivation for continuing to take drugs is to get that feeling of pleasure induced by the drug.
- People addicted to drugs just love their drugs and don't want to quit. They could stop at any time.
- For a number of reasons, people who have quit drugs often start using them again.
- Very few women are addicted to drugs.

Injecting Drug Use

- The only reason people who use drugs prefer to use injections is that injecting produces a strong and immediate effect.
- Most people who inject drugs inject on their own, doing it quietly without anyone knowing.

Sharing Injection Equipment (Needles and Syringes)

People share the use of needles and syringes because of the following:

- They are afraid they will be identified as a person who uses drugs and be caught by the police if they are seen buying or carrying their own needles or syringes.
- They are poor and would prefer to spend the money on the drug itself, rather than on needles and syringes.

HIV and Injecting Drug Use

- It is not drug use or injecting drugs that is the major cause of HIV transmission, but rather the practice of sharing needles and syringes among people who use drugs.
- HIV is the only health problem people who inject drugs face.

Treatment of Drug Addiction

- Using harsh punishment, including locking people up, is the best method to treat people addicted to drugs.
- Needle and syringe programs, which provide sterile needles and syringes to people who use drugs, result in more drug use and more people who use drugs.
- Discarding used syringes is a potential source of HIV transmission.

Drug Substitution

- Drug substitution programs reduce HIV, crime, and deaths by overdose, and help people who use drugs to function again in their families and community.
- Drug substitution programs, which replace one drug used by a person with another one, encourage drug use.
- Buprenorphine or methadone are miracle cures for drug addiction.

Drug Use and the Law

- Laws that criminalize possession of injecting equipment stop people who inject drugs from injecting.
- Drug addiction creates a huge burden on families.

ANSWERS

Drug Use and Drug Addiction

Not everyone who starts using illegal drugs, such as heroin, becomes addicted.

TRUE. Many people use drugs without being addicted. They take drugs on an occasional, experimental basis. People who use drugs become addicted only when they take drugs on a regular basis over a period of time, varying from a few weeks to many years. Drug use becomes habitual and the drug user becomes dependent on the drugs. Thus, drug use and drug addiction are two different things. In the United States, for example, out of 25 million people who use drugs, it is estimated that only 1–2 million people (8%) become addicted.

Cigarettes and alcohol are as addictive as heroin, but they are legal substances.

TRUE. Cigarettes also produce an addictive effect on the body. Nicotine is one of the most addictive substances known—smokers develop a dependence on nicotine quickly. Many people want to stop this habit but they find it very difficult to stop. If they do stop, they feel very uncomfortable. Tobacco prices are low, so many people become addicted. Smoking has serious effects on the body—and prolonged use can cause lung, heart, and blood vessel damage, and cancer. The WHO estimates that smoking is responsible for one out of five deaths, or 3 million people per year worldwide; more than 50

percent of smokers will die prematurely as a direct result of tobacco-induced illnesses. Alcohol consumption also carries a risk of adverse health and social consequences related to its intoxicating, toxic and dependence-producing properties. In addition, many chronic diseases, such as liver cirrhosis, some cancers and cardiovascular diseases, may develop in those who consume large amounts of alcohol over an extended number of years. Alcohol use is also associated with an increased risk of acute health conditions, such as injuries, including those from traffic accidents. The WHO estimates that nearly 6 percent of global deaths in 2012 could be attributed to alcohol consumption. Despite these adverse consequences, tobacco is a legal substance.

Once people who use drugs become addicted, their main motivation for taking drugs is to get that feeling of pleasure induced by the drug.

FALSE. People start taking drugs to get a pleasurable feeling but, once they are addicted, their main motivation is to overcome the feelings of withdrawal. The initial attraction to drugs is the feeling of happiness that the drugs induce in the body. These pleasurable feelings produce strong memories, which are stored in the brain and create a desire to take more drugs—to bring back those pleasurable feelings. But once people become addicted, they encounter withdrawal or painful symptoms when the drug wears off, including fast heartbeat, anxiety, increased blood pressure, perspiration, and pains in the body. At this stage, their main motivation in taking the drugs is to deal with these symptoms of withdrawal, e.g., to get back to "normal." Their main focus is to feel normal—not happy.

People addicted to drugs love their drugs and don't want to quit. They could stop any time.

FALSE. Many people don't understand the nature of addiction. They assume that it is easy for people addicted to drugs to stop—that it is only a matter of will. They assume that people addicted to drugs "just don't want to quit their bad habits," that they are "weak people." They don't see that drug addiction is beyond the control of the people who use drugs. The craving for drugs makes it difficult for them to break their addiction—not because they don't want to, or are weak, lazy, or don't try, but because of the power of the addiction. Drugs create a strong physical dependency, forcing the person who uses drugs to continue taking them. Once addicted, people who use drugs experience very painful withdrawal symptoms when the drugs wear off. These feelings have such a powerful effect on the body that people addicted to drugs would "do anything" to get the drugs to get over the painful withdrawal feelings and return to normal.

For a number of reasons, people who have quit drugs often start using them again.

TRUE. It is hard to break the drug habit. Many people quit for a short or long time and then start using drugs again. The reasons for this include (a) they were forced to quit by others—it was not their decision, (b) they start feeling better and tell themselves that taking drugs will cause them no harm, (c) they are persuaded by other users to take drugs again.

Very few women are addicted to drugs.

FALSE. Although the majority of people who use drugs in the world are men, increasing numbers of women use and are addicted to drugs—and many of them are involved in sex work.

Injecting Drug Use

The only reason people who use drugs prefer to use injections is that injecting produces a strong and immediate effect.

FALSE. This is only one of the reasons why people who use drugs prefer to use injections—there are a number of others. Most people who use drugs are poor and want to get more out of the drugs they buy. Injecting is an effective way of getting a drug into the body, since all of it is used. If you inhale the drug, much of it is lost as smoke. In addition, injecting can be done much more quickly than smoking, so users are less exposed to police action. Injecting takes little time, can be done anywhere, and it is easy to dispose of the needle and syringes.

Most people who inject drugs inject on their own, doing it quietly without anyone knowing.

FALSE. Most people who inject drugs inject with others in small groups. There is a strong group ethos of sharing. They share the same injection equipment, and often the drugs. The shared use of needles is what makes it possible for HIV to be transmitted from one injecting drug user to another.

Sharing Injection Equipment (Needles and Syringes)

People prefer to share the use of needles and syringes because:

TRUE. They are afraid they will be identified as a person who uses drugs and be caught by the police if they are seen buying or carrying their own needles or syringes.

They are poor and would prefer to spend the money on the drug itself, rather than on needles and syringes.

TRUE. A person who uses drugs injects two or three times a day every day of the week. This cost mounts up quickly, so, given their limited resources, they would prioritize buying the drugs, rather than the injecting equipment.

HIV and Injecting Drug Use

It is not drug use or injecting drugs that is the major cause of HIV transmission, but rather the practice of sharing needles and syringes among people who use drugs.

TRUE. Drug use itself does not transmit HIV (e.g., inhaling drugs does not transmit HIV) nor does injecting drugs if you are using your own sterile equipment. The problem is sharing the needles and syringes, especially with many other people. HIV spreads among injecting people who use drugs mainly because of the sharing or reuse of needles and syringes that have become contaminated with HIV-infected blood. Small amounts of blood, which are not necessarily visible, can remain in the needle and syringes after they have been used. HIV can survive up to one week in the blood left in a syringe or needle. If the equipment is reused, this blood will be injected directly into the bloodstream of the next person who uses the equipment. If the blood is infected with HIV, then HIV can be passed on to that person.

HIV is the only health problem people who use drugs face.

FALSE. Injecting can also lead to drug overdose, abscesses, septicemia, thrombosis, scarring, circulatory problems, collapsed veins, and poor healing of wounds.

Treatment of Drug Addiction

Using harsh punishment, including locking people up, is the best method to treat people addicted to drugs.

FALSE. The international experience of dealing with drug addiction over the years has shown that severe punishment does not change behavior. If anything, it just makes the situation worse.

Needle and syringe programs, which provide sterile needles and syringes to people who use drugs, result in more drug use and more people who use drugs.

FALSE. Studies of NSPs have shown that these programs do not lead to more use of drugs by people who use drugs, nor do they encourage other people to start taking drugs. NSPs encourage safe use of drugs and personal responsibility by people who use drugs, and through this slow or stop HIV transmission. Using sterile needles and syringes to inject drugs without any sharing is the most effective approach for limiting HIV transmission.

Discarding used syringes is a potential source of HIV transmission.

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

Drug Substitution

Drug substitution programs reduce HIV, crime, and deaths by overdose, and help people who use drugs to function again in their families and community.

TRUE. Drug substitution programs reduce HIV among people who use drugs by reducing the number of incidences of injecting, switching people from opioid-based drugs (e.g., heroin) to legal drugs (e.g., buprenorphine or methadone), minimizing the risks of overdoses and medical complications, and reducing the need for addicts to commit crimes to raise money for drugs. Overall, this therapy helps people who are using drugs to stabilize their lives and reintegrate with the general community.

Drug substitution programs, which replace one drug used by a person with another one, encourage drug use.

FALSE. The aim of drug substitution programs is to reduce the health, social, and economic harm to individual users and the community, not to promote more drug use. These programs have a number of objectives, including the following:

- Reducing dangerous drug use (e.g., sharing injection equipment)
- Reducing the risk of a drug user contracting or transmitting HIV
- Helping users switch from criminalized drugs (e.g., heroin) to legal drugs (e.g., methadone)
- Minimizing the risks of overdoses and medical complications
- Reducing the need for addicts to commit crimes to raise money for drugs
- Helping people who use drugs stabilize their lives and reintegrate with the general community

Buprenorphine or methadone are miracle cures for drug addiction.

FALSE. Buprenorphine or methadone do not cure drug addiction. When on buprenorphine or methadone, a client is still physically dependent on a drug. What buprenorphine and methadone do is to help people who use drugs normalize and stabilize their lives, and lessen the risks associated with drug use, such as sharing injecting equipment and contracting HIV and other blood-borne infections. Buprenorphine and methadone help to stabilize people who inject drugs, remove them from a life of criminality (to get money to buy drugs), and help them get into a more socially acceptable environment, where they can receive counseling and other social services.

Drug Use and the Law

Laws that criminalize possession of injecting equipment stop people who inject drugs from injecting.

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

Drug addiction creates a huge burden on families

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

What Do You Know About Prisoners?

- Prisoners are not at risk of contracting HIV in prison, so they do not need condoms.
- Giving condoms to prisoners is wrong because it encourages homosexual behavior.
- MSM in prison are not a risk to general society since they have sex only with other men like them.
- Prisoners who have HIV do not have rights and should not be treated like other people. If they wanted to be treated properly, they should not have gotten imprisoned in the first place.
- Prisoners with HIV receive adequate HIV-related healthcare because they are being cared for in prison.
- Prisoners are forced to be tested for HIV.
- Prisoners who have sex in prison are gay or lesbian.
- Women in prison have higher HIV infection rates than men in prison.
- The HIV prevalence in prisons is higher than national rates.
- Some people contract HIV in prison.

ANSWERS

Prisoners are not at risk of contracting HIV in prison, so they do not need condoms.

FALSE. There is abundant evidence that prisoners are at risk of getting HIV while in prison through injecting drug use, tattooing with unsterilized needles, and sex between inmates. For this reason, making condoms available will help reduce the risk of infection, although it is by no means the only solution. Other responses should include projects to provide sterile needles for injecting people who use drugs and tattooing, and those that protect inmates against rape and other forms of sexual violence that may place them at risk of contracting HIV.

Giving condoms to prisoners is wrong because it encourages homosexual behavior.

FALSE. There is no evidence that providing condoms to prisoners encourages them to engage in same-sex sexual intercourse. Even to say that distributing condoms means that the government is condoning same-sex sexual activity is a non-starter. It is like saying that teaching adolescents about sex or denying them access to condoms means that you are condoning pre-marital sex. We should be cautious not to overlook its purpose, which is to protect public health. Moral reasons for not addressing public health concerns that do not meet public health goals are counterproductive.

Men who have sex with men in prison are not a risk to general society since they have sex only with other men like them.

FALSE. By denying condoms to prisoners, those who otherwise would have used them had they been available are denied an effective method of protecting themselves from HIV infection. This denial has a far-reaching impact: the majority of prisoners are released back into society, thus presenting the risk that other people will become infected, hampering public health for all.

Prisoners who have HIV do not have rights and should not be treated like other people. If they wanted to be treated properly, they should not have gotten imprisoned in the first place.

FALSE. Although incarcerated, prisoners continue to be entitled to exercise their rights, including their right to access proper healthcare. The state has a responsibility to ensure that prisoners receive the same quality of healthcare, treatment, and support than if they not been imprisoned. This responsibility is supported by key international human rights instruments, and is clearly expressed in the United Nations Basic Principles for the Treatment of Prisoners, which states that:

> *Except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights, and, where the*

> *State concerned is a party, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights and the Optional Protocol thereto, as well as such other rights as are set out in other United Nations covenants.*

Prisoners with HIV receive adequate HIV-related healthcare because they are being cared for in prison.

NOT ALWAYS. There is evidence that access to HIV treatment, care, and support, even in the prisons of industrialized countries like the United Kingdom, is less than adequate. One study found that access to ARV medication and maintaining confidentiality with regard to this access was problematic. However, in some countries, prisons are a significant source of healthcare for PLHIV. For example, in 1997, 20–26 percent of all HIV-positive people in the United States passed through a correctional facility. Out of the estimated 1,600 PLHIV in Ireland, between 300 and 500 had been through the prison system. Considering these data, it is likely that in less-industrialized countries, the quality of healthcare is less than adequate.

Prisoners are forced to be tested for HIV.

SOMETIMES. In some countries, prisoners are forced to be tested for HIV by law. Not only is forced HIV testing an ineffective method of addressing HIV, it violates a multitude of prisoners' rights, including the rights to dignity, privacy (confidentiality), security of the person, basic freedom, and choice. It also puts prisoners at risk of discrimination, such as segregation from other prisoners on the basis of their HIV status and mistreatment by other inmates and prison wardens. International authorities such as the United Nations prohibit mandatory testing of any groups of people. The WHO Guidelines on HIV Infection and AIDS in Prisons state that:

> *Compulsory testing of prisoners for HIV is unethical and ineffective, and should be prohibited. Voluntary testing for HIV infection should be available in prisons when available in the community, together with adequate pre- and post-test counseling. Voluntary testing should only be carried out with the informed consent of the prisoner. Support should be available when prisoners are notified of test results and in the period following. Test results should be communicated to prisoners by health personnel who should ensure medical confidentiality.*

Prisoners who have sex in prison are gay or lesbian.

NOT ALWAYS. Although there are undoubtedly men and women who identify as gay or lesbian who enter the prison system, it is a generalization to say that all prisoners engaged in same-sex activity are gay or lesbian by virtue of this activity. This statement equates sexual identity with sexual practices. Being gay, lesbian, bisexual, or heterosexual relates to sexual orientation and personal desire, whereas people who engage in same-sex sexual activities do not necessarily identify as gay or lesbian, or admit to being attracted to the same sex. In other words, there are many different reasons why people engage in same-sex sexual practices.

For some, the health rights of MSM, whether identifying as gay or heterosexual, are irrelevant and should, on the basis that they are considered social evils, be ignored. However, this selective approach to health would be detrimental to the health of all. Prisoners who engage in same-sex sexual activity may, upon release, return to heterosexual relationships. If people in prisons are not provided with methods of preventing HIV infection, such as provision of condoms and harm reduction methods, the health interests of the wider community will also be affected.

Women in prison have higher HIV infection rates than men in prison.

SOMETIMES. HIV rates among women in detention are particularly high. According to the UNAIDS 2014 Gap Report, women who inject drugs, have been sex workers, or have experienced sexual violence are disproportionately represented among the female prison population. A 2010 report from Indonesia found that HIV prevalence was more than five time higher among women (6%) than men (1%).

The HIV prevalence in prisons is are higher than national rates.

TRUE. According to the United Nations Office on Drugs and Crime, the prevalence of HIV, hepatitis, and tuberculosis in persons is two to 10 times—and in exceptional cases up to 50 times—as high as in the general population.

Some people contract HIV in prison.

POSSIBLE. Prisons are set up in ways that increase the risk of the transmission of various health problems, including HIV and tuberculosis; thus, it is safe to say that there is a good chance that some people contract HIV while in prison. However, little evidence exists to prove this supposition. This is not because the evidence does not support this claim, but because researchers have difficulty in actually doing research with and accessing prison populations to find out whether this is the case.

