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Understanding and challenging HIV stigma in the MENA region:

Toolkit for action



Acknowledgements

Funding for this publication was provided by the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID) under contract no. GHH-I-00-0700068-00.

The stigma toolkit was originally developed by the International Center for Research on Women (ICRW) and then revised by the International HIV/AIDS Alliance (Alliance) with support from Sweden and Norad. A further adaptation focusing on the Middle East and North Africa (MENA) region was undertaken under the C-Change project of USAID and published under AIDSTAR-Two.

Thanks are due to the MENA review committee (Badri Affeur, Badr Baabou and Hicham Merhi) and to Antoine Badoui who adapted the stigma pictures. Thanks are also due to Alliance staff for their support (Wilson Ashimwe, Manuel Couffignal, Tania Kissnerli, Kevin Orr, Caroline Perraut, Catherine Simmons), and to partner organisations:

- Association de Protection contre le SIDA (APCS), Oran, Algeria
- Association Tunisienne de Lutte contre les IST/MST/SIDA (ATL), Tunis, Tunisia
- Soins Infirmiers et Développement Communautaire (SIDC), Beirut, Lebanon
- Association for the Protection of Lesbians, Gays, Bisexuals and Transgenders (HELEM), Beirut, Lebanon
- Association Marocaine de Santé et de Développement (AMSED), Rabat, Morocco
- Organisation Pan Africaine de Lutte Contre le SIDA (OPALS), Fès and Rabat, Morocco.

Special thanks to Sarah Johnson and Yadira Almodovar from AIDSTAR-Two, and to Jennifer Mason and Laurie Rushton from USAID for their review of the toolkit and valuable comments.

Some exercises in this toolkit have been adapted from '*Understanding and challenging HIV stigma: toolkit for action*' (International HIV/AIDS Alliance, 2007) and others from '*Understanding and challenging stigma toward men who have sex with men*' (PACT and ICRW, 2010).

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Registered charity number 1038860

First published in June 2013
www.aidsalliance.org

Designed by Jane Shepherd

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Introduction

This toolkit has been adapted from *Understanding and challenging HIV stigma: toolkit for action. Module H: MSM and stigma*,¹ which was developed by and for African trainers, and has been used extensively around the continent to support HIV stigma reduction programmes. This version has been designed to use in the Middle East and North Africa (MENA) region, and includes adapted exercises and stories that are more relevant to this context. In different countries in the MENA region there are emerging concentrated HIV epidemics among key populations, notably men who have sex with men (MSM), male and female sex workers and people who inject drugs.

Thus tackling HIV stigma in the MENA region goes hand in hand with tackling homophobia (see page 58). It also means challenging negative attitudes and treatment towards other marginalised groups like sex workers, people who inject drugs and people living with HIV. Stigma reduction interventions need to be integrated into prevention work with MSM and other affected groups to increase access to HIV information and healthcare services. HIV can be a taboo topic, avoided even among those who are aware of other discrimination issues.

How the toolkit was developed

USAID's Middle East and North Africa Regional Programme, implemented by the Alliance, has been working with local partner organisations in Morocco, Tunisia, Lebanon and Algeria since 2004. We have been responding to the sexual health needs of MSM and other key populations through support to capacity-building, peer education, advocacy and outreach programmes.

In 2009 representatives from partner organisations in Lebanon, Algeria, Morocco and Tunisia were trained as stigma reduction trainers. They began using the 2007 stigma toolkit to integrate stigma reduction education into their existing programmes. They also began to adapt exercises to suit the MENA context. This MENA toolkit has been developed in partnership with a review committee that includes some of the MENA stigma trainers. They have added stories and case studies, and helped to make it more relevant and appropriate for the region.

The toolkit is a training resource containing many participatory exercises to use in order to understand and challenge stigma. MSM are the main target group, but it is worth highlighting that other affected groups are intended to benefit from the toolkit too. There are messages, information and activities that can be adapted and used for these key populations.

1. Kidd, R., Clay, S., Chiya, C. (2007), 'Understanding and challenging HIV stigma: toolkit for action. Module H: MSM and stigma', International HIV/AIDS Alliance.

Introduction

The HIV epidemic in the MENA region

Only 2% of the estimated global number of people living with HIV reside in the MENA region, and available epidemiological data across the region points to continued low levels of HIV infection in the general population. However, the epidemiological situation, particularly among key populations, has started to raise serious concerns. Recent estimates show that MENA is one of two regions with the fastest growing epidemics. The rise in the estimated number of people living with HIV presumably is the result of an increased HIV prevalence among key populations at higher risk and a forward transmission of the virus to a larger number of individuals who are generally at lower risk of infection. Annual estimated new infections have almost doubled in the past decade. Similarly, AIDS-related mortality has also almost doubled in the past decade.

The HIV epidemic reflects the diversity of the region, with different populations more heavily affected in different places, and a variety of attitudes, policies, political commitments and availability of and access to HIV services. In some countries the epidemic is primarily concentrated among people who inject drugs; in other countries it affects MSM or sex workers. A large proportion of women living with HIV are believed to have acquired their infection from their spouses who practice high-risk behaviours. Sex between men reportedly accounts for nearly one quarter of all new HIV infections in the region, and stigma and discrimination and high rates of sexually transmitted infection contribute to MSM becoming highly vulnerable to HIV infection.

The current response is characterised by a low coverage of prevention programmes for key populations at higher risk, which contributes to the limited HIV knowledge and high levels of risk behaviour within these populations. However, there is a growing awareness of the importance of working with these populations on HIV prevention, and efforts are increasingly being made to understand the issues and address the shortcomings.

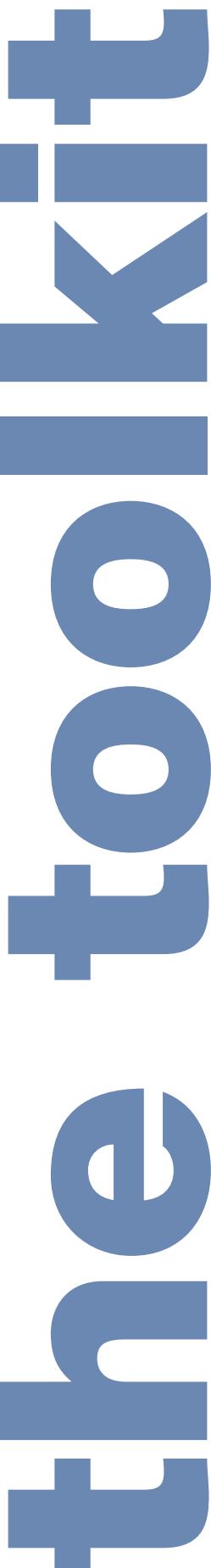
Stigma and discrimination exist in all countries in the region. It is one of the primary reasons why people living with HIV and other key populations do not have access to essential HIV services.

About terminology

MSM We have used the term ‘MSM’ (men who have sex with men) after consultation with partner organisations in the MENA region. However, trainers should use the terms most appropriate in their context (of course, ensuring that local terminology does not reinforce stigma).

Key populations We use the term ‘key populations’ to describe the groups most affected by HIV in a concentrated epidemic. Sometimes we also use the term ‘marginalised groups’. These groups vary in different countries, but generally include MSM, sex workers, people living with HIV and and people who inject drugs.

How to use the toolkit



This section describes how to make the most of the toolkit.
It includes advice on:

- target audiences
- understanding the exercises
- planning a training programme
- using participatory techniques in a workshop.

Target audiences

The exercises in the toolkit can be used with a wide range of audiences. However, they have been developed particularly to support HIV prevention programmes in the MENA region, where HIV is a concentrated epidemic. The exercises focus on work with key populations – primarily MSM, sex workers, people who inject drugs and people living with HIV.

Primary audiences include:

- **peer educators** working in HIV prevention; for example, MSM who are recruited from the community to undertake outreach work, or former sex workers who provide health information to sex workers
- **NGO staff** – people who are involved in HIV programming, including HIV prevention interventions
- **service providers**, including healthcare professionals, counsellors and community and social workers, whose services are relevant to key populations
- **MSM** in the community, together with sex workers and people who inject drugs; for example, as part of a capacity-building programme.

Most exercises can be used with all audiences, but some have been specifically designed to use with MSM-only groups. The target audience is shown at the beginning of each exercise.

Facilitators

The toolkit is designed for facilitators who have some experience in delivering participatory training sessions. Stigma exercises achieve the best results when they are facilitated by at least two people. Co-facilitation ensures high-quality training and creates teamwork. It enables facilitators to plan and prepare together, and to manage difficult situations. It also creates opportunities for less-experienced trainers to work alongside those with more training experience. Additionally, it can help to build community capacity in facilitation through mentoring.

Number of participants

Many exercises to address stigma require participants to share personal experiences, discuss tricky issues and explore long-held beliefs and attitudes. It is important that workshops feel safe and confidential. For this reason the optimum number of participants for these exercises is between 15 and 25.

How to use the toolkit

Working with mixed groups

If you are running a training course with a mixed group – for example, of men and women, or health workers and other professionals, or MSM peer educators and sex workers – there will be some exercises where it will be most appropriate and effective to split into smaller peer groups. This is especially relevant when discussing sensitive issues around sex and sexuality. Once groups have had a chance to feel safe and discuss issues openly, you can report back in a plenary where each group listens to the others.

Start with yourself

Before you begin training others around stigma it is important to reflect on your own attitudes, beliefs and values. You might want to share your own experience of being stigmatised or being the stigmatiser with your co-facilitator or your colleagues. You might also want to find out more about marginalised groups, and talk to group members or to others who are already working with them.

Using a participatory approach

The toolkit is designed for participatory learning. The idea is to get participants learning through doing: sharing feelings, concerns and experiences; discussing and analysing issues; solving problems; planning and taking action.

The toolkit is not designed as a series of lectures. Changing attitudes around stigma requires more than giving people information. People learn best when they work things out for themselves.

The important thing is to create a safe space where participants can express their fears and concerns, and freely discuss sensitive and sometimes taboo issues. A process of reflection, sharing experiences, discussion and opening up to new ideas is what starts to change stigma on an individual level. As the trainer you help to facilitate this process.

Helping participants to engage on sensitive topics

In the MENA region there are many topics that are taboo or highly sensitive; in particular, topics related to sexuality. Many participants will probably be reluctant, shy or embarrassed to engage on sensitive topics around sexuality, stigma and discrimination.

During the introductory session of your workshop (perhaps after introducing yourself and asking participants to introduce themselves and describe how they feel about being here), explain that the issues that are going to be raised are potentially sensitive. Explain that in order to contribute to discussions people will need to feel safe enough to express their thoughts and feelings, secure in the knowledge that their confidentiality will be respected. Ask participants to agree on ground rules, and make sure they include:

- We will value difference (of opinion and experience).
- We will keep everything shared within this workshop confidential.

Pay special attention during the workshop to ensuring that these two crucial rules are respected and endorsed by all participants.

How to use the toolkit

Helping participants move from awareness to action

The toolkit is designed not only to build awareness but also to support participants to take action. Participants should be encouraged to put their new learning into action and start challenging stigma and violence in their own lives, families and communities.

The learning and action is done collectively. Working with others makes it possible to learn together about stigma. Together, participants develop common ideas about what needs to be done. They set group norms for new attitudes and behaviours, and support each other in planning and working for change.

Understanding the exercises

The exercises are laid out in a simple format so you can read through and understand how to use them.



Objectives

The objectives outline the purpose of the exercise and show what should be achieved.



Facilitator's notes

These provide guidance on facilitating the exercise. They may draw attention to particular issues related to the exercise, or give options for varying the exercise.



Target audience

This states which groups the exercise should be used with.



Time

This is the approximate time needed for the exercise (it will vary according to the size of the group).



Materials and preparation

This notes any preparation and materials required for the exercise.



Action ideas

These are ideas you can suggest for follow-up activities to carry on the learning after the workshop or take back to the community.

Description of exercise

This is a brief overview of the exercise, stating the main theme and key activities.

Step-by-step activity

The activity guide provides instructions for facilitating the exercise. These may include activities for splitting participants into groups, discussion questions, reporting back activities, and processing (how to help participants understand the learning from the activity).

Summary

These are extra points that you can use to help summarise an exercise. Always try to use points that have been discussed by the participants, and then add any extra points that have not been already raised.

Examples

Sometimes we include examples of answers or responses that have come up when the exercise has been used in a workshop. These are just to give you an idea of what to expect. You do not need to copy these or present them to the participants.

How to use the toolkit

Planning a training programme

The toolkit is organised into eight chapters, each addressing a different theme. There is an overview at the beginning of each chapter.

- Chapter 1** **Identifying stigma** – identifying the forms, causes and effects of stigma
- Chapter 2** **Building more understanding of HIV and AIDS** – addressing the fears about HIV transmission that lie behind stigma
- Chapter 3** **Judgments, values and stigma** – exploring beliefs, attitudes and judgments that can lead to stigma
- Chapter 4** **Stigma and MSM** – focusing on why and how stigma towards MSM happens
- Chapter 5** **Disclosure** – strategies for disclosing information that may lead to stigma
- Chapter 6** **Sex, gender and stigma** – exploring sensitive issues linked to gender and sex
- Chapter 7** **Coping with stigma and fighting for our rights** – combatting stigma by maintaining rights
- Chapter 8** **Ideas for planning action against stigma**

In most chapters there are core exercises that we recommend you include in any stigma training session. There are also exercises that address similar topics. This means that as a trainer you can pick and choose exercises to suit your audience and the amount of time and space you have. It also enables you to use a range of training techniques and methodologies.

How to plan the programme

When you are planning stigma reduction training you may want to include stigma among a number of topics in a training programme. For example, you could integrate stigma exercises into a counselling training programme or an HIV update for health workers, or you may want to run a short workshop just about stigma. The exercises in the toolkit are flexible. Choose which ones you will use according to your target audience, training time and the context in which you are working.

How the stigma exercises have been used by Alliance MENA partners

In Algeria APCS are using the exercises with religious leaders to raise awareness of stigma towards MSM, sex workers and groups of people living with HIV.

In Tunisia peer educators from ATL use stigma exercises with public sector voluntary counselling and testing staff to help create a more MSM-friendly environment within the HIV services for key populations.

In Lebanon SIDC stigma trainers have integrated stigma awareness-raising modules into a cycle of trainings with social workers and family planning/sexual and reproductive health workers to challenge stigma towards MSM and people living with HIV.

SIDC also used the stigma exercises with journalists from TV and print media to help change stigmatising images of people living with HIV.

How to use the toolkit

Core exercises

Any stigma training programme should contain core exercises from the toolkit. These are used to introduce the topic of stigma and help participants to identify what stigma looks like in their community, why it happens and its effects on individuals, families, communities and HIV prevention.

Once participants have been taken through these core exercises, other exercises can be used to explore different types of stigma and go into more detail.

The core exercises are marked with a  and the facilitator's notes explain why the exercise is important.

Mixing techniques

Once you have selected your core exercises, choose other exercises from the toolkit that will help you meet your training objectives. You could choose a different exercise from each section or you might want to focus on one topic according to the theme of your training course; for example, 'disclosure' or 'stigma towards MSM'.

Try to ensure that you use a range of techniques. For example, if you plan an exercise that involves a lot of discussion in a large group, make sure that the next exercise involves working in small groups, doing role-plays or something else active. Mixing techniques helps to keep energy and interest levels high, and prevents a workshop from becoming boring. It also ensures that your training will appeal to the different learning styles among participants.

Adapting the exercises to fit your own context

Once you are familiar with the stigma exercises, feel free to adapt them to fit your own context. For example, you might want to change the case studies a little, or make up your own case studies based on your experiences or stories that emerge out of the stigma workshops. You might want to use only one part of an exercise or add a different scenario. So long as the exercise will still meet your objectives, you can use the toolkit as a guide and rely on your own creativity and experiences to make an exciting and effective programme.

Summary of exercises

There is a summary of the toolkit exercises at the end of this section so that you can see them at a glance. This will help you with your planning.

How to use the toolkit

Sample training programmes

In order to help you design your programme, we are providing some sample timetables.
Use these as a guide for your planning.

Audience: MSM peer educators	
One-day workshops	
Sample timetable 1	Sample timetable 2
Purpose of session	Purpose of session
<ul style="list-style-type: none">Introduce participants to the concept of stigma and explore what it looks like in their community.Help participants give clear information about HIV transmission.Identify what could be done to cope with stigma.	<ul style="list-style-type: none">Help participants identify forms, causes and effects of stigma faced by key populations, and discuss real-life stories.Help participants understand how to use assertiveness to fight for and defend their rights.Explore how family and friends can play an important role in successful antiretroviral treatment.
Exercises	Exercises
1A: Naming stigma through pictures	1D: Analysing stigma against key populations
1E: Stigma towards MSM in different settings	1F: Mapping stigma in health settings
2B: Fears about non-sexual, casual transmission of HIV	4C: MSM and stigma case studies
7B: Strategies for coping with stigma	7A: Stigma, assertiveness and human rights

Audience: service providers/NGO staff	
Half-day sessions	
Sample timetable 1	Sample timetable 2
Purpose of session	Purpose of session
<ul style="list-style-type: none">Help participants identify what stigma looks like in their community, what causes it and its effects.Identify different types of stigma faced by MSM in different places.Identify some of the feelings linked to stigma and understand how stigma can impact at an individual level.	<ul style="list-style-type: none">Identify different types of stigma faced by MSM in different places.Understand better the link between language and stigma.Help participants understand that we are all at risk of becoming infected with HIV.
Exercises	Exercises
1A: Naming stigma through pictures	1E: Stigma towards MSM in different settings
1B: Our own experiences of stigma	3B: We are all in the same boat!
1C: Forms, causes and effects of stigma – stigma problem tree	3C: Things people say

How to use the toolkit

Audience: all groups		
Three-day workshop		
Day one	Day two	Day three
Purpose of session	Purpose of session	Purpose of session
<ul style="list-style-type: none"> Introduce participants to the concept of stigma; identify forms, causes and effects; explore the link between language and stigma. Help participants give clear information about HIV transmission and lessen misconceptions that lead to fear and stigma. 	<ul style="list-style-type: none"> Explore attitudes, beliefs and values that influence judgment towards different groups of people. Explore how families can support a member with treatment adherence. 	<ul style="list-style-type: none"> Help participants appreciate assertiveness as one of the skills that can be used to defend the rights of marginalised groups. Help participants understand the important role of a family in supporting a person living with HIV. Increase participants' understanding of issues facing marginalised groups. Help participants imagine how the community could be without stigma.
Exercises	Exercises	Exercises
1A: Naming stigma through pictures	3C: Things people say	3A: Roundtable discussion
1B: Our own experiences of stigma	3D: Value clarification	5C: Who should I tell?
1E: Stigma towards MSM in different settings	3E: Bingo!	7A: Stigma, assertiveness and human rights
2B: Fears about non-sexual, casual transmission of HIV	3G: Preaching and stigma	8A: Start with a vision – a world without stigma
5A: Let's talk about disclosure	5B: Disclosing our HIV status as MSM	

Using participatory techniques in a workshop

The exercises in this toolkit rely on a wide variety of participatory training techniques. We have outlined some key points about the most common techniques below to help you plan and facilitate your stigma training.

Creating the atmosphere ('setting the climate') As the facilitators of a stigma session, it is important to plan how you can create an atmosphere where participants feel safe, accepted and free to share experiences, opinions and feelings. You should try to create a 'stigma-free' atmosphere.

As a trainer you will find your own ways to do this. However, some of the components that may help include:

- welcoming all participants as they arrive
- learning participants' names (use name tags to help)
- starting with some warm-up fun activities like a song and dance, and a game for introductions
- agreeing clear ground rules or contracts
- acknowledging that tackling stigma can be challenging and that each group member has a responsibility to help create a safe atmosphere
- moving participants' seats around for different exercises to get the group to mix and talk to each other
- keeping energy levels high with energisers and movement.

How to use the toolkit

Discussion is an important part of stigma exercises. It enables participants to reflect on their own experience, share with others, analyse issues and plan for action together. All of the exercises are built around discussion.

Presentations can be used but keep them to a minimum. Use them mainly for summarising sessions or explaining HIV facts where participants are confused.

Small group work is used to maximise participation in discussions. Some trainees feel shy in a large group but find it easier to talk in a small group. Small groups can also be used for task-based group work, with different groups exploring different topics or carrying out different activities.

Buzz groups – two people sitting beside each other – are a trainer's 'secret weapon'. They help get instant participation and are especially useful when starting a brainstorm or large group discussion. Get people to talk to the person next to them for a few minutes to get ideas flowing. 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: ask for one new point from each group going around the circle. This ensures that all groups get a chance to contribute equally. You can also use a 'gallery walk'. Each group reports from a different part of the room, flipcharts can be displayed and the participants move around the room together to keep energy levels high.

Card storming is a quick way of getting ideas and keeping everyone involved. Participants, working individually or in pairs, write single points on cards and tape them on the wall, creating a quick brainstorm of ideas. Once everyone is finished, the cards are organised into clusters and discussed or used for other group activities like role-plays and small group analysis.

Rotational brainstorming is another form of brainstorming done in small groups. Each group is given a starting topic and records points on its topic on a flipchart. After two to three minutes, groups move to a new topic and add points. During the exercise, groups contribute ideas to all topics.

Pictures – the toolkit includes pictures that can be used in different exercises. These show various aspects of stigma as a focus for discussion. Participants can also use the pictures as a trigger for talking about their own experiences, or as a cue for a role-play or problem-solving topic. For example, ask them to discuss, "What would change this situation?"

Stories and case studies are provided in many of the exercises as a way of describing what stigma looks like in a real situation and as a focus for discussion. In other exercises participants are asked to write their own stories about stigma.

Drama or role-plays are an alternative to stories. Participants act out either the stories in the exercise or their own stories. They can also act out their analysis of an issue as a way of reporting back what they have discussed. Drama helps to make things real.

How to use the toolkit

Summary of exercises

Chapter 1: Identifying stigma		
Exercise	Purpose	Description
1A: Naming stigma through pictures	Identify different forms of stigma in different contexts and how stigma affects individuals, families and communities. Identify different types of stigma faced by MSM, sex workers and people living with HIV. Begin to understand why stigma happens, with specific examples of stigma from their own communities.	Participants work in small groups. Each group looks at and discusses the pictures that have been displayed on the wall. After a few minutes groups select one picture and discuss three key questions. Participants come together for report-back and plenary discussion.
1B: Our own experiences of stigma	Help participants to describe their own personal experiences of stigma and identify some of the feelings linked to stigma. Help participants understand how stigma can impact at individual level.	Participants sit alone and reflect on a time when they have experienced isolation or rejection. They then discuss their experiences in pairs. In the large group, participants who feel free to share their experiences are given time to do so without coercion. Some processing questions are discussed to see what has been learnt from the reflection. The session ends with a song or an activity that brings participants together.
1C: Forms, causes and effects of stigma – stigma problem tree	Identify different forms of stigma and how stigma affects people. Identify some of the root causes of stigma.	Participants discuss in pairs and write on cards all the forms of stigma that have been mentioned so far in the workshop. They then discuss and write down the causes of stigma, followed by the effects. The cards are clustered by participants, then discussed and used for further analysis.
1D: Analysing stigma against key populations	Identify the forms, causes and effects of stigma faced by key populations. Identify the different contexts where stigma faced by key populations occurs.	This exercise is an alternative to 1C and involves small group card storms. Participants identify the various groups that are stigmatised in their society and work in small groups to analyse the stigma. Report-back is done as a gallery walk, going from one group to the other as the group members give presentations. The activity ends with a discussion about possible action.
1E: Stigma towards MSM in different settings	Help participants explore MSM stigma in different contexts and begin to look at the forms and causes of MSM stigma. Look at how stigma affects MSM and impacts on HIV.	Participants work in small groups to analyse the stigma faced by MSM in particular settings. Types of stigma are written on cards and then groups prepare a role-play to show how this stigma happens.
1F: Mapping stigma in health settings	Explore different forms of stigma faced by key populations in different departments of a health facility. Identify how stigma acts as a barrier to accessing HIV services, and discuss ideas for tackling stigma in health facilities.	Participants identify five different departments of a health facility and stick them on cards around the room. Participants then work in groups according to the key population relevant to that group, discussing the kind of stigma they face in different departments. Each group reports back to the plenary.

