

Reducing HIV Stigma and Gender-Based Violence

Toolkit for Health Care Providers in India

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This project built on two training manuals developed through ICRW's earlier projects: (1) the Stigma and Violence Reduction Intervention Project, conducted in Andhra Pradesh, India (2003–2005), with interventions geared toward transient populations; and (2) the HIV Stigma Reduction Toolkit (2001–2003), designed for use among communities in high-prevalence areas in Africa.

The SVTH project adapted these earlier toolkits for use with a new target group: health care providers. This toolkit was pilot-tested with health care providers in Ichchapuram District, Andhra Pradesh.

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Health care providers in Ichchapuram District, where the toolkit was tested, also made a huge contribution. Their enthusiastic participation during the field tests gave the toolkit the benefit of their ideas and experience and helped to keep it focused on the practical needs and challenges of people who work on the HIV and AIDS issue.

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Copies of this manual are available from ICRW's Web site: www.icrw.org.

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Introduction to the Toolkit

This toolkit is a guide for the trainers of health care providers. The overall aim is to prevent the spread of HIV and AIDS by making it easier for people living with HIV to access health services, disclose their status and prevent the spread of HIV to others, while also eliminating some of the barriers that impede the ability of uninfected women to protect themselves from the virus. Using the toolkit, you will be able to plan and organize educational sessions with health care providers to challenge HIV-related stigma and gender-based violence (also referred to as gender violence in this toolkit). The toolkit will help you raise awareness of the causes and consequences of stigma and violence, and promote action and advocacy to combat them.

The toolkit was developed and tested through the Reducing Stigma and Violence Toolkit for Health (SVTH) project, which the International Center for Research on Women (ICRW) and Bhoruka Public Welfare Trust (BPWT) conducted in Andhra Pradesh, India from 2005 to 2007. This project builds on an earlier stigma and violence reduction project in Andhra Pradesh, which focused on sex workers, truckers' helpers and the partners of both groups (2003–05),¹ and on earlier ICRW work in Africa on HIV stigma, which resulted in the production of an HIV Stigma Reduction Toolkit.²

The SVTH project drew on the training materials of the two earlier projects to develop this new toolkit tailored for health care providers in India and tested the toolkit in a pilot project in Ichchapuram District, Andhra Pradesh.

■ What is the Toolkit?

The toolkit is a collection of participatory educational exercises for educating health care providers on the issues of stigma and gender-based violence. Trainers can select from the exercises to plan their own courses for different types of health care providers.

1 Duvvury, N., N. Prasad and N. Kishore. 2006. *HIV and AIDS Stigma and Violence Reduction Manual*. Washington, D.C.: ICRW.

2 Kidd, R. and S. Clay. 2003. *Understanding and Challenging HIV Stigma: Toolkit for Action*. Washington, D.C.: Academy for Educational Development.

The modules use a **learner-centered, participatory approach to training**—one built around discussion and small-group activities. The goal is to facilitate open discussion on HIV stigma and gender violence, and on what health workers can do to promote a change in attitude and practice in their own lives and the lives of their clients, families and communities.

Using the toolkit exercises, trainers can create a safe space where health care providers can talk about their fears and concerns about HIV and AIDS; look at the roots of stigma and gender violence and how they affect people living with HIV and AIDS, women, families, health services and communities; examine their own attitudes and judgmental habits; and develop strategies and skills to confront stigma and violence in their health practice.

■ How the Toolkit Is Organized

This toolkit is divided into five chapters:

Chapter A: HIV Stigma—Naming & Owning the Problem

Chapter B: Gender Violence—Naming & Owning the Problem

Chapter C: Shame and Blame—Stigma & Emotional Violence

Chapter D: More Understanding and Less Fear

Chapter E: Moving to Action

These chapters include individual modules or training exercises. The full set of modules is *not* meant to be used as a complete package in a single course; the exercises are meant to be used selectively. Choose the modules that fit your objectives and target groups, and feel free to select and adapt the materials to suit your own situation.

In addition, the annexes, which include fact sheets, timetables, games, pictures and information on India's Protection of Women From Domestic Violence Act, can be used to support your training.

Why Focus on Stigma and Gender Violence?

Stigma and gender violence fuel the spread of HIV and prevent people from adopting HIV-prevention behaviors and accessing HIV and AIDS programs.

■ Why Include Stigma in HIV and AIDS Prevention Efforts?

Fear of being stigmatized because of HIV can keep people from learning their HIV status, disclosing their status to their partners, protecting others from infection and accessing services and treatment. As a result, the virus continues to spread, because people who do not know they are HIV-positive—or who are afraid to discuss their status—infect their partners. In addition, people with HIV who avoid testing for fear of being stigmatized are forgoing potentially life-saving treatment, care and support. Stigma and discrimination must be addressed so that people living with HIV feel safe enough to be tested, share their results, practice prevention and access treatment.