What Do You Know About Migrants?

- HIV is a problem brought by migrants; therefore, to control HIV, migrants should be denied access to other countries.
- To control HIV, migrants should be tested for HIV before they enter other countries.
- Migrants living with HIV who are from poorer countries only migrate to take advantage of their host country's resources, such as public health benefits.
- Migrants are all criminals.
- Migrants steal jobs from locals.
- Migrants are taking our women from us.
- Migrants fear being reported to police because many are illegal immigrants.
- Host countries should provide services to migrants.

ANSWERS

HIV is a problem brought by migrants; therefore, to control HIV, migrants should be denied access to other countries.

FALSE. Although there is evidence to show that HIV prevalence is higher among some groups of migrants, there is no evidence to show that denying access to migrants will lessen the risk of HIV. This is also a dangerous belief because it erroneously implies that local people who engage in otherwise unsafe sexual practices and injecting drug use are not at risk of contracting HIV. Also, this statement does not consider the risk of HIV infection that migrants face from contracting HIV from the local people within other countries. In the end, arguments of this nature are simply not helpful, logical, or effective in dealing with HIV. In its publication, *Recommendation Concerning HIV/AIDS and the World of Work (2010)*, the International Labour Organisation (ILO) recommends that migrants should "not be excluded from migration by the countries of origin, of transit or of destination on the basis of their real or perceived HIV status."

To control HIV, migrants should be tested for HIV before they enter other countries.

FALSE. Testing migrants for HIV before they enter another country has not been shown to be an effective means of controlling HIV. The fact is that migrants are mobile—they may enter and leave a country within any timeframe. To attempt to test migrants for HIV at each instance of entry would be very impractical and pose a huge burden on the state. There are far better alternatives, which have been shown to work, such as behavior change interventions. Needless to say, this kind of testing is discriminatory and amounts to forced HIV testing, which is prohibited according to international human rights standards. Also, restrictive measures to address HIV only heighten stigma, violence, and discrimination against migrants living with, or perceived to be living with, HIV.

Migrants living with HIV who are from poorer countries only migrate to take advantage of their host country's resources, such as public health benefits.

FALSE. First, foreigners are not likely to be able to take advantage of state resources. Studies have not shown that migrants are more of a burden to social services than locals. Many migrants do not use social services for fear of being arrested and deported. Being an undocumented migrant heightens their health challenges as they may be reluctant to access public health services—even free ones—for fear of being found out. In most countries, healthcare benefits are linked to employment, and where migrants are working menial and low-paying jobs, they may not receive healthcare benefits. They are thus forced to pay to receive healthcare services, making access difficult. Second, this statement ignores the fact that many migrants flee to foreign countries out of necessity, to escape political instability, persecution, and/or economic hardship. One must also not forget the significant amounts in tax revenue that migrants contribute to a host country.

Migrants are all criminals.

FALSE. This is a generalization that does not apply to all migrants. Although there is evidence showing that some migrants are involved in criminal activities in their host countries, this cannot be said of all migrants. This statement also does not acknowledge evidence that many migrants are forced into engaging in criminal activities as a result of forced servitude and human trafficking. Many migrants move between countries in search of honest work, and many take jobs which in fact risk their lives. This unfounded belief is a form of xenophobia against foreigners and perpetuates and justifies S&D against migrants, leading to acts of violence and the denial of their rights, including the denial of health services that should be provided by the host country.

For instance, much evidence exists from research conducted by the International Organization for Migration (IOM) showing that, more often than not, migrants are the victims of crime, ranging from human trafficking for sexual and labor exploitation to the failure to provide conducive working environments for migrants engaged in menial labor.

Migrants steal jobs from locals.

FALSE. This is a generalization based on no evidence. Interestingly, research from the IOM shows that in the event of a global economic crisis, migrants are those most likely to lose their jobs. From evidence of xenophobic attacks that continue to occur, it is clear that statements such as this one endanger the lives of migrants. A news release posted on the IOM website, "Immigration Debates Should Not Demonize Migrants," states that "competition for low skill jobs is largely between migrant communities themselves; migrants have negligible if any impact on lowering wages."

Migrants are taking our women from us.

FALSE. This is not only untrue, it is inherently sexist, xenophobic, and undermines women's dignity, agency, and freedom. It implies that women do not choose their partners—that they somehow are forced into relationships by men, with no agency or cooperation of their own. It should be nobody's business who a woman chooses as her partner—migrant or local—as long as it is a choice she herself has made. Choosing a partner or lover is an entirely personal decision that cannot be made by another person. Such a statement perpetuates S&D and violence against migrants, which is completely unfair and unjust.

Migrants fear being reported to police because many are illegal immigrants.

TRUE. Migrants may be illegally residing in or passing through other countries as a result of entering illegally, possessing expired visas, or having been smuggled or trafficked into their host countries. They fear being reported to the police because they may not want to be deported to their countries of origin. As a result, many undocumented migrants are vulnerable and become victims to a variety of crimes committed against them, such as sexual violence and abusive working conditions. They are also less likely to access social services, as indicated above.

Migrants may fear not only being deported, but also the living conditions in the detainment centers that hold illegal immigrants before they are deported. Research has reported conditions in these centers as being at times even worse than conditions in prisons. Also, a review of the literature reveals that migrants in detainment centers are vulnerable to contracting HIV.

Host countries should provide services to migrants.

TRUE. International cooperation between hosts, transit countries, and countries of origin should work together to ensure that migrants can access health services.

F5. Men Who Have Sex with Men and Stigma

Handout for Exercises B1, B2, and B6

Borrowed from:

GNP+, ICW, Young Positives, EngenderHealth, IPPF, UNAIDS, UNFPA, WHO. 2007. *Creating a Supportive and Enabling Environment for the Sexual and Reproductive Health of People Living with HIV: Legal and Policy Considerations with Areas for Action.*

Men have sex with men in every culture and society, although the extent varies from region to region. The term "MSM" describes a wide variety of sexual practices and identities, including gay men, bisexuals (including married MSM), prisoners who self-identify as heterosexual but have sex with men while they are in prison; and male sex workers who see themselves as heterosexual but sell sex to men.

MSM are at increased risk of getting HIV if they have multiple sex partners, use condoms irregularly, and inject drugs. Sex between men involving unprotected anal sex carries a very high risk of HIV infection; the risk is greater for the receptive partner. At least 5–10 percent of HIV infections worldwide are estimated to occur through sex between men, though this figure varies considerably between countries and regions.

Many MSM also have sex with women; if HIV positive, they can transmit the virus to their female sexual partners or wives through unprotected sex; they can also be infected by their female partners.

Men who sell sex to other men are at particularly high risk because their turnover of partners tends to be high and they may be pressured or paid more to have unprotected sex. When male-male sexual behavior overlaps with drug use, the risk of HIV infection may increase through the shared use of injecting equipment, unsafe sex, or both.

MSM often have limited access to information on HIV prevention strategies, condoms, and water-based lubricant because of S&D.

In many countries, sexuality is still a taboo subject for discussion, and sex between men is socially disapproved, legally prohibited, and criminalized.[2] As a result, health workers often discriminate against MSM, and police may harass or arrest them. Furthermore, many MSM may fail to be open with health workers, meaning that anal STIs may go undiagnosed and untreated. Many governments fail to acknowledge that sex between men happens and that unprotected anal sex contributes to the transmission of HIV, and many national AIDS programs do not give sufficient attention to the needs of MSM.

Guideline 4 of the **International Guidelines on HIV/AIDS and Human Rights** states:

> *Criminal law prohibiting sexual acts (including adultery, sodomy, fornication, and commercial sexual encounters) between consenting adults in private should be reviewed, with the aim of repeal. In any event, they should not be allowed to impede provision of HIV prevention and care services.*

2. As of 2014, 78 countries criminalize same-sex sexual practices, with seven countries exacting the death penalty. Itaborahy, L., and J. Zhu. 2014. "State-sponsored Homophobia. A World Survey of Laws: Criminalization, Protection, and Recognition of Same-Sex Love." Geneva: International Lesbian, Gay, Bisexual, Trans and Intersex Association. Available at: http://old.ilga.org/Statehomophobia/ILGA_SSHR_2014_Eng.pdf.

F6. Sex Workers and Stigma

Handout for Exercises B1, B2, and B4

Borrowed from:

GNP+, ICW, Young Positives, EngenderHealth, IPPF, UNAIDS, UNFPA, WHO. 2007. *Creating a Supportive and Enabling Environment for the Sexual and Reproductive Health of People Living with HIV: Legal and Policy Considerations with Areas for Action.*

Sex work has many dimensions, including (a) all sexes—men, women, and transgender persons; (b) all sexual orientations—heterosexual, homosexual, and bisexual; (c) a wide range of ages; (d) varying legal status and work environments; (e) high mobility; (f) sexual transactions for cash, favors, or goods; (g) dynamic supply and demand patterns influenced by social changes; and (h) overlap between sex work and drug use.

The majority of sex workers have few other income sources, often because their education and marketable skills are limited. Individuals who have low-income jobs may supplement their income with part-time sex work, and many women engaged in transactional sex do not identify as sex workers.

Some sex workers enjoy the work, whereas others hate it. Some work in brothels along with others, some on the streets or as escorts. Sex workers can be women, men, or transgender people.

HIV prevalence among sex workers is higher than in the general population. Sex workers are vulnerable to HIV because they have more sexual partners, may not be in a position to negotiate condom use due to financial pressures, or because of violence or rape. However, even when their clients use condoms, the rate of condom use with their regular sexual partners is lower.

Female sex workers often have limited access to reproductive health and family planning information. HIV programming for sex workers has tended to focus on preventing sex workers from infecting their clients, rather than responding to sex workers' sexual and reproductive health needs.

Sex work can be legal, regulated, or illegal. In countries where sex work is illegal, criminalization drives sex workers underground and away from services, and often leads to distrust of police and health workers. As a result, many sex workers in those countries may not access health services, have no information on HIV/STI prevention, and find it difficult to negotiate with their clients.

Sex workers may see their day-to-day survival, improvement of their rights, reducing violence, and other factors as more urgent than HIV prevention—a disease they may in any case lack the power to prevent. In most countries, sex workers known to be HIV positive are more likely to be dismissed from their workplaces. Upon losing their jobs, they may work underground, pushing them further away from healthcare services.

Some national responses have grasped the role of sex work in the HIV epidemic and have been willing to take a pragmatic approach to engage sex workers in HIV and STI prevention activities. However, in many other countries, government staff find it difficult to work with sex workers, since sex work is a criminal activity that should be reported to the authorities.

F7. Understanding Drug Abuse

Handout for Exercises B7 and B8

Borrowed from:

Institute for Social Development Studies and ICRW. 2010. *Understanding and Challenging Stigma Towards Injecting Drug Users: Toolkit for Action*. Hanoi: Institute for Social Development Studies and International Center for Research on Women.

What is drug abuse?

According to the WHO, drug abuse refers to "the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs." When people who use drugs repeatedly use psychoactive drugs, they may develop what is called a dependence syndrome, in which the drug user develops a cluster of behavioral, cognitive, and physiological symptoms. The drug user tends to have a strong urge to use the drug, encounter difficulty in controlling its use, persist in its use despite harmful consequences, place a higher priority on drug use than other activities and obligations, experience increased tolerance, and sometimes experience a physical withdrawal state.

What is a person who injects drugs?

A person who injects drugs injects a drug into the bloodstream using a needle or syringe. Worldwide, more than 185 million people use illicit drugs, including opiates, cocaine, and amphetamine-type stimulants; an estimated 13.2 million people inject these drugs.

Why do people start taking drugs?

- People start to use drugs for a number of reasons—to experiment, improve their sex drive, forget poverty or other problems, relieve pain or depression, or due to peer pressure.
- People use drugs because they are easily available.
- Young people may start using drugs as an easy way to have fun and escape from problems, often influenced by other young people.
- Older people often start using drugs to get relief from a painful illness.

Which groups of people get involved in drugs—rich or poor people?

- In the past, the main users were rich people who could afford to buy drugs.
- Now many people who use drugs are poor people who have limited education and are unemployed.
- They take drugs to overcome feelings of despair regarding their poverty and unemployment.

What is drug addiction?

- When a person takes drugs on a regular and intensive basis, the mind and body can begin to feel an overpowering need for the drug. When the mind feels this way, it is called dependence. When the body feels this way, it is called physical addiction.
- When a person starts taking drugs, one of the main motivations is to get a pleasurable feeling. These feelings produce strong memories, which are stored in the brain and create a desire to take more drugs to bring back the pleasurable feeling.

- Once a person is addicted, the main reason for taking drugs is to overcome the feelings of withdrawal when the drug wears off. These painful feelings force addicts to take more drugs. At this stage, the main reason for taking the drugs is to deal with these symptoms of withdrawal, i.e. to get back to feeling "normal."
- Symptoms of withdrawal include fast heartbeat, anxiety, increased blood pressure, perspiration, and pains in the body. Addicts often feel very uncomfortable, as if they cannot breathe properly.

What is the difference between a person who uses drugs and a drug addict?

- A person who uses drugs takes drugs but can stop; a DRUG ADDICT takes drugs but cannot stop and cannot live without drugs—s/he depends on drugs and repeatedly increases the dose.
- Many people use drugs without becoming addicted. They take drugs on an experimental or occasional basis. Other people use drugs on a regular basis; over time, some take them more intensively and become hooked, almost without realizing it.
- Some people become addicted after the first time they try a drug; others become addicted only after using it many times.

Why is it difficult for people to quit drugs?

- The feeling of withdrawal forces people who use drugs to take more drugs.
- Peer pressure: People who use drugs force other people who use drugs to continue—they won't allow other people who use drugs to quit.
- Stigma from family or community: Whenever a person who uses drugs quits, the community still looks at him/her as a drug user—they don't change their attitudes toward him/her—so the user thinks "Why not just continue to use drugs?"

Why do people who use drugs use injecting, rather than other ways of using drugs?

- Some people who use drugs prefer to inject because injecting produces a strong and immediate effect.
- Many people who use drugs are poor and want to get more out of the drug they buy; injecting is an effective way of getting the drug into the body, since all of the drug is used. If the drug is inhaled, much of it is lost as smoke.
- Injecting can be done much more quickly than smoking, so users are less exposed to police action. Injecting takes little time, can be done anywhere, and it is easy to dispose of needles and syringes. However, users do need needles and syringes to inject.

Is it true that people addicted to drugs do not have a strong will?

- Saying people who use drugs have a weak will stigmatizes them. It shows a lack of understanding of addiction.
- Addiction is very powerful. When the effects of drugs wear off, the addict feels very uncomfortable, as if he/she cannot breathe properly. This feeling is what is called "withdrawal."
- The symptoms of withdrawal are fast heartbeat, anxiety, increased blood pressure, perspiration, and pains in the body.
- These feelings have such a powerful effect on the body that drug addicts will "do anything" to get the drugs so as to overcome these feelings and get back to "normal."
- So it is wrong to assume that people who use drugs "don't have a strong will" or are "weak people." Drug addiction is beyond the user's will or control—the craving for drugs makes it difficult for them to break the addiction—not because they don't want to, are weak, or don't try, but because of the power of the addiction.

Is it true that people addicted to drugs do not want to quit?

- Yes, some addicts don't want or are not ready to quit drugs, but many do want to quit.
- Also many countries have few services to support drug addicts wanting to stop.

F8. Harm Reduction

Handout for Exercises B7 and B8

Borrowed from:

Institute for Social Development Studies, ICRW, and Pact Vietnam. 2008. *Fact Sheet on Drug Addiction and HIV.* Hanoi: Institute for Social Development Studies, International Center for Research on Women, and Pact Vietnam.

What is harm reduction?

Harm reduction is a public health strategy designed to prevent or reduce negative health consequences associated with certain behaviors.

In relation to HIV and injecting drug use, harm reduction aims at preventing the transmission of HIV and other infections that occur through the sharing of non-sterile injecting equipment and drug preparations. The aim is to reduce the harm or negative effects of drug injecting, such as the spread of HIV and criminal activities to finance drug use.

Harm-reduction programs start from the understanding that drug use is a medical condition and the drug user a person with an illness. Harm reduction takes a morally neutral stance to drug use, neither condoning nor opposing drug use. It focuses on responding to actual and potential harm, and assumes that some people will continue to use injecting drugs despite a government's attempts to prohibit it. It therefore assumes that people who use drugs should be given the option to use injecting drugs in ways that reduce the associated risks and cause the least harm to themselves and others. Harm-reduction strategies meet people who use drugs "where they are at," addressing conditions of use along with the use itself.