How to use the toolkit

Chapter 2: Building more understanding of HIV and AIDS

Exercise	Purpose	Description
2A: Assessing knowledge levels Brainstorming on the move Things we want to know	Help participants identify what they know and do not know about HIV and AIDS.	<p>Participants choose one of these exercises only. With <i>Brainstorming on the move</i>, participants work in pairs to answer different questions that are posted on flipcharts around the room. When all the pairs have finished, the responses are reviewed and clarified where possible.</p> <p>In <i>Things we want to know</i> participants are paired up then handed five cards. Each pair writes one thing on each card that they would like to learn about HIV. When they have finished, participants are asked to help with clarifications.</p>
2B: Fears about non-sexual, casual transmission of HIV	Help participants to name their fears in relation to specific forms of non-sexual contact and enable them to give clear information about how HIV is and is not transmitted.	In pairs, participants do a card storm of fears in the community around non-sexual transmission of HIV. They prioritise the most common fears and discuss the reason behind the fear. The facilitators present the QQR tool. Participants then try out the QQR tool in a carousel/Margolis wheel.

Chapter 3: Judgments, values and stigma

Exercise	Purpose	Description
3A: Roundtable discussion	Help participants to have a greater understanding of marginalised groups and discuss how stigma affects them. Explore some of the complexities of stigma they face, and discuss what could be done.	A panel is selected in advance. Participants submit questions about key populations also in advance to allow time for preparation. The key activity is a facilitated TV-style talk show with members of key populations on the panel.
3B: We are all in the same boat!	Enable participants to recognise that everyone is at risk of getting HIV, so there is no point in stigmatising those who already have HIV.	A short game where some participants are excluded, followed by questions and debriefing linking feelings and actions to stigma.
3C: Things people say	Identify labels used by people to stigmatise marginalised groups and understand better the link between language and stigma.	The activity starts with a game that helps to divide participants into small groups. This is followed by a rotational brainstorm, listing the things people say about different groups. At the end of the activity participants sit in a circle and the activity is processed.
3D: Value clarification	Understand why different people are judged differently and explore why we make judgements about certain groups in society.	The activity starts with participants individually filling in a questionnaire about different value statements. The results are tabulated and discussed.
3E: Bingo!	Participants mix freely with others in the group and reflect on assumptions and values they hold about other members of the group. Understand how some topics are more difficult to discuss than others.	The activity is a fun-based game. Participants are given sheets of paper containing statements and questions. They have to find people who agree with the statements, and fill in the boxes. When someone completes the boxes the game ends. Then the group reflects on what happened.

How to use the toolkit

Chapter 3: Judgments, values and stigma

Exercise	Purpose	Description
3F: Sex work and stigma	Understand better why some people sell sex. Participants explore their own attitudes to sex work and understand how stigma towards sex workers can hamper HIV programmes.	This exercise is based around sex work stories. It has two options: either a testimony is provided by a sex worker or stories are used that are based on real-life experiences. Participants listen to the story and then discuss their feelings and opinions in small groups.
3G: Preaching and stigma	Understand the different forms of stigma that may occur in a church or mosque, and explore how religious messages can be used to challenge stigma and encourage greater love and acceptance.	Participants brainstorm together about the different forms of stigma found in a mosque or church. In small groups they explore different religious messages and stories that can be used to challenge stigma.
3H: Living with HIV case studies	Understand the impact of stigma on people living with HIV, particularly key populations, and share experiences of local resources and support services.	Participants discuss in small groups case studies about people living with HIV, with some focus on the role that stigma plays in influencing disclosure. Participants share their knowledge of local resources and services.

Chapter 4: Stigma and MSM

Exercise	Purpose	Description
4A: How stigma towards MSM leads to HIV infection	Enable participants to understand how stigma and the fear of being stigmatised stops MSM from accessing healthcare services. Understand the importance of communication between sexual partners about sexual health issues. Understand how stigma prevents MSM from practising safer sex, which increases the risk of catching and transmitting HIV.	The facilitator reads a story and participants break into small groups to discuss questions and issues arising in the story.
4B: Sharing experiences as MSM	Help participants feel less inhibited about talking about condoms. Share experiences and build team spirit.	Participants work in teams to complete a two-part task. The first part involves going out on the street; the second is a group discussion about sexual experiences.
4C: MSM and stigma cases studies	Explore MSM stigma in more depth through discussing real-life stories. Look at ways of challenging stigma.	Participants discuss case studies about different experiences of MSM and problem-solve the scenarios.

How to use the toolkit

Chapter 5: Disclosure		
Exercise	Purpose	Description
5A: Let's talk about disclosure	Enable participants to think about why it is important as MSM to disclose their sexual orientation or identity. Explore barriers to disclosing. Identify opportunities for disclosing.	The exercise starts with a quick brainstorm and then participants work in small groups to respond to key questions about the process of disclosing their sexual orientation and identities as MSM. The groups report back to the large group. The exercise is processed, with participants sharing their ideas, experiences and opinions.
5B: Disclosing our HIV status as MSM	Help participants to think about why as MSM it is important to disclose their HIV status. Explore barriers to disclosing. Understand how disclosure can help reduce 'compound stigma' associated with HIV and sex between men.	This exercise involves participants drawing in small groups of MSM and responding to key questions, then reporting back to the larger group. The participants share their work and the exercise is processed.
5C: Who should I tell?	Enable participants to identify who they should tell about their HIV status. Share some of the challenges involved in disclosing their HIV status.	This activity complements exercise 5B, so be sure to do that exercise first. Participants map their 'universe', with themselves at the centre. They identify three layers of important people in their lives to whom they may or may not disclose their HIV status, pointing out likely challenges and consequences of disclosure. Participants then map the 'universe' of 'a person like us'.
5D: Disclosing to families	Help participants to share experiences as MSM of disclosing their HIV status to family members. Prepare storyboards and practise disclosing to family members in role-plays.	In small groups participants share experiences of how they have disclosed (or not) to family members as HIV-positive MSM. They identify common elements in the process of disclosure, and develop a storyboard to present to the large group as role-plays. The exercise ends with a discussion about coping strategies to use if disclosure to family members becomes a negative experience.

Chapter 6: Sex, gender and stigma		
Exercise	Purpose	Description
6A: Gender boxes	Explore society's expectations of our roles as men and women and share different experiences of stepping outside of traditional roles. Deepen understanding of the relationship between gender roles and stigma, and examine the link between homophobia and gender stereotyping.	Participants work in gender groups to explore definitions and expectations of their gender. This is followed by discussion about stepping outside of gender norms and how this links to stigma.
6B: Sex, gender identity, gender expression and sexual orientation	Explain the meaning of gender identity, gender expression and sexual orientation. Use these concepts to explain different identities within the MSM community.	The exercise begins with a short explanation of definitions. Participants apply their understanding of the definitions by analysing character studies of different MSM.
6C: Lets talk about sex	Talk more openly about sex and their feelings about sex. Recognise how the taboos around sex link to stigma towards people living with HIV and other key populations.	Two exercises – choose one. <i>Our images of sex</i> is a simple brainstorm to get participants talking about sex. <i>Anonymous participatory sex survey</i> is a confidential survey that participants complete individually. The results are collated and shared, and trigger discussions about sex.
6D: Carrying condoms (and lubricant) carries stigma	Understand how carrying condoms and lubricant can be stigmatising. Think about different ways to challenge this form of stigma when talking about HIV.	The activity starts with a card storm. Then participants work in small groups to act out role-plays about attitudes to condoms and lubricant in different situations. Participants also think about their attitudes to lubricant.

How to use the toolkit

Chapter 7: Coping with stigma and fighting for our rights		
Exercise	Purpose	Description
7A: Stigma, assertiveness and human rights	Identify some of the rights that get violated if we are living with HIV or are from a marginalised group. Identify situations in which we may be denied our rights. Understand how we can use assertiveness to fight for our rights.	Participants work in small group to identify the rights of marginalised groups that get violated. In the large group they brainstorm the meaning of assertiveness and then practise using skills in paired role-plays.
7B: Strategies for coping with stigma	Help participants recognise different strategies for coping with stigma. Explore different coping mechanisms and how groups can support each other.	A buzz and card storm about individual coping strategies, followed by small group work to test out strategies in role-plays.

Chapter 8: Ideas for planning action against stigma		
Exercise	Purpose	Description
8A: Start with a vision – world without stigma	Help participants to begin to define what the result of successful interventions would look like. Identify some key obstacles to challenging stigma and identify specific actions that need to be taken to challenge stigma.	A simple, yet creative exercise where participants imagine and draw a large shared picture of a world without stigma.
8B: Challenging stigma in our institutions	Help participants to identify points of stigma within different institutions. Develop action plans to make specific changes in institutions to reduce HIV stigma and discrimination.	An exercise that is designed to take place in an organisation or institution. It starts with a stigma-mapping exercise by walking around the building. After a debriefing, participants plan a meeting to discuss how to tackle the stigma that has been identified.

Chapter 1: Identifying stigma

Identifying stigma

The exercises in this chapter can be used at the beginning of a workshop or the start of a stigma reduction activity. The exercises help people to identify what stigma looks like in their community or from their perspective. Several of the core exercises are contained in this chapter.



Two women are gossiping about the HIV status of their female colleague (sitting at the back). They don't want to use her teacup.



Facilitator's notes

This is a good starter activity to get participants talking about stigma and doing a simple task in small groups.

At this point participants start by analysing stigma externally – by commenting on what they see in the pictures – and then relate the pictures to their own experiences.

It is a good lead into the reflection exercises.

During the report-back you could use different handclaps to ‘appreciate’ each group.



Objectives

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

- identify different forms of stigma in various contexts
- identify how stigma affects individuals, families and communities
- identify different types of stigma faced by MSM, sex workers and people living with HIV
- begin to understand why stigma happens
- discuss examples of stigma from their own communities.



Target audience

All



Time

1 hour

Participants work in small groups. Each group looks at and discusses the pictures that have been displayed on the wall. After a few minutes groups select one picture and discuss three key questions. Participants come together for report-back and plenary discussion.

Step-by-step activity

Picture discussion

1. Display the selection of stigma pictures on the wall (or floor).
2. Divide participants into small groups of two or three people. Ask each group to walk around and look at as many pictures as possible.
3. After a few minutes ask each group to select one of the pictures. Ask them to discuss the following questions (you could give a question sheet to each group):
 - *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 own community? If so, discuss some examples.*

Report-back

4. Ask each group to present their analysis.
5. Record key points on flipchart sheets.

Processing

6. Read through key points from the flipchart, especially those that reflect forms, causes and effects of stigma.
7. Ask the whole group, “*What do we learn from this exercise?*”

Summary

Use the points raised by the participants to show the different forms of stigma that take place. Add the points below if needed.

Forms of stigma

Moral judgments – people blamed for their ‘behaviour’. Since HIV is a sexually transmitted infection, people assume that the person has had many partners or extra-marital affairs, or has ‘sinned’. If someone does not conform to society’s norms they may be blamed because of their lifestyle or sexual choices; for example, if they are MSM.

Separation – physical or social. People may not want to associate with us if we are living with HIV or if we are MSM. They distance themselves from us. This creates an ‘us’ versus ‘them’ dynamic.

Devaluing people is a dynamic of stigma. Stigmatised groups may be treated as useless and no longer able to make a contribution. This undermines self-esteem and self-confidence. It also acts as a control mechanism. People feel they are being watched all the time.

Self-stigma – some people may blame and isolate themselves as a reaction to stigmatisation from society. They internalise the shame and blame of society. Sometimes they even accept it as normal.

Stigma by association – partners, family members or orphans may get stigmatised. The family status or honour is affected.



Materials and preparation

- Copies of the stigma pictures (see pages 84–91) – laminated for a long life, if possible
- Display pictures around the room, leaving enough space for participants to crowd around them
- Write questions on a flipchart or make copies of questions for each group



Action ideas

- Give participants a set of photocopied pictures. Ask them to take the pictures home and discuss them with family members and friends.
- Help others to see how stigma impacts on people's lives.

Gender-based violence – the violence and stigma and discrimination faced by MSM often find their roots in homophobia, or fear of homosexuality, as well as a general fear of those whose gender identity does not adhere to traditional gender norms. Those who enact violence against MSM may feel a sense of entitlement to greater power based on perceptions that their gender is of a higher social status than that of the victim. Moreover, evidence points to the fact that intimate partner violence faced by MSM mirrors intimate partner violence that women experience – the perpetrator uses violence as a way to maintain power and control over the victim. In this way, violence against MSM can be considered a form of gender-based violence. Gender-based violence is also targeted toward MSM: it is experienced both early in life, often as child sexual abuse, and later as punishment for breaking social norms around masculinity or in an effort to prove masculinity.

Examples from the MENA stigma training workshop

Naming stigma through pictures

MSM cannot be open about who they are in public. When they are discovered they can face violence or blackmail.

Where the young girl is pregnant, maybe she is not married and the family is worried about losing their honour. They reject her to protect themselves. The power of dishonour within Arabic culture and society is very powerful and cannot be neglected.

Employers do fire you if they know your status. HIV and AIDS are misunderstood by the majority of people (especially by employers). Many prejudices exist around the productivity of an HIV-positive person. Many employers and Arab companies require an HIV test as part of the recruitment process, as well as the work permit application process for non-nationals in many countries in the region.

As MSM we are not even free to relax and enjoy ourselves openly. You can see the way people are looking at us.



Objectives

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

- describe some of their own personal experiences of stigma
- identify some of the feelings linked to stigma
- understand how stigma can impact at the individual level.



Target audience

All



Time

45 minutes



Preparation

- Arrange the chairs separately so that each person can sit alone
- Decide how you will bring the group together at the end

Participants sit alone and reflect on a time when they have experienced isolation or rejection. Then they discuss their experiences in pairs.

In the large group, participants who feel free to share their experiences are given time to do so without coercion. Some processing questions are discussed to see what has been learnt from the reflection. The session ends with a song or activity that brings participants together.



Facilitator's notes

This is one of the most important exercises in the toolkit because it makes the discussion of stigma more personal. It asks participants to reflect on their own experience of being stigmatised and how it feels. These feelings help participants get an insider's view of stigma – how it hurts and the impact it can have.

The exercise looks at stigma in general, not just HIV-related stigma. This is why the instructions are, *"Think of a time in your life when you felt isolated or rejected for being seen to be different from others."* Sometimes the reflection can trigger painful memories for participants. Acknowledge this and check that everyone is OK at various points in the exercise. If you can, use outside space for the reflection.

You might have to push people a little to sit alone for Step 1. Participants may automatically sit together.

The sharing in the big group should be voluntary – no one should be forced to tell their story. The final step of bringing the group back together is very important. Make sure you agree with your co-facilitator what you will do.

Step-by-step activity

Individual reflection

1. Introduce the exercise as a simple reflection that can be very difficult to do. Ask participants to sit alone, at a distance from other participants. If possible use outside space.
2. Then say, *"Spend a few minutes alone thinking about a time in your life when you felt isolated or rejected for being seen to be different from others."* Explain that this does not need to be about HIV. It could be any form of isolation or rejection for being seen to be different (by family, peers, friends and so on). Ask them to think about, *"What happened? How did it feel? What impact did it have on you?"*
3. Tell participants that after spending a few minutes reflecting alone, when they feel ready they can pair up with a partner and share their experience with someone with whom they feel comfortable.

Report-back

4. Arrange chairs in a close circle. Bring the large group back together. Begin by asking, *"How was the exercise? What kind of feelings came up?"*
5. Invite participants to share their stories in the large group. Give people time. There is no compulsion – people will share if they feel comfortable.
6. This can be an emotional exercise. Find a way to bring participants gently back to the group. You could ask participants to stand and hold hands, and use a gentle song to come together.



Examples from the Tunisia stigma training workshop

Our own experiences of stigma

During my teenage years I noticed that I was different. I wasn't like my friends, and I began to notice that I liked men. I knew it wasn't the norm in my circle of friends and family. I felt inferior. I became very withdrawn and alone most of the time to protect myself.

I was married for 10 years without children. A lot of people started stigmatising me. Some people were even thinking that I would never have children. It was so stigmatising: every time there was someone getting pregnant, people would look at me strangely and wonder what was wrong with me.

I have to be very careful about who I tell about my status. I have discovered that HIV is not just any illness. As soon as someone finds out, I notice how they change towards me. I feel a distance grow between us. Now I only tell people I trust.

J'ai le VIH depuis cinq ans. Je n'accepte pas ma situation. Des amis m'ont aidé et m'ont convaincu d'aller à l'hôpital pour me soigner et prendre mon traitement ... à l'hôpital les agents d'accueil et les infirmiers ont remarqué que j'étais différent et là c'est le début de mon calvaire, j'étais stigmatisé et j'ai fini un jour par trouver à l'entrée du service infectieux une pancarte avec mon nom et c'est marqué : ce gay à le sida.

Cela m'a énormément choqué et j'étais désespéré ... j'ai donc arrêté de prendre mon traitement, je suis maintenant entrain de perdre du poids et mon moral est au plus bas.



Facilitator's notes

This is a high-priority activity and we encourage all groups to use it. It helps participants to analyse and understand the forms, causes and effects of stigma using the problem tree method for analysis.

You can expand the session by following the stigma problem tree exercise with the optional activities.



Objectives

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

- identify different forms of stigma and how stigma affects people
- identify some of the root causes of stigma.



Target audience

All



Time

45 minutes



Materials and preparation

- Draw a large outline of a tree on a flipchart to stick on the wall
- Have three sets of different cards (different colours or shapes) and a marker for each pair
- Arrange chairs so that participants are facing the wall for the card storm

Participants discuss in pairs and write on cards all the forms of stigma that have been mentioned so far in the workshop. They then discuss and write down the causes of stigma, followed by the effects. The cards are clustered by participants, then discussed and used for further analysis.

Step-by-step activity

1. Ask participants to work in pairs. Think about all the different forms of stigma we have discussed so far. Write each example on a card and tape the cards on the wall near the position of the trunk of the tree (see diagram on page 23).
2. Then move on to discuss and write cards for the causes of stigma (roots) and then the effects of stigma (branches).
3. Ask for volunteers to cluster similar points together for each category and then to give a summary of each part of the tree.
4. Discuss the different levels of stigma in each section. For example, the impact of stigma begin with the immediate effects, followed by the impact on individuals (isolation, rejection by family), spin-off effects (loss of jobs) and wider effects on the economy (loss of employment, lack of productivity, no development). When you discuss the causes of stigma, look for the ‘root’ causes that underlie some of the immediate judgments. For example, strong religious beliefs might lead to judgments about morality.

Processing

5. Ask participants:

- *What do you see here?*
- *What stands out for you?*
- *What does the tree show us?*

6. If you want to, you can choose to expand the session with the following optional activities.

Option 1: Further analyse the cards

Participants can further analyse the cards in small groups. One group looks at effects:

- *What are the effects on the family, on marginalised groups, the community, the nation?*
- *How can we as programmers/trainers minimise the effects of stigma?*

And the other group looks at causes:

- *Why is this a root cause? Can you explain, using examples?*
- *What can you do to change or challenge the causes of stigma?*

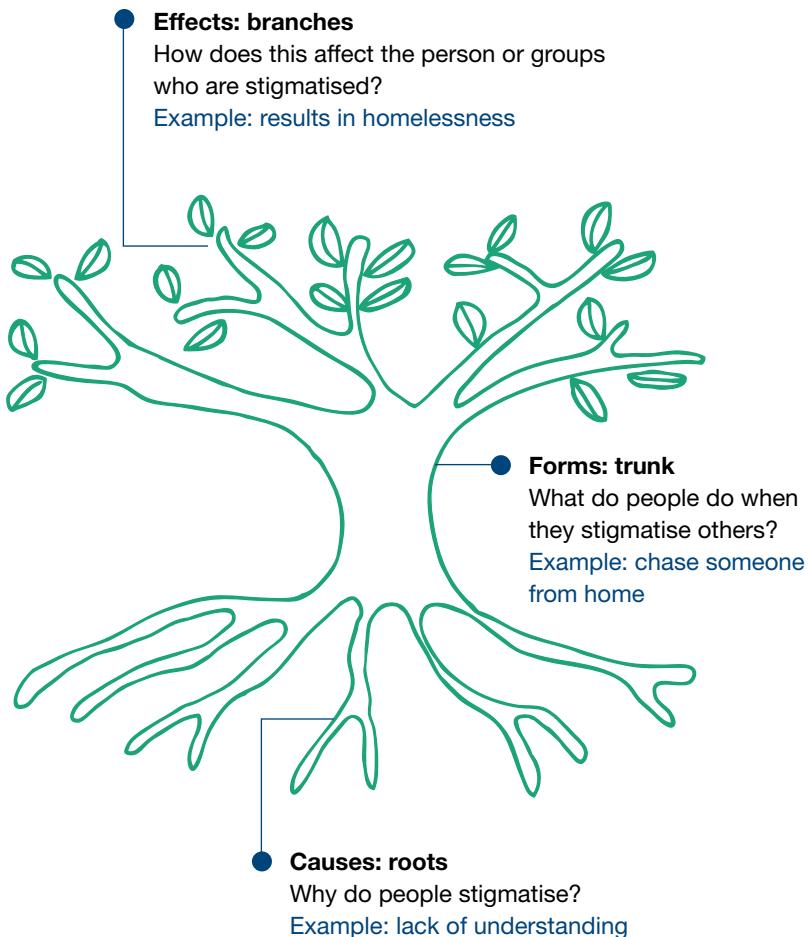
Option 2: Planning action

Organise a topic group for different cards and ask groups to do a detailed analysis:

- *As people who are concerned about stigma, what can we do to change these root causes?*
- *How can we design our HIV programmes to support marginalised groups such as MSM to deal with the effects of stigma?*



The problem tree



Examples from the MENA stigma training workshop

Forms, causes and effects of stigma

Forms: Being chased from home; not welcomed at the clinic; rejected by family; finger-pointing; name-calling; being attacked; violence; losing your job; mistreated by police; blackmail; loss of inheritance; devalued.

Causes: judgments; blaming; lack of confidence in own sexuality; conservative religious beliefs; fear of infection; ignorance; poverty; belief in myths; moral judgments.

Effects: isolation; loss of dignity; viewed as an object; suicide; depression; loneliness; going into hiding; increased HIV infections; increased risk-taking; breakdown of family relations; low self-esteem; loss of family honour.



Facilitator's notes

This is an alternative exercise to the problem tree. The exercise is good at the start of the workshop. It helps people identify stigma from their own experiences. It uses an 'Aha!' technique – a step-by-step analysis, using different-coloured cards. If you have enough space, set up each group card storm on a different wall.



Objectives

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

- identify the forms, causes and effects of stigma faced by key populations
- identify the different contexts where stigma faced by key populations occurs.



Target audience

All



Time

1 hour



Materials and preparation

- Different-coloured cards, markers and sticky stuff or tape
- Plan which spaces you will use for the card storms

This exercise is an alternative to 1C, and involves small group card storms. Participants identify the different groups of people that are stigmatised in their society and work in small groups to analyse the stigma. Report-back is done as a gallery walk, going from one group to the other as the group members give presentations. The activity ends with a discussion about possible action.