Stigma is directly responsible for people who have HIV dying quickly. As a result of stigma and discrimination they become depressed, isolate themselves, and avoid treatment and other support. Under these circumstances their health declines quickly. If, on the other hand, they are shown love and support, they can live much longer and healthier lives.

Health care providers themselves often have stigmatizing attitudes around HIV and AIDS. Seventy percent of health workers who participated in a baseline study for the SVTH project believed AIDS is “punishment for bad behavior” and that people living with HIV “deserve” illness. Nearly 85 percent said they would be ashamed if they got HIV.

Health care providers’ incomplete knowledge and fear about getting HIV from their patients is a major source of their stigma toward people living with HIV. More than 70 percent avoid treating people living with HIV because of fear of infection. The stigma toward their patients is also rooted in their own fears of being stigmatized for treating people living with HIV. This fear of “stigma by association” poses a dilemma: They want to provide care for their patients, including those who are HIV-positive, but don’t want to be perceived as “HIV doctors” for fear of losing business from their other clients. So they either reject people living with HIV outright, or treat them in secret.

The project’s baseline study indicated that other forms of stigma among health providers toward positive clients include:

- Minimizing contact with people living with HIV, which the patients perceive as a form of rejection;
- Asking people living with HIV to sit separately from other patients;
- Breaking confidentiality—gossiping to other patients about people living with HIV;
- Charging extra fees to treat people living with HIV; and
- Referring people living with HIV to private testing centers for a commission.

Why Include Gender Violence in HIV and AIDS Prevention Efforts?

Gender violence is psychological, physical or sexual violence that is rooted in the power differential between men and women. Gender violence is prevalent in heterosexual relationships in countries around the world, including India. An ICRW household study conducted across seven sites in India revealed that 52 percent of the nearly 10,000 women surveyed reported physical or psychological abuse perpetrated by their husbands.³ Further, 15 percent of those women reported forced sex in the previous 12 months.

Gender-based sexual violence has significant implications for the spread of HIV and for HIV prevention. Sexual violence and rape place women and men at risk of infection, particularly in high-prevalence settings. In addition, research conducted in diverse countries found that violence and the fear of violence often prevent women from negotiating condom use or fidelity with their partners or choosing to leave risky relationships. Fear of violence also limits women's use of HIV/AIDS counseling and testing services and inhibits women's disclosure of their HIV status. For example, a study in Tanzania among women who sought HIV testing and counseling services found that more than half who did not disclose their status to their partner reported they were afraid of a violent reaction.⁴

Experience of gender violence has been found to be strongly linked to HIV infection. In the Tanzania study cited above, young HIV-positive women (ages 18–29) were almost 10 times more likely to report partner violence than women the same age who were HIV-negative.⁵ Further, a review of the literature on sexual and physical violence showed increased likelihood of engaging in unprotected sex, having multiple partners and trading sex for money or drugs among individuals who had been sexually abused as children.⁶

Many health care providers in India do not recognize gender violence as a problem. They view it as a norm—something that is acceptable. In their view, a husband has a right to beat his wife. Roughly one-quarter of male health providers participating in the baseline study for the SVTH project felt that violence is justified if the husband suspects his wife is unfaithful; if his wife refuses to have sex or asks him to use a condom; or if she burns the food. These health providers did not see that beating affects a woman's physical and psychological health. Health providers do provide treatment to battered women, but they often fail to probe the source of the violence, offer counseling and support to the woman, or offer to counsel the husband. They treat the wound or injury, but do nothing to deal with the woman's feelings or help to find a long-term solution.

Many health providers in India also do not recognize that women's vulnerability to violence makes them vulnerable to getting HIV. A woman who suspects her husband of having an affair may not be able to ask him to wear a condom, because if she does she will be beaten. And at times women are forced by their husbands to have sex. HIV can also exacerbate the problem of gender violence: Once HIV is discovered in the family, women are often beaten and verbally abused by their husbands, even if it is the husband who has HIV.

Health workers therefore need to be sensitized on gender violence and encouraged to develop new codes of practice related to gender violence.

3 ICRW and CEDPA. 2000. *Domestic Violence in India: A Summary Report of a Multi-Site Household Survey*. Washington, D.C.: ICRW.

4 Maman, S., et al. 2000. "The intersections of HIV and violence: Directions for future research and interventions." *Social Science and Medicine*, 50(4):459–78.

5 Ibid.

6 Heise, L., M. Ellsberg and M. Gottemoeller. 1999. Ending Violence Against Women. *Population Reports*, 27(11):8–38.

Purpose of the Toolkit

■ Goal

Break the silence on the issues of HIV stigma and gender violence and build a climate in which women and people living with HIV feel empowered to access HIV and AIDS services because they no longer fear being stigmatized or abused by their partners.