Harm-reduction programs include needle/syringe exchange programs, opioid substitution therapy, health education, medical referral, and support services.

Why harm reduction?

Because drug use is a criminal offense in many countries, people who use drugs hide their use of injecting drugs and, as a result, are not careful about their drug taking and end up harming themselves and others, including contracting and transmitting HIV. Harm-reduction strategies, such as methadone substitution and needle/syringe exchange (NSE) programs, encourage safe use of drugs, build the personal responsibility of people who use drugs, and slow or stop HIV transmission. The aim is to reduce the health, social, and economic harm to individual people who use drugs and the community through the following:

- Reducing dangerous drug use, e.g., sharing injection equipment
- Reducing the risk of a drug user contracting or transmitting HIV
- Helping users switch from illegal drugs (e.g., heroin) to legal drugs (e.g., methadone)
- Minimizing the risks of overdoses and medical complications
- Reducing the need by addicts to commit crimes to raise money for drugs
- Helping people who use drugs stabilize their lives and reintegrate with the general community

What harm-reduction programs are used in the HIV field?

Research and experience confirm that HIV epidemics among people who use drugs can be prevented, stabilized, or even reversed by using a comprehensive package of HIV prevention and care activities provided in the context of respecting

human rights. The programs that tend to work best are those that are comprehensive in their approach, not only addressing drug use and addiction, but also assisting people who use drugs in other areas of their lives that may have an effect on their drug use practices.

Needle and Syringe Exchange Programs

NSE programs educate people who use drugs about HIV prevention and provide clean needles and syringes for free in exchange for used ones. Their aim is to ensure that all drug injections are done with clean needles as a way of reducing HIV transmission among people who use drugs.

Studies conducted in Australia, Canada, Sweden, the UK, and the United States all have shown that NSE programs—particularly when carried out in concert with other interventions—help reduce the use of non-sterile injecting equipment and the transmission of HIV and other blood-borne infections. In fact, NSE programs are considered an international "best practice" in HIV prevention. Furthermore, such programs have been shown to serve as points of contact between people who use drugs and service providers, including drug abuse treatment programs. The benefits of such programs increase considerably if they also include AIDS education, counseling, and referral to a variety of treatment options.

Opioid Substitution Therapy

Opioid (opium-based drugs, such as heroin) substitution therapy, using methadone or buprenorphine, is a very effective form of treatment for opioid dependence. It is based on the understanding that addiction is a chronic medical condition. The aim of this therapy is to reduce the health, social, and economic harm to people who use drugs and the community. It has been shown to contribute significantly to the following:

- Reduction in illegal drug use, including injecting drugs
- Reduction in the risk of HIV infection and other blood-borne viruses
- Reduction in crimes associated with drug use
- Deaths due to drug overdose

Why are countries reluctant to implement harm-reduction programs?

Despite the evidence in support of harm-reduction programming, these programs have yet to be launched in some countries. Further, in other countries with such programs, investment in them is still low.

This fact is linked to beliefs that harm-reduction programs result in more drug use and more people who use drugs. There also is a belief that harm-reduction programming condones and encourages drug use. There is no evidence that NSE programs increase the number of people using drugs, the frequency of injecting drug use, or other public health dangers in the communities served—in fact, the findings are quite the opposite. NSE programs encourage safe use of drugs, personal responsibility by people who use drugs, and a resultant slowdown in HIV transmission. Methadone maintenance therapy helps reduce dangerous drug use (e.g., sharing injection equipment), helps people who use drugs switch from illegal to legal drugs, and reduces addicts' need to commit crimes to raise money for drugs. The recent 2013 UNAIDS Global AIDS Report states that, with the exception of Latin America, Asia, and the Pacific, survey data indicated that at least 70 percent of people who inject drugs used sterile equipment at their last injection. Furthermore, as of 2012, 23 of the 40 reporting countries have reached the global target of 80 percent sterile equipment use. These data show that harm-reduction programs do work to make drug use safer.

Guiding principles for harm reduction

Harm reduction meets people who use drugs "where they are at," thus humanizing them, as it treats each drug user as an individual. Usually, drug use is treated alongside other personal challenges the drug user may be having, thus taking a holistic approach to helping people.

The guiding principles that health workers may use when treating people who use drugs include the following:

- Accept that drug use, legal or not, is part of our world and choose to work to minimize its harmful effects, rather than simply ignore or condemn people who use drugs
- Understand that drug use is a complex, multifaceted phenomenon that ranges from severe abuse to total abstinence, and acknowledge that some ways of using drugs are clearly safer than others
- Establish the quality of both individual and community life and well-being as the criteria for successful interventions and policies—not necessarily stopping all drug use
- Call for the nonjudgmental, noncoercive provision of services and resources to people who use drugs and the communities in which they live to assist them in reducing harm
- Ensure that people who use drugs have a real voice in creating programs and policies designed to serve them
- Affirm people who use drugs themselves as the primary agents for reducing the harm of their drug use and empower them to share information and support each other in strategies that meet their actual conditions of use
- Recognize that the realities of poverty, class, racism, social isolation, past trauma, homophobia, sex-based discrimination, and other social inequalities affect people's vulnerability to and capacity for effectively dealing with drug-related harm
- Do not attempt to minimize or ignore the real and tragic harm and danger associated with drug use

What can health workers do to promote harm reduction?

1. Learn about harm reduction as a solution to these problems. The aim is to reduce the negative effects of drug use—e.g., HIV transmission, overdose, criminal activities, etc. Some countries have started to introduce methadone maintenance treatment (MMT) for people addicted to heroin. Look for this program in your country and, if needed, have your loved ones start using MMT or use it yourself if it is available and suitable.
2. Support people who are trying to quit drugs with lots of patience and without forcing them. Give them support and encouragement if they fail and consistently assist them when they want to make another try at quitting drugs. If they can't give up drugs right away, help them with harm-reduction methods, e.g., use of clean needles, stopping the sharing of needles, etc. Create awareness of the risks of sharing equipment and how people who use drugs can inject safely. Increase the availability of clean injection equipment and decrease the availability of used equipment—some programs provide clean needles and syringes on an exchange basis.
3. Give people who use drugs opportunities and something to live for. Help people who use drugs find jobs and take up family responsibilities so they have things other than using drugs to think about.
4. Work with people who use drugs to change the norms and practices of injecting to reduce risks. Provide psychosocial support and care to help tackle why people use drugs.

F9. QQR—Quantity, Quality, and Route of Transmission

Handout for Exercises C1 and D1

What is QQR?

For HIV transmission to take place, the quality of the virus must be strong, a large quantity must be present, and there must be a route of transmission.

Quality

For transmission to take place, the quality of the virus must be strong. HIV does not live on the surface of the skin—it lives inside the body. HIV cannot survive outside the human body—it starts to die as soon as it is exposed to air. If it is exposed to heat (e.g., if someone bleeds into a cooking pot), it will die. The only place the virus can survive outside of the body is in a vacuum (like a syringe), where it is not exposed to air.

Quantity

For transmission to take place, there must a sufficient quantity of the virus in body fluids to pose any risk. HIV is found in large quantities in blood, semen, vaginal fluids, and breast milk—so with these fluids, there is a risk of transmission. HIV is found in small amounts in saliva, vomit, feces, and urine, and not at all in sweat or tears—in all of these cases, there is no risk of transmission unless blood is present. Thus, cleaning or bathing a patient is also quite safe, provided all wounds are covered. It is easiest to transmit HIV when someone tests negative (but is actually positive) because it is during the "window period" that someone has the highest quantity of virus. Once infected, it can take up to three months for someone to test positive for HIV.

Route of Transmission

For HIV transmission to take place, the virus must get inside your bloodstream. Our body is a closed system. Healthy skin is an excellent barrier against HIV. It cannot pass through unbroken skin, or even broken skin, very easily. If you cut yourself, the blood flows outward, away from the bloodstream. If you touch someone else's cut, blood will not *swim* into your bloodstream!

> Common sense and everyday hygiene mean that many concerns people have would not really happen in everyday life. For example, you wouldn't share a toothbrush if it was covered in blood, you would wash if you cut yourself, and you would wear gloves or cover your hands if you were cleaning up someone's diarrhea.

These three conditions—**Quantity, Quality, and Route of Transmission (QQR)**—help to explain why HIV cannot be transmitted by such activities as the following:

- Touching the skin or sweat of a person living with HIV
- Changing the clothes of or serving food to a person living with HIV
- Taking the blood pressure of a person living with HIV
- Shaking hands with someone living with HIV
- Hugging someone with HIV
- Kissing someone with HIV when your mouths are clean and clear of cuts or sores

Other Factors that Increase the Risk of Sexual Transmission

- **Viral load of infected person.** Higher viral load increases the risk of HIV transmission. The highest viral loads occur at the initial stage of HIV infection (before an individual even tests positive for HIV) and the final stages of AIDS.
- **Having multiple partners.** If you have sex with multiple people regularly and do not use condoms with all partners, HIV can pass quickly through your sexual network. Remember, a viral load (quantity) is highest right after infection. If you became infected last week and have unprotected sex with someone else today, you can pass on the virus. This is during the window period, before you would even test positive.
- **Presence of cuts or wounds.** Wounds or cuts on either partner increase the chance of HIV entering the bloodstream.
- **Presence of other STIs.** STIs can cause sores or broken skin, making it easier for infected blood to get through the skin into the bloodstream.
- **Having sex during the menstruation period or when a woman is bleeding.**
- **Not using a water-based or silicone-based lubricant during anal sex.** Lack of lubricant could cause additional tearing to the rectum and even cause the condom to break.

THE HIV TRANSMISSION EQUATION

Human host with HIV—someone has to carry the virus to infect someone else

+

Body fluid that carries large amount of HIV—blood, semen, vaginal fluid, breast milk

+

Opening into the bloodstream—needle holes; mucous membranes such as those of the vagina, rectum, urethral opening of the penis and foreskin, esophagus, eyes; cuts/tears in the vagina, anus, penis, or mouth

+

Activity that can move these fluids between people—unprotected sex (anal, oral, or vaginal), sharing injection needles, breastfeeding, blood transfusion

= **POSSIBILITY OF HIV INFECTION**

F10. HIV Transmission and Men Who Have Sex with Men—Risk Continuum

Handout for Exercise C2

Borrowed from:

ICRW and Pact International. 2010. *Understanding and Challenging Stigma Towards Men Who Have Sex with Men: Toolkit for Action (Cambodia)*. Phnom Penh, Cambodia: International Center for Research on Women and Pact International.

- **Receptive anal intercourse without a condom: HIGHEST RISK.** The rectum has a large surface area, and the skin in the rectum is lined with a mucous membrane, a very sensitive part of the body that tears very easily, especially if the insertive partner is not using lubricant. Once the skin of the rectum gets broken/cut, HIV in the sperm or blood from cuts on the penis of the insertive partner can easily get into the body and bloodstream of the receptive partner, if the former is not using a condom. Adolescent boys, whose skin in the rectum is not fully mature, are more likely to develop cuts during anal sex and are therefore at higher risk of getting HIV.
- **Insertive anal intercourse without a condom: HIGH RISK.** This is also risky for HIV transmission, but not as risky as receptive anal sex. The skin on the penis is stronger than the skin in the anus. It is less prone to cuts, so it is less vulnerable to penetration by HIV. However, HIV contained in blood and rectal fluids can pass through the urethra of the penis or under the foreskin of someone who is uncircumcised.
- **Receptive oral sex: VERY LOW RISK.** Receptive oral sex is more risky than insertive oral sex. The person sucking is more at risk than the person whose penis is being sucked. Why? Sperm gets into the mouth of the person who is sucking and can penetrate the skin around the teeth, which can easily get cut. The skin is strong in most parts of the mouth except around the teeth (the gums), so there is a potential for HIV entering the body through cuts or bleeding in the gums.
- **Insertive oral sex: VERY LOW RISK.** The skin on the penis, especially if circumcised, is strong and less vulnerable to cuts. The person sucking may have cuts in the mouth that produce blood, but saliva in the person's mouth protects the penis, and the acid in the saliva neutralizes the blood from the gums.
- **Thigh sex: NO RISK.** Sperm does not get into the anus or mouth, where it then could get into the body and the bloodstream.
- **Mutual masturbation: NO RISK.** When men masturbate each other, their hands may come into contact with sperm, but the sperm remains outside of the body, where it is exposed to air, and dies. There is no risk if there are no cuts or broken skin on the participants' hands.
- **Kissing: NO RISK.** As long as there are no cuts or sores in the mouth, kissing is completely safe. The saliva of the infected person may get into the mouth, but saliva contains very low quantities of HIV.
- **Anal sex without lubrication: HIGH RISK.** With a condom and water- or silicone-based lubricant, anal sex can be practiced and enjoyed safely.

The risk of a man acquiring HIV during unprotected receptive anal sex is 10 times higher than during unprotected insertive anal sex (with a man or woman) or unprotected vaginal sex with a woman. The high risk of HIV transmission in receptive anal sex is because of the following:

- Anal sex is more traumatic than vaginal sex, sometimes resulting in abrasions and cuts that damage the body's barrier to HIV infection.
- Unlike the vagina, the anus and rectum have no natural lubrication.

- Lack or misuse of inappropriate lubricants (e.g., Vaseline, oil) may worsen trauma or damage condoms. Some MSM do not use condoms for anal sex; when they do, they may not use safe, water-based lubricants.

Sex between men need not always involve penetrative anal sex: oral sex, masturbation, and thigh sex carry a much lower risk of HIV transmission, and men may choose to avoid anal sex to protect themselves or their partners.

Use of condoms and water-based lubricants for anal sex considerably reduces the risk of HIV transmission. Water-based lubricants can be used with male latex condoms, as they do not damage the latex. Most male and female condoms already have water-based lubricant on them. However, adding lubricant is especially important for anal sex, as the lining of the anus does not produce its own natural lubrication and is prone to tearing.

Oil-based lubricants must NOT be used with a male condom, as they damage the latex and may increase the risk of condom breakage. Examples of oil-based lubricants include hand lotion, body lotion, baby oil, vegetable oil, cooking oil, massage oil, and petroleum jelly (e.g., Vaseline).

Untreated STIs greatly increase one's risk of getting HIV. Many STIs cause sores, which make it easier for HIV to enter the body. MSM may not have symptoms of STIs or see the sores because they are inside the anus or mouth.

F11. Drug Use and HIV

Handout for Exercise C3

Borrowed from:

ICRW and Pact International. 2010. *Understanding and Challenging Stigma Towards Men Who Have Sex with Men: Toolkit for Action (Cambodia)*. Phnom Penh, Cambodia: International Center for Research on Women and Pact International.

How is HIV transmitted through the use of injecting drugs?

People who use drugs are more likely than others to get HIV. They can get HIV through sharing injecting equipment or unsafe sex.

People inject drugs for several reasons. Injecting is an effective way of getting drug into the body, since all of the drug is used. If the drug is inhaled, much of it is lost as smoke. In addition, injecting can be done much more quickly than smoking, so users are less likely to be discovered. Injecting takes little time and can be done anywhere, and it is easy to dispose of needle and syringes.

Injecting drugs makes it possible for HIV-infected blood to enter the bloodstream of the uninfected person directly—a condition for HIV transmission. However, infected blood already must be in the needle for HIV to be transmitted. This happens only when people who use drugs SHARE the needles and syringes with other users. It is common for two or three drug user friends to use the same needle and syringe to inject, often without properly cleaning the needle between injections. Small amounts of blood, which may not be visible, can remain in a needle and syringes after they have been used. HIV can survive up to one week in blood left in a syringe or needle. If the equipment is reused, this blood will be injected directly into the bloodstream of the next person who uses the equipment, and s/he then can become infected.

Summary

- Drug use itself does not transmit HIV (e.g., inhaling drugs does not transmit HIV), nor does injecting drugs if the person uses her/his own sterile equipment.
- The problem is the sharing of needles and syringes, especially with many other people. HIV spreads among people who use drugs mainly because they share or reuse needles and syringes that have become contaminated with HIV-infected blood.
- Small amounts of blood, not necessarily visible, can remain in a needle and syringes after they have been used. HIV can survive up to one week in the blood left in a syringe or needle.
- If the injecting equipment is reused, this blood will be injected directly into the bloodstream of the next person who uses the equipment. If the blood is infected with HIV, HIV can be passed on to that person.