Step-by-step activity

Buzz and card storm

1. Ask participants, "Which groups get stigmatised in our society?" Then write a card for each group and stick them on the wall in different parts of the room. Use a different colour for each group if possible.
2. Divide participants into small groups and hand out cards and markers. Ask each group to focus on one of the identified groups that get stigmatised and discuss the following questions, writing points on cards (one point per card):
 - What are some of the things that these groups get stigmatised for?
 - Where does stigma take place?
 - Why does the stigma happen?
 - What are the effects of this stigma?
3. Ask each group to cluster the cards into similar points and prepare a brief summary of the main points to the larger group.

Report-back – gallery walk

4. Walk around the different card storms together and listen to presentations. Ask any questions for clarification and take comments from participants.

Processing

5. In the large group, ask and discuss:
 - What are the effects of this stigma on key populations?
 - What can we do about it?

Summary

- Many groups get stigmatised in society in different ways and for varied reasons. This is usually because the groups are seen as 'different' from the norm and viewed as behaving outside of what is culturally acceptable.
- Many factors influence why some groups are more stigmatised than others. Often stigma is about power. Those with more power and influence in society use stigma and prejudice to keep others down.
- HIV has increased the stigma experienced by some groups, especially when people look for certain groups to blame for the epidemic. Sex workers, MSM and drug users have all been blamed.
- Stigma increases vulnerability to HIV. It leads to more isolation and secrecy, and makes it more difficult for people to talk openly about HIV or disclose their HIV status.



Examples from various stigma training workshops

Analysing stigma against key populations

MSM

Stigmatised for: not getting married; not being a 'real man'; being effeminate; gestures; voice; the way they dress; being different.

Where? School; work; family; cafés and bars; mosque; public ceremonies; local neighbourhood; police station; prisons.

Why? Lack of understanding; fear of difference; cultural beliefs; religion; judgments; laws that punish same-sex acts.

Effects: isolation; suicide; anger; unwanted or forced marriage; risk-taking; poverty; unemployment.

Sex workers

Stigmatised for: having multiple partners; earning money from sex; living a 'reckless' life; not conforming to societal norms.

Where? Family; clinic; bars; in the streets.

Why? Moral judgments; cultural beliefs.

Effects: living a secret life; violence; depression; children stigmatised; avoid attending the clinic; ostracised from local community and society; no marriage prospects.

People who inject drugs

Stigmatised for: being seen to be putting their lives in danger; being irresponsible.

Where? Home; clinic; in public; school.

Why? Fear that they are out of control; seen as not caring; seen as dangerous or rule-breakers.

Effects: further drug use; increased vulnerability to risk-taking; isolation; avoid seeking treatment.

People living with HIV

Stigmatised for: being 'careless'; being 'promiscuous'; seen as immoral.

Where? Health facilities; family; community; workplace.

Why? Fear; moral judgments; traditional beliefs.

Effects: lack of adherence; depression; loss of employment; suicide.

1E: Stigma towards MSM in different settings



Facilitator's notes

If you are working with a mixed group, be aware that some participants will want to blame MSM for the causes of stigma – for the way they look, dress, speak and so on (this might be internalised stigma if an MSM is saying it). Emphasise to groups that we are looking for why society *judges* MSM: there will be links with gender (*MSM are not real men*); culture (*this is not how we are*); religion (*it's immoral*), and so on.



Objectives

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

- describe how stigma takes place towards MSM in different settings
- begin to understand the forms and causes of this stigma
- understand how stigma affects MSM and impacts on HIV.



Target audience

All, MSM groups



Time

1 hour



Materials and preparation

Make cards with pictures or signs for each setting (such as café, police station, family, workplace, clinic, mosque or church) and stick them around the room

Participants work in small groups to analyse the stigma faced by MSM in particular settings. Types of stigma are written on cards and then groups prepare a role-play to show how this stigma happens.

Step-by-step activity

1. Ask participants to spend a few minutes walking around the room or area, stopping in front of the picture or sign for each setting to think about the type of stigma that MSM might face there.
2. Break into small groups and ask each group to choose one of the settings. In small groups, brainstorm the types of stigma you think MSM might face in these places. Write one point per card and stick the cards under the picture or sign.
3. Ask each group to prepare a role-play showing an example of stigma in their setting, and the way it affects the people involved.

Processing

4. Watch each role-play as a large group and discuss:

- *Were these realistic examples?*
- *What were some of the effects of stigma that were shown?*
- *What did we learn about the relationship between stigma and HIV prevention, care and treatment?*

Summary

Use the points raised by the participants and add the points below if needed.

- Stigma against MSM happens in many places. A person may face different types of stigma in different places, building up layers that can increase feelings of isolation and rejection.
- The right to education, healthcare and family support should not be denied just because a person identifies as gay or has sexual relations with other men.
- Stigma impacts on HIV prevention efforts. Sometimes MSM may not be able to access the right information about HIV, or may not feel able to go to a clinic because of the discrimination they face.

Optional step

Strategies for change

1. In small groups, discuss and write on flipcharts: *What would help to change things? Where can we start?*
2. Feedback from each group.
3. Agree on some action steps.

1E: Stigma towards MSM in different settings

Examples from the Tunisia stigma training workshop

Stigma towards MSM in different settings

School and university

Malicious gossiping; contempt; need to hide sexuality; rejection; reluctance to be in the same class as MSM; isolation; physical attacks; beatings; verbal attacks; hurtful and shocking words shouted at MSM; intolerance.

Cafés, bars and nightclubs

Violence; MSM are victims of beatings and injuries; denied access to nightclubs and bars; insulted when we try to enter; fingers pointed at us wherever we go because of the way we are dressed; contempt; sometimes insulted by the same people who would like to get involved with us; yelling; some people are reluctant to greet us or even to sit next to us; sometimes sex workers are the ones who gossip about us; aggressive looks.

Family

Assumptions; malicious words about us; rejection; isolation; denigration; lack of respect; hostile looks; contempt; insults; violence; brutalisation; giving us women's work; repercussions on other family members; mothers get blamed for son's behaviour.

Mosque or church

Gossiping; prejudice; banning; taboo (sex is taboo in religious and/or traditional families); punishment; exclusion; puritanism; *haram* (not allowed by religion); guilt; inciting intolerance.

Clinic

Received in an unfriendly way (looks, gestures, etc.) at reception; rejection – we feel like we are not wanted in the clinic; over-protection; our sickness is not taken care of by health workers; we are kept waiting or given another appointment; contemptuous looks by health workers; we are examined with disdain and contempt; bitter words about how we are dressed; we are asked to come another day; some medical doctors do not accept MSM in their clinics; treated like we have a psychological condition that can be cured.

1F: Mapping stigma in health settings



Facilitator's notes

This exercise helps participants to identify the different types of stigma experienced by members of key populations in health settings. It helps them identify how stigma can be a barrier to HIV services for many groups.

The exercise can be used with groups of health workers and with mixed groups, especially if there are members of key populations among them. Remember that some health workers may also be members of key populations. Participants can work together to share their experiences of stigma in health facilities.

Before you use this exercise, ensure that participants have been through one or two of the core exercises so they are familiar with the many forms of stigma.



Objectives

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

- identify different forms of stigma faced by key populations in various departments of a health facility
- identify how stigma acts as a barrier to accessing HIV services
- discuss ideas for tackling stigma in health facilities.



Target audience

Health workers, mixed groups



Time

1 hour



Materials

Cards and markers

The participants identify five different departments of a health facility and stick them on cards around the room. Participants then work in groups according to the key population relevant to that group. They discuss the kind of stigma they face in different departments. Each group reports back to the plenary.

Step-by-step activity

1. Ask the participants to identify five departments or services in the health facility that they believe to be priority services for vulnerable groups to access. These might be reception, sexually transmitted infection clinic, urology, antiretroviral treatment clinic, labour ward. Write each one on a card and stick these up around the room in different 'stations'.
2. Divide participants into four different groups representing MSM, sex workers, people living with HIV and people who inject drugs.
3. Give each group a pile of cards – a different colour for each group. Ask groups to move randomly around the stations, writing on the cards the different types of stigma they might experience in each place.

Gallery report-back

4. Move around the stations as a group and ask one member from each group to read through the cards and clarify any points. Allow time for discussion and experience sharing.

Processing

5. Come together as a group and discuss:

- *What are the similarities across the departments or services?*
- *What are some of the causes of stigma in these different places?*
- *What could help to change stigma in health facilities?*

Summary

Use the points raised by the participants and add the points below if needed.

- Stopping stigma will take a huge effort by everyone. The starting point is to change ourselves – the way we think, talk and act towards our clients and colleagues.
- Our health services need to be open and welcoming to all clients, regardless of sexual orientation or lifestyle. Health workers have a duty of care to provide services to all clients. Many groups who are stigmatised are at greater risk of HIV. They depend on health workers for clear information and equal access to services.
- As we start to understand more about the needs of clients from different groups, we can start to educate and challenge others. It takes courage to stand up and challenge others when they are stigmatising clients. However, this is one of the ways to stop stigma and reduce vulnerability. Breaking the silence and getting people talking openly is the first big step.
- Talk with your family, colleagues and managers about speaking out against stigma. Help everyone make these problems visible and unacceptable.

1F: Mapping stigma in health settings

Examples from a tool development workshop

Mapping stigma in a hospital

Reception area

Support staff treat you badly; look and gossip about MSM with more effeminate mannerisms; waiting time is longer – no one wants to see you; some staff insult you; if they know you use drugs they even refuse you entry.

Medical ward

Health workers don't want to carry out the procedures if someone is known to be HIV positive; you get passed to junior staff; told that there is no point in treating you.

Sexually transmitted infection clinic

Staff ask difficult questions about your history; told to bring your wife; judgments if you have an anal infection; no clear information available for MSM.

Labour ward

Women living with HIV get treated differently; some nurses shout at you and say you are irresponsible; you are just left on your own to deliver; nurses gossip – “Be careful of this one, she's positive.”

Optional step

Finding solutions and action planning (separate session)

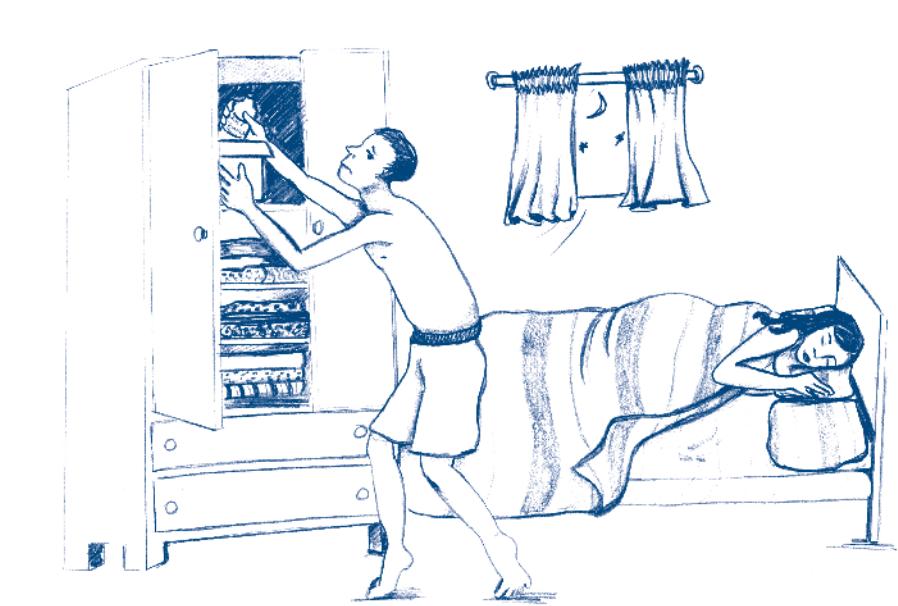
1. Divide into groups and assign each group to work on causes and solutions to the stigma in one of the settings. Emphasise that we are looking for actions that can be implemented by participants and their organisations (for NGO professionals), not recommendations for government.
2. Make a list of solutions – things you can commit to doing yourself or help organise in your health facility.
3. Prioritise two or three actions you will work on.
4. For each of the priority actions decide: Who will do it? How? To whom? With what?

Report-back

5. Each group gives a brief presentation of their ideas. Agree together how participants can support each other to ensure that the action plan is implemented.

Exercise 2 HIV and AIDS

Although HIV is no longer a new disease, there are still many people who have not had access to clear information about transmission of the virus. This is particularly so in countries where the epidemic is focused rather than generalised. It is often this lack of information that leads to the fears that fuel stigma. This short chapter has two exercises that help to assess participants' knowledge levels about HIV and address some of the fears that lie behind stigma – usually fears linked to myths and misinformation about HIV transmission.



A husband hides his antiretrovirals from his wife.

2A: Assessing knowledge levels



Facilitator's notes

The aim of these two exercises is to help the facilitator gain a sense of the participants' knowledge levels of HIV.

Use the QQR factsheet (see page 34) as a resource for answering questions or clarifying areas of confusion.

Do not spend too long on these exercises or people will get bored. Emphasise that the games are not exams!



Objective

By the end of this session participants will be able to identify what they know and don't know about HIV and AIDS.



Target audience

All



Time

30 minutes

Choose one of these exercises only. With *Brainstorming on the move*, participants work in pairs to answer different questions that are posted on flipcharts around the room. When all the pairs have finished the responses are reviewed, and clarified where possible. In *Things we want to know*, participants are paired up then handed five cards. Each pair writes one thing on each card that they would like to learn about HIV. When they have finished, participants are asked to help with clarifications.

1. Brainstorming on the move

Preparation

Put up flipchart paper on different walls of the room and write a question at the top of each sheet (choose the questions to suit the group or add your own):

- *What is HIV?*
- *What is AIDS?*
- *How can you get HIV?*
- *What are the different ways you can have safer sex?*
- *How can you prevent HIV transmission?*
- *How can you live positively with HIV?*
- *What do we know about antiretrovirals?*
- *Which groups are more affected by HIV in our country?*

Step-by-step activity

1. Ask participants to walk around in pairs and write down:

- *What do you know about the topic?*
- *What are your questions, concerns or fears?*

2. Then review each sheet with the large group and ask participants to respond to questions, concerns or misinformation. As the facilitator you can clarify where necessary.

2. Things we want to know

Materials

Cards, markers

Step-by-step activity

1. Divide into pairs. Hand out five blank cards to each pair. Ask pairs to write on each card questions or something they want to know about HIV or AIDS.
2. Tape the cards on the wall. Eliminate any repetition.
3. Discuss each of the questions, with participants contributing their ideas. Help to sort out fact from misinformation. If any question is unclear to trainers and participants, ask the group to research this question for homework.



Objectives

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

- name their fears in relation to specific forms of non-sexual contact
- be able to give clear information about how HIV is and is not transmitted.

Target audience

All

Time

1 hour

Materials and preparation

- Decide which wall you can use for the card storm. Make copies of the QQR factsheet and sets of two different question sheets for the Margolis wheel. You will need cards and markers for the card storm
- Plan a brief break or energiser between the card storm and Margolis wheel to allow time to move the chairs.

In pairs, participants do a card storm of fears in the community around non-sexual transmission of HIV. They prioritise the most common fears and discuss the reasons behind the fear. The facilitator presents the QQR tool (see page 34). Participants then try out the QQR tool in a carousel/Margolis wheel.

Facilitator's notes

This is a high-priority exercise that explores some of the fears and misconceptions about transmission of HIV through casual contact – that is, non-sexual contact with someone who is HIV positive. For example, many people still believe that there is a risk of catching HIV just by touching someone or washing their clothes. This fear then manifests as stigma, where those people avoid physical contact with anyone who is HIV positive or suspected of being positive.

If information about HIV transmission is not clear, it leaves room for doubts and fears to grow. This exercise helps participants to explain transmission in a clear way. By asking, “*What fears do you think people in the community have about catching HIV?*” we find out indirectly what are participants’ own fears. We then have an opportunity to explore and dispel those fears.

Keep the group focused on non-sexual contact. If there are a lot of fears or questions about sexual transmission you can make time to discuss these later in the training.

The QQR tool is a useful way of explaining HIV transmission. Read through it to ensure you can explain it clearly to the group. If you are working with a mixed gender group, be sensitive to the fact that talking about sex can cause embarrassment. Emphasise that you are talking from a professional point of view. Alternatively, ask participants if they would prefer to split into gender groups for the discussion. If you are working with health workers, you can share the factsheet with the person in charge and ask them to contribute or clarify any points if needed.

The Margolis wheel technique provides an opportunity to see whether participants have understood the QQR tool and can give clear information about transmission. This is a semi-active technique to get people addressing different problems that are part of a single issue or different aspects of the same problem. Questions or topics are posted at different stations around a room or in different rooms. The group is divided into smaller sub-groups (the same number as there are stations). Each station has a recorder or rapporteur who notes down responses. After a set time (a few minutes), each group allocated to a station moves around to a different station and repeats the discussion, adding their comments to those of previous groups. This is repeated until all questions or stations have been covered by each group.

Step-by-step activity

Card storm

1. Introduce the exercise and explain the link between fear and stigma.
2. Divide participants into pairs and buzz, “*What fears do you think people in the community have about non-sexual, casual HIV transmission?*” Give one or two examples (you can catch HIV from shaking hands with someone or swimming in the same pool). Ask pairs to write single fears on cards and tape them to the wall.
3. Cluster similar fears. Then ask participants to prioritise, “*What do you think are the most common fears?*”
4. Hand out the QQR factsheet and give a brief presentation on the tool.



Margolis wheel

5. Organise a Margolis wheel (or carousel) with two circles of chairs facing each other: an inner circle and outer circle.
6. Ask those who feel confident to use the QQR factsheet to sit in the inner circle and be the 'experts', and those who are less confident will be the 'researchers' (sitting in outer circle, opposite an expert).
7. Give each researcher a set of questions to find the answer to. The researcher spends a minute with an expert asking one of the questions and listening to the answer. Then when a signal is given, the researcher moves chairs to a different expert and asks a different question. Allow researchers to change at least three times to collect the answers to the questions.
8. Then ask participants to change roles so that everyone has turn to practise using the QQR tool – the researchers become the experts and vice versa. Give the new researchers a set of different questions.
9. Come back into the large group. Ask, "How was the exercise?" Clarify any outstanding issues.

Sample questions for the Margolis wheel

(Note they are in the negative form to emphasise the lack of risk.)

- Can you tell me why it is **impossible** to get HIV from shaking hands with someone?
- Can you explain why there is **no risk** of getting HIV from sharing food?
- Can you tell me why there is **no risk** of getting HIV from a mosquito bite?

Summary

- As professionals working in HIV, it is important that we are able to give clear information about HIV transmission. This is in order to dispel fears that people may have about catching HIV, which can lead to stigma.
- Nearly all HIV is transmitted through sex. The other main forms of transmission are from mother to baby or from sharing injecting equipment.

Examples from the MENA stigma training workshop

Fears about non-sexual, casual transmission of HIV

Swimming in the same pool; working together; sharing an office; shaking hands; washing a dead body; sharing clothes; sweat; visiting a patient; sharing toilets; drinking from the same glass; eating from the same plate; eating with a person living with HIV; sleeping together; mosquito bites; saliva; childbirth; at the dentist; kissing; giving blood; getting a tattoo; sharp objects; praying together in a mosque or church.

QQR factsheet

QQR: quality, quantity, route of transmission

For HIV transmission to take place, the **quality** of the virus must be strong, a large **quantity** of the virus must be present, and there must be a **route of transmission** into the bloodstream. All of these three things must be present for someone to get infected with HIV.

Quality

For transmission to take place, the quality of the virus must be strong.

- HIV cannot survive outside the human body. It starts to die the moment it is exposed to the air.
- HIV is not an airborne virus.
- There is no risk of transmission from sitting close to or sharing the same room with someone living with HIV.
- If the virus is exposed to heat (for example, if someone bleeds into a cooking pot) it will die.
- HIV does not live on the surface of the skin; it lives inside the body. There is no risk from shaking hands or hugging someone. The only place the virus can survive outside the body is in a vacuum (like a syringe) where it is not exposed to air.

Quantity

For transmission to take place, there must be enough quantity of the virus to pose a risk.

- The only place that HIV is found in enough quantity is in semen, blood, vaginal fluids and breast milk.
- HIV is not found in sweat or tears.
- HIV can be traced in urine, faeces and saliva in laboratories but there is not enough quantity to pose any risk.
- Kissing, even deep kissing, poses no risk.

Route of transmission

For HIV transmission to take place, the virus must get inside your bloodstream.

- The body is a closed system – there are only certain points where the virus can enter (anal, vaginal, oral, intravenous).
- HIV cannot pass through skin.
- Even if you have cuts and sores, there is no risk for the following reasons:
 - If you have just cut yourself the blood flows outwards, away from the bloodstream. It is impossible for anything to swim into your body against that flow. Cuts do not suck things in.
 - If you touch someone else's cut their blood will not swim into your bloodstream (and yours will not swim into theirs).

Everyday common sense and hygiene

Common sense and normal hygiene mean that many of the things people worry about would not happen in everyday life. For example, you wouldn't share a toothbrush that was covered in blood; you would wash if you cut yourself; you would wear gloves or cover your hands if you were cleaning up someone's diarrhoea.

Remember, there must be enough quantity of the virus, the quality of the virus must be strong and there must be a route of transmission for the virus to get inside your bloodstream for there to be any risk.

Standard Precautions in healthcare settings

Some health workers worry about catching HIV through medical procedures. Standard Precautions are a set of measures to ensure that accidental exposure of health workers and clients to infected blood or body fluids is reduced to a minimum.

Standard Precautions are based on the assumption that all blood and body fluids are potentially infectious, whether they are from a client or health worker and regardless of their known HIV status. They should be applied to all clients. They include things like handwashing, wearing gloves, safe disposal of sharp instruments and proper waste management.

Women's vulnerability

Women have higher biological vulnerability to HIV, meaning that in unprotected heterosexual intercourse a woman is more likely to contract HIV from an infected partner. This is because semen has higher concentrations of HIV than women's vaginal excretions, and women have a larger surface area of mucosa exposed during sexual intercourse. Young women who are physiologically immature have even less of a barrier against HIV than mature women. Coercive or forced sex further increases the risk of HIV transmission to women.

Social factors stemming from gender inequalities aggravate this vulnerability. Inadequate access to education and employment opportunities forces many women to sell sex to survive. Economic and social dependence on men can limit their power to refuse sex or to negotiate the use of condoms. In addition, women and girls are often hardest hit by HIV and AIDS, since they take on the major share of care work by nursing the sick and caring for children affected and infected with HIV.

Women's vulnerability to HIV infection is often increased not only by their own behaviour, but by that of their partners. Married women are vulnerable to their partners bringing sexually transmitted infections, including HIV, into the home, from extra-marital relationships with female sex workers or with men. Several surveys in various countries have evidenced that many MSM in the MENA region commonly practise sex with women. MSM report being married or engaging in sexual intercourse with women as a means of coping with their same-sex preference in an extremely stigmatising environment. Having multiple concurrent partners increases vulnerability to HIV.

HIV transmission from mother to child

HIV can be transmitted from mother to baby before birth (HIV can be passed from mother to baby in the uterus), at the time of labour and delivery, and after birth through breastfeeding. In the absence of any intervention, an estimated 15–30% of mothers with HIV infection will transmit the infection during pregnancy and delivery, and 10–20% through breast milk. Women are more vulnerable if they are not aware of their HIV status during pregnancy. For example, their partners may be engaged in risky sexual practices that are hidden, which means women are less likely to perceive the increased risk to themselves and therefore the need for HIV testing for themselves or their child.

judgments and stigma

A lot of stigma is related to people's attitudes, beliefs and values that influence the way they view and judge others. Often these beliefs are deeply held and link to cultural and social upbringing. They are difficult to change!

This chapter contains exercises to help participants explore their own values and understand how these influence their behaviour.