■ Specific Objectives

1. Help health workers see that stigma and gender violence exist, that these issues hurt women and people living with HIV and fuel the HIV epidemic, and that by changing their own attitudes and actions they can help reduce stigma and gender violence and make health services more accessible to everyone.
2. Provide space in which health workers can discuss their own feelings and fears, and the values that underlie stigma and gender violence. Help them look critically at their own attitudes and take ownership of a new set of values and norms.
3. Help challenge the view that gender violence is an acceptable norm, and help health workers develop a new code of practice on how they deal with cases of battered women, including the provision of counseling.
4. Help health workers learn skills to provide health care services to people living with HIV and women in a supportive and caring way.
5. Improve health workers' knowledge about HIV and AIDS to overcome fears and misconceptions about HIV transmission through non-sexual casual contact.
6. Help health workers become "HIV competent" by improving their knowledge about HIV testing and counseling, anti-retroviral therapies, universal precautions, the role of opportunistic infections and other relevant issues. This increased understanding and awareness will allow them to serve as community hubs of information on HIV and AIDS, model more supportive approaches through their own behavior, and advocate effectively for the reduction of HIV stigma and gender violence.
7. Provide opportunities for people to talk about how they can help reduce stigma and develop practical strategies for challenging stigma and discrimination.

■ Target Groups

The toolkit is designed for use with different types of health care workers, including:

- **Front line health care providers**—registered medical practitioners (RMPs), traditional birth attendants (TBAs), pharmacists and lab technicians; and
- **Government health workers**—doctors, nurses and community health workers based in government health centers and clinics.

The Toolkit Modules

The Toolkit consists of a number of **training modules or session plans**—detailed, step-by-step descriptions of how to facilitate a learning activity. The modules will help you run each training session.

Each module is divided into the following parts:

FACILITATOR'S NOTE: A brief note to the trainer on the significance of this module or extra advice on how to facilitate it.

OBJECTIVES: What trainees will **KNOW** or be able to **DO** by the end of the session.

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

MATERIALS & PREPARATION: Role plays, stories, pictures, etc. that are used during the training session. We assume that the basic training materials that will be needed in most exercises—flipcharts, markers, masking tape and “cards” (half sheets of blank A4 paper)—are available.

STEPS: The learning activities or training methods involved in the session, described “step by step,” and the training content. “**STEPS**” are the core of each session plan. This section includes information on:

- **SUB-TOPICS:** The sub-topics covered within the session.
- **METHODS:** Discussion, rotational brainstorming, card storming, role playing, stop-start drama, case studies, picture discussion, etc.
- **GROUPS:** Suggestions on group size and tasks.
- **QUESTIONS:** Specific questions used to guide discussion—presented in *italics*.
- **RESPONSES:** Examples of typical responses—presented in boxes. These are only examples—they are not meant to be the required output.
- **REPORT BACK:** Procedures for asking groups to give reports after discussion.
- **PROCESSING:** Additional questions and discussion, conducted after the report back, are included to help deepen understanding by relating the new learning to participants’ own context.
- **SUMMARIES:** Points to be emphasized in a summary at end of the session.
- **ACTION IDEAS:** Suggestions on how participants can start trying out what they have learned when they return to home and work.

How the Toolkit Is Organized

The modules in each chapter are organized to help participants learn in a gradual, cumulative way. In Chapter A, for example, health workers sequentially learn the concept of stigma, how it occurs in different settings, how they feel about it, how their own health care practice is stigmatizing, what they can do to change their own practice and what they can do as a group to challenge the community to change.

These steps provide a gradual process to build understanding, commitment, strategies and collective action to create a “stigma free” world. Each module prepares the ground for the next module. For instance, the first modules (A1 and A2) are impersonal—analyzing stigma in pictures with no personal involvement. Then the process becomes personal (A3), asking participants to reflect on the question, “How are we all implicated as stigmatizers?” The first modules use pictures to get people talking and sharing. This creates the trust and openness necessary to do the more challenging modules in which people share feelings about being stigmatized.

Step	Module	Learning process and key outcomes
A1	Introduction to Stigma (Animal cards)	Animal and bird pictures are used to introduce the concept of stigma in simple language. At this stage, there is no major link to HIV—discussion is focused on “stigma” as a concept.
A2	Naming HIV Stigma Through Pictures (Stigma pictures)	Participants talk about HIV stigma through analyzing pictures. The pictures allow for distancing—stigma is described in an objective way, not yet personalized. We are simply saying it exists. We are not yet saying, “We are the stigmatizers.”
A3	How It Feels to Be Stigmatized (Reflection)	In this module, participants reflect on a time in their lives when they were stigmatized—“What happened and how did it feel?” This process makes things personal and brings in feelings.