How does drug use contribute to the global HIV epidemic?

It is estimated that 13.1 percent of people who inject drugs are living with HIV.

Preliminary analyses of the 2013 global AIDS response progress reporting (GARPR) data estimate that people who inject drugs account for 30 percent of new HIV infections outside of sub-Saharan Africa. The 2013 UNAIDS Report on the Global AIDS Epidemic found that the number of new cases of HIV among people who inject drugs constituted up to 40 percent of new infections in some countries. Although there has been a decline in HIV infections on average globally, HIV prevalence appears to be rising in the Asian and Pacific regions as well as in Eastern Europe and Central Asia. According

to the 2014 UNAIDS Gap Report, national HIV epidemics in these regions are driven by the use of contaminated injecting equipment and further transmission to the sexual partners of people who use drugs.

In Asia and the Pacific, where it is estimated that at least 3.8 million people inject drugs, more than half live in China, although India, Pakistan, and Vietnam also have large numbers of people who inject drugs.

In Africa, Kenya, Mauritius, Nigeria, South Africa, and Tanzania show newly emerging drug use activity. For instance, in Kenya, an estimated 3.8 percent of new HIV infections derived from injecting drug use. Unique to sub-Saharan Africa, which has a general epidemic, drug use is the main driver of HIV in Mauritius.

Asia is estimated to have the largest number of injecting drug-related HIV infections.

Do all people who inject drugs get HIV?

No. People who use drugs who use their own sterile needles will not get HIV. Injecting drug use transmits HIV only when there is sharing of injection equipment.

Are people who use drugs only at risk of contracting HIV through drug use alone?

No; in fact, one study in Vietnam found that 30 percent of people who use drugs have STIs, which shows that people who use drugs have a high risk of getting STIs, including HIV. When people who use drugs first use drugs, many experience an increase in their libido and they are sexually active. As drugs become a routine part of their lives, many male people who use drugs experience prolonged ejaculation, which may lead to more abrasions on their own and their partner's sexual organs, thus creating an entry point for HIV. In addition, because people who use drugs need money to buy drugs, some male and female people who use drugs sell sex. Some clients are willing to pay more to have sex without a condom, so people who use drugs and are desperate for money may end up having unsafe sex and, in some cases, transmitting or acquiring HIV.

How does injecting drug use interact with sex work in relation to HIV?

As a way of keeping their drug use secret, many people who use drugs seek out the company of sex workers, with whom they may feel more comfortable and establish romantic relationships. Although many sex workers use condoms with their clients, they tend not to protect themselves with those they consider their lovers or long-term partners, some of whom are people who use drugs. As mentioned above, the clients of sex workers who also use drugs are at risk of contracting HIV from unprotected sex.

According to the 2010 UNAIDS Global AIDS Report, the interplay between sex work and injecting drug use is accelerating the spread of HIV in Eastern Europe and Central Asia. For example, at least 30 percent of sex workers in the Russian Federation have injected drugs, and the high HIV infection levels found among sex workers in Ukraine (14% to 31% in various studies) are due to the overlap of paid sex with injecting drug use. As the epidemic spreads from (predominantly male) people who inject drugs to their sexual partners, the proportion of women living with HIV is also growing in Eastern Europe. As of 2010, an estimated 35 percent of women living with HIV in Eastern Europe probably acquired HIV through injecting drug use, and an additional 50 percent were probably infected by partners who inject drugs. Furthermore, a 2013 study on the convergence of sex work and drug use in Central Asia demonstrated the severe burden of HIV and risk factors for HIV acquisition and transmission among sex workers who inject drugs.[3]

3. Baral S., C. Todd, B. Aumakhan, J. Lloyd, A. Delegchoimbol, and K. Sabin. 2013. "HIV Among Female Sex Workers in the Central Asian Republics, Afghanistan, and Mongolia: Contexts and Convergence with Drug Use." *Drug and Alcohol Dependence* 132(Supplement 1):S13–S16. doi:10.1016/j.drugalcdep.2013.07.004.

Women and drug use

Often people think people who use drugs are men, but there are an increasing number of female people who use drugs. Studies show that female people who use drugs have a higher risk of getting HIV due to sharing needles and syringes, and unsafe sex. Many female people who use drugs have an injecting drug user boyfriend, and many sell sex to finance their own and their boyfriends' drug habit. Many female sex workers use drugs to forget their problems and the stress in their lives. They may get HIV through unsafe sex with clients or sexual partners (who may be people who use drugs) and through sharing injecting equipment.

Female people who use drugs are more severely stigmatized and discriminated against, and interventions for people who use drugs are usually tailored to the needs of men. There are few intervention programs tailored to the needs of female people who use drugs. Female people who use drugs are more likely to die younger than their male counterparts.

Apart from HIV, what are the other health problems caused by injecting drugs?

Injecting drugs can also lead to drug overdoses, abscesses, septicemia, thrombosis, scarring, circulatory problems, collapsed veins, poor healing of wounds, and other blood-borne infections, such as hepatitis B and C.

How can an injecting drug user prevent getting HIV?

People who use drugs can prevent getting HIV by not sharing injecting equipment and using sterile injecting equipment. Where available, people who use drugs can access harm-reduction programs, including needle and syringe exchange programs, drug substitution therapy programs, and detox clinics.

What can be done to prevent the sharing of injection equipment?

- Make people who use drugs aware of the risks of sharing equipment and how they can inject safely
- Increase the availability of clean injection equipment and decrease the availability of used equipment—some programs provide clean needles and syringes on an exchange basis
- Work with people who use drugs to change the norms and practices of injecting
- Promote drug substitution, e.g., methadone maintenance

F12. Introduction to Standard Precautions

Handout for Exercise D1

Borrowed from:

EngenderHealth. 2004. *Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers. Participant's Handbook*. New York: EngenderHealth.

Institute for Social Development Studies and ICRW. 2008. *Safe & Friendly Health Facility: Trainer's Guide (Vietnam)*. Hanoi: Institute for Social Development Studies and International Center for Research on Women.

Health workers can get HIV through injuries on the job

Healthcare workers can get HIV accidentally through injuries sustained on the job. Two main types of injury can lead to HIV transmission:

- Needle-stick injuries—skin pierced by a contaminated needle or sharp instrument
- Splashes on the nose, eyes, or mouth by blood or body fluids from infected clients

The risk of HIV infection from these forms of occupational exposure is very low:

- The risk from a needle-stick or sharp instrument injury is around 0.3 percent
- The risk from splashing blood or body fluids on nose, mouth, and eyes is about 0.1 percent

Nonetheless, staff need to avoid these forms of exposure.

Support staff who clean up and dispose of contaminated instruments are also at risk of getting HIV through their handling of these instruments.

Clients can get HIV when health workers use the wrong practices

Clients themselves are also at risk of HIV infection when health workers use instruments that are not cleaned or sterilized properly. For example, health workers may reuse contaminated needles that have been rinsed in water between injections, or change the needle but not the syringe for use with many clients.

The community can also get HIV through improper disposal of medical waste

The community is also at risk of HIV infection from improper disposal of medical waste, including contaminated dressings, tissues, needles, syringes, and scalpel blades. These items can be found by children or others scavenging in open dumps.

What are Universal Precautions?

Universal Precautions refers to practices performed to protect health workers from exposure to blood-borne microorganisms. "Universal" means that these precautions should be applied universally—with all clients, irrespective of whether health workers know their health status or not.

What are Standard Precautions?

"Standard Precautions" has replaced the term "Universal Precautions." It is a broader term that includes not only safety for health workers but also for clients and visitors. It is also a broader term covering safety from exposure not only to blood and bodily fluids, but also other healthcare-associated infections.

Standard Precautions is a system for infection control used to make health facilities safe for health workers and clients. It involves the use of precautions designed to help minimize the risk of HIV exposure by health workers and clients.

The first principle of Standard Precautions is that health workers apply them to ALL clients, regardless of whether or not they think the client may be HIV positive or have any other infectious disease. It is important to emphasize, however, that Standard Precautions deal with all healthcare-associated infections, not just HIV.

It is safer to act as if every client is infected, rather than to apply Standard Precautions to some clients and not to others. This is important, because it is impossible to tell who is infected with viruses such as HIV and hepatitis based on appearance. Most blood-borne diseases that pose a risk to health workers and clients cannot easily be detected and could be present in the blood of ALL persons, including health workers themselves. Diseases do not discriminate, so healthcare workers should not discriminate.

The second principle is that Standard Precautions are designed to PROTECT BOTH HEALTH WORKERS AND CLIENTS from infection.

Standard Precautions in healthcare settings

Standard Precautions are simple infection-control measures designed to help minimize the risk of exposure to blood and other bodily fluids by health staff and clients. Use the following precautions to avoid injury and reduce the risk of infection:

Hand washing

- Wash your hands with soap and water after coming into contact with blood, body fluids, and contaminated items, whether you have worn gloves or not.
- Wash your hands immediately after removing gloves and between client contacts to avoid transferring microorganisms among the clients.

Gloves

- Wear gloves when coming into contact with blood, body fluids, and contaminated items.
- Put on clean gloves before touching eyes, nose, mouth, or non-intact skin.
- Put on a new pair of clean gloves between tasks or procedures for the same client after contact with blood or body fluids.
- Rinse gloved hands in a 0.5 percent chlorine solution before removing them.
- Remove gloves immediately before touching noncontaminated items and surfaces.
- If gloves are not disposable, wash and disinfect them after use with each client.

Note: Health staff with open cuts or rashes should avoid direct client contact and not handle contaminated equipment because breaks in the skin provide points for microorganisms to enter the bloodstream and cause infection.

Eye Protection

Wear eye protection, a face shield, and mask to protect mucous membranes of the eyes, nose, and mouth during procedures (e.g., during delivery, cutting of the umbilical cord) and client care activities that might produce splashes or sprays of blood or body fluids.

Protective Clothing

- Wear clean, non-sterile gowns to protect skin and prevent clothes from getting soiled during activities that might produce splashes or sprays of blood or body fluids.
- If possible, use a plastic or rubber barrier (e.g., apron) to protect clothing if large amounts of soiling are anticipated, as during delivery.
- Remove a soiled gown immediately, placing it in a designated container for decontamination, and wash hands.

Instrument Processing

- Decontaminate, clean, disinfect, and/or sterilize the instruments, using standard infection-prevention procedures.
- Make sure instruments are not used on another client before this processing has been done.

Handling Sharps

- Don't recap needles after use. This is the most common cause of needle-stick injury.
- Don't bend, break, or cut needles after use.
- Don't remove a needle from a syringe before disposal.
- Dispose of used needles in a puncture-proof container immediately after use.

If injured by a contaminated needle or sharp instrument, wash the injured area immediately with soap and water, and then apply PEP.

Maintaining a Clean Environment and Waste Disposal

- Make sure that liquid waste is placed in a container with enough disinfecting solution to kill organisms.
- Make sure that all contaminated waste (bloody dressings, swabs, tissues, gauze, cloths soiled with body fluids, etc.) is placed in designated and clearly marked containers, collected, and taken for incineration or other safe disposal.
- Immediately clean up surface spills of blood and body fluids with a disinfectant solution, such as a 0.5% chlorine solution, and clean the area with detergent and water.

Handling and Processing Soiled Linen

- When handling linen soiled by blood or body fluids, wear gloves and place items in designated and clearly marked bags. If using a plastic bag, use double bags.
- Transport the soiled linen in a way that avoids puncturing the bag or any loss of soiled items on the way to the laundry.
- Wash soiled linen using detergent and germicide, following standard infection-prevention guidelines.

Summary

- Regard all blood, body fluids, and blood- and body fluid-soiled objects as contaminated and infected.
- Follow the same procedures of cleanliness, sterility, hygiene, and precautions that you have followed for other viruses, e.g., hepatitis B.
- Avoid accidental exposure to areas of broken or cut skin, scratches, rashes, acne, chapped skin, or fungal infections.
- Avoid accidental splashes of blood or body fluids, especially on the eyes or mouth. Report needle-stick injuries or accidental splashes to clinic authorities.
- Dispose of all contaminated materials in an appropriate way.

- Use gloves, masks, and protective eye shields when coming into contact with the blood or body fluids of the clients.
- Wash hands thoroughly with soap (a) after coming into contact with blood and body fluids, (b) before and after each procedure, and (c) after removal of gloves.

Remember

1. Assume that blood and body fluids from all persons are infected with HIV, regardless of the known or supposed status of the person.
2. The aim of Standard Precautions is to isolate the virus and body fluids, not the client.

F13. Fears of Getting HIV in Health Facilities & How to Overcome Fear Through Standard Precautions

Handout for Exercises C1 and D1

Borrowed from:

EngenderHealth. 2004. *Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers. Participant's Handbook*. New York: EngenderHealth.

Institute for Social Development Studies and ICRW. 2008. *Safe & Friendly Health Facility: Trainer's Guide (Vietnam)*. Hanoi: Institute for Social Development Studies and International Center for Research on Women.

What are possible causes of infections in health facilities?

- Poor environmental hygiene
- Poor handling of blood and bodily fluids
- Poor handling of contaminated needles, sharps, and waste
- Poor processing of instruments
- Poor hand-washing practices

What are other possible causes of infections in health facilities?

- Infections transmitted by coughing (e.g., TB, measles, chickenpox)
- Infections transmitted by a worker's hands (e.g., Clostridium difficile, Staphylococcus aureus)

Who is at risk of getting HIV and how could they get it in health facilities?

- Everyone who enters the health facility—health workers, clients, and visitors
- Nurses and doctors—during surgery and when giving injections
- Lab technicians—when drawing blood
- Cleaners—when cleaning and disposing of medical waste, including sharps
- Clients—through contact with health workers involving blood or bodily fluids

What are other modes of HIV transmission outside of health facilities?

- Unprotected sexual contact—through unprotected vaginal or anal intercourse
- Mother-to-child transmission—during pregnancy, delivery, or breastfeeding
- Intravenous drug use—through contaminated syringes
- Tattooing

What unnecessary safety practices are often used by health workers?

- Using gloves to serve food to a client, take a client's temperature, or do a physical examination when a client has no open sores or injuries
- Wearing masks to talk to a client with HIV, even when the client does not have an airborne disease such as TB

- Staying at a distance when attending to an HIV-positive client
- Focusing medical attention on those not suspected of being HIV positive

All of these practices may be perceived by clients as stigmatizing.

Why are these practices used?

- To make health workers feel safer.
- Some health workers fear getting HIV through contact with HIV-positive clients. They have incomplete knowledge about how HIV is transmitted.
- Some health workers are judgmental toward PLHIV, especially if the clients are sex workers, MSM, transgender persons, people who use drugs, prisoners, or migrants.

How can we ensure protection from infection and avoid stigma?

- Train all health workers (including cleaners and guards) on Standard Precautions so they know how to protect themselves and their clients from infection.
- Explain to clients about Standard Precautions so they know why certain precautionary practices are needed; this will make them feel less stigmatized.

How do our practices as health workers lead to stigma?

- Some health workers insist that it is their right to be told who is HIV positive so they can protect themselves against HIV. They claim that not knowing who has HIV puts them at risk. They identify who has HIV by isolating HIV-positive clients in separate rooms, marking HIV-positive clients' files, or simply telling other health workers. Or they use double gloves when they are working with clients they assume to be HIV positive. These practices are wrong—they stigmatize HIV-positive clients and create a climate of fear around them, and they do not decrease the risk of HIV transmission in a health facility.
- There is no medical justification for the above practices—they do not protect the health worker because HIV is not contagious—it is not spread through casual contact. Trying to put clients into two groups—those who are HIV positive and those who are HIV-negative—can be counterproductive. Health workers may be more cautious with HIV-positive clients and less cautious with HIV-negative clients, even though some of the negative clients may be in the window period, when people are at their most infectious, or may have other blood-borne infections, such as hepatitis.

How can Standard Precautions provide protection and help to overcome fear?

- Standard Precautions provide a better, non-stigmatizing method for protecting health workers and their clients. They are based on the assumption that all blood and bodily fluids are potentially infectious, whether they are from a client or health worker, regardless of their known HIV status, and should be applied to all clients. Standard Precautions give health workers more control over ensuring their own safety within the health setting while also ensuring the safety of their clients.
- We often assume that we as health workers are the ones who are in danger of being infected but, in some cases, we may be the ones who are passing the infection. Standard Precautions protect both health workers and clients—and health workers should realize that they can potentially pass on infection to clients.
- Everyone in a health facility is at potential risk of contracting HIV—nurses, doctors, nonclinical health workers, clients, and visitors are all at risk in different ways. For example, medical staff are at risk during clinical procedures, whereas members of the cleaning staff are at risk of infection when cleaning instruments or disposing of waste.