A man has just been fired after his employer discovered his HIV-positive status.
“Fired! What am I going to do now?” he exclaims.

**Objectives**

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

- have a greater understanding of key populations most affected by HIV that also experience high levels of stigma and discrimination
- explore some of the complexities of stigma faced by key populations
- have discussed how stigma affects these groups and what can be done to address it.

**Target audience**

All

**Time**

1 hour

A panel is selected in advance. Participants submit questions about key populations also in advance to allow time for preparation. The key activity is a facilitated TV-style talk show with members of key populations on the panel.

**Facilitator's notes**

This exercise helps participants understand more deeply some of the issues facing key populations (marginalised groups). They can ask questions in order to understand the needs of those groups, especially in relation to health and HIV. It also provides an opportunity for members of key populations to tell their story and be listened to.

It is important to have members of those groups at the table. They must be properly briefed about the exercise and aware of what is being asked of them. The facilitator at the roundtable should be able to act like a friendly TV chat show host. They should ensure that the session is handled with sensitivity, and that the questions asked are not too intrusive or inappropriate.

This exercise has worked well with groups of health workers. If facilitated successfully, it can result in a real change of attitudes and greater understanding.

**Materials and preparation**

- Agree who will be on the panel. If you are working with a mixed group that includes members of key populations, the panelists can be from the group. If not, you will need to invite panelists from outside: members of MSM groups, sex worker projects, groups of people who inject drugs, or support groups of people living with HIV.
- Discuss the exercise with the roundtable panel in depth, ensuring that they are well briefed about what is being asked of them.
- Ask the participants in the audience to submit their questions in advance of the exercise (the night before, or during a break) to allow time for facilitators to edit the questions. Explain that they can ask anything they would like to know to help them understand more about MSM issues/sex work/living with HIV/drug use (depending on who you have on the panel).
- Read through the questions and combine any similar ones. Edit out any that are offensive. Arrange them in a way that will help panelists to warm up and discuss openly. You can even give the panelists the questions in advance so that they can prepare a little.
- Arrange the room with a table up at the front for the roundtable discussion.

Comments from the tool development workshop**Roundtable discussion**

Yesterday we got down to reality. It was a different approach. I want to thank the panelists.

I think I've seen a change in my attitudes. I'll think about people in a different way.

Topics came from real-life situations – sharing from real-life experiences.

We were anxious about doing the roundtable, but during the session we let out our emotions yesterday. It helped to make sure people understand our feelings.

Step-by-step activity

1. The facilitator introduces the exercise in the style of a TV chat show. They introduce the panel, or let the panel introduce themselves. The facilitator then explains that the aim is to listen properly to the voices of the panel as they answer the questions that come from the audience.
2. Try to have about 10 questions and allow the panel to discuss for up to an hour. If it feels appropriate, the audience can come in at the end with further questions.
3. It can be useful to reflect together on what participants have learnt at the end of the exercise (or the following day).

3B: We are all in the same boat!



Facilitator's note

This is a warm-up game or energiser to introduce the idea that we are all affected by HIV, and yet we stigmatise those who have HIV. You can use any game that eliminates or excludes participants. These games trigger discussion on how it feels to be eliminated or excluded from a group.



Objective

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

- recognise that everyone is at risk of getting HIV, so there is no point in stigmatising those who already have HIV.



Target audience

All



Time

15 minutes



Preparation

Decide where you will play the game

A short game where some participants are excluded, followed by questions and debriefing linking feelings and actions to stigma.

Step-by-step activity

1. Facilitate the game described below or use a similar local game that involves excluding people. Use the local language to make it easier for everyone to participate.

In the river, on the bank

Ask players to stand in a line, all facing in the same direction (or in a circle). Then explain the game.

Where you are standing is the bank. When I say, "In the river", you should take one step forward. If I say, "On the river", you should not move. Then when I say, "On the bank", you should take one step back to our starting position, here on the bank. If I say "In the bank", you should not move. If anyone makes a mistake, they will be eliminated from the game.

Then start the game. Give the commands quickly. If anyone makes a mistake, they should stand in the middle of the circle or facing the line. Play until only a few people are left in the game, then stop to debrief while participants are still standing.

2. Stop the game and ask participants to freeze (stay where they are standing).

Processing

3. Ask participants:

- Those who are out of the game – how do you feel?
- Those who are still in the game – how do you feel?
- How did the first one to be out feel?
- What happened when someone made a mistake?
- What can we learn from the game about stigma?

Summary

- This game shows us that 'We are all in the same boat'. There is no separation between 'us' and 'them'. We are all facing and living with this epidemic together. We are all affected. We have all taken risks at one time in our lives and many of us still do.
- Lots of people like to laugh at and make fun of others. But one day they may also 'fall into the river' and others will laugh at them. Remember, HIV can affect us all.
- Stigmatising makes us feel superior – that we are right and others are wrong.

Examples from the Morocco stigma training workshop

What can we learn from the game?

- People laugh when others make a mistake. This is a form of exclusion and makes the person eliminated feel bad.
- Laughing at others making mistakes can be interpreted as a form of blaming.
- Laughing at the behaviour of others happens naturally or unconsciously. It just comes out. Stigma is like this. Often we are unaware that we are doing it. We are only acting out the way we have been socialised.
- It is easy to make a mistake in the game – and in real life; for example, not using a condom or taking risks in our sexual behaviour.
- Those who were still in the game were watching and judging others' behaviour. This is just like the way we stigmatise.



Objectives

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

- identify the words and labels used by people to stigmatise marginalised groups
- understand better the link between language and stigma.

Target audience

All

Time

1 hour

Materials and preparation

- Set up four to six flipchart stations (blank sheets of flipchart paper on different walls of the room) with a heading on each sheet; for example, *Things people say about sex workers*, *Things people say about MSM*
- Your headings could also include people living with HIV, young single mothers, sexually active girls, people who inject drugs, orphans and widows – select the groups that are the most relevant in your area
- Have a marker pen for each group

Action idea

Try this exercise with your own community group or family and friends. Discuss the power of language and how it links to stigma.

The activity starts with a game that helps to divide participants into small groups. This is followed by a rotational brainstorm, listing the things people say about different groups. At the end of the activity participants sit in a circle and the activity is processed.

Facilitator's notes

This exercise helps participants to verbalise stigma towards different types of people. The language used can be very strong so the activity needs to be carefully facilitated.

In this exercise participants can express their own stigmatising labels for other groups under the cover of attributing them to the community. So while some of the words are those commonly used by the community, some are also 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 stigmatising words hurt. In debriefing this exercise it is important to focus on how participants feel about these names, rather than focusing on the words themselves. This helps to avoid embarrassed laughter. The whole point of this exercise is to help people recognise how these words can hurt.

Extra tips

- The number of flipchart categories depends on the number of participants and the amount of time you have. With many participants you will need lots of categories so that the groups are not too big.
- The rotational brainstorm is fun, but the real learning comes in the debriefing. So make sure you allow enough time/energy for this.
- You need to explore your own feelings about these issues before trying to facilitate this discussion with others.
- Try to create an atmosphere of seriousness and stay quiet, even if some people laugh.
- The exercise can make people feel sad and the group energy may dip. Be ready to use a song or other method to bring the group back together at the end of the exercise.

Step-by-step activity

Fruit salad warm-up

1. Set up the chairs beforehand in a circle. Write the names of groups on a piece of paper and go around allocating a role to each person according to the groups you have on the flipcharts. For example, say, “You are a person living with HIV”, “You are a sex worker”, “You are a young single mother”, “You are a sexually active girl”, “You are an MSM” and so on. Go back to the beginning of the list if necessary and 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 the names of two groups – for example, “People living with HIV” and “Sex workers” – all the people living with HIV and sex workers have to stand up and run to find a new chair. I will try to sit in a chair. The person left without a chair becomes the new caller – and the game continues. The caller may also shout “Revolution!” When this happens everyone has to stand up and run to find a new chair.

Start the game by shouting, “People living with HIV and sex workers”, and get the people living with HIV and sex workers to run to a new chair. Continue playing for a few minutes.

3C: Things people say

Rotational brainstorm

2. Divide into groups based on the roles used in the fruit salad game (for example, a group of sex workers, a group of orphans). Ask each group to go to its flipchart station. Hand out markers and ask each group to write on the flipchart all the things people say about their group (include all languages). After two minutes shout, “Change!” Ask groups to rotate clockwise to the next flipchart and add points to the next sheet. Continue until groups have contributed to all of the flipcharts and end up back at their original list.

Report-back

3. Bring everyone together into a large circle. Ask one person from each group to take turns to stand in the middle of the circle and read out the list of things people say from their flipchart. Ask them to say, “*I am a widow (or other group) and this is what you say about me ...*” (these exact words are important).

Processing

4. When all the lists have been read out, ask:

- *How do we feel about these names?*
- *Why do we use such language?*
- *When we use these words, what assumptions are we making about the person?*
- *What does this show us about the relationship between language and stigma?*

Summary

- We are socialised or conditioned to judge other people based on assumptions about their behaviour.
- MSM, people living with HIV and sex workers are often faced with judgments about their sexual morality.
- Remember, there can be layers of stigma and you can belong to more than one group. You could be a gay man who is HIV positive, or a young, pregnant, unmarried woman who is a sex worker. This means you get stigmatised for different things in different places – layers of stigma.
- All of these labels show that when we stigmatise we stop treating people as human beings. We forget their humanity when we use mocking or belittling words. This gives us a feeling of power and superiority over them.
- Stigmatising words *devalue* people. They have tremendous power to hurt and humiliate, and to destroy people's self-esteem and social status.
- Whether or not we agree with the way someone lives their life, we don't have the right to belittle them. We must look at everyone as a human being and empathise as though they are our sons and daughters, brothers and sisters. We can try to put ourselves in the shoes of the other person. How would we feel if we were called these names?

Examples from the MENA stigma training workshop

How do we feel about these names?

Sad; angry; humiliated; unfairly treated; rejected; embarrassed; ashamed; they are pointing fingers at me – it makes me sad and ashamed; I wish I could disappear; I feel really bad – rejected and criticised by others; they are pushing me away; it makes me feel unfairly treated – it's through no fault of mine I acquired HIV, but I am blamed; no wonder we keep our sexuality a secret; I feel hopeless; all my confidence is gone; I don't know how I will survive; I have teenage daughters and it makes me angry to hear these names.

3D: Value clarification



Facilitator's notes

This type of exercise can be used at the start of a training session to assess the opinions of participants. The difference of opinion can be used to drive the discussion.

It is a good idea to discuss the statements first with your co-facilitator to explore possible views about each issue. As much as possible, facilitators should avoid expressing any stigmatising judgments, regardless of personal values.



Objectives

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

- analyse why different people are judged differently
- explore why we make judgments about certain groups in society.



Target audience

All



Time

45 minutes



Materials and preparation

Make a copy of the questionnaire for each participant. Write the answers up on a flipchart with a simple results table – Agree/disagree/not sure – so that you can fill it in with the group



Action idea

Discuss the value statements at home with family or friends.

The activity starts with participants individually filling in a questionnaire (see page 42) about different value statements. The results are tabulated and discussed.

Step-by-step activity

1. Explain that the exercise is intended to help us reflect on our own values and beliefs. Hand out the questionnaires and emphasise that the answers are confidential. No one will know anyone else's answers.
2. Allow 10–15 minutes for participants to complete the questionnaires. Collect them in a bag or box (so that you don't see the answers).
3. Hand out the questionnaires so that everyone has someone else's. Read each statement and count how many participants have answered 'Agree', 'Disagree' or 'Not sure' to that statement.
4. Take time with each statement. Ask the group:
 - *What do you think of these answers?*
 - *What does this show us?*

Processing

5. When you have completed all the statements, ask the group:
 - *What have you learnt about your own values and beliefs from this exercise?*
 - *How might our values and beliefs affect the way we work with vulnerable groups?*

Summary

- Values play a key role in forming judgments. We often judge others based on our values.
- Our values are influenced by our upbringing, family, culture, religion and other social factors. They often change over time or according to our experiences.
- The more we are exposed to different cultures, the more flexible our values may become.
- Some values can lead to harsh judgments and cause us to stigmatise others who are different to ourselves.

3D: Value clarification

Values questionnaire			
Statement	Agree	Disagree	Not sure
A person living with HIV should eat and sleep separately from the rest of the family			
It is not natural for two men to be in a relationship together			
Family members should be told when a member tests positive for HIV			
People with HIV deserve it because they have been immoral			
All young people should have access to information about safer sex and HIV/sexually transmitted infections			
Islam encourages love and tolerance for our brothers and sisters			
People should be allowed to choose who they love, regardless of gender			
Condoms should only be available to unmarried people			
People who inject drugs should be able to access clean needles when they need them			
If you are friends with gay people you could become gay yourself			
Everyone should have access to free condoms – at all times and at any age			
It is unacceptable for women to express their own sexual desires			
A real man never rejects a sexual opportunity			
Sex work should be made illegal in all circumstances to reduce the spread of HIV/sexually transmitted infections			
Islam condemns women who have sex before/outside of marriage			
People who inject drugs should not be allowed to have children			

3E: Bingo!



Facilitator's notes

This is a simple mixer game that also helps us to see the assumptions we make about each other. It is good to use on the second or third day of a workshop when participants have got to know each other a little. It is not appropriate to use in a shorter workshop unless participants already know each other.

The game is fun, but make sure you include the debriefing so that participants reflect on their values and assumptions.

The Bingo! sheet should always include some questions that are sensitive or link to taboo topics, as this reveals personal values. You can change the boxes to suit the target group you are working with.



Objectives

By the end of this exercise participants will be able to:

- mix freely with others in the group
- reflect on the assumptions and values they hold about other members of the group
- understand how some topics are more difficult to discuss than others.



Target audience

All



Time

30 minutes

The activity is a fun-based game. Participants are given sheets of paper containing statements and questions. They have to find people who agree with the statements, and fill in the boxes. As soon as someone completes the boxes the game ends. Then the group reflects on what happened.



Materials and preparation

- Make photocopies of the Bingo! sheet for each participant.
- Write up the rules of the game on a flipchart:
 - The aim is to complete all the boxes on the page.
 - You need to get each box signed by someone who is willing to sign for that category.
 - Each player can only sign another player's card once.
 - Don't feel pressured to give out personal information if you don't want to.
 - The game ends when someone shouts "Bingo!" (or when 10 minutes is up).

Step-by-step activity

1. Explain how the game works. Each person has a sheet with 12 boxes. Each box has a description. You need to find a member of the group who fits that description and ask them to sign the box. When all boxes are signed, shout "Bingo!" You are racing against each other.
2. Play the game. When someone shouts "Bingo!" check their sheet and bring the game to a close.

Debrief the game

3. Ask participants:
 - *How was the game?*
 - *What happened during the game?*
 - *What did you learn?*

Feedback from the Morocco stigma training workshop

Bingo!

- Felt stigmatised – others made assumptions about me and what I do (like drinking alcohol, loving sex).
- Helped me become more comfortable with other participants – I was willing to say, "*I like sex*".
- Had to be quite firm in refusing to sign one of the boxes asked of me.
- The exercise helped me get to know others and to mix with the group.
- I was more focused on finishing and winning than paying attention to the questions and finding the right person to sign.
- We used different techniques to get signatures (negotiating, partnering up, bribing and targeting them).
- The rules did not state that one had to be truthful, but people generally assumed one had to be.

3E: Bingo!

Sample Bingo! sheet

Someone who speaks more than one language Sign	Someone who loves loud music Sign	Someone who loves to talk about politics Sign
Someone who loves to dance and drink alcohol Sign	Someone who uses condoms and lubricant Sign	Someone who loves sex Sign
Someone who has more than two children Sign	Someone who prays in the mosque every week Sign	Someone who has more than one girlfriend or boyfriend Sign
Someone who is a peer educator Sign	Someone who likes dressing up Sign	Someone who leads a secret life Sign

3F: Sex work and stigma



Facilitator's notes

This exercise gives participants an opportunity to understand more about sex work. If your organisation is already working with sex workers you can see if it is possible to invite one or two sex workers to share their stories. Be sure to brief them well, and brief your participants too. They should not ask questions that are too personal or intrusive.



Objectives

By the end of this exercise participants will be able to:

- understand better why some people sell sex
- explore their own attitudes to sex work
- understand how stigma towards sex workers can hamper HIV programmes.



Target audience

All



Time

1 hour

This exercise is based around sex work stories. It has two options: either a testimony is provided by a sex worker or stories are used that are based on real-life experiences. Participants listen to the story and then discuss their feelings and opinions in small groups.

Option 1: Testimonies

Preparation

- If you are inviting sex workers to speak, brief them about the purpose of the exercise. Ask them if they are happy to answer questions like:
 - *How did they start selling sex?*
 - *What are positive and negative aspects of sex work?*
 - *Have they ever experienced stigma because of their work?*
 - *What are their experiences of health services?*
 - *What can NGOs and health workers do to provide more accessible services for those who are involved in sex work?*
- One technique for helping people to give testimonies is for a facilitator to interview the person in front of the audience. This can be easier than just asking them to talk.

Step-by-step activity

1. Ask your guest speakers to tell their story or carry out an interview as described above.
2. Ask participants to buzz with the person next to them, to talk about what they felt about the story and decide if there is a question they would like to ask the speaker.
3. Get feedback or questions from each pair in a round robin.
4. Ask the speaker if they would like to respond to any questions or comments.

Processing

5. Ask the group:

- *What have you learnt from this exercise?*
- *What did we learn about stigma and sex work?*
- *How can we make our services more user friendly for sex workers?*

Option 2: Stories

Materials and preparation

Copies of the stories (see page 46) for each group.

Step-by-step activity

1. Divide participants into groups and give each group one of the stories. Ask participants to read the story together and discuss the questions.
2. Ask each group to report back about their discussions in the large group.

Processing

3. Ask participants to bring any thoughts or feelings back to the big group. Ask:

- *What did we learn about stigma and sex work?*
- *How can we make our services more user friendly for sex workers?*

3F: Sex work and stigma

Sex work stories

Nadia

Nadia was brought up in Rabat. Her parents died when she was nine years old and she went to live with her aunt. She was happy there at first, but her aunt's husband was very harsh and often shouted at her for the smallest mistake. Nadia always felt that she was treated differently from her cousins, and she was sometimes scared of her uncle.

When she was a teenager, Nadia started spending more time with one of the neighbours, Miriam, with whom she developed a friendship. Miriam was an older lady, and sometimes invited her to stay at her house when things got very difficult with Nadia's uncle. Nadia's aunt allowed her to stay as she understood that things were awkward for her at home.

Nadia noticed that Miriam went out a lot, and also that she had nice things like jewellery, perfume and clothes. Nadia didn't understand where Miriam got her money from, and asked her to explain since she would like to buy nice things too. So Miriam invited a male friend over one evening and then left him alone with Nadia. The man was kind to Nadia and asked if she would be his girlfriend. He offered her some nice perfume. Every time he came he would bring her presents, and soon the relationship became physical. Nadia didn't know how to say no as she felt grateful for the presents.

Slowly, Miriam suggested Nadia become friends with another man, who also brought her presents. As the men demanded more favours from Nadia, Miriam advised Nadia to ask for money. Nadia didn't know that Miriam also received money

from these men. This is how Nadia began selling sex. Rumours started spreading about Nadia in the neighbourhood, and her uncle told her to leave home as she was an embarrassment to the honour of the family. So Nadia had to share a room with another girl who was working on the streets in Rabat. She learnt how to invite clients to her house, and sometimes to a hotel. One night, Nadia's flatmate was accused of stealing from a client and was beaten. This frightened Nadia, as she realised this could happen to her too. She asked advice from one of the other sex workers who also used the hotel with clients, and she suggested Nadia contact a local NGO that helped sex workers.

Nadia received advice from the counsellors and peer educators at the NGO, and they also helped her apply for a job in a local supermarket. This earned her enough money to pay for a room with two other women she met through the NGO. Nadia is still not in contact with her family, but she feels safer now. She hopes to be able to meet someone who will not ask too many questions and will want to marry her because she is a nice person.

- *What stands out for you from this story?*
- *What kinds of risks has Nadia faced in her life?*
- *Do you think the story is realistic? Have you heard any similar stories about sex workers?*

Nabil

Nabil was 20 years old and studying foreign languages at the university. He loved modelling and dressing up in the latest fashion. Nabil's mother died when he was young, and he lived with his father, Mohammed, and grandmother, Fatima. Fatima did not approve of the way Nabil looked and dressed. She was always criticising him and worrying about what their neighbours might think.

One day when Nabil came home with a new hairstyle Fatima shouted at Mohammed, saying he needed to control his son. He was bringing dishonour to the family because he acted and dressed in a feminine way. Mohammed told Nabil that he needed to change the way he looked or he would have to leave home.

The situation deteriorated and Nabil decided to move in with a friend. He started to spend more time in bars, but he didn't have a job. One day Nabil, agreed to have sex with a man in exchange for money. He began to sell sex more in order to pay for his studies and living costs, since his family no longer supported him. He also started drinking more because many clients bought him drinks as they got to know him. Nabil started to miss classes at school and knew that he was getting into trouble. He missed his family but was scared to return home. He did not know how to get out of his situation.

- *What do you think about this story?*
- *What kind of risks did Nabil face?*
- *Do you know anyone who has been in a similar situation?*

3G: Preaching and stigma



Facilitator's notes

Religion can be a sensitive topic. However, many members of key populations have experienced stigma in religious settings, or have been stigmatised in the name of religious beliefs.

Many NGOs are now working with religious leaders, who can play an important role in challenging stigma. They can use their influence to promote positive messages and encourage greater acceptance.

Annex 2 offers some quotes from the Holy Quran and Hadith about human dignity and respect in the face of vulnerability, compassion, privacy and justice.



Objectives

By the end of this exercise participants will be able to:

- discuss the different forms of stigma that may occur in a mosque or church
- explore how religious messages can be used to challenge stigma and encourage greater love and acceptance.



Target audience

All



Time

1 hour

Participants brainstorm together about the different forms of stigma found in a mosque or church. In small groups, they explore different religious messages and stories that can be used to challenge stigma.

Step-by-step activity

1. Divide into buzz groups. Ask, “*What forms of stigma could be found in a mosque or church?*” Collect answers from each pair and record on a flipchart.
2. Role-play: divide into small groups and give each group one of the examples from the brainstorm. Ask them to prepare a short role-play to show how the stigma happens.
3. Watch the role-plays together and ask participants if they are realistic:
 - *Have they experienced or witnessed this kind of stigma before? Discuss some examples.*
 - *Why does this happen?*
4. Ask participants to return to their small groups and discuss which stories in the Quran, Sunna or Bible teach about love, tolerance and acceptance. How can we use these messages to promote acceptance and fight stigma (refer to examples in Annex 2)? Ask participants to write other examples on flipcharts and report back.
5. Buzz and brainstorm in the large group, “*How can we work with more religious leaders to reduce stigma at the community level?*” Record answers on a flipchart and suggest that participants identify possible activities to take back to their organisations after the workshop.

Summary

- Stigma occurs in all parts of society, including religious institutions. Some religious leaders preach lack of tolerance towards certain groups.
- Religious stories and texts contain many messages of love and acceptance that leaders can use to help to challenge stigma.

Examples from the regional MENA stigma training workshop

Stigma in a mosque or church

- Preaching against people with HIV. They say HIV is a punishment from God.
- Accusing gay men of being sinners.
- People living with HIV are asked to move in front to be prayed for.
- Don't handshake or sit next to the sick. Don't visit someone who is sick with HIV.
- Judgments about immoral behaviour, those who do not conform.
- People living with HIV not allowed to participate; for example, don't involve HIV-positive people in Quran study groups.
- Excommunicate HIV-positive members.

3H: Living with HIV case studies



Facilitator's notes

This exercise uses case studies based on real-life experiences to explore the different types of stigma that is particularly faced by key populations.