We encourage you to use the modules selectively to develop your own training programs, keeping in mind the importance of building learning gradually. Ideally, the training program will move participants through the 10 steps to stopping stigma and gender violence:

1. Create a **SENSE OF COMMUNITY** and build **OPENNESS AND SAFETY** to talk about HIV and AIDS, stigma, and gender violence.
2. **NAME THE PROBLEM**—get participants to describe how stigma and gender violence occur in different contexts.
3. Help participants **OWN THE PROBLEMS OF STIGMA AND VIOLENCE**—to recognize that “*we are all part of these problems.*” Help participants reflect on **their own** words, attitudes and actions.
4. Help participants see the **EFFECTS** of stigma and gender violence on people living with HIV, women, their families and communities—how it hurts people who are stigmatized and abused, and indirectly hurts people who are perpetrating the stigma and violence.
5. Analyze the **ROOT CAUSES** of stigma and gender violence, such as fears and misunderstanding about HIV transmission, moralizing attitudes, and men’s use of force to control and dominate women.

6. Address FEARS AND MISCONCEPTIONS about getting HIV through non-sexual casual contact, and develop TECHNICAL KNOWLEDGE on HIV and AIDS services (testing, counseling, etc.).
7. Challenge the VALUES that underlie stigma and gender violence and help people get a read into their own attitudes.
8. Build COMMITMENT to changing attitudes and doing something about stigma and gender violence.
9. Help participants learn the attitudes and skills to provide SUPPORT AND CARE for people living with HIV and provide counseling to women who have been abused.
10. Develop STRATEGIES and PLANS for taking action against stigma and gender violence.

Making Your Own Training Program

■ Help Participants Learn through Doing

The toolkit is designed for participatory learning—learning through doing, e.g. sharing feelings, concerns, and experiences, discussing and analyzing issues, solving problems, planning and taking action. Participants learn through interaction with the trainers, but also through discussion among themselves in small groups.

Do not convey the information in a lecture format. Changing attitudes around stigma and gender violence requires more than giving people information. This form of change cannot be achieved through spoon-feeding—treating participants as a passive audience. People learn best by thinking through their own ideas and sharing them with others.

To help health workers rethink their attitudes and behavior, you need to allow them to reflect on their ideas and feelings, and discuss and plan with others what can be done to challenge stigma and violence. The idea is to create a safe space where they can talk about their fears and concerns, freely discuss sensitive and taboo issues such as sex, death and sexual abuse, and clear up misconceptions.

■ Help Participants Move from Awareness to Action

The toolkit is designed not only to build awareness but also to help health workers move to action. Participants should be encouraged to put their new learning into action by challenging stigma and violence in their own lives, families and communities. The learning and action is done collectively. Working with others makes it possible for health workers to learn together about stigma and violence, develop common ideas about what needs to be done, set group norms for new attitudes and behavior, and support each other in working for change.

Many of the modules have suggestions on immediate **MINI-ACTIONS** that participants can try out at home, at work or with their friends. The final chapter—**MOVING TO ACTION**—helps participants start planning actions that they can take as a group.

■ Mainstream stigma and violence awareness in AIDS education activities

The toolkit focuses solely on stigma and violence, and workshops can be organized on this theme alone. We also encourage you to integrate these sessions into other AIDS education activities. The aim should be to “mainstream” awareness of stigma and gender violence—to make it a regular part of all educational activities for AIDS educators and communities.

■ Select the modules that suit your objectives, target groups and context

The toolkit is **NOT** a standardized package for a single training course or program. You are not expected to work your way through all of the modules. **Use it selectively.** Pick out those exercises that suit your own target group and needs and devise your own training program.

The modules can be used to design different types of workshops for different groups. For instance, you may want to introduce stigma as one of a number of topics in a course for health workers; or you may want to run a short workshop on stigma and gender violence as their own topics. Feel free to select and adapt the materials to suit your own purposes.

In our pilot training workshops, we combined some of the modules on stigma and gender violence into single exercises. This is appropriate because the two are closely connected. For example, in the module “When HIV Enters the Home” (A12), family members react with both stigma and violence, so it makes sense to combine these topics in a single exercise. In other cases, however, we have found that combining these topics makes the analysis too complex and may confuse participants. A flexible approach is needed—sometimes in the circumstances (e.g., shortage of time) it makes more sense to combine them; other times it may be better to treat them separately for purposes of clarity.

We have provided many options to keep trainers and participants interested. Different trainers like different types of activities. Some modules may provide some of the same points provided in earlier modules. A little bit of repetition is good—it helps to reinforce the learning and ensure everyone understands the underlying message.

In Annex 2, you will find examples of training plans based on the modules, each for a different target group.

Annex 2 provides sample training plans for the following types of workshops:

- I. Nine-Day Course for Registered Medical Practitioners (over several months)
- II. Nine-Day Course for Traditional Birth Attendants (over several months)
- III. Four-Day Workshop for Staff of a Community or Primary Health Center
- IV. One-Day Joint Workshop for Health Workers (Action Planning)
- V. Three-Day Community Workshop
- VI. Half-Day Workshop for Policy-makers

Use the modules yourself to reflect on your own attitudes, values, language and behavior toward people living with HIV before you try to educate others.

Once you have selected a module, **read the entire activity first** and get an idea of what is required. Ensure that you are clear about the purpose and methods of the module. This will help you prepare.