- Knowing how HIV is actually transmitted is an important first step in preventing HIV infection in a health facility. It is equally important to learn how HIV is NOT transmitted, so that health workers know how to properly protect both themselves and others.
- Practicing correct precautionary measures and explaining why these measures are taken are two good ways to ensure that people in a health facility are adequately protected and clients feel less stigmatized by any necessary precautions.
- Infection in a health facility may occur through contact with blood or other body fluids, which may occur through broken skin, injuries with contaminated needles and/or sharp instruments, transfusion of infected blood or blood products, splashing of contaminated body fluid onto the mucous membranes, or the use of contaminated razors.
- There is no evidence of transmission through other modes. Transmission does not occur through the following:
  - Casual social contact, such as talking, hugging, or sitting next to someone with HIV
  - Working together with someone who has HIV
  - Feeding clients or taking their temperature with a thermometer

F14. When to Use Different Protective Apparel

Handout for Exercise D2

Borrowed from:

EngenderHealth. 2004. *Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers. Participant's Handbook.* New York: EngenderHealth.

Institute for Social Development Studies and ICRW. 2008. *Safe & Friendly Health Facility: Trainer's Guide (Vietnam).* Hanoi: Institute for Social Development Studies and International Center for Research on Women.

WHO. 2009. *Glove Use Information Leaflet.* http://icnjp.net/reading/glove-use-information-leaflet-world-health-organization-p0eb.html#

Introduction to the use of Protective Apparel

- Protective apparel is worn to protect both health workers and clients to prevent exposure to blood or bodily fluids. It should be used with all clients, not only when the client is known or suspected to have HIV.
- Protective apparel should be used only when there is a realistic chance of splash or contact of the body, skin, or mucous membranes from the following:
  - Blood or body fluids
  - Blood- or body fluid-contaminated items and surfaces
  - Broken skin and mucous membranes
- Protective apparel should protect only the area of the body likely to be contaminated or spattered.
- Although health workers need to protect themselves and others by wearing protective apparel, the feelings of clients should be considered. When necessary, the health worker should explain to a client why certain apparel is being worn, emphasizing mutual safety.
- Gloves should be discarded after use with each client. Wearing one pair of gloves to provide care for many clients increases their risk of infection.
- Protective apparel should be strategically placed throughout client care, cleaning, and waste management areas for rapid and emergency access. It should be available on trolleys for procedures or at the bedside if contamination is anticipated.

When to use gloves?

- When you are likely to touch blood or body fluids and mucous membranes.
- When performing procedures that could cause bleeding or discharge of body fluids, feces, vomit, wound drainage, joint or cerebrospinal fluid, sputum, breast milk, or any bodily fluid containing blood.
- Intact skin is the best protection. Clean intact hands are safer than dirty or torn gloves.
- Broken skin offers the entrance for pathogens to enter the body.

Examples of appropriate times to wear gloves

- Blood taking. Inserting IVs. Entering bloody wounds. Removing drains or IVs.
- Inserting indwelling devices, catheters. Handling unclean specimen containers.
- Cleaning up blood spills. Caring for bleeding clients.

When should gloves be discarded?

- Remove gloves after each procedure or after providing care for each client.
- Use a separate pair of gloves for each client; wash hands right after caring for one client and before caring for another.
- Change gloves between performing contaminated and clean activities for the same client.
- Change gloves when they are torn, pierced, or punctured by a needle.
- Remove gloves when writing in a client's records, attending to phones or office duties, or leaving the client area.

What are the benefits of gloves?

- Protects Patients: reduce risk of germ dissemination to the environment, as well as from one patient to another.
- Protect health workers: prevent blood and bodily fluids from clients splashing on health workers during procedures.

Mask and Face Protection

Masks should be worn routinely ONLY in the following situations:

- By providers, when the mouth, nose, or face may be splashed with blood and body fluids
- By clients, when a client has a constant moist cough and there is a chance of secretion or droplet contamination
- When respiratory/droplet/airborne precautions are in place

When should masks be changed?

- Masks should be provided and used as a disinfected/sterile medical device.
- Cloth masks, if reused, should be washed every day.
- Whenever isolating precautions are in place, masks should be disposed as infectious medical waste.
- Masks are not needed when performing common procedures, such as intra-muscular injection; taking temperatures, pulses, or blood pressure; or with services involving no risk of a splash or infections transmitted through the respiratory tract.

When should goggles be used?

- Goggles protect the eyes of health workers from blood, bodily fluids, or small particles from clients.
- Use goggles during procedures when a splash is anticipated, such as delivery assistance, abortion, intubation, aspiration, tooth extraction, etc.
- Health workers who have eye infection should not share goggles.
- After using goggles, soak them in a decontamination solution, then clean with water and detergent.

When should other apparel be used?

- Eye covers and face shields protect the health worker's eyes, nose, and mouth from splashes of blood or other fluids.
- Gowns prevent microorganisms from the health workers' arms, torso, and clothing from entering the client; they also protect the health workers' skin and clothes from splashes of blood and other fluids.
- Caps help to minimize the risk of microorganisms from the hair and skin on the provider's head entering the client.
- Footwear minimizes the number of microorganisms brought into the surgical area and protects health workers' feet from injury and splashes of blood and other fluids.

F15. Use and Disposal of Sharps

Handout for Exercise D3

Borrowed from:

EngenderHealth. 2004. *Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers. Participant's Handbook.* New York: EngenderHealth.

Institute for Social Development Studies and ICRW. 2008. *Safe & Friendly Health Facility: Trainer's Guide (Vietnam).* Hanoi: Institute for Social Development Studies and International Center for Research on Women.

Introduction to the use of sharps

Every year, 3 million health workers experience occupational exposure involving sharps, which cause infections with HIV, hepatitis B, hepatitis C, and other blood-borne microorganisms. This is the most common occupational exposure among health workers. Nevertheless, most of these injuries could have been avoided if health workers followed procedures on how to handle sharps.

What are sharps?

Sharps are any sharp instrument used in providing healthcare services, including hypodermic needles, suture needles, scalpel blades, sharp instruments, IV catheters, and razor blades.

What activities often lead to accidents related to sharps?

- Recapping needles with two hands
- Passing sharps by hand to other health workers
- Leaving sharps around, resulting in someone who is cleaning up getting pierced
- Giving injections or performing procedures on clients who are unstable, or children
- Leaving sharps among linens
- Not concentrating, chatting, or paying attention to something else
- Handling or disposing of waste that contains sharps, e.g., disposing of sharps in plastic bags or a plastic box but not covering them with a safe lid and a note on the outside
- Working in a small, confined space, such as during gynecological procedures

How to handle sharps in a safe way?

- Be extremely careful—concentrate and keep your eyes on the task at hand.
- Always warn the client before giving an injection.
- Always use a new needle and syringe for every injection.
- Don't recap needles. If a needle needs to be recapped, use the "one-hand" technique.
- Don't bend, break, or cut needles before disposal.
- Don't routinely remove a needle from the syringe before disposal. If a needle must be removed, use long forceps.
- Never leave sharps among linens or on trays where they can be lost—and later cause injury.

- Never attempt to catch a falling sharp; let it drop.
- Don't pass sharps by hand. Only pass one sharp at a time in a puncture-proof tray.
- Don't walk with a needle in your hand. If you carry needles, carry them in a tray.
- Keep your hand behind the needle and don't bring your hand toward the needle.
- Don't attempt to guide needles in or out of the injection site with your fingers.
- Minimize the hands used at the site of the operation. If a hand is not needed at the site, move it away.
- Don't apply an adhesive bandage to an injection site until the needle is removed and away from the area.
- If the client is a child or an uncontrollable person, get the help of a colleague to stabilize that person. Otherwise, always ensure that your client knows it is important to keep still.
- Dispose of used needles in a puncture-proof container immediately after use.
- Ensure that your work area is uncluttered and you are not giving needles over or through obstacles.
- Don't use invasive procedures requiring sharps without a proven clinical reason. For example, if oral medicine is good enough, don't prescribe an injection.

Practical steps to dispose of sharps

- Dispose of sharps in a small cardboard box, empty plastic jug, or metal container.
- Store in a puncture-proof container immediately after use at the site of the injection.
- Change the container when it is three-quarters full and don't overfill.
- Dispose of one sharp at a time.
- Put sharps disposal containers at convenient places where sharp objects are frequently used.

F16. Facility Hygiene and Waste Management

Handout for Exercise D4

Borrowed from:

EngenderHealth. 2004. *Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers. Participant's Handbook.* New York: EngenderHealth.

Institute for Social Development Studies and ICRW. 2008. *Safe & Friendly Health Facility: Trainer's Guide (Vietnam).* Hanoi: Institute for Social Development Studies and International Center for Research on Women.

Who is at risk from contaminated waste?

- Contaminated waste, when not disposed of correctly, poses a risk of infection to health workers, clients, and the community.
- Anyone who handles medical waste—from the time it is thrown out by a service provider until it reaches the site of final disposal—is at risk of infection or injury.
- Proper handling of medical waste minimizes the spread of infections and reduces the risk of accidental injury to staff, clients, and the community.
- Many health workers often do not know what happens to the waste generated from their facilities, nor do they know who handles it after it is put in the trash container.

What are examples of dangerous waste?

- Needles and sharps
- Blood and bodily fluids
- Cotton used for clients

What are the risks involved in mixing waste?

Someone handling regular waste could get a needle injury. For example, if a cleaner sees a blue bag and assumes that it is regular waste and touches it, he may be injured by a needle inside.

Principles for cleaning

- Cleaning removes all foreign material (dirt, body fluids, and lubricants) from objects by washing or scrubbing the object using water and detergents or soap. Detergents and hot water are generally adequate for the routine cleaning of floors, beds, toilets, walls, and rubber draw sheets.
- Cleaning is intended to remove the dirt and contaminated material on the surface, rather than redistributing the dirt.
- Emphasize: These are steps to clean surfaces with blood or bodily fluids of any client, regardless of their HIV status.

Methods for cleaning

- Each department should have a room/closet for cleaning equipment and adequate equipment (e.g., mops) for cleaning.
- Cleaners should wear protective apparel.
- The number of moppings and wipings are more important than the volume of cleaning products used.
- Tidy up the place and collect trash before sweeping the floor.

- Only use a broom in exterior areas, not inside wards or rooms. Ensure that cleaning is used to remove dirt and not redistribute dirt.
- To reduce the spread of dust and microorganisms, use a damp or wet mop or cloth for walls, floors, and surfaces instead of dry dusting or sweeping.
- Use a separate, clean mop for each area of the health facility.
- Mopping should be done (a) from the cleanest to the most contaminated place, (b) from up to down, (c) from inside to outside.
- Do not clean while other people are working.
- Mops and wipes must be washed clean after being used (wash and then hang them in the sun to dry or send them to the laundry).

How to clean blood and bodily fluids on surfaces?

- Wear gloves and personal protective apparel.
- Use absorbent paper or disposable cloth to absorb fluids and then gather and put them into bags designated for contaminated waste.
- Pour decontamination solution (0.5% chlorine) onto contaminated surface and leave for 10 minutes.
- Clean using a mop/wipe with detergent or decontamination solution.
- Change the mop/wipe and clean with water.
- Clean the cleaning equipment.
- Wash hands thoroughly right after removing gloves.

F17. PEP Management Procedures

Handout for Exercise D5

Borrowed from:

EngenderHealth. 2004. *Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers. Participant's Handbook.* New York: EngenderHealth.

Institute for Social Development Studies and ICRW. 2008. *Safe & Friendly Health Facility: Trainer's Guide (Vietnam).* Hanoi: Institute for Social Development Studies and International Center for Research on Women.

Post-Exposure care and prophylaxis for injured health workers

The risk of becoming infected with HIV following a needle stick or sharp instrument injury is around 0.3 percent (that is, 1 in 300) on average; most injuries do not result in infection. The risk of becoming infected with HIV after mucous membrane or non-intact skin has been exposed is 0.1 percent (1 in 1,000), depending on the amount of infected material, length of time of exposure, and the amount of HIV in the material. Following an injury with a contaminated needle or a sharp instrument, or a mucous membrane exposure, immediate action should be taken to reduce the risk of infection.

The WHO, UNAIDS, and the U.S. Centers for Disease Control and Prevention recommend PEP for health workers exposed to blood and other body fluids—where ARV drugs are available—if it is determined that the risk of infection is significant. Treatment is not recommended after every occupational exposure because most exposures do not result in infection and the side effects of the treatment may be serious. Taking zidovudine (ZDV, or AZT) alone can lower the risk of acquiring infection by about 80 percent; with triple therapy, the risk is reduced further. However, health workers have become HIV positive following occupational exposure even though they received PEP.

Immediately following exposure

- If a mucous membrane has been injured or splashed, flush with a large amount of water. If there has been a splash to the eyes, irrigate with clean water, saline, or sterile irrigating solution. If there is no water, an antiseptic solution can be used to flush the area, although antiseptic solutions have not been proven to be any more effective than soap and water.
- Flush the injured area with running water and wash with soap and water. Where there is bleeding, allow the site to bleed briefly. There is no scientific evidence that squeezing the wound decreases the risk of transmitting blood-borne organisms.
- Assess the injured health worker's risk for infection following exposure.
- If feasible, determine the HIV status of the source client, following appropriate counseling and informed consent (see below). This is particularly important in settings with limited resources, where ARV drugs may not be readily available. Determining that the source client is HIV negative will eliminate the need for drug therapy, its attendant side effects, costs, and the emotional stress of not knowing the risk following exposure or whether the drug therapy will work.
- Risk of infection following occupational exposure is increased when the following are true:
  - The source client has very advanced AIDS
  - The needle or instrument is visibly contaminated with blood
  - The needle was used directly in an artery or vein before the injury occurred
  - The injury is deep

If, following counseling, the injured worker decides to undergo PEP

- Blood should be drawn for HIV antibody testing as soon as possible.
- Drug treatment should be started as soon as possible after the injury, i.e., within one to two hours, or at most within 24 hours of the injury, and continued for four weeks from the day of exposure.
- Possible side effects associated with the drugs should be reviewed.
- Information should be given about behaviors to prevent transmission of HIV, such as not donating blood and practicing safer sex.
- Counseling should be provided, including discussing with the injured healthcare worker her/his emotional response, fears, and/or concerns regarding the reaction of his/her partner or spouse.
- **Note:** In settings where breast milk substitutes are affordable, accessible, and can be safely used, nursing women may be advised to avoid breastfeeding during the PEP period.

Follow-up care for those undergoing PEP should include the following:

- Periodic HIV testing for up to six months after exposure (e.g., at six weeks, 12 weeks, six months)
- Routine monitoring for toxicity with complete blood count, kidney, and liver-function tests
- Ongoing counseling and support as needed—often the emotional toll following occupational exposure is substantial

Testing the source client and related issues

When the HIV status of the source client is not known, this person must be informed about the accident to obtain consent to test for HIV. Confidentiality of the results is important to the quality of care and must be maintained. The source client has the right to refuse testing.

If the person refuses or consent is not possible (e.g., the client is unconscious), prophylaxis should be considered if there are indications of possible infection—depending on the prevalence of infection among the clients in the institution or suspicion of a risk factor in the source client. When the HIV status is unknown, we must assume that the client is infected if the exposure occurs in a country with a high prevalence of HIV.

PEP guidelines for facilities

- Have in place or create a mechanism for reporting workplace injuries to facility authorities, noting the type of exposure and the actions taken. If completion of accident forms is required, complete and submit them to the appropriate authorities. Accident forms should include information about how the incident occurred, who witnessed the incident, and the name of the client, if known.
- For accidental exposure to blood and other body fluids, provide written guidelines for healthcare supervisors and staff regarding recommended immediate care, HIV risk assessment, voluntary counseling, HIV testing, prophylaxis, and follow-up. Periodically review policies for consistency with international standards.
- Provide in-service training of all healthcare staff on prevention and management of occupational exposure to blood and other body fluids.
- Establish a system to manage post-exposure care at all hours, with access to counseling and available ARV drugs.