As the groups report back on the case study discussions, check out their ideas for solutions with the rest of the group. Be ready to ask for clarifications or explanations for any tricky answers



Objectives

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

- understand the impact of stigma on people living with HIV, particularly key populations
- share experiences of local resources and support services.



Target audience

All



Time

1 hour



Materials

Copies of the case studies (see pages 48–49)

Participants discuss in small groups case studies about people living with HIV, with some focus on the role that stigma plays in influencing disclosure. Participants share their knowledge of local resources and services.

Step-by-step activity

Case studies

1. Divide the participants into small groups and give each group a case study to read and discuss. Ask groups to record their points on flipcharts. Report back to the large group by sharing the case study and issues discussed.

Processing

2. Ask the groups:

- *What did we learn?*
- *What role does stigma play in influencing disclosure?*
- *What services can be provided for members of key populations living with HIV?*

Case studies about people living with HIV

Ali

Ali is 22 years old and has been with his boyfriend for the last two years. He has recently tested HIV positive and has decided not to tell his boyfriend yet. He has been given information about re-infection, and he also wants to protect his boyfriend, so he needs to start using condoms. However, he doesn't know how to start talking to him about it.

- *How can Ali start talking about condoms?*
- *Do you think Ali should tell his boyfriend about being positive? If so, how? If not, why not?*
- *If Ali lived in your area, what types of services could Ali go to for support?*

Jamilla

Jamilla is 19 years old and is the youngest member of a new support group for people living with HIV. She is keen to represent young people who are HIV positive, but feels that sometimes she is not taken seriously by older group members. She finds it difficult to speak in meetings when everyone talks loudly. Although she is thinking of leaving the group for this reason, she would rather stay involved in it because she cannot talk about HIV to her friends.

- *Why do you think the rest of the group do not take Jamilla seriously?*
- *What tips could you give Jamilla to help her be heard in the group?*
- *What particular issues do young people face when they are living with HIV that older people may not recognise?*
- *Are there any services available specifically for young people in your area?*

3H: Living with HIV case studies

Ibrahim

Ibrahim is 20 years old and is living with HIV. He was rejected by his family and has been selling sex to men in the capital city for the last nine months to make ends meet. He often attends group meetings for MSM led by peer educators from a local NGO, but he has not told anyone there that he is HIV positive. He wishes he could be more open and talk to someone about his situation but does not know where to start. He fears they may reject him from the group because he is HIV positive.

- *What do you think are some of the reasons why Ibrahim has not told anyone in his peer education group about being HIV positive?*
 - *What can NGOs do to help people in Ibrahim's situation to be open about their status?*
 - *Are there any services in your area that could support someone like Ibrahim?*
-

Zahia

Zahia is a 23-year-old sex worker who is HIV positive. She is taking antiretrovirals and is very healthy. She always uses condoms with her clients but not with her boyfriend, who refuses to use them. Zahia is now worrying that she may be pregnant. She does not know whether to tell her boyfriend, and wonders how she will survive if she needs to stop working as a sex worker. She doesn't trust her boyfriend as he is unreliable.

- *Why do you think Zahia does not use condoms with her boyfriend?*
 - *What tips would you give Zahia to tell her boyfriend about being pregnant?*
 - *Are there any services in your area that could help someone in Zahia's situation?*
-

Hadi

Hadi is 20 years old and has recently found out that he is HIV positive. He has been seeing his new partner for just one month. He would like to tell his partner about the HIV result but is worried about what might happen. He is falling in love, and the thought of his partner leaving him has given him sleepless nights. He doesn't know what to do.

- *Do you think Hadi should tell his new partner about being HIV positive? If so, why? If not, why not?*
 - *Do you know anyone who has been in this situation? If so, discuss.*
 - *What role do you think NGOs or other service providers can play in supporting someone in Hadi's situation?*
-

Kaamil

Kaamil is 19 years old and has been using drugs for the last three years. Last week he injected drugs for the first time with a friend, sharing the same needle. Now he has started to worry about HIV but is scared to go to a clinic in case they find out about his drug use.

- *What do you think would help to reassure Kaamil to go to the clinic?*
- *What kind of support do you think Kaamil might need?*
- *Are there services in your area for people in Kaamil's situation?*

Stigma and MSM

This chapter contains exercises to use specifically with MSM participants. The exercises help to explore the stigma faced by MSM and how it impacts on HIV prevention, care and treatment. As participants share experiences of stigma, and strategies for coping with and challenging it, the exercises can be used to support capacity-building of MSM groups. Ideally, at least one facilitator should be from the MSM community.



Two men are gossiping about a rumour that the neighbour sitting next to them is an MSM.

4A: How stigma towards MSM leads to HIV infection



Facilitator's notes

One of the issues that can be explored in this exercise is how stigma can stop MSM from talking openly to each other about HIV and risk. Sometimes stigma among MSM towards those living with HIV increases vulnerability and risk-taking.



Objectives

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

- understand how stigma and the fear of being stigmatised stops MSM from accessing health services
- understand the importance of communication between sexual partners about sexual health issues
- understand how stigma can undermine people's commitment to practising safer sex, which increases the risk of catching and transmitting HIV.



Target audience

MSM



Time

1 hour



Materials and preparation

Write each question on a flipchart. If you are asking a participant to read the story, ask in advance to give them time to read it through first

The facilitator reads a story and participants break into small groups to discuss questions and issues arising from the story.

Step-by-step activity

Story

1. Read the story below to the participants (or ask a participant to read it).

Khalid

Khalid started to have sex with men when he was a young man but managed to hide this from his family. He knew that he was gay and was comfortable liking men. However, he was worried his family would find out and make his life miserable. Other MSM friends had been 'discovered' by their parents and their lives had become hell. He wanted to avoid this.

As he grew older he remained in the same town as his family but lived on his own. His family suspected he might be MSM, but they didn't bother him. Then when he became 30 they started to pressure him to get married. He agreed to marriage hoping they would leave him in peace.

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 they find out that he was MSM? How would he be treated? Although Khalid was married he had continued to have male partners, and had recently started a relationship with a man whom he really liked.

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

He started to worry about infecting his wife and his new male partner. So he insisted on using condoms with his wife. However, she got angry saying she wanted to have children. He was so worried about losing his new male partner that he had sex with him without using a condom. Khalid became very depressed and worried about what to do next.

2. Break into small groups. Give each group a different question to answer:

- *Why did Khalid behave the way he did?*
- *What role did the family and community play in Khalid's situation?*
- *How did stigma affect Khalid's disclosure to his sexual partners (his wife and his male partners)?*
- *How did stigma affect Khalid's use of health services?*
- *Thinking about Khalid's experiences, how does MSM stigma result in the continuing spread of HIV?*

Report-back

3. Ask each group to present their answers.

4A: How stigma towards MSM leads to HIV infection

Processing

4. Ask the whole group:

- *How can we help to challenge stigma towards MSM and reduce HIV transmission?*
- *How can we reduce HIV stigma between MSM so that we can talk more openly about prevention and care?*

Record answers on a flipchart.

Summary

Bring the session to a close by summarising the main points that participants have made during the exercise. Use some of the following points if participants have not already mentioned them:

- Stigma or the fear of stigma can become a barrier to MSM getting tested for HIV and sexually transmitted infections. It can prevent them from asking for condoms and lubricant from clinics. It can also stop MSM from insisting on condom use with their partners.
- Stigma stops MSM from being able to talk openly about their sexual orientation.
- Stigma can stop MSM from disclosing their status if they are HIV positive. Because of HIV-stigma, MSM are afraid to tell others about their HIV status.
- MSM can work with service providers to make services user-friendly to MSM. They can also raise awareness about how reducing stigma means MSM will be more likely to access health services and take precautions in sexual relationships.

4B: Sharing experiences as MSM



Facilitator's notes

This is a light exercise that could be used with MSM groups to help participants get to know each other.



Objectives

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

- feel less inhibited about talking about condoms
- share experiences and build team spirit.



Target audience

MSM



Time

1.5 hours

Participants work in teams to complete a two-part task. The first part involves going out into the street; the second is a group discussion about sexual experiences.

Step-by-step activity

1. Divide the participants into small groups of three or four. Explain that the first part of the task will take place outside.
2. Give instructions to the group. Tell them they have 20 minutes to complete the following three activities and return to the venue:
 - Find four people (a man, a woman and two young people) and ask them what they think about condoms. Write down their answers.
 - Find two different types of condoms (these could belong to a group member, or you could buy them or ask members of the public to provide them).
 - Find an object (for example, lubricant or a dildo) that you can creatively link to one of the following topics: sex, HIV or condoms. Use your imagination and creative skills to develop an explanation of why you have chosen that object.
3. As each group returns, give them the instructions for the second part of the task. Tell them they have 30 minutes to complete it.
 - Take turns to talk among your group about one of your first sexual experiences. Share as little or as much as you like. When you have all shared, answer the following questions as a group and present the answers on a flipchart:
 - *What are some of the similarities among the experiences you shared?*
 - *Did any of your experiences involve condoms or safer sex?*
 - *What advice would you give to young men who are starting to have sex with other men?*

Report-back

4. Ask each group to present their results from the two-part task. Make sure that all group members are involved in the presentation.

Processing

5. Ask the participants:
 - *How was it to work in your team?*
 - *What lessons can we learn from this exercise?*

Source: this exercise came from ATL, Tunisia, and has been used in their capacity-building programme with MSM peer groups.

4C: MSM and stigma case studies



Facilitator's note

These case studies are based on real-life experiences and can be used in several ways to explore different experiences of stigma. You can use them for small group discussions, role-plays or scenarios to practise challenging stigma.



Objectives

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

- explore stigma towards MSM in more depth
- discuss real-life stories and look at ways of challenging stigma.



Target audience

MSM groups



Time

45 minutes



Materials and preparation

- Copies of case studies (see page 55)
- Write up the stop-start technique (see opposite) on a flipchart

Participants discuss case studies about different experiences of MSM in small groups and problem-solve the scenarios.

Steps-by-step activity

- Divide participants into small groups. Give each group a different case study. Ask the groups to read their case study together and then discuss the following questions:
 - Why do you think this happened?*
 - What do you think about the situation?*
 - What could help to change things?*

Report back

- Ask each group to report back on their case study.

Stop-start drama

- Explain the stop-start technique to the group (see below). Ask the large group to choose one of the case studies that can be role-played. Ask for volunteers to be in the role-play. Give the players a few minutes to prepare (do an energiser with the remaining audience).
- Watch the role-play and use the stop-start technique to try out one of the problem-solving options.

Processing

- Ask the large group:
 - What do we learn from these case studies?*
 - What can we do to challenge stigma towards MSM?*

Stop-start technique

- Start the role-play and play it for a few minutes until the problem has been revealed.
- Shout “*Stop!*” and ask the actors to freeze – to stay where they are and stay in role.
- Ask the audience, “*What was happening in the role-play?*”
- Ask the actors, “*How are you feeling about this?*”
- Ask the audience, “*What do you think should happen next to help change the situation?*” Take a few suggestions and then agree with the group which one to try out.
- Start the play again and continue the technique until there is a resolution of the problem (try out another suggestion if the first does not work).

Case studies about MSM

Abdel

Abdel is 28, married and a father of two children. He had developed good relationships with his friends and neighbours. Although he is married, Abdel sometimes has sex with men. His family did not know about his sexual orientation. However, some people in his neighbourhood had their suspicions.

One day his family heard a rumour that Abdel was seen with a group of MSM. Since then he has faced rejection and threats in the neighbourhood and at his children's school. He finally left his house when he could no longer cope with the situation.

- *Why do you think this happened?*
 - *What do you think about the situation?*
 - *What could help to change things?*
 - *Do you know about any similar experiences among your community?*
-

Badiane Emile

Badiane Emile is a 42-year-old MSM who has always wanted children. He works in a bar where most of the customers are gay. Badiane's family has never accepted his job, and he has been rejected and isolated by them.

Three years ago Badiane met a woman with whom he had two children. She does not know that he used to have sexual relations with men. Last year he started getting sick, and since then has become progressively more ill. He keeps worrying about his health and whether he should go for an HIV test. His biggest fear if he tests HIV-positive is for his children's future.

- *Why do you think this happened?*
 - *What do you think about the situation?*
 - *What could help to change things?*
 - *Do you know about any similar experiences among your community?*
-

Zaheer

Zaheer is 25-year-old fruit seller who lives with his family in Marrakesh. He has three sisters and is very close to his mother. One day Zaheer was at home with his friend Bashir when his mother came back unexpectedly early from the market. She saw them kissing.

Zaheer's mother was shocked and no longer speaks to him. She told his father, who now refuses to acknowledge him. Zaheer's parents did not wish to tell anyone in the community, and also insisted that his sisters must never know. In fact Zaheer had already told his oldest sister but did not let his mother know this. The atmosphere at home is very tense and Zaheer has decided to leave as soon as he can afford to.

- *Why do you think this happened?*
- *What do you think about the situation?*
- *What could help to change things?*
- *Do you know about any similar experiences among your community?*

4C: MSM and stigma case studies

Mahfuz

Mahfuz is 26 years old and lived with his family in Algiers. Mahfuz is from a well-respected, religious family and is well known in the neighbourhood. Each day he went to the mosque to say his prayers.

One day his parents caught him in a compromising position with his friend's uncle. Mahfuz was evicted from the family house and the following Friday he was denied access into the mosque.

- *Why do you think this happened?*
 - *What do you think about the situation?*
 - *What could help to change things?*
 - *Do you know about any similar experiences among your community?*
-

Zaki

Zaki lives with his family. One day he went to meet some friends in town and chatted with them about arrangements for the weekend. Later that day he met a friend from the neighbourhood, who said, "I saw you earlier with that group of people. Do you know they are gays?"

Zaki thought that the friend was open-minded so told him that he is gay. The next day when Zaki went to the shop several neighbours stared and didn't greet him. Some even start shouting names at him. It seems that his friend had told everyone that he is gay. Zaki feels that he will not be safe or free to walk around any longer.

- *Why do you think this happened?*
 - *What do you think about the situation?*
 - *What could help to change things?*
 - *Do you know about any similar experiences among your community?*
-

Nabih

Nabih is a 35-year-old businessman. He is unmarried and living with his family. He has a girlfriend, Saba, and a male friend, Raashid, an MSM. Both are very supportive to him, and he does not mix with the gay community.

One day Nabih went to the hospital for a consultation. After the doctor asked Nabih some questions he concluded that he was an MSM. Then the doctor's attitude changed: he looked at Nabih as if he was no longer a human being. Nabih had trusted this doctor, believing he was tolerant and understanding. Now he felt insulted and ashamed. He vowed he would never go to a clinic again.

- *Why do you think this happened?*
- *What do you think about the situation?*
- *What could help to change things?*
- *Do you know about any similar experiences among your community?*

Lessons

The exercises in this chapter help participants to explore the process of disclosure. They look at why MSM may or may not choose to disclose their sexual orientation and, if applicable, their HIV status to others, and how to identify who those people might be. The exercises address the steps MSM can follow to come out in a safe and secure way. They include practical tips for coming out, and provide a space for participants to discover for themselves how they might benefit from disclosure.



A man is lonely and depressed because he feels he needs to hide his sexual identity.

What is disclosure?

Usually ‘disclosure’ (other terms include ‘coming out’ or ‘opening up’) refers to a person’s decision to share their sexual orientation or identity with others. Disclosure is a term also used to describe the process of an HIV-positive person making their status known to others. Disclosure doesn’t happen automatically. It is a personal process of understanding, accepting and valuing one’s sexual orientation or identity. It implies a person exploring their sexual orientation or identity, and making the decision to share it with others. Approaching disclosure as a process of steps and strategies can help people who decide to come out to do so in a positive way and to cope with societal responses and attitudes toward MSM.

MSM in the MENA region face many of the same difficulties most MSM encounter in other parts of the world. MSM almost everywhere are forced to come to terms with what it means to be different in a society that tends to assume everyone to be heterosexual and that judges variances from sexual and social norms in negative ways. The process of disclosure, being a very personal one, happens in different ways and at different ages for different people. Some people are aware of their sexual identity at an early age; others arrive at this awareness only after many years. Coming out is an ongoing and sometimes a lifelong process. Since positive role models are often difficult to identify in conservative or religious environments, MSM may feel alone and unsure of their sexual identities. Fear of rejection is greater in unfriendly and discriminatory social environments due to prejudice against MSM, and is normally linked to homophobia.

What is homophobia?

‘Homophobia’ is the term used to describe the irrational fear, hatred and aversion towards or discrimination against people who are gay, bisexual or MSM, or who are perceived to be gay, bisexual or MSM.

The three ‘I’s of homophobia

Internalised homophobia: fear or hatred of homosexuality that exists inside one’s own mind.

Examples include:

- making a determined effort to dress or act in such a way as to not appear to be gay or MSM
- having low self-esteem because of concerns around being gay or MSM
- a gay man discriminating against another gay man for acting ‘too feminine’ or ‘too gay’.

Interpersonal homophobia: homophobic speech and/or actions of an individual towards others who are, or who are perceived to be, gay, bisexual or MSM. Examples include:

- violence, physical harassment, name-calling, anti-gay hate crimes
- jokes that misrepresent or put down gay people, and the suggestion that we should ‘understand’ when we are treated differently.

Institutional homophobia: the ways in which government, business, churches and other organisations discriminate against gay and bisexual people and MSM. Examples include:

- policy or legislation that actively criminalises same-sex relations
- ignoring sexuality as a category on data collection sheets
- being prevented taking up from career opportunities or being fired from a job for being gay or perceived as gay.

Homophobia can be extremely hurtful and harmful, not only to your physical wellbeing and safety but also to your mental health and happiness and to society as a whole.

5A: Let's talk about disclosure



Facilitator's notes

Disclosing their sexual orientation or identity is an important concern for MSM, especially in unfriendly and discriminatory social environments.

Disclosure is never easy, and confidentiality is a key factor here. Remind participants of the workshop ground rule on confidentiality, and encourage the group to respect it and avoid judging each other. This is particularly important since disclosure may lead to discussions of sensitive personal, social and religious issues.



Objectives

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

- think about why it is important as MSM to disclose their sexual orientation or identity
- explore barriers to disclosing
- identify opportunities for disclosing.



Target audience

MSM



Time

2 hours 30 minutes



Materials and preparation

- Worksheet: Are you thinking about disclosing your sexual orientation or identity?
- Flipchart paper, markers, tape

The exercise starts with a quick brainstorm and then participants work in small groups to respond to key questions about the process of disclosing their sexual orientation and identities as MSM. The groups report back to the large group. The exercise is processed, with participants sharing their ideas, experiences and opinions.

Step-by-step activity

1. Tell participants that the exercise helps them think about why it is important as MSM to disclose their sexual orientation or identity, and to identify opportunities for disclosure. The exercise also enables them to explore barriers to disclosing. Make it clear that the exercise is intended to support them to make a right decision rather than impose disclosure on them.
2. In a plenary, facilitate a 15-minute brainstorm on disclosure. Ask:
 - *Who has already disclosed?*
 - *Why did you decide to disclose and how did it go?*
 - *Who has not disclosed yet?*
 - *Why have you not disclosed so far?*
 - *Do you think you will disclose soon?*
3. Divide participants into five small groups and hand out the worksheet (see page 61). Tell them they have 15 minutes to read the questions and comments.
4. Assign two questions to each group (they can be in any combination, such as questions 2 and 7) and tell them they have 30 minutes to discuss these in detail, providing examples of personal or known experiences of coming out or deciding not to come out. Ask each group to nominate a participant who will report back for the plenary.
5. Ask participants to write a summary of their discussions, including quotations and personal experiences, to present during the plenary.

Report-back

6. Come together as a large group and allow 25 minutes for the nominated participants to present the flipcharts, ensuring that other group members are also involved in the presentations.
7. Ask anyone who has already disclosed their sexual orientation to share one reason why they decided to tell others. Ask another participant to share a different reason. Keep going for 10 minutes until participants have shared a number of different reasons.
8. Then allow 10 minutes for participants to discuss on flipcharts how relevant they found the worksheet questions. Ask: *"Did the questions help you to decide whether or not to disclose your sexual orientation? What do you think was missing from the comments?"*
9. Allow a few minutes to highlight reasons why MSM might choose to disclose their sexual orientation, emphasising any reasons already identified by participants and adding some of your own. Make sure you include:
 - reducing feelings of isolation and stress
 - self-acceptance as MSM
 - peace of mind for MSM, family and friends
 - helping others overcome barriers to disclosure
 - regaining self-esteem
 - serving as a role model for peers who have not yet disclosed
 - preparing family members for possible homophobic attitudes of other family members, friends or neighbours.

5A: Let's talk about disclosure

Practical tips for disclosing

- Start with a family member who you are already close to.
- Find a time when it is easier for the family member to concentrate and a place where there will be no interruptions.
- Establish trust and warmth.
- Go slowly and at each stage notice how the person is responding.
- Ask for their advice and support.
- Disclose to other people gradually – each time you get a supportive response it will give you the courage to continue.
- If the response is poor and hurtful, you may decide not to continue to disclose.
- Use your own status to encourage others to be careful with their lives.

10. Based on their personal experience, allow a few minutes for participants to share ideas for diminishing or overcoming barriers to disclosure, and suggestions for making best use of opportunities to disclose.

11. Then allow a few minutes for them to identify reasons why disclosing as MSM presents an opportunity to reduce stigma around sexual diversity.

Processing

12. Discuss for 15 minutes:

- *How did you feel doing the exercise? Was it easy or difficult?*
- *If you haven't already disclosed your HIV status, how feasible would this be in your context?*
- *Was this exercise useful for you?*
- *What are some of the lessons you learnt?*

Summary

- Disclosing our sexual orientation as MSM is a crucial decision that needs to be supported and nurtured by family, peers and allies to minimise negative social reactions.
- Disclosing as MSM is not mandatory. Each individual has their own personal, family or professional reasons for coming out in their own time or deciding not to come out.
- Many people do not want to share information about their sexual orientation with others. This is their right and no one should force them to do so. However, they should consider that disclosure is closely linked to taking action to look after their own health and that of others, including actions related to HIV and sexually transmitted infection prevention.

Am I an MSM?

- Having a homosexual encounter does not necessarily mean you are gay or bisexual, just as smoking one cigarette does not make you a smoker! Of course, there will always be people who say that smoking one cigarette does make you a smoker. What makes you gay or straight (or a smoker) is having a history of behaving in a certain way, and using that history to predict how you will act in the future.
- If you have sex with men you could be anywhere on a continuum between gay and straight. Many people who later identify as gay have had heterosexual encounters, many of them satisfying. Many straight people, too, have experimented with people of the same sex out of curiosity or attraction. Remember, having sex with a man only once doesn't define your sexual orientation.
- Choosing an orientation for yourself is not a 'magic bullet' that will change how you feel. You can try to force a gay or bisexual identity on yourself just because you have sex with men, but the chances are you won't be very successful. For example, a male sex worker might have to accept that he is bisexual for commercial purposes but that his personal sexual orientation is heterosexual. There are no rules against identifying with a different orientation at a later date. For example, many transgender people first identify as gay before discovering more about their sexual orientation.

5A: Let's talk about disclosure

Worksheet: Are you thinking about disclosing your sexual orientation or identity?

You are a man who has sex with other men, although you may or not identify as gay or bisexual. You haven't told anybody about your sexual orientation yet, but you have been thinking about coming out to people who are important to you. Reflecting on these questions may help you to decide whether or not to disclose to them.