Try to use the toolkit’s modules just as they are presented here at least once, especially if you do not have much experience using the methods described. Once you are comfortable using the toolkit, you can adapt and change the modules to suit your purpose and target groups.

Do not do any module with which you are not comfortable. You may wish to work with another, more experienced trainer who can help you to manage the more challenging modules.

Methods and Materials

The toolkit uses a wide variety of participatory training methods and materials:

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

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

SMALL GROUPS are used to maximize participation in discussions. Some trainees feel shy in a large group and are more comfortable speaking in a small group. Small groups also can be used to do “task group” work—different groups exploring different topics.

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

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

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

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

PICTURES: The toolkit includes 122 pictures for use in different exercises. Some pictures show various aspects of stigma or gender violence. Others show activities that may or may not involve HIV transmission, and others show different members of a family.

STORIES offer a way to describe how stigma or violence looks like in a real situation and provide a focus for discussion. Some modules include stories, while in others participants are asked to write their own stories.

DRAMA OR ROLE PLAYS can be used with stories. Participants act out the stories in the module or their own stories, or they act out their analysis of an issue as a way of reporting what they have discussed. Drama helps to make things real.

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

WARM-UP GAMES AND SONGS: Trainers are encouraged to use their own games and songs to break the ice, build group spirit and create energy for sessions.

Stop-Start Drama—A Special Technique

One of the techniques used in the toolkit is called “Stop-Start Drama.” This technique is new for many trainers so it requires more explanation.

Stop-Start Drama uses role playing and discussion in a continuing rotation to look at problems and how to solve them. A few participants act out a short scene to show the problem, and then the facilitator shouts, “Stop,” and asks the group to discuss the problem, e.g. “*Is the problem real? Why is there a problem? How can we solve it?*” Ideas emerging from the discussion are then developed into new scenes performed by participants. Each new role play is stopped in turn for further discussion.

The role of the facilitator is to keep the drama-making and discussion focused on the problem and how to solve it. She or he gets each scene going, stops the drama at appropriate points, asks questions, draws out ideas from participants, encourages them to act out their ideas and then leads the discussion.

In summary Stop-Start Drama involves:

- Short improvised role plays performed by participants;
- Discussion to analyze each of the role plays;
- A facilitator who leads and shapes the whole process; and
- The aim of understanding issues, solving problems or practicing skills.

In the toolkit, for example, Stop-Start Drama is used to help health workers practice counseling skills. Two participants perform a drama to show how a health worker deals with a client who has HIV. Then the facilitator shouts, “Stop,” and asks the group, “*What happened? What approach was used? What was the impact of this approach?*” The facilitator might also ask the patient, “*How did you feel when he used this approach?*” The facilitator then invites participants to suggest other approaches, and asks the person who makes each suggestion to take over the health worker’s role and play out the scene again. At the end of this second role play, the facilitator leads a discussion on the approaches used and how the situation might be improved. The process continues until the group has agreed on and tried out (through role playing) a number of approaches health workers might use to treat people living with HIV.

Facilitation Techniques

- Ask a few participants to show the problem in a short, problem-posing drama.
- Stop the drama and get everyone’s attention. “*What do you think? Does this show the real problem? What is missing?*”
- Get responses and turn the most appropriate into another role play.
- Invite people who make suggestions to act them out.
- Give the actors enough time to develop the scene before “stopping” it.
- Ask questions at the end of each scene—or when another problem arises.
- Use questions to:
 - Analyze the problem;
 - Pull out solutions;
 - Assess the realism and consequences of each solution tried; and
 - Get agreement on action.
- Direct some questions to the actors, e.g. “*How are you feeling right now?*”
- Keep restating the focus to ensure the group is on track—“*We are trying to figure out how we can treat people living with HIV in the most caring and supportive way.*”
- Connect play acting with reality—“*This has been a fun drama, but what does it mean for us? What are we going to do in real life tomorrow?*”

Tips for Participatory Trainers

BE WELL PREPARED

- Plan each session before the training.
- Bring all materials—toolkit, handouts, flipchart paper, markers, cards, etc.
- Arrive early so you are ready to welcome participants when they arrive.

PREPARE THE ROOM

- Remove tables to make room for activities and to create a less formal atmosphere.
- Set up the meeting space in a semi-circle, ensuring that all can see the flipchart. Some sessions where you are sharing can be done sitting in a full circle.
- Put flipchart sheets on the front wall.
- Set up a separate table for markers, tape, handouts, cards, etc.

MAKE PARTICIPANTS FEEL COMFORTABLE

- Break the ice and put participants at ease at the start of the workshop.
- Learn participants' names; be informal; use games, songs or buzz groups.

ASK WHAT THE PARTICIPANTS REALLY NEED TO LEARN

- What do they really need to know or do?
- What are some of the problems they are facing in their work?
- What new attitudes or knowledge would make a difference to their work?