F18. Examples of Codes of Conduct

Contents

A: EXAMPLE CODE OF CONDUCT FROM ST. KITTS & NEVIS (2014)

A. We the staff of ..... pledge to

- Provide service that is fair, equitable, and respectful, regardless of clients' race, religion, age, education, economic status, political affiliation, national origin, gender, health status, or sexual orientation
- Provide the best possible care we are able
- Keep all patient information private and confidential
- Provide appropriate and timely information on patient care and treatment
- Communicate effectively and respectfully to provide the necessary support to you and your persons of concern
- Ask for consent before services and treatment are administered
- Provide you with the most professional health service

B. We ask you to

- Offer your understanding and cooperation
- Respect our staff and other patients
- Respect the privacy and confidentiality of other patients
- Ask questions and be engaged in your care or treatment
- Adhere to the rules and policies of this facility

For Compliments & Concerns

St. Kitts

Private Medical Doctors: Chief Medical Officer
869–467–1270/1173/1172

Hospital Administration and Operations: Health Operations Manager
869–465–2551 Ext 104

Hospital Medical Staff: Medical Chief of Staff
869–465–2551 Ext 110

Hospital Nursing: Director of Institutional Nursing
869–465–2551 Ext 107

Community Nursing: Director of Community Nursing, Health
869–467– 1273

Community Health: Director of Community-based Health Services
869–467–1134

Nevis

Doctors in Hospital: Medical Chief of Staff
869–469–5473

Private Doctors: Medical Officer of Health
869–469–7080

Community Health Nursing: Supervisor of Community Health Nursing
869–469–5521 Ext 2051

Community Health Doctors: Medical Officer of Health
869–469–7080

Hospital Nurses: Matron
869–469–5473

Hospital Support Staff: Hospital Administrator
869–469–5473

Public Health Support Staff: Health Services Administrator
869–469–5521 Ext 2112

*Note: This code of conduct was developed by stakeholders from St. Kitts & Nevis during a participatory workshop in December 2013.

B: EXAMPLE OF CODE OF PRACTICE DEVELOPED FOR A HOSPITAL IN VIETNAM (2008)

1. **Reception, healthcare, and treatment of HIV-infected clients**
    1. The hospital shall ensure equality in the reception, healthcare, and treatment of HIV-infected clients as well as the quality of the services provided for them.
    2. HIV-infected clients shall not be arranged to stay in a separate ward or department.
    3. The hospital shall guarantee to provide the contact address of and introduce HIV-infected clients to organizations and institutions that offer material and spiritual assistance and services to HIV-positive people in their locality.
    4. The hospital shall set up a counseling unit and a hot line that operate regularly to deal in a timely manner with clients' inquiries and complaints.
    5. The Administration Room shall be responsible for monitoring the implementation of these regulations.
2. **Consultation and HIV tests**
    1. All cases shall be tested for HIV based on the client's willingness (according to the client's request or doctor's assignment and the client's permission). Compulsory cases subject to diagnosis and treatment shall be under Ministry of Health regulations.
    2. Those clients that have had HIV tests with positive results certified by a functional institution shall not need to be tested again.
    3. All cases subject to HIV tests shall be counseled before being tested by a professionally trained consultant.
    4. HIV test results shall be given to clients through after-test counseling by a professional trained consultant.
    5. The Administration Room shall be responsible for monitoring the implementation of these regulations.
3. **Confidentiality of HIV test results**
    1. The attending physician shall be informed of a client's HIV-positive result directly by relevant staff from the testing department. The attending physician shall inform the client's consultant and other health workers who are directly involved in taking care of and treating the client.
    2. The consultant shall inform the client of his/her test result through after-test counseling and encourage the client to ask his/her partner to see the consultant regarding the client's positive result.
    3. The head of the department and attending physician shall be responsible for managing clients' case records and keeping all clients' HIV test results confidential.
    4. Hospital staff shall not give HIV-positive results to anyone else.
    5. An HIV-infected client's wards, beds, medical records, clothes, and other belongings shall not have any mark so that his/her infection is unable to be recognized.
    6. The Administration Room shall be responsible for monitoring the implementation of these regulations.
4. **Infection prevention and control**
    1. All hospital staff shall always take universal prevention measures.
    2. Hospital staff shall wash their hands in the following situations:
        a. Before
            i. Putting on gloves
            ii. Having contact with each client

iii. Preparing medical instruments and medication
iv. Processing and distributing food

b. After
i. Being exposed to a client's blood, fluid, or waste
ii. Having direct contact with clients
iii. Leaving contaminated areas for clean areas
iv. Having contact with items close to clients
v. Taking off gloves

3. Hospital staff shall wear clean gloves in the following situations:
   a. Being exposed to a client's blood, fluid, and waste
   b. Having contact with contaminated tools
   c. Having their skin grazed
4. Hospital staff shall wear sterilized gloves in the following situations:
   a. During a surgical operation
   b. During incision care of a client
5. Needles and pointed and sharp instruments shall be disposed of according to the regulations.
6. All used needles shall be disposed of.
7. In case of occupational exposure to HIV, hospital staff shall inform the anti-infection department for timely handling of the situation.
8. All hospital staff shall be vaccinated against super-bacterial hepatitis.
9. The hospital shall supply sufficient equipment and facilities for the practice of universal prevention, including the following:
   a. Running water taps or solution for quick hand sterilization to wash hands in all the situations prescribed in this convention.
   b. Clean and sterilized gloves to be used in all the situations prescribed in this convention.
   c. Safety goggles for healthcare workers carrying out operations in surgical and obstetric departments.
   d. Sterilizing chemicals packaged in the size convenient for use.
   e. Tools for cleaning and collecting cloth items. The anti-infection, care assistance, and pharmacy departments shall be responsible for monitoring the implementation of these regulations.

5. Training on HIV

1. A group of nurses, doctors, and care assistants shall be responsible for learning and updating knowledge of anti-infection and HIV, and disseminating that knowledge in a timely manner to other hospital staff.
2. All hospital staff shall be trained on basic knowledge of HIV and universal prevention.
3. Administration room—The anti-infection and care assistance departments shall be responsible for organizing training courses.

6. Popularizing HIV-related regulations and policies

1. Legal and professional regulations shall be popularized in a timely manner to all appropriate individuals in the hospital through regular meetings and written documents sent to their departments.
2. Patient-related written regulations shall be popularized weekly in the client meetings in wards and made public in health check rooms, waiting areas, and treatment rooms.
3. The Administration Room shall be responsible for monitoring the implementation of these regulations.

C: CODE OF CONDUCT FOR HEALTH WORKERS WORKING WITH SEXUAL MINORITIES

Every individual has the need and desire for proper medical care for a variety of reasons throughout their lives. Lesbian, gay, bisexual, transgender, and intersex (LGBTI) people are no different and deserve the same healthcare as anyone else.

For example, under the current code of conduct for health workers in Botswana, every client has the right to confidentiality about their medical issues and anything they share with a medical practitioner unless they are causing harm to another human being or someone is causing harm to them, privacy during any medical exams or tests, and equal treatment without judgment for their behavior or identity.

Too often, LGBTI people are judged or harassed—even to the extreme of denying them basic medical care. Therefore, we encourage the use of the following affirmations in your health practice, health facility, or hospital to ensure equal treatment of all clients and clients:

- I/we will give everyone the same type of medical care, to the highest quality possible at our facility, regardless of their identity or behavior.
- I/we welcome lesbian, gay, bisexual, transgender, and intersex individuals; men who have sex with men; women who have sex with women; and any other sexual minorities (henceforth referred to by the acronym LGBTI) and their families into my/our practice, and offer all health services to clients on an equal basis, regardless of sexual orientation, gender identity, sexual behavior, marital status, and other non-medically relevant factors.
- I/we believe that LGBTI identities are within the spectrum of normal human experience and are not in themselves pathological, "unnatural," or sinful. I/we therefore do not promote or support attempts to change clients' sexual orientation or gender identity.
- I/we respect the visitation and healthcare decision-making rights of LGBTI client/clients, their unmarried partners, their non-biological children, and any others they may define as family for the purposes of visitation and healthcare decision making.
- I/we commit to taking steps to make my/our practice fully inclusive to LGBTI people as reflected in written forms, policies and procedures, appropriate training for all health facility and administrative staff, and standardized assessments.
- I/we commit to taking steps to learn about the unique health concerns of LGBTI individuals and families so that I/we can provide the highest quality care to all people.
- I/we will maintain confidentiality about an individual's identity and/or behavior just as I/we would keep medical records of any client completely confidential.

D: PLHA-FRIENDLY ACHIEVEMENT CHECKLIST – A Self-Assessment Tool for Hospitals and Other Medical Institutions Caring for PLHIV

Horizons Program. 2006. *Reducing AIDS-related Stigma and Discrimination in Indian Hospitals.* Sharan, Institute of Economic Growth.

1. ACCESS TO CARE SERVICES

Practice

2. Care for PLHIV (or clients awaiting results of an HIV test) is not denied, delayed, or referred elsewhere for services available within the facility.
3. Care for PLHIV is of the same quality as the care provided to other clients.
4. PLHIV are not segregated or isolated.
5. The hospital actively links PLHIV to sources of ongoing palliative care and social support in their own communities.

Training

1. All staff are trained in clients' rights and the rights of PLHIV to equal care and confidentiality.

Quality Assurance

1. An accessible client grievance cell, which registers and addresses client complaints, is in place and open daily.
2. The existence of the grievance cell is posted in each ward and client waiting areas.

Policy

1. Hospital policy guarantees all of the above.
2. Hospital policy on access and right to care is posted in all departments and client waiting areas.

2. HIV TESTING AND COUNSELING

Practice

1. All HIV tests are voluntary.
2. All HIV tests are accompanied by informed consent.
3. All HIV tests are accompanied by pre-test counseling by a trained counselor.
4. All test results are communicated to the client during post-test counseling by a trained counselor.

Training

1. All treating health workers are trained in principles and procedures of voluntary testing and counseling.
2. HIV test counselors are trained and receive ongoing refresher training.

Quality Assurance

1. A committee is in place that ensures that the above procedures and training are operational.

Policy

1. Hospital policy guarantees all of the above.
2. Hospital policy on testing and counseling is posted in all departments and client waiting areas.

3. CONFIDENTIALITY

Practice

1. Information about HIV status is communicated only to the client and treating health workers, and is otherwise kept confidential.
2. Information about HIV status is never disclosed to the client's family or friends, except with the explicit informed consent of the client.
3. The beds, wards, and files of PLHIV are not labeled in ways that would convey information on HIV status to other clients or staff.

Training

1. All health workers are trained in the principles of and clients' rights to confidentiality.

Quality Assurance

1. A committee is in place that monitors the management of information systems to ensure that it adequately protects confidentiality.

Policy

1. Hospital policy guarantees all of the above.
2. Hospital policy on confidentiality is posted in all departments and client waiting areas.

4. INFECTION CONTROL

Practice

1. Universal Precautions are practiced in the same manner with all clients at all times.
2. Sound waste management is practiced at all times by all staff.
3. All staff are informed about and provided with free hepatitis vaccines and, if required, PEP.

Training

1. All staff are trained in the basics of HIV and hepatitis transmission and prevention, infection control (including Universal Precautions), waste management, and PEP.

Quality Assurance

1. Essential supplies for Universal Precautions, infection control, and PEP are available at all times to all staff.
2. An infection control team is in place and meets regularly (once a month or more) to monitor infection control practices and supplies.
3. Information, education, and communication materials on infection control procedures are posted in all wards and staff areas.

Policy

1. Hospital policy guarantees all of the above.
2. Hospital policy guarantees a safe working environment for all HCWs.
3. Hospital policy on infection control and staff safety is posted in all departments and client waiting areas.

5. QUALITY OF CARE

Practice

1. PLHIV are provided the highest available standard of health facility management and care.
2. Pregnant women are offered, though not compelled to accept, HIV testing, ARV treatment to reduce likelihood of mother-to-child transmission of HIV during delivery, and advice on infant feeding.
3. Testing of pregnant women is voluntary and confidential, and is accompanied by pre- and post-test counseling.
4. PLHIV are offered or referred to advice about nutrition and health-promoting lifestyles.

Training

1. Clinical staff are regularly trained and re-trained in case management of HIV.

Quality Assurance

1. ARVs and/or essential drugs for reducing mother-to-child transmission and treating OIs are consistently stocked and administered.
2. A team is in place to oversee care for PLHIV and track advances in health facility management of HIV/AIDS.
3. Guidelines for HIV/AIDS case management are available in each department.

Policy

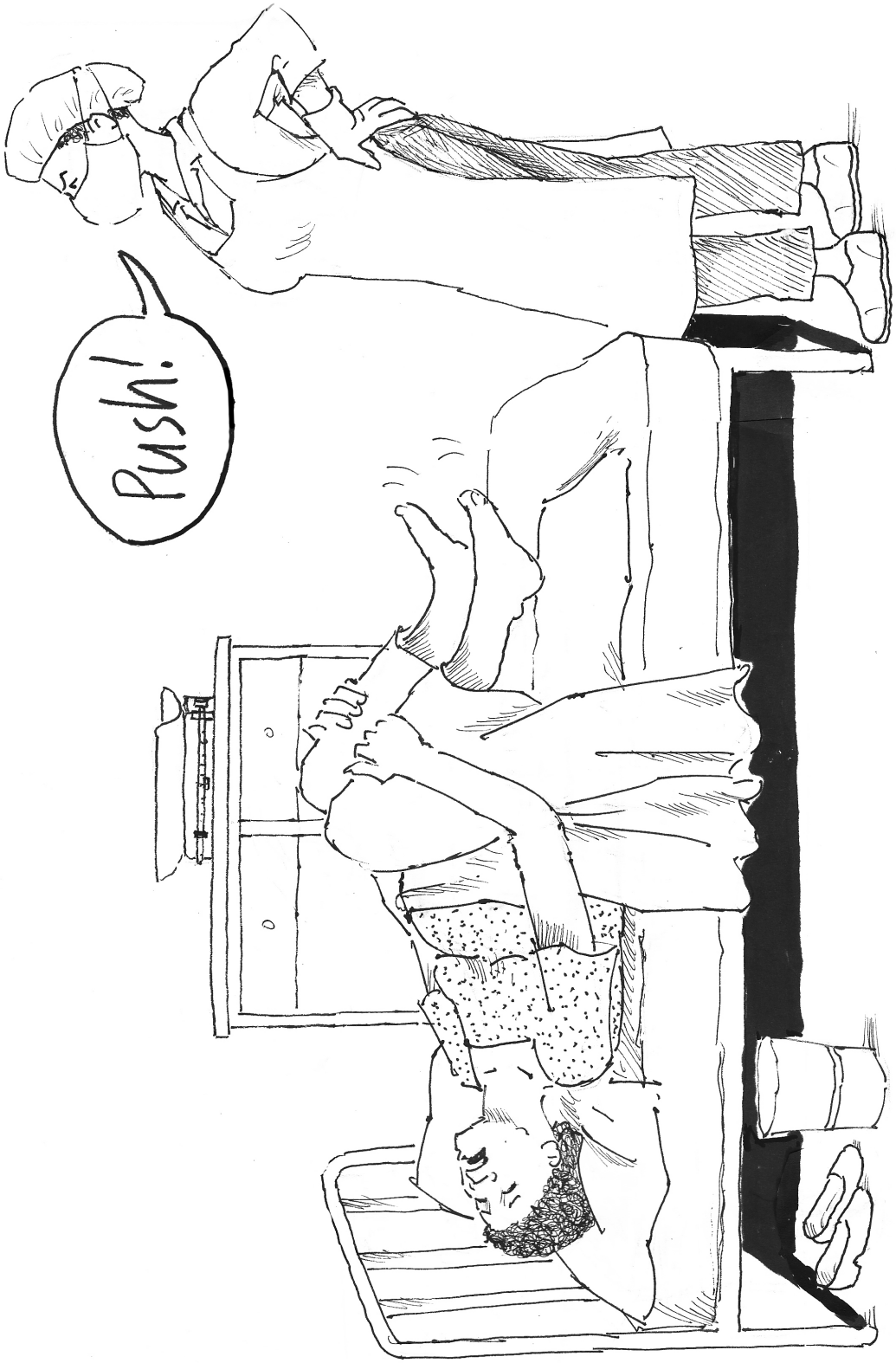
1. A policy is in place that guarantees all of the above.
2. The policy is posted in all departments and client waiting areas.