Ten questions to consider before coming out

1. Am I gay, bisexual or MSM?	If you are still trying to find out whether you are gay, bisexual or MSM, it is generally unadvisable to start telling people about your sexual orientation or identity yet. It is usually better to disclose only after you have finally accepted it, so you don't complicate your life unnecessarily by changing your mind later on. However, if you are particularly close to a family member or friend and don't tell them before they find out for themselves, they may be shocked. So you might want to talk to them early on in order to prepare them for your eventual decision. This may also help you decide how to go on to tell others.
2. I feel attracted to other men but I do not identify as gay or bisexual. Am I an MSM?	You are sexually attracted to other men and you have already engaged in sexual activities with men, but you do not identify as gay or bisexual. You like women too, and want to get married and have a family in the future. Disclosing as an MSM in these circumstances can be difficult. Consider talking first with your male sexual partners about how you feel. This is a way of opening up your sexual orientation and identity for discussion without putting yourself at risk with someone who is less likely to understand you.
3. How safe will I be or feel if I tell people I am an MSM?	Make sure you will be safe if you decide to tell others about your sexual orientation or identity. MSM have been thrown out of their homes or beaten by family members, and it is important not to endanger yourself. If your family is very anti-gay, conservative or religious, they may not take the news well and even attempt to 'cure' you. If this is the case, it may be best not to disclose until you can survive on your own. Alternatively, if there is an NGO that you trust and is good at handling situations like yours, ask them for advice about your sexual orientation and your wish to come out. The NGO counsellor might mediate between you and your family to help ensure your safety.
4. What kind of questions might people ask after I have disclosed? What answers might I prepare?	Many MSM date girls and women, and some go on to marry due to family and peer pressure. If a friend or family member knows you date women and then finds out that you also date men, they might ask, "So what happened? Have you stopped liking women?" Others might ask intrusive questions about who visits or calls you. They might want to know who you go out with and why you have male friends and no female friends. By preparing yourself for these kinds of questions, you have a better chance of avoiding trouble.

5A: Let's talk about disclosure

5. Who should I disclose to first?	Start with your best friends. They are likely to be the people who accept you most. However, if your friends have said negative things in the past about gay people, it might not be wise to start with them. In reality not everyone accepts homosexuality without difficulty, especially in very religious or conservative environments. This might also include your family. It is very important that you have a safety net should your family reject you so you are not alone. If you do not have a friend you can trust, you could talk to your sexual partners. As well as learning from their experiences, it might also help to express your concerns and worries with someone who is just like you.
6. What should I say to start disclosing?	Be prepared with a solid opening statement about yourself and your sexual orientation. If you hesitate or are evasive this might worry or confuse your friend or family member. It might also give the impression that you are ashamed or making the whole thing up. Simply make your statement calmly and then go on to discuss as necessary. For example, you could begin: " <i>Hi my friend, I called you here because I have something important to share with you. I'm gay, and you being one of my best friends, I wanted you to know and to get your support.</i> " Alternatively, you could start: " <i>I'm so lucky to have a good friend like you that I can trust. I've been going through something and I'm hoping I'll be able to count on you for your friendship and support once I let you know that I'm gay.</i> " Make sure you do not dramatise your statement unnecessarily – and let them know it is important to you. Just take a deep breath and say <i>it!</i>
7. How should I react after disclosing?	The people you choose to open up to are important to you. Understand that homosexuality in your family, community or locality may not be viewed positively, and if your disclosure were to go beyond your immediate circle, your friends or family might also be discriminated against. Be gentle with them and give them time to get used to the idea. Remember, you didn't just wake up one day and say, "Wow, I'm gay!" Just as it took time for you to accept it, it will take time for others too.
8. What kind of changes should I expect after disclosing?	Be aware that disclosing is likely to have a huge impact on your life. Some friends may need to distance themselves for a while. Some family members may act differently towards you: they may react angrily or even disown you. Others may be drawn towards you. Either way, things will certainly change. However, if you are patient and do not try to force the issue – but at the same time refuse to suppress or deny your sexual orientation – there is a good chance that the changes will end up being positive.
9. How should I react and behave after disclosing?	You will discover that disclosing to friends and family or acquaintances can be a relief. Coming out is great because they become aware of who you are and you no longer have to anticipate a difficult 'revelation' later on. If you are comfortable with casual acquaintances knowing about your sexual orientation, then the sooner you disclose the better. When people know who you are right from the start, they are more willing to simply accept you. It becomes harder to tell people after you've known them for a while because they have already formed their own idea of who you are. Try to act naturally and don't change how you behave. As more people in your social circle get to know you as an MSM, you'll have less explaining to do.
10. How can I cope with any backlash after disclosing?	If you have disclosed, it means you feel willing and able to discuss your sexual orientation with people who are sincerely interested and are important to you. Don't put up with people who just want to harass, humiliate or make fun of you.

5B: Disclosing our HIV status as MSM



Facilitator's notes

Disclosing their HIV status is an important concern for people living with HIV, especially in unfriendly and discriminatory social environments. Disclosure is never easy, and it can be particularly difficult when the person who has received a recent HIV-positive result belongs to a population that is highly stigmatised and discriminated against, such as MSM, sex workers (male or female), transgender people and people who inject drugs.

Confidentiality is a key factor. Remind participants of the ground rule on confidentiality, and encourage the group to respect it and avoid judging each other. This is particularly important since disclosure may lead to discussions of sensitive personal, social and religious issues.



Objectives

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

- think about why as MSM it is important to disclose their HIV status
- explore barriers to disclosing
- understand how disclosure can help reduce 'compound stigma' associated with HIV and sex between men.



Target audience

MSM



Time

1 hour

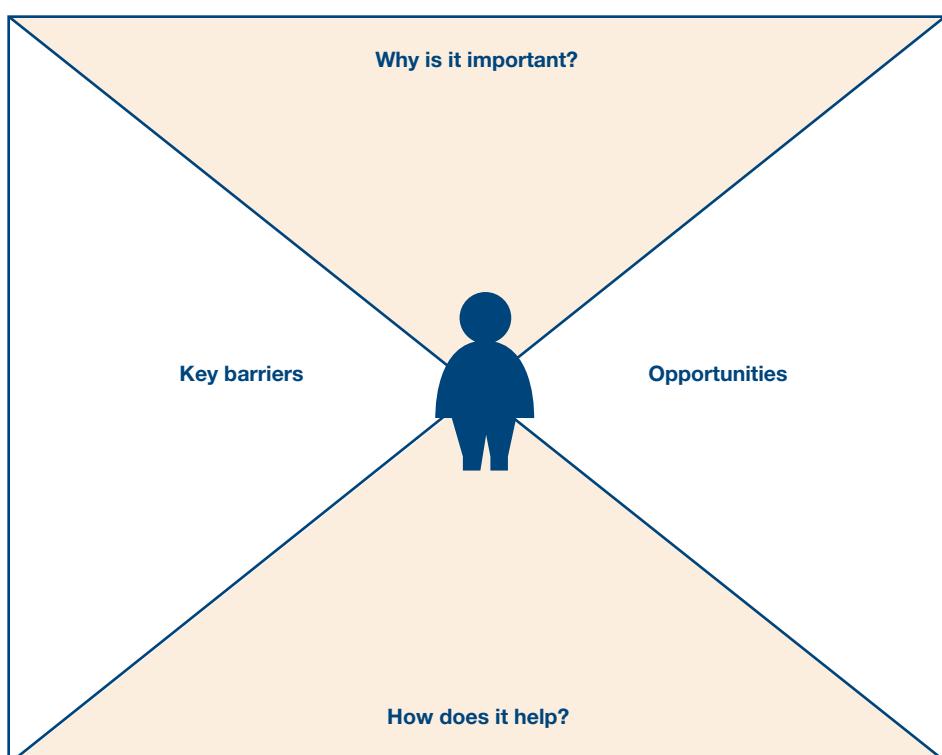
This exercise involves participants drawing in small groups of MSM and responding to key questions, then reporting back to the larger group. The participants share their work and the exercise is processed.

Step-by-step activity

1. Explain that the exercise will help participants to understand the benefits of disclosing their HIV status as MSM and identify opportunities to open up if they wish to. Make it clear that the exercise does not intend to persuade anyone to disclose; rather to help them make a decision that is right for them.
2. Divide into small groups and hand each participant a sheet of flipchart paper and markers. Ask them to draw a small picture of a 'person like us' in the middle of the paper and to give this person a name and some basic information about him (for example, single, married, age, work, studies). A 'person like us' should be someone typical in the community, such as 'a married MSM with three children', but not a real person or having the name of a participant or real person. Remind participants that the quality of their drawing is not important. Then ask them to divide the sheet into quarters (see diagram below).

Distribute a sheet of the following questions to each group and tell them they have 20 minutes to write responses to each question in the quarters:

- *Why might it be important for a 'person like us' to tell others he is living with HIV?*
 - *What are the most important barriers to a 'person like us' disclosing his HIV status (family, community, religion, work and so on)?*
 - *What opportunities can you identify in your context that might help you to disclose safely?*
 - *How can disclosure of our HIV status and sexual orientation help to reduce stigma around people living with HIV and MSM?*
3. Ask groups to tape their responses to the walls and tell them they have five minutes to review the work of the other groups and identify similarities and differences.



5B: Disclosing our HIV status as MSM



Materials and preparation

- Flipchart paper, markers, tape
- Questions on smaller sheets of paper

Report-back

4. Come together as a large group and ask each of the small groups to nominate a participant to do a short presentation of the flipcharts, ensuring that other group members are also involved in the presentation.
5. Ask anyone who has already disclosed their HIV status to share one reason why they decided to tell others. Ask another person to share a different reason. Keep going until participants have shared a number of different reasons.
6. Then ask if there is anyone has not yet disclosed their HIV status and invite him to share one reason why. Ask other groups to share different reasons.
7. Highlight any of the following reasons not already mentioned by participants why a person living with HIV would disclose their status to others:
 - reducing feelings of isolation and stress
 - self-acceptance, both as a person living with HIV and an MSM
 - peace of mind
 - having a safer and healthy sex life
 - planning to have children safely
 - planning their future and that of their family
 - preparing family members for possible ill health.
8. Ask participants to share ideas on ways to diminish or overcome barriers to disclosure and to make best use of opportunities for disclosing.
9. Finally, ask participants to identify ways in which disclosure as HIV-positive MSM provides an opportunity to reduce stigma around sexual diversity and people living with HIV.

Processing

10. Discuss:

- *How did you feel doing the exercise? Was it easy or difficult?*
- *If you haven't already disclosed your HIV status, how feasible would this be in your own context?*
- *Was this exercise useful for you?*
- *What are some of the lessons you learnt?*

Summary

- As HIV-positive MSM, disclosing our HIV status to family, friends and colleagues is a crucial decision that needs to be supported and nurtured by family, peers and allies to minimise any negative reactions.
- Disclosing as MSM living with HIV is not mandatory. Each individual has their own personal, family or professional reasons for opening up in their own time or deciding not to come out.
- Many people do not want to share their HIV status with others, nor the fact that they are an MSM. This is their right, and no one should force them to do so. However, they should consider that disclosure is closely linked to taking action to look after their own health and that of others, including actions related to HIV and sexually transmitted infection prevention.

5C: Who should I tell?



Facilitator's notes

It can be difficult for MSM to find a safe space to share concerns about living with HIV, and become empowered through listening to similar men communicating their life stories. Exploring the ‘universe’ of relationships that surrounds HIV-positive MSM and then sharing this universe with others, facilitates horizontal learning and provides participants with a range of insights and experiences. It also gives them a practical tool to more accurately identify the people in their universe to whom they can safely disclose their HIV status.



Objectives

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

- identify who they should tell about their HIV status
- share some of the challenges involved in disclosing their HIV status.



Target audience

MSM



Time

45 minutes



Materials and preparation

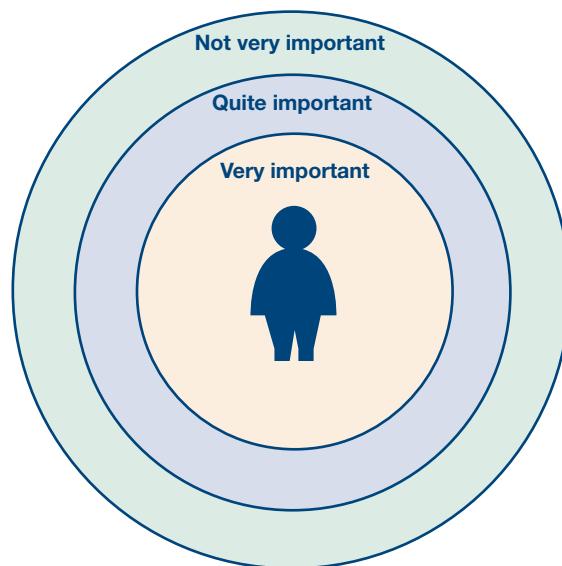
- Flipchart paper, A4 sheets of paper, pens and markers for each participant, three different-coloured markers per small group, tape

This activity complements exercise 5B, so be sure to do that exercise first. Participants map their ‘universe’, with themselves at the centre. They identify three layers of important people in their lives to whom they may or may not disclose their HIV status, pointing out likely challenges and consequences of disclosure. Participants then map the ‘universe’ of ‘a person like us’.

Step-by-step activity

Mapping the environment

1. In a large group, distribute A4 sheets of paper and markers, and tell participants they have five minutes to draw a map of their universe of relationships: for example, family, partners, friends, colleagues, neighbours (see diagram below).
2. Ask them to start by drawing a small figure or a symbol representing themselves in the centre of the page and then draw three concentric circles around it:
 - In the inner circle show people who are closest to them on a daily basis, such as partners, parents, children and siblings (*Very important*).
 - In the middle circle show people who are significant in their daily life but less close, such as a healthcare worker, neighbours, friends or a religious or community leader (*Quite important*).
 - In the outer circle show people who are present in their daily life but less important, such as work colleagues, a shopkeeper, the dentist or the hairdresser (*Not very important*).
3. While mapping out the people in their universe, participants should reflect on their reasons for either disclosing or not disclosing their HIV status to them.
4. Ask participants to form groups of five people and tell them they have five minutes to share the map of their universe with at least one other person.



Disclosing HIV status

5. Tell each group they have 15 minutes to draw ‘a person like us’ in the middle of three concentric circles, and identify people in the universe of the ‘person like us’ who are closest, people who are significant but less close, and people who are present but less important.

5C: Who should I tell?

6. Hand out three different-coloured markers to each group. Ask them to make a different-coloured mark next to each person to show how important it is for them to know that the ‘person like us’ is an MSM living with HIV:
 - Use colour 1 to make a mark next to people who it is *very important* for the ‘person like us’ to tell that he is an MSM living with HIV.
 - Use colour 2 to make a mark next to people who it is *quite important* for the ‘person like us’ to tell that he is an MSM living with HIV.
 - Use colour 3 to make a mark next to people who it is *not very important* for the ‘person like us’ to tell that he is an MSM living with HIV.
7. Ask groups to look at the people marked with colour 1 and list the reasons why it is very important for the ‘person like us’ to disclose to them. Then ask them to share some of the reasons why it is quite important for the ‘person like us’ to disclose to the people marked with colour 2. Finally, ask them to look at the people marked with colour 3 and list the reasons why it is not very important for the ‘person like us’ to disclose to them.
8. If some participants feel it would be important for them personally to disclose their HIV status to people who the group identifies as unimportant for the ‘person like us’ to disclose to, tell them that this activity can only highlight some of the issues concerning disclosure, and other issues are just as important.

Processing

9. Come together as a large group and ask each group to share highlights of their process using these guiding questions:
 - *What were the main similarities and differences between each other’s maps of the people who appear in each of the three circles?*
 - *How easy was it to get consensus on the people who appear in the three circles?*
 - *What were the main challenges to the ‘person like us’ disclosing his HIV status as an MSM?*
 - *Why might MSM living with HIV avoid disclosing their HIV status?*
10. It can be useful to have a closer look at why disclosure may be more difficult for MSM living with HIV. If some participants have already disclosed their sexual orientation but not their HIV status to significant people, explore further why this might have happened and how they feel about it. Ask:
 - *Why might it be particularly hard for younger MSM who have kept their sexual orientation secret to tell their parents that they are living with HIV?*
 - *Why might it be particularly difficult for MSM to tell their brothers that they are living with HIV?*
 - *How do family, community and religious traditions influence the decision of HIV-positive MSM to disclose or not? If MSM are still single, how can they cope with family and peer pressure to marry? How do they react to the way others treat them, knowing they are MSM but not that they are HIV-positive?*

Summary

- Disclosure to the important people around them is a crucial decision for MSM after acquiring HIV.
- Family, community and religious traditions can be significant obstacles to MSM telling other people they are living with HIV.
- Regardless of the difficulties disclosure entails, it is an important part of the lives of MSM living with HIV.

5D: Disclosing to families



Objectives

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

- share experiences as MSM of disclosing their HIV status to family members
- prepare storyboards and practise disclosing to family members in role-plays.



Target audience

MSM



Time

2 hours



Materials and preparation

- Flipchart paper, markers

In small groups participants share experiences of how they have disclosed (or not) to family members as HIV-positive MSM. They identify common elements in the process of disclosure, and develop a storyboard to present to the large group as role-plays. The exercise ends with a discussion about coping strategies to use if disclosure to family members becomes a negative experience.



Facilitator's notes

Supportive families are essential to the wellbeing of people living with HIV, and especially HIV-positive MSM. Disclosing their HIV status to family members can be a turning point in their lives.

If any participants have not yet disclosed their HIV status and sexual orientation to their families, suggest they imagine doing so. Expect some resistance due to fear, shame or low self-esteem.

Storyboards and role-plays enable participants to express their family's reactions of surprise, pain or shock, which can sometimes turn physically violent. Conversely, families can also express their acceptance, solidarity and love. The storyboards and role-plays help participants to become aware of what they say or do in response.

Underline how important it is to remember and record the exact expressions used by family members, regardless of the kind of language used. By faithfully capturing these words, it is possible to identify patterns in family attitudes that can help facilitate inclusion and solidarity. Discuss strategies to cope with being an HIV-positive MSM in the family setting.

Step-by-step activity

1. In a plenary, ask participants who have not yet disclosed their sexual orientation to family members to raise their hand. Now ask those who have done so to raise their hand.
2. Ask participants who have not yet disclosed their HIV status to family members to raise their hand. Now ask those who have done so to raise their hand.
3. Ask:
 - *Why did you or did you not disclose?*
 - *If you disclosed, was it your decision or did someone else tell your family?*
 - *How did you feel when disclosing?*
 - *How did your family members react?*
 - *How did you react?*
 - *What did your family members say?*
 - *What did you say?*
4. Divide participants into small groups of three to four people. Tell them they have 45 minutes to prepare and present a role-play:
 - Ask them to discuss in their groups how and why they disclosed their HIV status and sexual orientation to family members, including what they said and did, and what their family members said and did.
 - Ask the groups to prepare a storyboard in the form of a cartoon, capturing common elements from individual stories. Ask them to write in the text balloons the exact words family members used.

- Ask them to prepare a five-minute role-play using the storyboards. Present the role-plays to the large group.

5. Post the storyboards on the wall.

Processing

6. In a plenary ask:

- Were the role-plays realistic? Were they showing situations you are familiar with or that can easily happen?*
- What advice would you give to the characters to improve how they disclose their HIV status and sexual orientation to family members?*
- What do you think works best when disclosing to family members? What doesn't work?*
- If you have disclosed, what worked for you? What didn't work and what would you never do?*

Summary

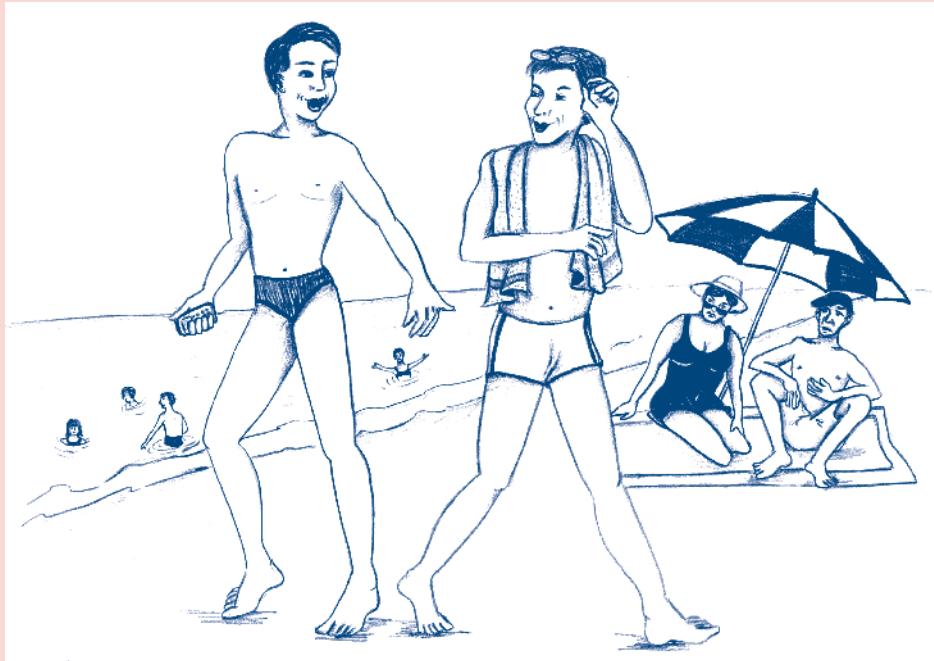
- During the activities we have been doing in this stigma workshop we have discovered that disclosing their HIV status to their families is an important moment in the lives of MSM.
- We have also seen how vital it is for people living with HIV to access safe and friendly spaces where they can address important issues such as disclosing their HIV status to family members, especially when they are MSM.
- By remembering the exact words used by family members towards MSM when they learn of their HIV status, we are able to go beyond possible harsh responses to identify coping strategies for MSM and their families.
- Personal histories of MSM successfully disclosing their HIV status suggest that ideally this should happen by choice, at a time to suit the MSM disclosing, and in a safe and confidential environment where the person can receive support if needed.

Remember!

- Coming out is a process that takes time. Don't rush it.
- Nobody but you should decide whether to disclose or not. Don't let anxiety or external pressure influence you.
- Be safe. If disclosing your sexual orientation or HIV status is likely to provoke aggression and bullying, consider your options and stay strong. Remember, discretion is the better part of valour. If it makes you safer to keep quiet with people who are likely to be antagonistic, then it is smarter to be discreet.
- If you aren't bisexual don't come out as bisexual to soften the blow. This can make you look confused about who you are. If you are gay, come out as gay.
- Sexual orientation is only one of many characteristics that define our identity.
- You didn't choose to be attracted to people of the same sex, and you will find that attempts to change your orientation are usually painful and pointless in the end.

Sex + gender stigma

The exercises in this chapter explore issues around gender and sex. People often link HIV to sex. Since cultural taboos can prevent open discussion about sex, many judgments and assumptions remain unspoken and these can lead to stigma. Although gender issues can be complicated they are important to explore. This is because homophobia and stigma towards key populations can be based on gender stereotypes.



A couple stare disapprovingly at the 'behaviour' of two young men.

6A: Gender boxes



Facilitator's notes

If you are working with a single-sex group you can either do just one gender box or ask half the group to focus on their opposite gender.



Objectives

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

- explore society's expectations of our roles as men and women
- share different experiences of stepping outside of traditional roles
- deepen understanding of the relationship between gender roles and stigma
- examine the link between homophobia and gender stereotyping.



Target audience

All



Time

1 hour



Materials and preparation

- Flipcharts and markers
- Optional – organise the room so there are two 'boxes' for participants to sit in (make the boxes with chairs and tables)

Participants work in gender groups to explore definitions and expectations of their gender. This is followed by discussion about stepping outside of gender norms and how this links to stigma.