ASK QUESTIONS AND LEAD DISCUSSION

- Ask clear, simple, open questions that allow people to give their opinions.
- Fish for contributions—use your hands and body to encourage participation.
- Wait for responses. Give people time to think and come up with an answer.
- Encourage everyone to talk. Buzz groups get everyone talking.
- Keep asking probing questions: “Tell me more. Who would like to add to that?”
- If there is no response, rephrase the question.
- Show that you are listening and interested.
- Praise responses to encourage participation.
- Rephrase responses to check that you and other participants understood correctly.
- Redirect to involve others—“He said. . . . What do others think?”
- Summarize and check agreement before moving to the next question or topic.

“We found that PROBING was a crucial skill in helping the TBAs analyze issues. At first they seemed to have little experience on AIDS and stigma, but through probing—asking more and more questions—we were able to get them to bring out their rich life experience and draw out insights from it.” (Trainers, SVTH project pilot workshops)

USE SMALL GROUPS TO BUILD PARTICIPATION

- Give a clear explanation of the group task, time and reporting method.
- If the task is difficult, write it on a flipchart for quick and easy reference.
- Vary the size of groups for different sessions—pairs, trios, groups of four and five.
- Keep changing the groups so participants work with different people.
- When participants move into groups, go around to check they understand the task.
- Use “round robin” to make report backs more interesting and efficient.

KEEP PRESENTATIONS SHORT AND SIMPLE!

- Give a presentation only when you are **sure** people do not know your topic.
- Write out your main points in key words on a flipchart, and then explain them.
- Speak slowly, clearly and loud enough for everyone to hear.
- Look at people and use your hands and body to emphasize points.
- Keep it short and simple—no more than 10 minutes. Explain only the basics in presentation format.

KEEP CHANGING YOUR METHODS

- Use different methods for different topics to keep things interesting.
- Use your creativity: A story or case study can be turned into a role play, or a report back into practice on how to present a convincing argument.
- Use different sizes of groups. Do not “buzz” all the time—try groups of three or four.
- Change the space. For example, you could hold sessions outside.

CHECK THE ENERGY LEVEL

- Observe body language. Do participants look bored? Sleepy?
- Ask, “How are you feeling? Is it time for a break?”
- Change the topic, take a break or do a wake-up game.

WATCH THE TIMING AND PACING

- Be conscious of time. Decide how much time you need for each session.
- Remember that small group work takes more time than you expect. You will also need to allocate time for report backs.
- Do not go too fast. Let the group help you set an appropriate pace.
- Give groups enough time to do their work. Do not rush them.
- Do small group work in the afternoon when the energy level drops.
- Do not forget to take breaks to relax, get tea and talk informally.
- End on time! Do not drag things out at the end of the day.

EVALUATE THROUGHOUT THE WORKSHOP

- Evaluate as an ongoing activity, not just at the end of the workshop.
- Organize a short evaluation at the end of each day, or on the following morning get participants to review what was learned.
- Assess both what was learned and how the learning was done.

TEAM FACILITATION

- Plan and run the workshop with another facilitator and debrief afterward.
- Take turns in the lead facilitation role and as the recorder.
- Support each other. If one runs into trouble, help him or her out.

A Special Note on Working with Feelings

Many of the modules in the toolkit involve working with feelings. Examples of this are the reflection exercises on stigma (A3) and violence (B3), where participants are asked to reflect on their own experiences of being stigmatized or abused. This brings out strong feelings, which help participants see how hurtful stigma and violence can be: You need to be ready to deal with the emotions raised.

It is important to create a safe, non-threatening space where feelings and fears can be discussed and openly explored.

The following tips may help:

- Set clear ground rules and expectations around confidentiality and listening.
- Be aware of your own feelings and fears about the topics you are going to cover. This will help you feel more confident during the exercise. Try out the exercises yourself.
- Participants are more likely to trust you if you can share your own feelings openly—and by doing this, you lead by example. In the reflection exercises, you might start by giving your own story first to break the ice.
- Allow enough time for participants to share their feelings and help create an atmosphere where participants know they will be listened.
- If participants cry, tell them it is okay. Go sit next to them, touch them, offer them water or suggest a “time out.” Make them feel that we are all in this together.
- Remember that no feeling is *wrong*, but some participants may find it difficult to accept certain feelings.
- Feelings are a powerful tool. Use them with the group to develop dramas and role plays, to build on stories, and as examples for the future.
- After an emotional session, you may want to take a break or do a song to help people come out of the strong emotion and pick up their spirits.

Be aware that some participants may be HIV-positive or worried about their status. Many participants will be untested, so some of the activities may raise emotional responses.

Strategies and Approaches

The following strategies strengthened the pilot training program and may be helpful in your area:

Scheduling: The schedule was organized to suit each health cadre. For example, the Community Health Center asked for the training in one intensive four-day block, while the RMPs and TBAs asked for three days a month over three months. This more staggered approach enabled health workers to learn gradually over a period, apply what they learned after each training, and then return to reinforce it.