MODULE G

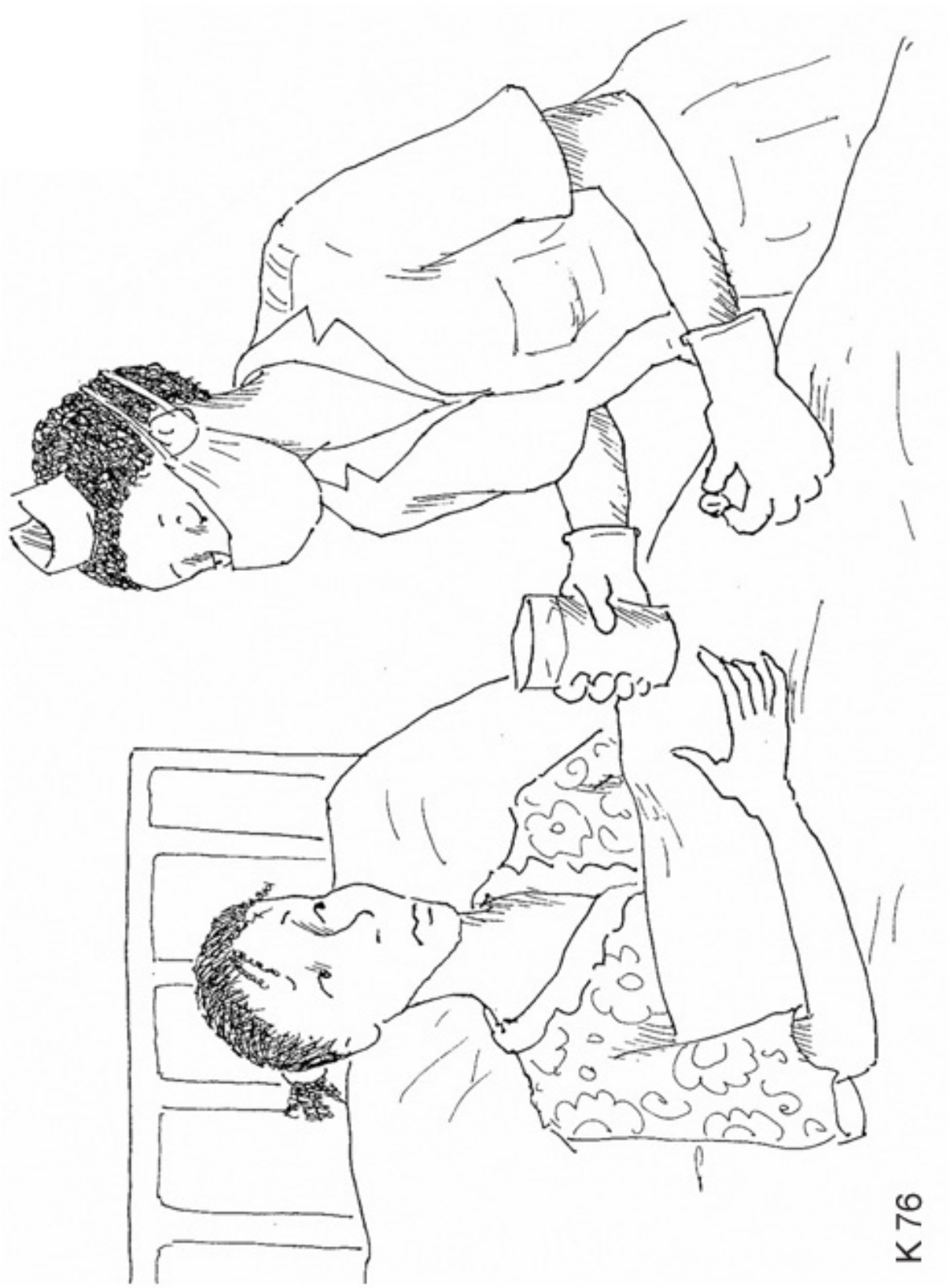
Images


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

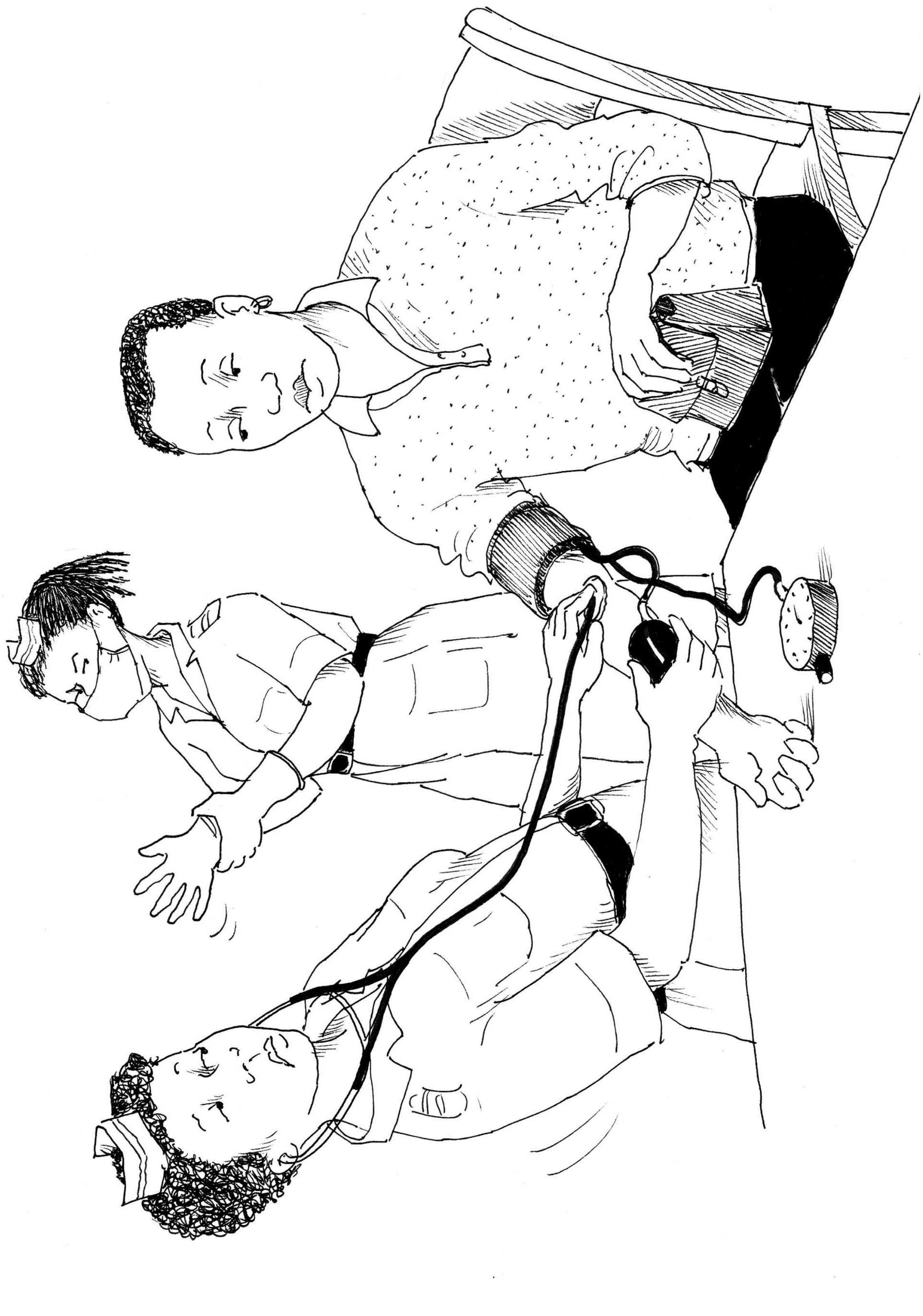

CLINIC


Push!

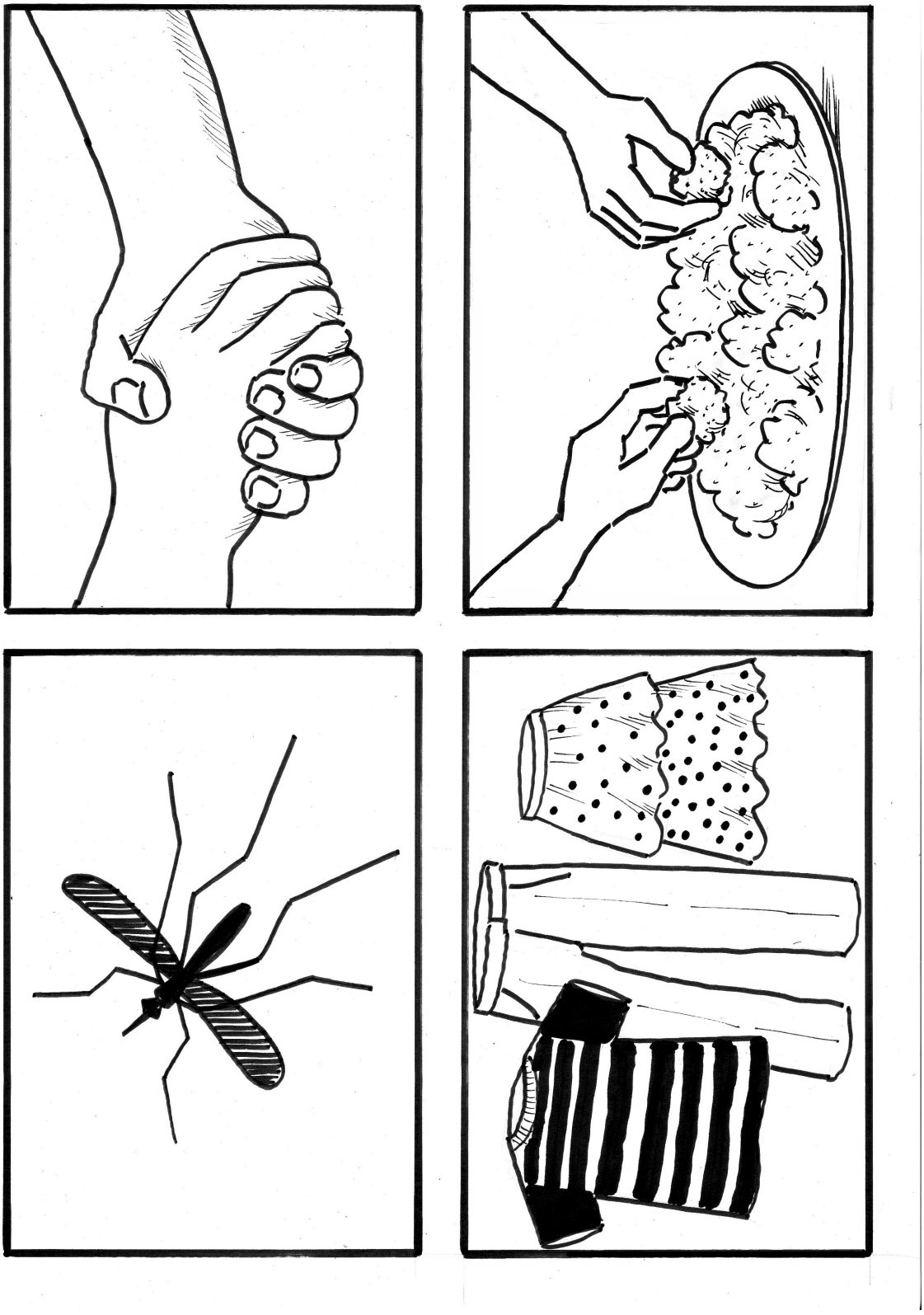
DOCTOR
CHILD HEALTH WEEK
You can not tell by looking....
AFRIGAY