Step-by-step activity

1. Divide the participants into women-only and men-only groups. If you have arranged the chairs as boxes, ask each group to sit in one of the boxes.
2. Ask each group to draw a medium-sized square. This is a gender box. Then ask them to draw a 'typical' woman (for the women's group) or man (for the men's group) inside the box.
3. Discuss the qualities, roles and behaviour that society expects of the 'typical' woman or man, and draw or write the key points inside the box.
4. Ask the participants to discuss where those expectations come from.
5. Ask the participants to think about what happens if a woman or man is not how society expects. Draw or write outside of the box the ways in which they may not conform to norms.
6. Bring the groups back together to compare their gender boxes.

Processing

7. When the activity is complete, encourage the participants to discuss what the gender boxes have shown. For example, ask:
 - *What pressure are people under to stay in their gender box? Where do those pressures come from?*
 - *What happens if we choose to step outside of the normal gender expectations?*
 - *What are the disadvantages of strict gender roles?*
 - *What are the advantages of stepping outside of gender expectations?*
 - *How do gender expectations affect MSM?*
 - *How does stigma link to gender expectations?*

Summary

- Society's expectations of gender roles are linked to culture and tradition but are changing all the time.
- If we step outside of society's expectations we can face pressures from family and friends to conform. If we choose not to, this may lead to stigma and exclusion.
- Some people feel threatened by MSM because they are judged as going against gender expectations and not conforming to being 'real men'.

6B: Sex, gender identity, gender expression and sexual orientation



Facilitator's notes

MSM are not all the same. There are lots of differences within the MSM community. If we are working with MSM to provide health services or as peer educators, it is useful to widen our knowledge about these differences in order to avoid judging and generalising.



Objectives

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

- explain the meaning of gender identity, gender expression and sexual orientation
- use these concepts to understand different identities within the MSM community.



Target audience

All



Time

1 hour



Materials and preparation

- Write up the definitions and continuum lines on flipcharts
- Photocopy character studies (see page 72)

The exercise begins with a short explanation of definitions. Participants apply their understanding of the definitions by analysing character studies of different MSM.

Step-by-step activity

Introduction

1. Explain that many people think that MSM all look, dress and behave the same. This is not true. MSM 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 the different identities.
2. Present the definitions (see below) and explain each of the terms. Present the continuum lines (see page 72) and explain that they can be used to show how masculinity, femininity and sexual orientation differ for each individual and may change over time.

Group work

3. Divide into small groups and hand out a character study to each group. Ask groups to think about and discuss each individual in each study in relation to the diagram of continuum lines on the wall. Ask them to decide where that character falls on each one of the continuum lines. Also ask the groups to discuss how the characters may get stigmatised

Report-back

4. Ask each group to report on one of the characters. In giving their report they should show or plot on the diagram the position of each character for each of the dimensions (sex, gender identity, gender expression, sexual orientation) and what kind of stigma they may face.

Summary

- Understanding more about gender identity and expression can help us to understand more about MSM. It can help to ensure that our services are user-friendly and appropriate for all MSM clients.
- Reflecting on gender identity and expression requires us to put our values and judgments aside and keep open to new learning and insights.

Definitions

Sex: the biological and physiological characteristics that define men and women.

Gender identity: people's sense of themselves as male or female, regardless of whether they have male or female sexual organs. While most people's gender identity matches their biological sex, this is not always the case; for example, transgender people are born biologically male or female yet have a different gender identity.

Gender expression: how a person shows their gender identity – usually expressed through appearance, clothing, body language and voice – in relation to what is culturally accepted as masculine or feminine.

Sexual orientation: whether a person is sexually attracted to members of the same sex or the opposite sex. Three sexual orientations are commonly recognised: homosexual (gay or lesbian), heterosexual or bisexual. While scientific studies have shown that an individual cannot change their sexual orientation at will, sexual orientation might change throughout a person's lifetime. So an individual's sexual orientation can move along the continuum as time passes.

6B: Sex, gender identity, gender expression and sexual orientation

Continuum lines

F	M
Sex	<hr/>
Gender identity	<hr/>
Gender expression	<hr/>
Sexual orientation	<hr/>

Character studies

Hassan is a 22-year-old MSM. When he was young he liked to dress in girl's clothing. In his teens he began to think of himself as female. His school friends used to tease him that he looked more beautiful than a woman. After trying to change him, his parents gave up and chased him out of the house. He moved to the city where he met a taxi driver called Anis, a 28-year-old MSM. They fell in love, developed a strong sexual relationship and moved in together.

Lotfi is an MSM 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 started work. One day at work his colleagues teased him that he was holding a cup "*like a homosexual*", 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 Ramy, who he has been seeing now for two years. Ramy loves to play football and drink with the boys, and no one has ever suspected that he is MSM.

Aymen is a 40-year-old married man. People sometimes gossip that he has "effeminate gestures", but everyone sees him as a happily married man. In reality he loves to have sex with men in secret, and often meets with male sex workers. One of his regular friends is Salim. Salim only has sex with men for money. He is sexually attracted to women, and in the future hopes to get married to his girlfriend.

Mehdi is a 30-year-old policeman. Men in the community make fun of him because of his walk, and this makes him less confident in his job. He has a male lover but also a girlfriend in order to keep up the appearance that he is not MSM. He also has joined other policemen in forcing male sex workers to provide free sex. He is struggling with leading this double life and wishes he could be more comfortable with himself as an MSM.

6C: Let's talk about sex



Facilitator's notes

These two exercises are designed to help people overcome their fears and talk more openly about sex. The purpose is to stimulate debate about attitudes and judgments around sex and sexuality. Select one of the two exercises that best suits your audience and context.



Objectives

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

- talk more openly about sex and their feelings about sex
- recognise how taboos around sex link to stigma towards people living with HIV and other key populations.



Target audience

All



Time

15 minutes

Two exercises – choose **one**. *Our images of sex* is a simple brainstorm to get participants talking about sex. *Anonymous participatory sex survey* is a confidential survey that participants complete individually. The results are collated and shared to trigger discussions about sex.

1. Our images of sex

Materials and preparation

One flipchart and markers for everyone

Step-by-step activity

Card storming

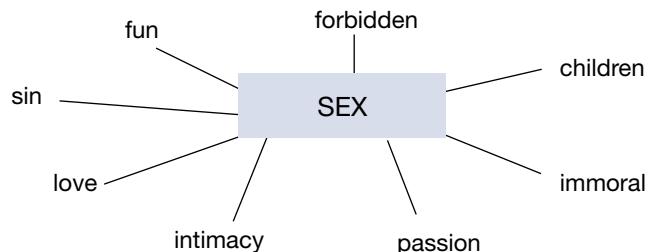
1. Put up the word 'sex' on a card at the centre of the wall.
2. Hand out cards and markers to participants, and ask them to write the first things they think of when they hear the word 'sex'. Tape the cards on the wall around the central card.
3. In pairs, ask participants to discuss, "*What was it like doing this exercise?*"

Processing

4. In the large group ask, "*What does this tell us about how people think about sex?*"

Examples from the Tunisia stigma training workshop

What do you think of when you hear the word 'sex'?



2. Anonymous participatory sex survey

Facilitator's notes

This activity gets people thinking about how they reveal information about their own experiences of sexual activity. It is a good way to get a discussion going. The point is not so much the survey as the discussion about the results.

You need at least two facilitators to run this exercise otherwise it can become too slow. One person asks the questions, the other collects the slips after each question and records the answers on a flipchart. Make sure you don't muddle up the answer slips!

Materials and preparation

- Prepare small slips of paper – if it is a mixed group use one colour for the women and one for the men. Each person will require 10 slips each (you can staple them into tiny booklets if you like).

6C: Let's talk about sex

- Write questions (see below) on a flipchart so that you can record the answers quickly.
- Move all the chairs apart so that participants are sitting alone.

Step-by-step activity

1. Introduce the exercise. Explain that the survey is anonymous and confidential – no one will know anyone else's answers. To ensure confidentiality, participants should sit alone so no one can see what anyone else is writing. Everyone should use the same colour pen. Hand out 10 small slips of paper to each participant.
2. Ask the first question (see sample questions below) and tell participants to put a tick or cross on the first slip depending on whether they agree or disagree with the question. Ask them to fold their papers so their answers are anonymous.
3. One facilitator collects these papers in a basket, counts the results and writes them on the flipchart. Meanwhile, the other facilitator can ask the next question (do not present results at this stage).
4. Continue in the same way until all the questions are asked.
5. Collate all the answers on flipcharts and present answers one at a time to enable discussion. Ask questions like, “*What do you think about this answer? Any surprises?*”

Processing

6. Ask participants:
 - *How was the exercise?*
 - *How did you feel answering the questions?*
 - *What did you learn from the process and from the survey?*

Summary

- Sex is an important topic to discuss when we are tackling stigma. HIV is inevitably linked to sex because it is mainly transmitted sexually. Yet it can be a difficult topic to discuss because of cultural taboos, personal feelings or traditions.
- As HIV trainers we need to approach the topic of sex with sensitivity. We can help to break down barriers to talking about it with simple games.

Sample questions

1. Do you feel that you can talk about sex openly to close friends?
2. Do you enjoy sex?
3. How many sexual partners have you had in the last year?
4. Have you ever paid for sex?
5. Have you ever used drugs or alcohol to make you feel sexy?
6. Do you like oral sex?
7. Do you know anyone who is living with HIV?
8. Have you ever been for an HIV test?
9. Do you find pleasure in kissing and cuddling without sex?
10. Did you use a condom and lubricant the last time you had sex?

6D: Carrying condoms (and lubricant) carries stigma



Facilitator's notes

Many messages about HIV prevention are simplified. They talk about the importance of using condoms as though carrying them, talking about them and using them is easy. Messages targeting MSM and sex workers also talk about the importance of using water-based lubricants with condoms. Yet many people – especially women – fear they will be stigmatised and judged if they talk openly about condoms and lubricant. This exercise provides an opportunity to explore this stigma.

Talking about condoms and lubricant inevitably involves talking about sex. Take care to tackle the topic with sensitivity, especially if you are training a mixed group. You may decide to split into gender groups to do the role-plays if it feels more appropriate, and then come together for the processing. You can adapt the role-play scenarios to suit your context.



Objectives

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

- understand how carrying condoms and lubricant can be stigmatising
- think about different ways to challenge this stigma when talking about HIV.



Target audience

All



Time

1 hour



Materials

- Packet of condoms
- Flipcharts and markers

The activity starts with a card storm. Then participants work in small groups to act out role-plays about attitudes to condoms in different situations. Participants also think about their attitudes to lubricant.

Step-by-step activity

1. Ask the group if anyone has a condom. Tell them you need one for the next exercise. Check out if people are free to ask each other. How do they feel? What happens as you ask?
2. Tape a condom pack on the wall. Divide into pairs and ask, “*Do condoms carry stigma? If so, why?*” Ask pairs to write their points on cards and tape them on the wall. Discuss.

Role-play

3. Divide participants into small groups and hand out the role-play scenarios (either use the scenarios below or some of your own). Ask participants to prepare a role-play based on the scenario to show the whole group.

A: A mother asks her son to borrow some money. As he brings out his wallet a packet of condoms falls out of his pocket.

B: Two partners are talking about having sex together for the first time. One brings out a packet of condoms.

C: A group of young friends are chatting together at home. One brings out a packet of condoms, and then a discussion starts about religion and morality. One person says he is very religious and is offended by condoms.

D: An MSM couple are talking – one has recently tested HIV positive. They discuss their future. One brings out a packet of condoms.

4. After watching all the role-plays, discuss:

- *How can we challenge stigma around condoms (and lubricant)?*
- *What would help to change the image of condoms so they are linked to responsibility?*

Summary

- Talking about condoms is not always easy. Many people make assumptions about a person’s sexual behaviour or past if they are seen carrying condoms.
- It is more difficult for women to discuss using condoms openly. They can be labeled as sex workers or promiscuous, or be accused of unfaithfulness.
- In relationships, partners may assume that you are HIV positive, or that you think they are, if you insist on condom use.
- We need to change things so that if we are seen with condoms we are assumed to be taking responsibility for our sexual health.
- If we talk openly about condoms, we can also talk about preventing HIV and other sexually transmitted infections at the same time.
- Few people have access to water-based lubricants because they are usually sold in pharmacies and at a price beyond the reach of most people who need them.
- Lubricants often carry the same stigma as condoms.

Chapter 7: Coping with stigma and fighting for our rights

Participate and act

These two exercises help participants to challenge stigma by focusing on rights, building assertiveness skills, and sharing strategies to cope with stigma.



Sometimes even those who are supposed to care for you and your wellbeing can make you feel different and alone.

7A: Stigma, assertiveness and human rights



Objectives

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

- identify some of the rights that get violated if we are living with HIV or are from a marginalised group
- identify situations in which we may be denied our rights
- understand how we can use assertiveness to fight for our rights.



Target audience

All



Time

1 hour



Materials and preparation

- Write the name of each group on the top of a flipchart and draw a vertical line down the middle
- Write up the definition of assertiveness (see below)



Action idea

Try the assertiveness techniques below with your friends and report back!

Participants work in small groups to identify the rights of marginalised groups that get violated. In the large group they brainstorm the meaning of assertiveness and then practise using skills in paired role-plays.



Facilitator's notes

This exercise is designed to help us recognise that everyone has rights, regardless of HIV status, sexual orientation and lifestyle. These rights should not be denied just because we are living with HIV or are MSM. Rights go hand in hand with responsibilities, and these too need to be recognised in this debate.

Stigma and discrimination lead to the erosion of rights, whether in a family situation, workplace or community. Learning assertiveness skills can be one strategy to help challenge stigma and defend rights.

Assertiveness skills need to be practised within a cultural context. In some cultures assertiveness could be interpreted as speaking out of turn; for example, a young person answering back to an elder, or sometimes a woman talking back to a man. Power relations also have an influence on how effective assertiveness can be. If you are too assertive with your boss you could end up being fired!

Step-by-step activity

1. Divide participants into four groups: people living with HIV, MSM, people who inject drugs, sex workers.
2. Ask each group to discuss:
 - *What are some of the rights that may be violated if we are living with HIV/sell sex/are MSM/inject drugs? (according to their group)*
 - *How are these rights violated?*

Participants should identify each right and give an example of how the right is violated.

Gallery report-back

3. Stick flipcharts up around the room and walk around as a group to listen to each report-back. After all the groups have reported ask, "*What are the similarities between the groups?*"

Buzz and brainstorm

4. Ask participants to discuss with the person next to them, "*What do we mean by assertiveness?*" Collect a contribution from each pair and write it on a flipchart.
5. Present the definition and compare it to the answers. Explain how assertiveness can be used to challenge stigma and fight for rights. Emphasise that it needs to be used in the right context and with cultural sensitivity.

Assertiveness is...

Standing up for your rights; saying how you want things to be done; being firm – stand up for what you believe in; being yourself; claiming your space by standing by your values; deciding for yourself; seeking recognition; not being passive; not being aggressive; trying to get what you want; being confident.

Definition of assertiveness

Saying what you think, feel and want in a clear and honest way that is good for yourself and others. It is not being aggressive or showing anger.

7A: Stigma, assertiveness and human rights

Practising assertiveness – simultaneous paired role-playing

6. Facilitators demonstrate a very short, paired role-play in which someone is not being assertive. Then they show the same situation with the person being assertive.
7. Ask participants to stand in two parallel lines facing each other, and pair up with the person in front of them. Ask each pair to decide their roles: one person will be the stigmatiser, the other will fight for their rights.
8. Read out a scenario (see examples below) or make one up based on an example from the previous group work on how rights get violated.
9. Then ask all the pairs to perform at the same time. After a few minutes shout “*Stop!*” Ask the participants to stand in a circle and then ask to see a few of the role-plays. After a few demonstrations stop and ask:
 - *What happened? How did you feel? Were they being assertive?*
 - *What made a difference – voice level, language, posture, confidence?*
10. Read out another scenario and continue with the same technique.

Processing

11. Ask participants: *What did we learn from this exercise?*

Summary

- Fighting for our rights is one of the ways we can challenge stigma. We can use assertiveness skills to help in our individual interactions to ensure that our voices are heard.
- Joining with others for collective action raises awareness of the discrimination we face. Assertiveness skills can be used to ensure our points are heard.
- Where the violation of our rights overlaps into legal or policy issues, we may need to take advice and get support from others.

Examples of scenarios

- One of you is an MSM but you have not told your family. The other is your young brother who keeps asking why you are not married.
- One of you is a sex worker and the other is the neighbour. The neighbour has just found out what you do for a living and has stopped her children playing with your children.

7B: Strategies for coping with stigma



Facilitator's notes

This exercise is designed to use with participants from key populations to explore their experiences of stigma and how they cope with it.



Objectives

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

- recognise different strategies for coping with stigma
- explore different coping mechanisms and how groups can support each other.



Target audience

Key populations



Time

1 hour



Materials

Flipchart, cards, markers

A buzz and card storm about individual coping strategies, followed by small group work to test out strategies in role-plays.

Step-by-step activity

Reflection

1. Ask people to pair up and ask them to think of the personal strategies they use to cope with stigma and discrimination. Ask:
 - *How do we cope with stigma in different situations?*
 - *How do we cushion or protect ourselves against the effects of stigma and discrimination?*

Ask pairs to write each strategy on a card. Stick cards on the wall. Ask for one or two participants to arrange cards in similar categories.

Small group work

2. Split into small groups and ask each group to pick one of the strategies (each group picks from a different category). Ask them to make a short role-play to demonstrate the strategy.

Processing

3. After watching all the role-plays, ask the group, "*How do we support each other to cope with stigma?*" After each idea ask, "*Is this realistic? How does this support you?*" Write points on the flipchart.

Summary

- We all find different ways of coping with stigma. Sometimes we ignore the stigma; sometimes we challenge it; sometimes we join with others for strength and protection.
- The support of friends and peers in similar situations can help us to cope with stigma and ensure that we do not get isolated.

Examples from the MENA committee

Strategies for supporting each other to cope with stigma

Share strategies with friends in focus groups; hold regular meetings; plan activities that help to build a sense of group belonging, like trips, parties, festivals, meetings; talk openly in support groups; run assertiveness skills-building sessions for MSM.

co de + a g e

Here are two exercises to give you ideas for activities after the workshop. Each stigma exercise should lead to some action to challenge and change stigma.



It can feel like everyone is pointing a finger at you because of who you are.

8A: Start with a vision – a world without stigma



Facilitator's notes

This exercise helps us to think about the kind of world we should be aiming to build – a starting point for action planning.



Objectives

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

- begin to define what the result of successful interventions would look like
- identify some key obstacles to challenging stigma
- identify specific actions that need to be taken to challenge stigma.



Target audience

All



Time

30 minutes



Materials and preparation

- Stick flipchart paper together to make one big sheet of paper – cover a wall or have it on the floor
- Markers, crayons, pencils

A simple yet creative exercise where participants imagine and draw a large shared picture of a world without stigma.

Step-by-step activity

1. Hand out markers. Ask participants to draw pictures and write words to create a group vision of a world without stigma. Allow 15 minutes or more depending on the group size.
2. Then ask the group to talk about their drawings. Ask:
 - *What does it mean?*
 - *What kinds of changes are envisaged?*
3. Discuss with the group what are some of the actions they can take after the workshop to move towards the vision. Write points on a flipchart.

Examples from the MENA stigma training workshop

A world without stigma

- When we disclose to our immediate families we get support and love.
- We are joined together and no longer isolated and hiding our situation.
- We are leading active and productive lives, and feeling good about ourselves.
- We are playing an active role in educating others.

What can we do to build this world?

- Increase understanding and reduce fears about HIV and AIDS.
- Educate the community to stop shaming and isolating us.
- Get community leaders to model and promote new behaviour.

8B: Challenging stigma in our institutions

Objectives

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

- identify points of stigma within different institutions
- develop action plans to make specific changes in institutions to reduce HIV stigma and discrimination.

Target audience

All – ideal for a workplace programme, or where all participants come from a similar institution

Time

1–2 hours

Preparation

- This exercise needs a lot of planning. Those involved will need to get permission to carry out the stigma walk and commitment from management for the follow-up meeting and action-planning
- If some members of the group are meeting for the first time, plan an introductory game and warm up before you start the walk

An exercise designed to take place in an organisation or institution. It starts with a stigma-mapping exercise by walking around the building. After a debriefing, participants plan a meeting to discuss how to tackle the stigma that has been identified.

Facilitator's notes

This exercise provides a simple approach to identifying stigma in different institutions. It also suggests how to trigger discussion with staff and community members to do something about it.

It could be used as part of stigma training in the workplace. Please be sure to seek permission from the institution before undertaking the exercise.

You can help participants to plan this exercise towards the end of a workshop. They could carry it out in their own organisations or with staff from other organisations. It could work well in a health facility, a university or even in the armed forces

Step-by-step activity

'Spot-the-stigma' walk and talk

1. Set up a joint group comprising the institution's staff and community members (including people living with HIV, or families and friends affected by HIV, and members of marginalised groups). This group will carry out the stigma walk and talk together.
2. Orient the group beforehand. Discuss the objectives and what they will be looking for – that is, places and activities where stigma is a problem. Also discuss how the activity will be debriefed and actions planned.
3. Conduct the stigma walk.
4. Take notes during the walk and record these on flipcharts. Show the various departments or sections and activities within the institution, and the places where stigma occurs.

Debrief

5. Hold a joint meeting with the institution's staff and community members to discuss:
 - *What major forms of stigma were identified?*
 - *What are their causes?*
 - *What can be done to avoid these problems?*
6. Develop an action plan that identifies:
 - specific change activities
 - who will do each activity and by when
 - policy issues that will help to change the stigma (for example, developing a client charter or a stigma-free service)
 - what indicators will show that the problem has been solved.
7. Ensure that the group agrees how the actions will be followed up. Plan a date in the future to review progress. Working out the detailed action plans could be done on a departmental basis (for example, clinic, general nursing) so that each department feels committed to the plans they have to implement.