Working with RMP association: RMPs run businesses, and time off for training means a loss of income. So the project worked closely with the RMP association to determine the best timing for the training and establish precisely what the RMPs wanted to learn.

Creating a demand for training: RMPs took time off to attend the training because they saw it as a good investment in expanding their knowledge and skills—and making a change in their communities.

Responding to learners' needs: RMPs indicated a strong interest in learning more about HIV and AIDS—practical knowledge that they could use in their own profession. So instead of teaching all the technical content in a single workshop, this content was spread across all of the workshops to sustain their interest.

Tailoring the training program to suit each target group: Government health workers receive lots of training on HIV and AIDS, so their training program gave less attention to these topics.

Building links between different health cadres: While most training was organized for single cadres, a few workshops were organized to bring RMPs and TBAs together to share learning about stigma and violence, build collaboration and allow them to plan community action together. At other times, links were built between government health staff and the paraprofessional health workers (RMPs and TBAs). Before this process, there were no links between these different groups of health workers. Now they have developed mutual respect and are working together on a regular basis.

Involving doctors as resource people: The doctors were very busy and showed little interest in the training. So the project invited doctors to teach the sessions on HIV and Universal Precautions. This strategy killed two birds with one stone—it provided the RMPs with strong, credible messengers for their technical content, and gave trainers an opportunity to brief and win the support of the doctors on the stigma issue.

Breaking the stigma toward RMPs: The doctors at first criticized RMPs as “quacks” and questioned the need for training them. Building more interaction between the two groups helped to overcome this prejudice.

Involving the network of people living with HIV: Getting personal testimonies directly from people living with HIV made a strong impression on participants, and people living with HIV became good allies in organizing the community rallies that flowed out of the training.

In-house training at Community and Primary Health Centers: This training brought together the whole team in each institution—doctors, nurses, and auxiliary staff including cleaners, washerwomen, etc. This process helped to reduce status differences, build dialogue and teamwork, and established consensus on the changes needed to create a stigma-free health facility.

What Have Health Workers Learned?

The SVTH project's pilot training workshops showed that the toolkit can have positive, practical outcomes. In the words of the participants:

The training has changed my whole outlook. Earlier I looked down on dalits, but I no longer do this. I learned so much from the workshops, especially the exercise where we think about our own experience of being stigmatized. I remembered how I was rejected and blamed as a widow when I was very young—and how painful it was. I cried. I now know how people living with HIV must feel to be stigmatized. (TBA)

Earlier I was scared to give an injection to someone I suspected to have HIV. Now I am no longer afraid. HIV is not a dreadful disease. There is no need to keep them away. If we love and respect them, they will live long. (TBA)

In the past when my clients asked how to treat people living with HIV, I told them to be careful and keep them at a distance. Now I have realized this is wrong, and I went back and corrected myself. You have to love, care for them and give them support. (RMP)

We have changed the way we deal with patients, not just AIDS patients—we now know how to treat patients. Earlier we didn't care for patients—we gave them a prescription and sent them away. Now we ask questions and listen to their feelings. (RMP)

I used to hit my wife, but now I know this is wrong and talk to my wife rather than hitting her. I have learned to control my temper—my own way of thinking has changed, I now tell myself that beating is wrong. (RMP)

We have mobilized many clients for ICTC [integrated counseling and testing centers] services. When ICTC was first established, there were very few clients—one case a day. But now there are 10–15 cases every day and there is less fear—people understand the importance of getting tested. On knowing about ICTC services and based on our learnings we feel responsible to make people understand the importance of getting tested. We are also educating women and getting them to use these services. (RMPs & TBAs)

I liked the way illiterate TBAs participated and grew in confidence as training continued. Some now have the courage to stand and speak out in community meetings. They also saw the need to take the learning and the pictures home so they could educate others. They were doing it from the heart—out of real commitment. (Trainer)

We learned that we can't change stigma on our own. We have to work together. We have organized two rallies, working together with the [people living with HIV] network. We challenged the fears and told people it is wrong to point fingers and reject people. (RMP)

In my village, I told people the story we created in the workshop on "what happens when HIV enters the home." I said that if poorly handled, it could be explosive, but if well handled, it is not so threatening. We shouldn't feel helpless or try to hide things. It is better to talk about things openly, to be caring and supportive, rather than stigmatizing people living with HIV. They need our love and support, not rejection. (TBA)

Before some of us would not use disposable syringes, but now we are all using disposable syringes. We have talked to the barbers about this—and we are even educating our patients about these changes. I talked to one grocery store in my village to stock and sell disposable syringes, just the same way he provides biscuits. (RMP)

In the past women knew very little about condoms and never accessed them. I have a medical store, and because of my talks women are coming to buy condoms. They are not shy about approaching me to buy condoms. (TBA)

Chapter A: HIV Stigma – Naming and Owning the Problem

“HIV is definitely going to weaken and kill people infected with HIV, without a doubt, but one should not kill them by stigmatizing.” (Traditional birth attendant’s [TBA] comments from the Reducing Stigma and Violence Toolkit for Health [SVTH] pilot workshop)