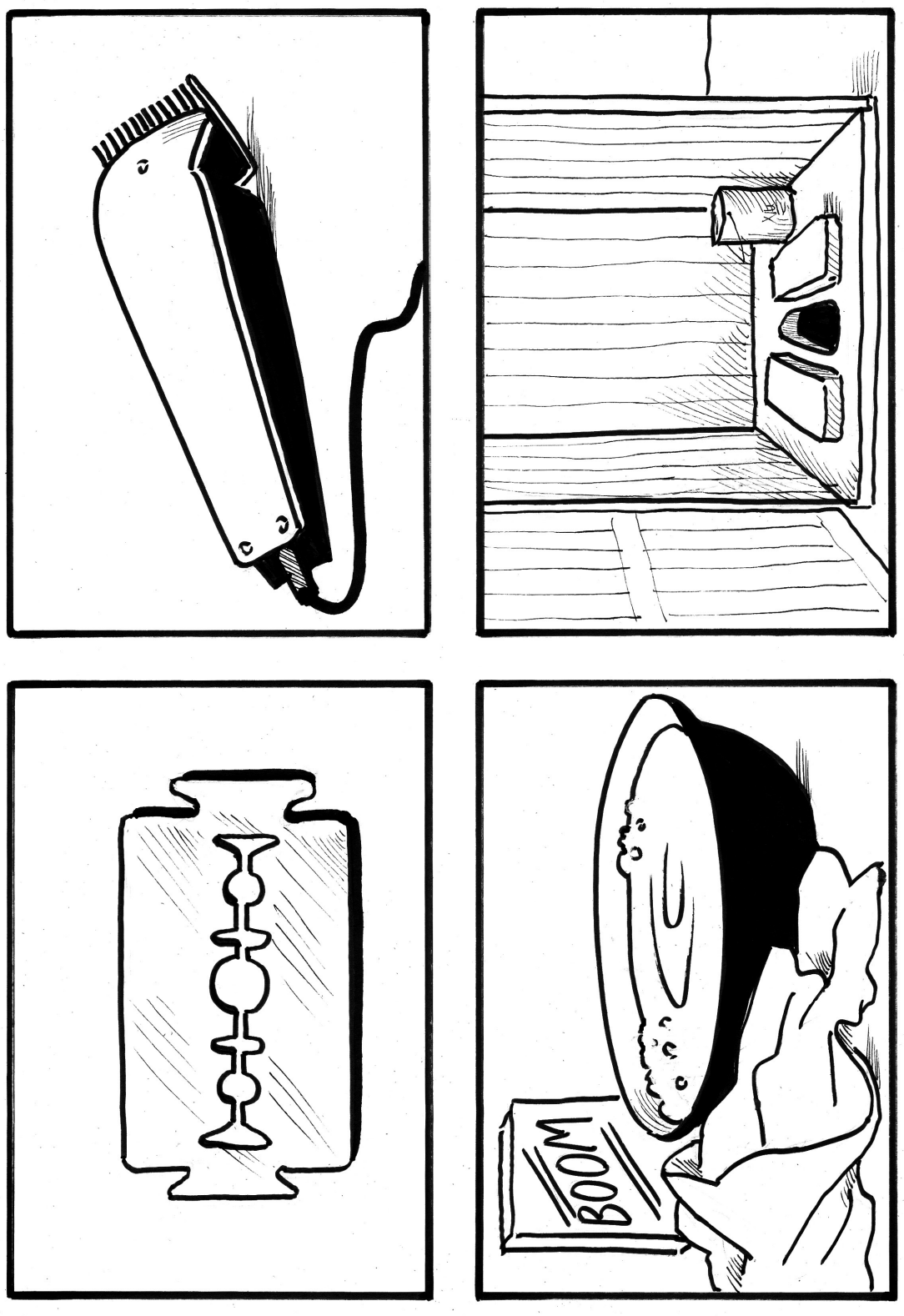

K 76

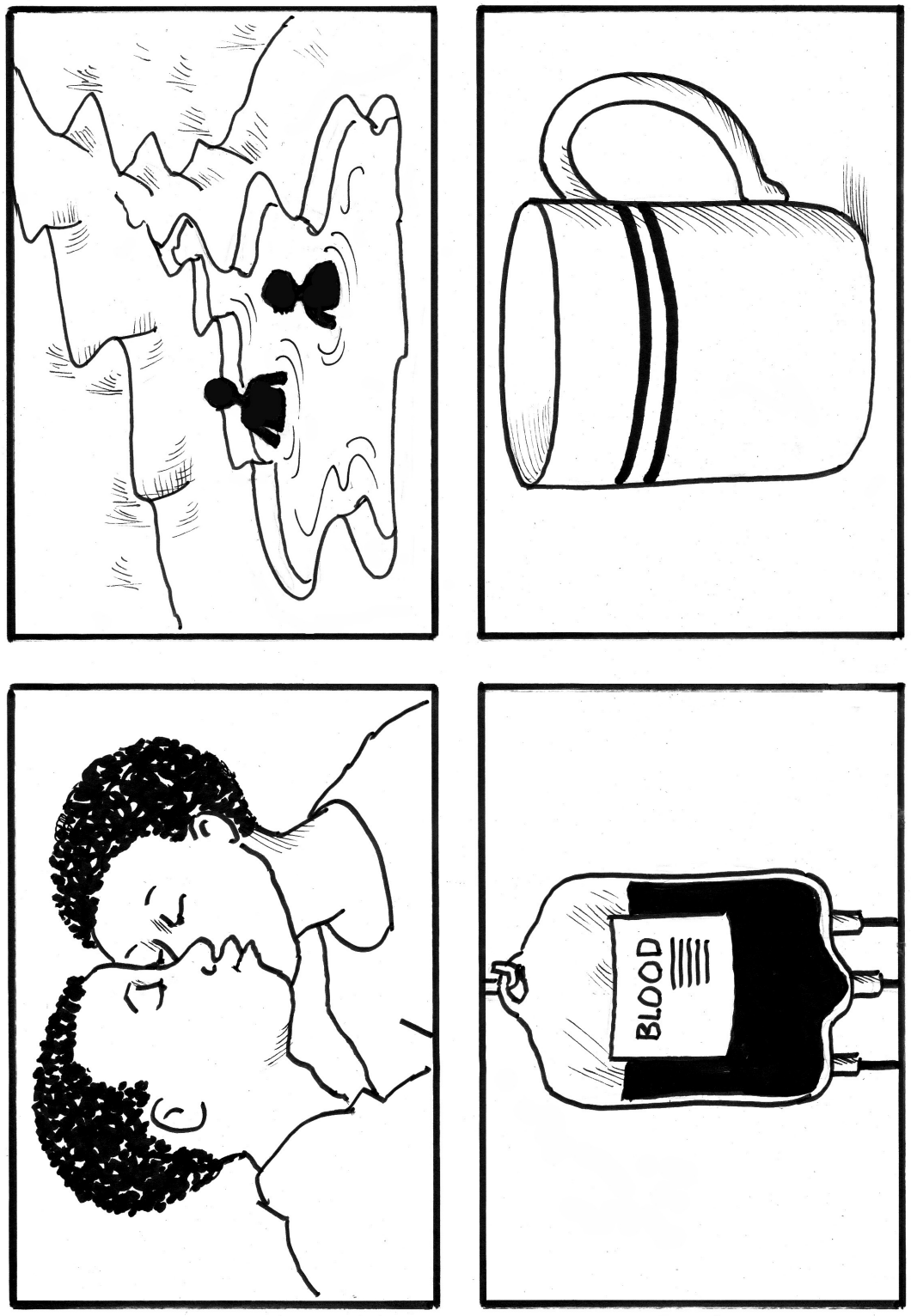
Formula

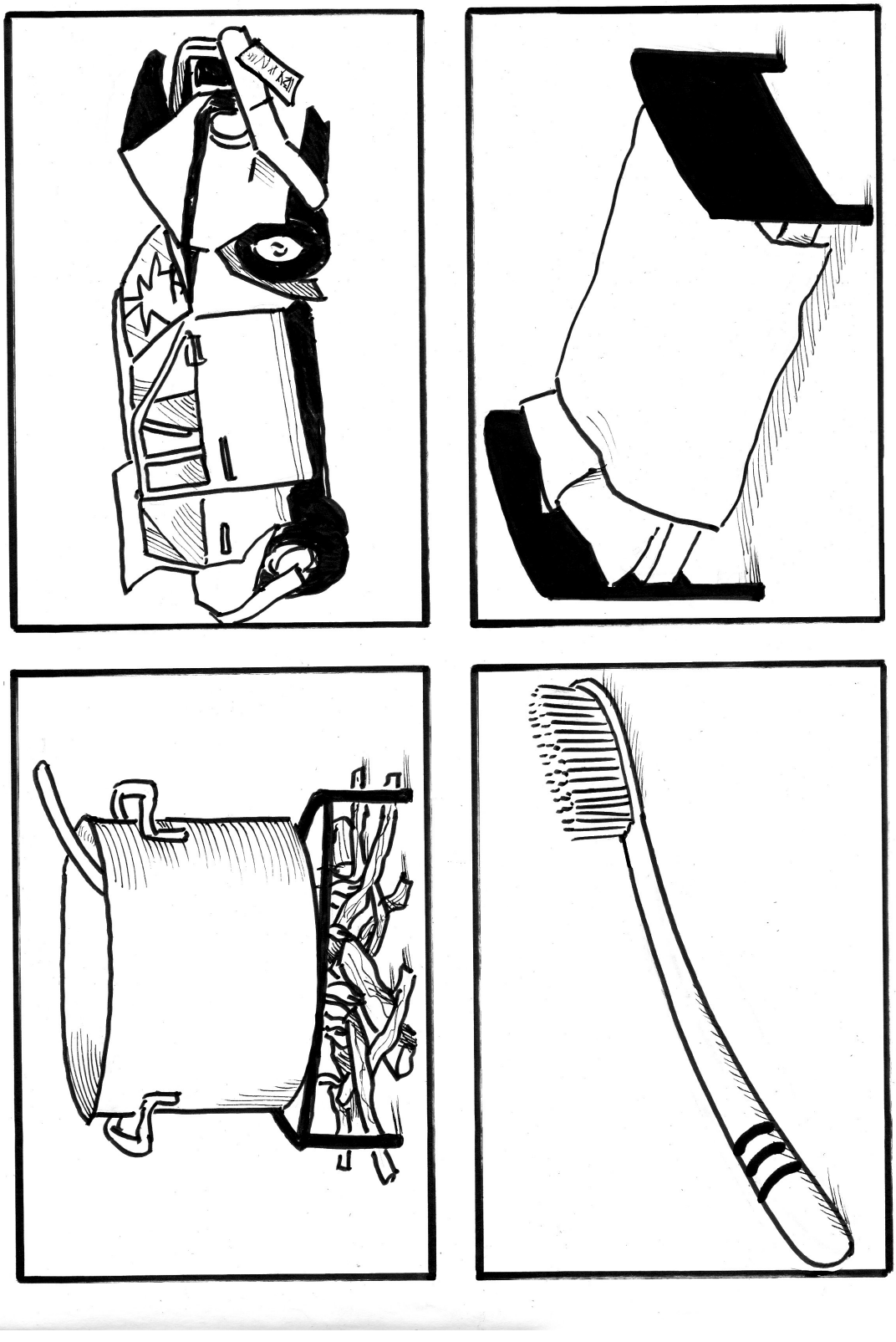


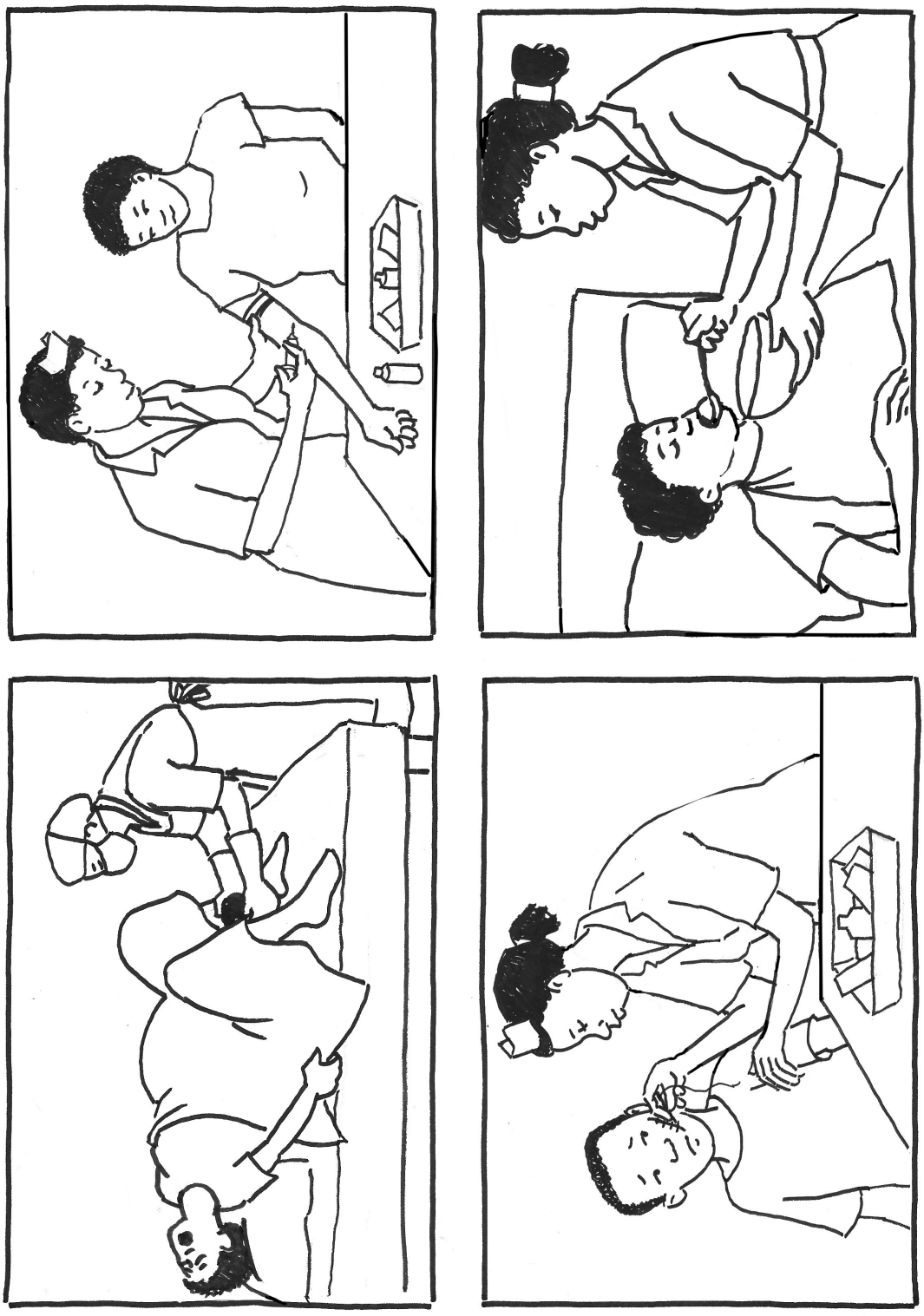

What? You've got an STI in your anus?

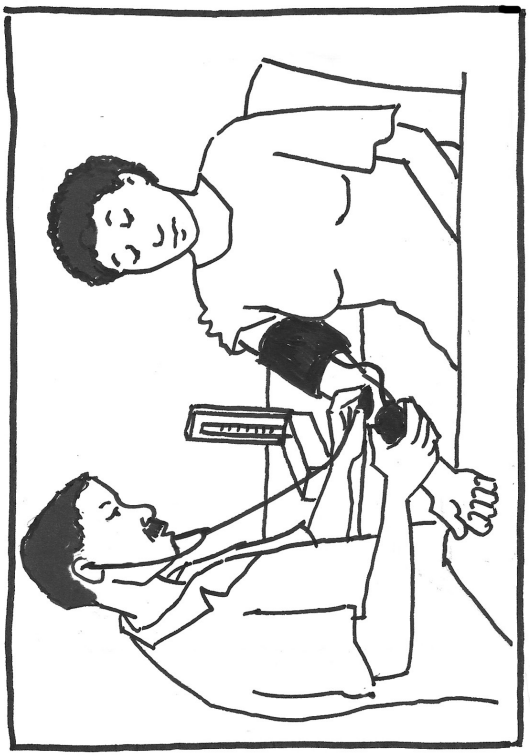


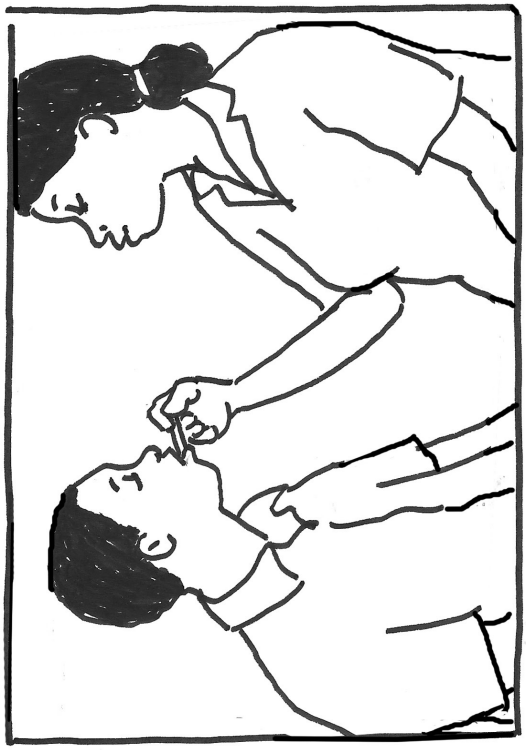

BOOM

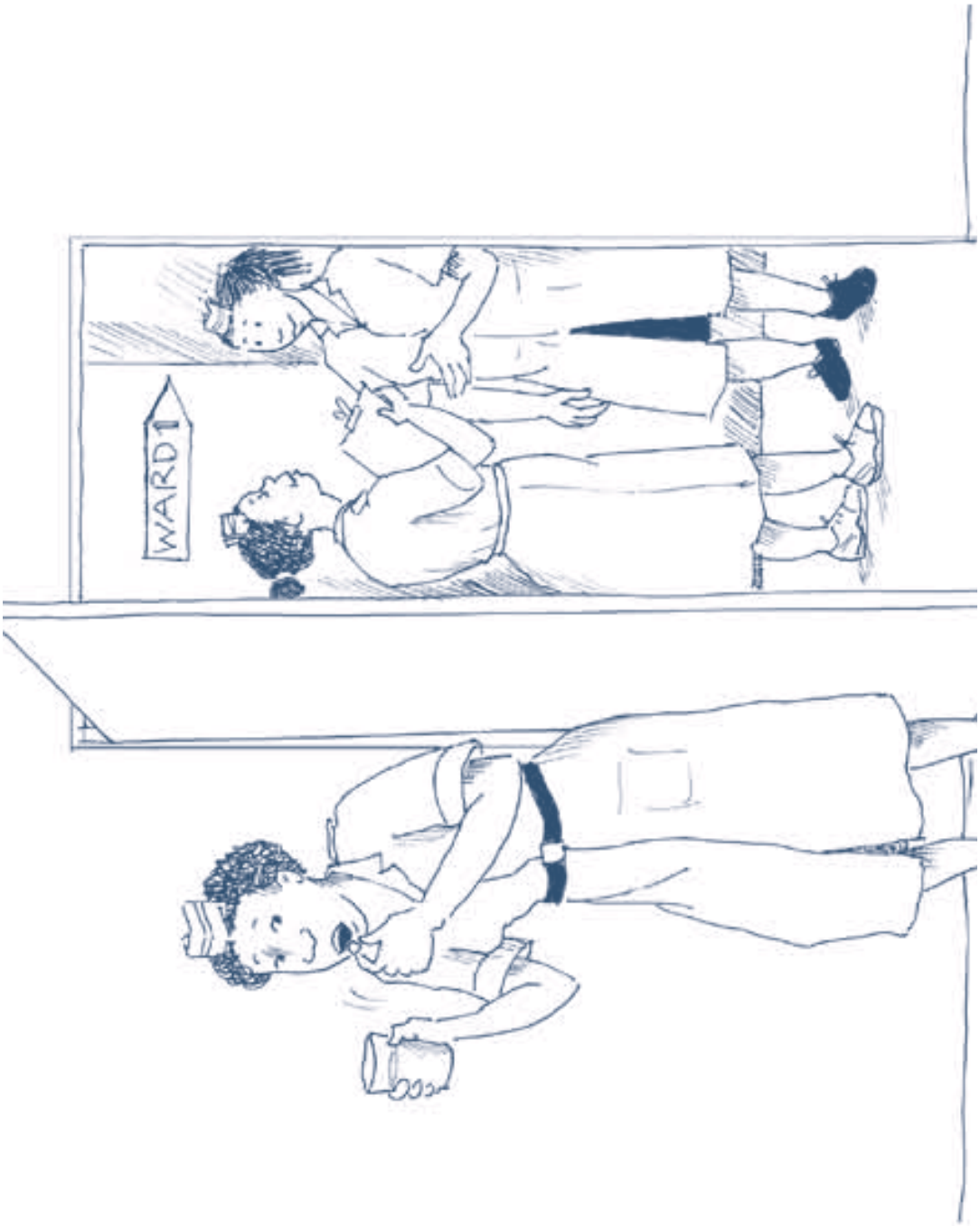

BLOOD










WARD 1

PART 3

Sources

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