8B: Challenging stigma in our institutions

Examples from the Beirut stigma training workshop

Challenging stigma in our institutions

Waiting area

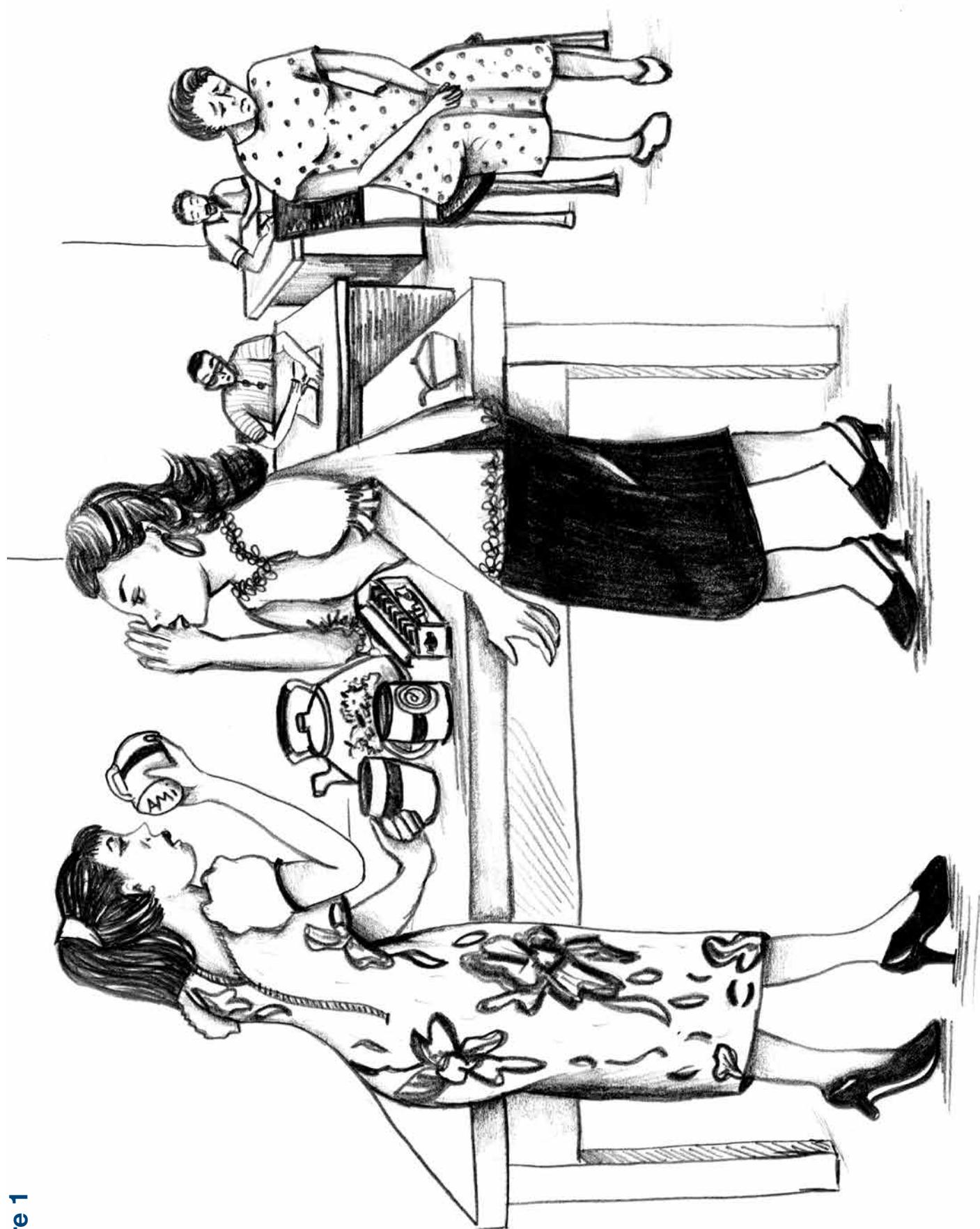
Patients gossip about other patients while sitting on the bench. Stigma is directed towards people they suspect have HIV. They give hostile looks about the way you dress and walk.

University campus

In the library people won't sit next to you if they know you are an MSM. There is gossip and isolation in the hostels. Lecturers make homophobic comments in front of students.

In the barracks

Being told to act like 'a real man'. Being segregated if people suspect you are HIV positive. Drinking too much when you get isolated. Going AWOL when you get stigmatised.

Annex 1: Stigma pictures

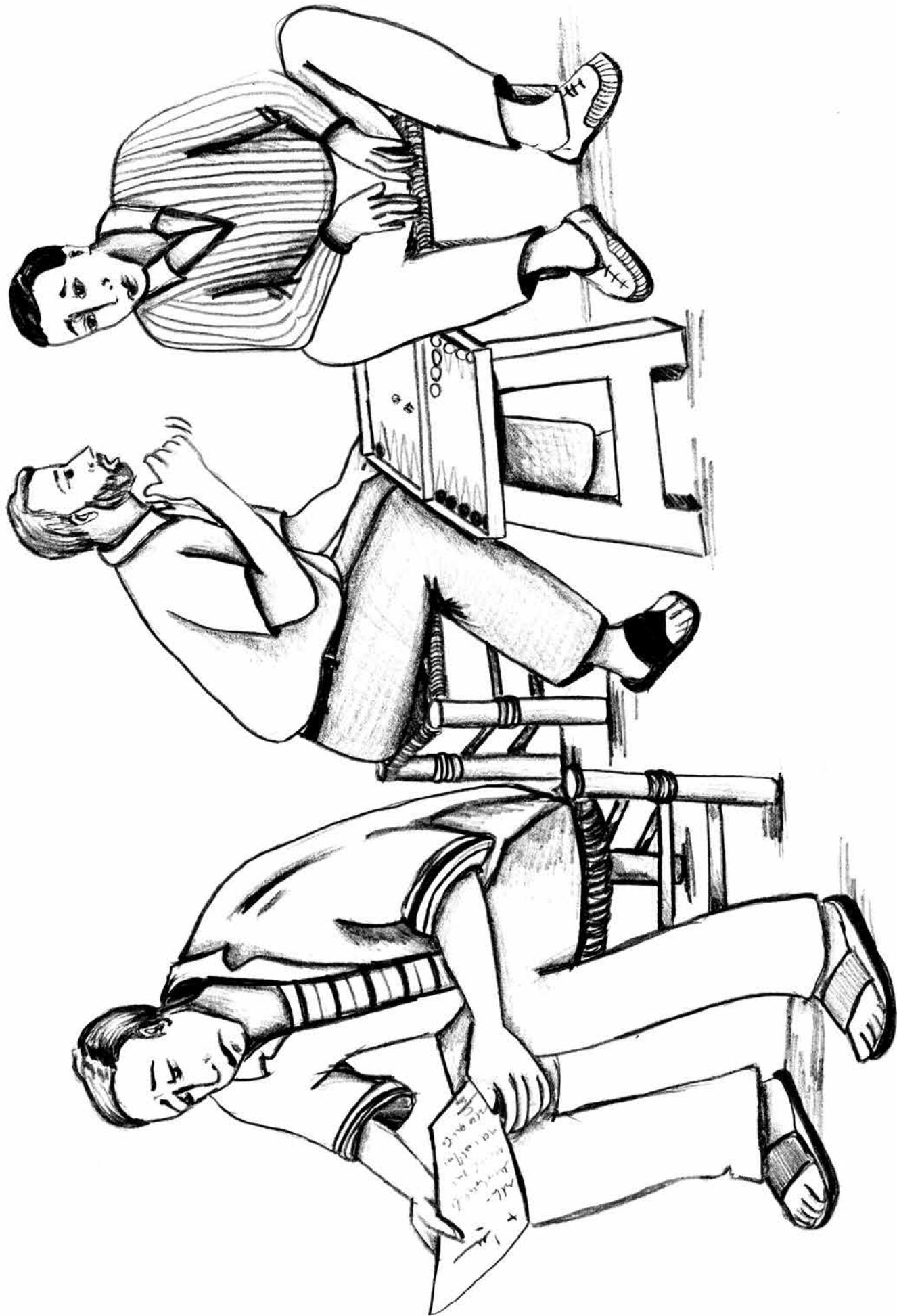
Picture 1

Picture 2

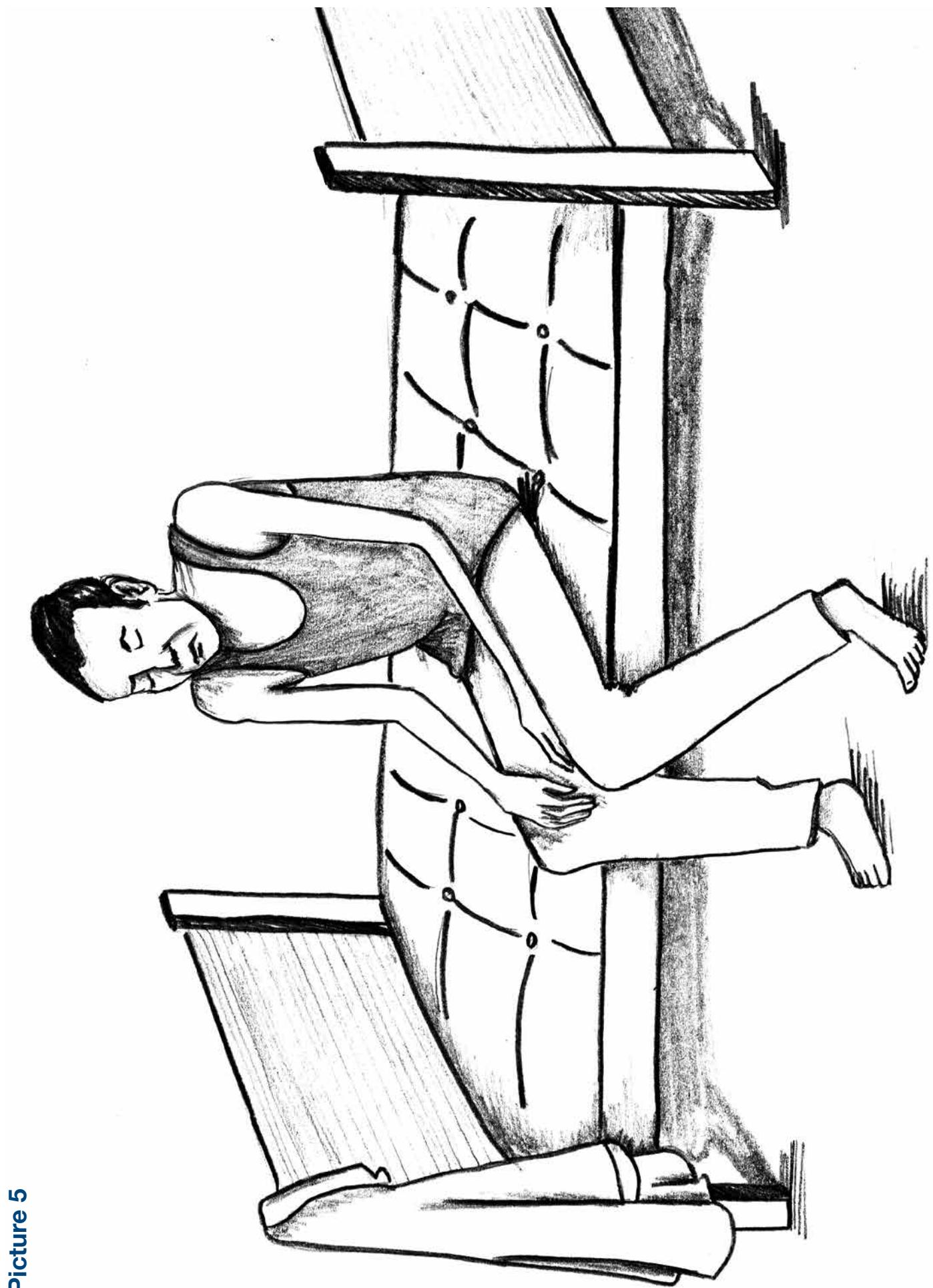




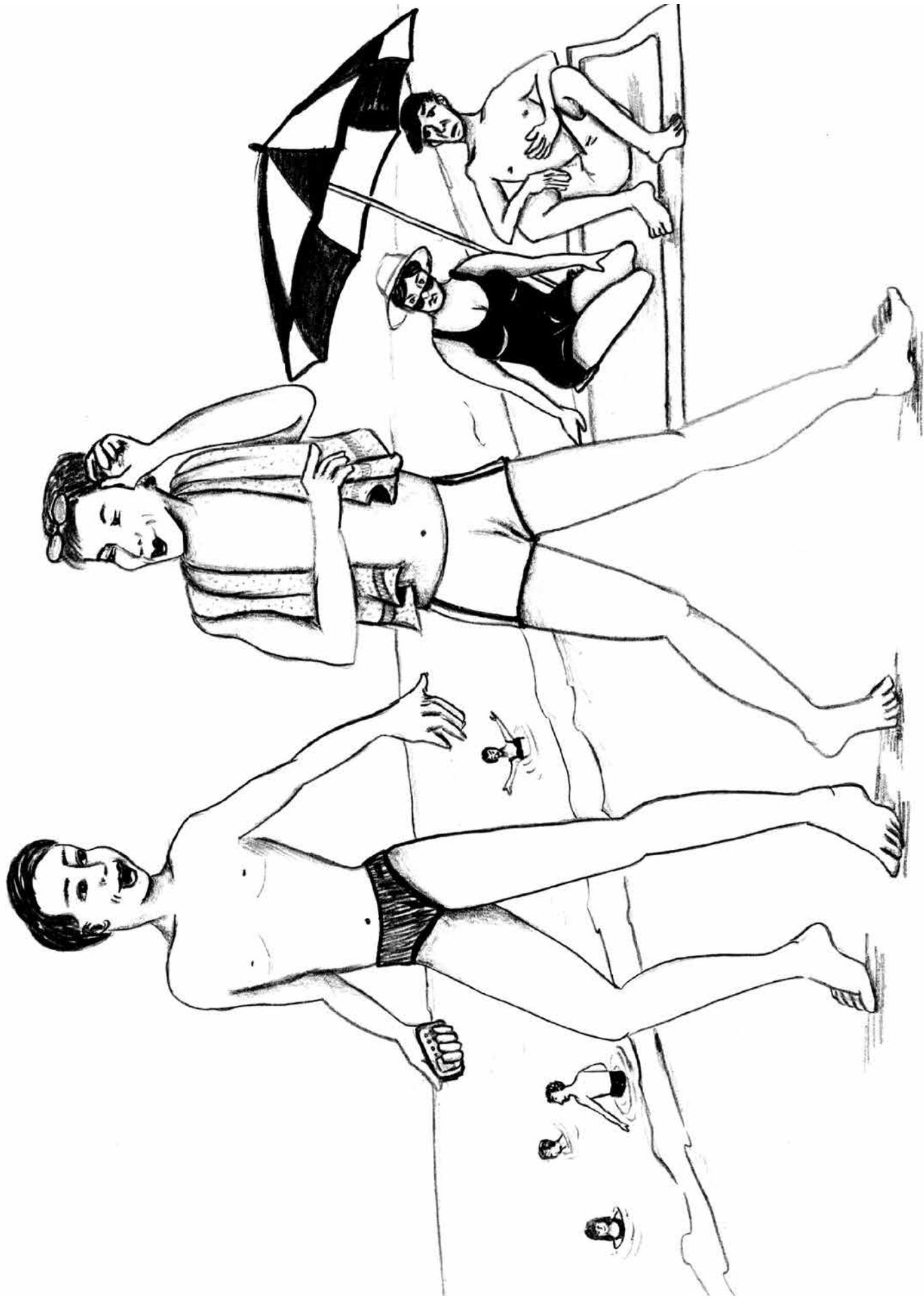
Picture 3



Picture 4



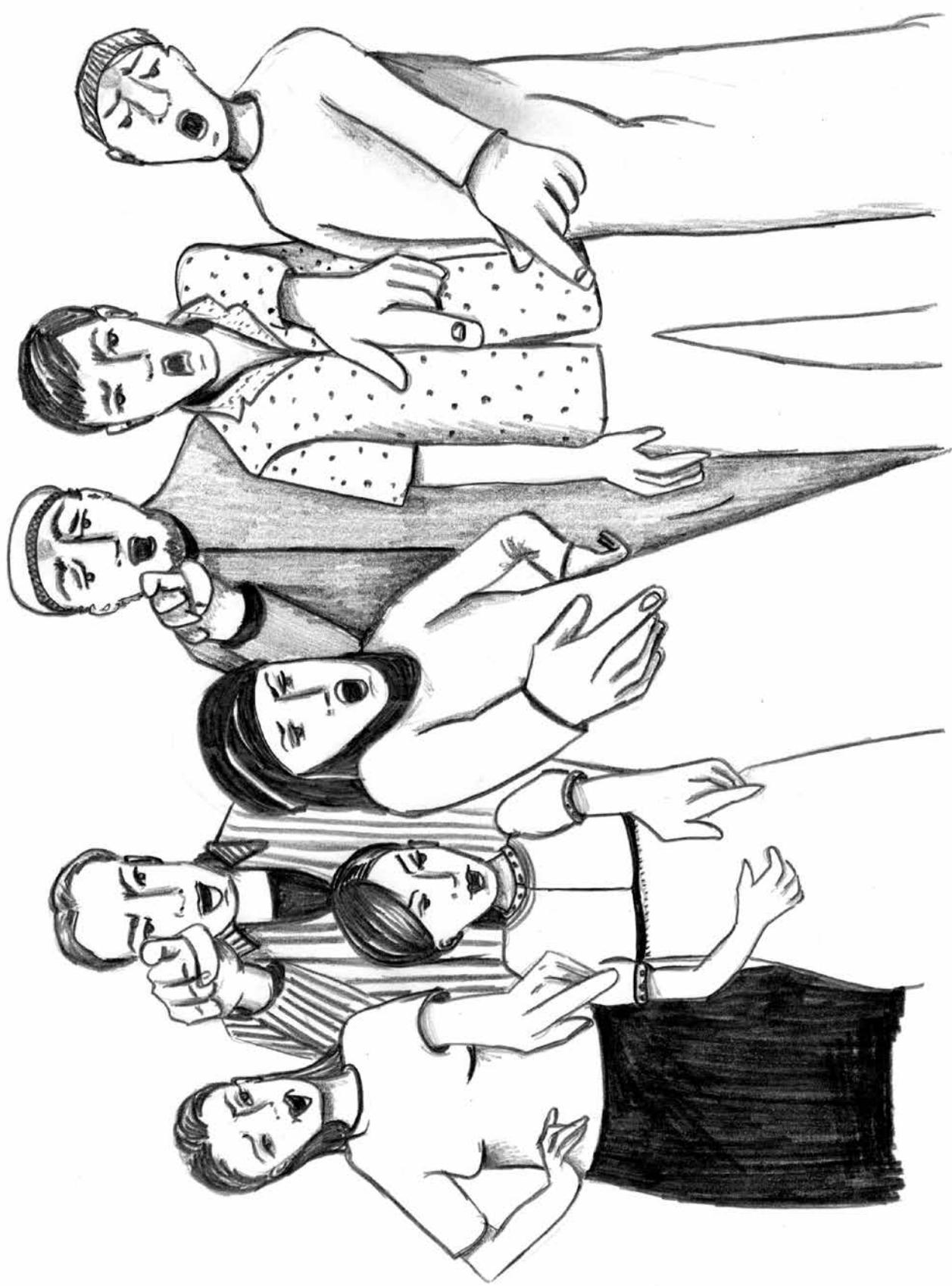
Picture 5



Picture 6



Picture 7



Picture 8

Annex 2: Examples of positive messages from the Holy Quran and Hadith* on compassion, justice and vulnerable people

On marginalised populations

- And We wish to bestow our favour upon those who had been marginalised in the land, to empower them, and to make them the inheritors.
(Quran, Surah al-Qasas, verse 5)

On stigma, rejection and ‘looking down on others’

- You believe! No men shall mock other men. It may well be that those [who are mocked] are better [than those who do the mocking]...
- Neither defame one another, nor insult one another by [hurtful] nicknames. Terrible is the name of wickedness after you have believed.
(Quran, Surah al-Hujrat, verse 11)

On respect for ‘privacy’**

- You believers! Avoid much suspicion; for indeed, some suspicion is a crime. And spy not on one another, nor backbite one another.
- Would anyone of you want to eat the flesh of his dead brother? You would detest that [so detest backbiting also] and keep your duty to Allah who is Forgiving and Merciful.
(Quran, Surah al-Hujrat, verse 12)

On love and compassion between partners

- Amongst His signs is that He created for you – from amongst you – partners, with whom to dwell in tranquillity, and He laid love and compassion between you.
(Quran, Surah al-Rum, ch. 30, verse 21)

All human are equal in the eye of God

- Humankind! Behold, We have created you all out of a male and female, and have made you into nations and tribes, so that you might come to know one another [and interact]. Verily, the noblest of you in the sight of Allah is the one who is most deeply conscious of him.
(Quran, Surah al-Hujrat, verse 13)

On care and support for sick people

- A’ishah (RAA) reported that when Allah’s Messenger (SAW) visited a sick person he would say, “Lord of the people, remove the disease, cure him [or her], for You are the Great Curer, there is no cure but through Your healing power, which leaves nothing of the disease.”
(Hadith, Sahih Muslim, ch. 26, no. 5434)
- Allah, the Lord of Honour and Glory, will say on the Day of Judgment, “O child of Adam, I was sick and you did not visit Me!”
The person will say, “My Lord! How could I visit You when You are the Sustainer of the Universe?”
And Allah will reply, “Did you not know that My servant so-and-so was sick and you did not bother to visit him? Didn’t you realise that if you had visited him, you would have found Me with him?”
(Hadith, Sahih Muslim, no. 2567)
- The Prophet (SAW) is reported to have said, “Visit the sick and follow the funeral, for these will keep you mindful of the Hereafter.”

* Quran is the Holy book in Islam (words from God revealed to the Prophet Muhammad) and Hadith are texts being told by the Prophet Muhammad (his own messages).

** The principle of ‘respect of privacy’ and the condemnation of ‘spying’ on others was used by the imams and scholars who made a statement about the unlawful practices against MSM in Islamic societies.

- And in another hadith, he said, “Whoever visits a sick person immerses himself [or herself] in mercy, and when he [or she] sits there he [or she] sinks down into it.”

On stigmatising the ill

The Prophet (SAW) put himself in the same group as people suffering from poverty and from terminal illness:

- A’ishah (RAA) saw several young children laugh at her sick friends; she told them that the Prophet (SAW) had said:

The people who experience disaster the most are the Prophet Muhammad, followed by pious people, and then people who are working towards piety. In between these two are the people who suffer from poverty and who only own one piece of clothing, and in between them are the people who are infected by a terminal illness.

(**Hadith, Sahih Bukhari and Muslim**)

On the value of each human, including the sinner

- ‘A prostitute ...was forgiven [by Allah] because of a dog she passed at a well, panting through intense thirst that was almost killing it. She took off her [leather] sock, tied it to her scarf and drew some water for it. She was forgiven her sins [for doing that].’

(**Hadith, Sahih Bukhari**, cited in Al-`Asqalani, ch. 17, no. 3321)

On the importance of seeking knowledge and basing opinions on knowledge or evidence

- The Holy Prophet (SAW) was instructed to say, “My Lord, increase me in knowledge.” (**Quran, Surah TaHa**, verse 114)
- He said, “Whoever strikes a path to seek knowledge therein opens a path for him into Paradise.” (**Hadith, Sahih Tirmidhi**, ch. 2, no. 2784)
- The Quran warns Muslims about things they ought not to do, not things they ought not to know. “And do not reach conclusions about that which you have no knowledge about.” (**Quran, Surah al-Isra**, verse 36)

Important education principle in Islam about marginalised people

Individuals should try to place themselves in the shoes of those who live on the edges of society, those whom the Quran describes as the ‘mustad’afun fi’l-ard’ – the marginalised of the earth. When they do this then their understanding of Islam will address the concerns of disease, stigmatisation, power, and powerlessness. Through this understanding of Islam as a faith of compassion and justice, individuals will see that Islam encourages a sense of community rather than individualism based on self-preservation and fear.

This challenges those interpretations of Islam that are based on self-preservation and self-interest at the cost of being unjust to other people.

(Extract from *Positive Muslims* (2004), ‘HIV, AIDS and Islam: reflections based on compassion, responsibility and justice’)

Islam is part of a broader compassionate life

A religious approach to HIV and AIDS that is limited to scolding, denial, judgment, and pity is inadequate. Awareness work must also be accompanied by political action that challenges the unjust social conditions which contribute to the spread of disease or make recovery much more difficult.

(Extract from *Positive Muslims* (2004), ‘HIV, AIDS and Islam: reflections based on compassion, responsibility and justice’)



A global partnership:
International HIV/AIDS Alliance

Supporting community action on AIDS in developing countries



The original *Understanding and challenging HIV stigma: toolkit for action* contains over 100 participatory exercises that can be adapted to fit different groups and contexts. The toolkit helps groups to identify stigma, and discuss the rights of HIV-positive people, gender and sexuality, and ethical issues linked to stigma. The toolkit includes the following booklets:

Introduction

Using the toolkit

Module A

Naming the problem

Module B

More understanding, less fear

Module C

Sex, morality, shame and blame

Module D

The family and stigma

Module E

Home-based care and stigma

Module F

Coping with stigma

Module G

Treatment and stigma

Module H

MSM and stigma

Module I

Children and stigma

Module J

Young people and stigma

Moving to action module

Thinking about change

Moving to action

Developing skills for advocacy

Picture booklet

General stigma pictures

Rights pictures

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