■ Introduction

This chapter gets participants to **NAME AND OWN THE PROBLEM**, to see that:

- Stigma exists and takes two major forms – isolating and blaming/shaming;
- HIV stigma has two major causes – fear and lack of understanding of how HIV is transmitted, and moral judgment of others;
- HIV stigma has two major causes – fear and lack of understanding of how HIV is transmitted, and moral judgment of others;
- We are all involved in stigmatizing, even if we are not aware that we do it;
- Stigma hurts – people living with HIV feel ashamed and isolated, and their self-esteem is damaged;
- Stigma results in people living with HIV avoiding getting tested or seeking services or comfort;
- Stigma puts the partners of people living with HIV at risk of infection;
- Stigma helps the virus to spread and exacerbates its impact;
- Stigma is harmful to ourselves, our families, our practice and our communities; and
- We can make a difference by changing our own thinking and actions.

This chapter also gets participants to **name the problem in their own work context** – to recognize how they, as health care providers, stigmatize people living with HIV. The aim is for them to declare their own behavior as stigmatizing and decide how they want to change.

Most of the modules focus solely on HIV stigma, but a few (A5, A10, A12, A13) deal with both stigma **and gender violence**.

■ Modules

- A1. Introduction to Stigma – Animal Cards
- A2. Naming HIV Stigma Through Pictures
- A3. How It Feels to be Stigmatized (Reflection Exercise)
- A4. How It Feels to be Stigmatized (Testimonials)
- A5. Stigma and Violence in Different Contexts
- A6. Naming Stigma in Our Own Workplace
- A7. Stigma Walk – Mapping Stigma in a Health Facility
- A8. How Health Providers Are Stigmatized
- A9. Forms, Effects and Causes of Stigma – Problem Tree
- A10. Effects of Stigma and Gender Violence
- A11. Effects of Stigma on the HIV Epidemic
- A12. When HIV Enters the Home – Stigma and Violence
- A13. Women’s and Men’s Life Cycles – Stigma and Violence
- A14. Comparing AIDS, Cancer, Leprosy, TB, etc.
- A15. Review – Ten Questions on HIV Stigma

A1. Introduction to Stigma – Animal Cards

Facilitator’s Note: This is a good starter activity to get participants talking about stigma and help them understand its meaning. It helps participants see that stigma is an everyday part of life and that we often stigmatize unconsciously.

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

- a) Understand the meaning of the word “stigma”; and
- b) Recognize that we are socialized to stigmatize others.

Time: 1 hour

Materials and preparation: Animal and occupation cards (Annex 5), organized into contrasting pairs.

■ Steps:

1. CHOOSING AND REJECTING (Individual Activity): Hand out a pair of cards to each participant and ask them to do the following:

Look at your two cards and decide which bird, animal or person you would select and which you would reject. Why are you attracted to one and not the other?

2. REPORT BACK (Circle): Ask each person around the circle to explain his or her choices – which picture was chosen, and which was rejected. Record the reasons why people prefer certain animals/people and reject others.

Sample Responses:

Positive characters – and why?	Negative characters – and why?
Sparrow – helps people	Vulture – victimizes other animals
Dove – bird of peace – good luck	Owl – bad omen – brings bad luck
Swan – beautiful and graceful	Crow – chases away other birds
Cow – provides milk and income	Ox – big and threatening
Horse – means of transport	Bear – dangerous – it bites
Deer – beautiful	Lion – dangerous
Squirrel – small and friendly	Elephant – big and threatening
Rabbit – harmless	Monkey – creates nuisance
Goat – source of income	Pig – dirty and ugly
Fisherman – honest living	Old man – can’t do anything
Tailor – provides services to people	Injecting drug user – harmful activities
Young man – able to do anything	Washerman – dirty job
Teacher – educates young people	Trucker – drinks alcohol, spreads HIV
Weaver – useful skill/craft	Migrant laborer – despised as dirty
Carpenter – provides useful services	Prisoner – danger to society
Rickshaw puller – hard worker	Beggar – dirty and bad habits
Businessman – high status	Dancing girl – promiscuous
Doctor – respected	Sweeper – low caste

3. PROCESSING: Ask–

- a) *Why do we like some animals/people and dislike (stigmatize) others? How do we form opinions of prejudice toward different animals or people?*
- b) *Why is stigma a problem?*
- c) *Why is it important to learn more about and take action against HIV stigma?*

Sample Responses:

Why do we stigmatize others? How do we form opinions of prejudice?

- All of us are taught to like certain animals or people, and to dislike others.
- Stigma is to look down on other people, attributing bad things to them.
- We stigmatize, often without realizing it, e.g. we all stigmatize crows.
- We are socialized to stigmatize, to think negatively about other people, occupations and even animals. We say they are “bad,” “dangerous” or “dirty.”
- These negative attitudes are not based on personal experience, but on what we have been told over the years by other people.

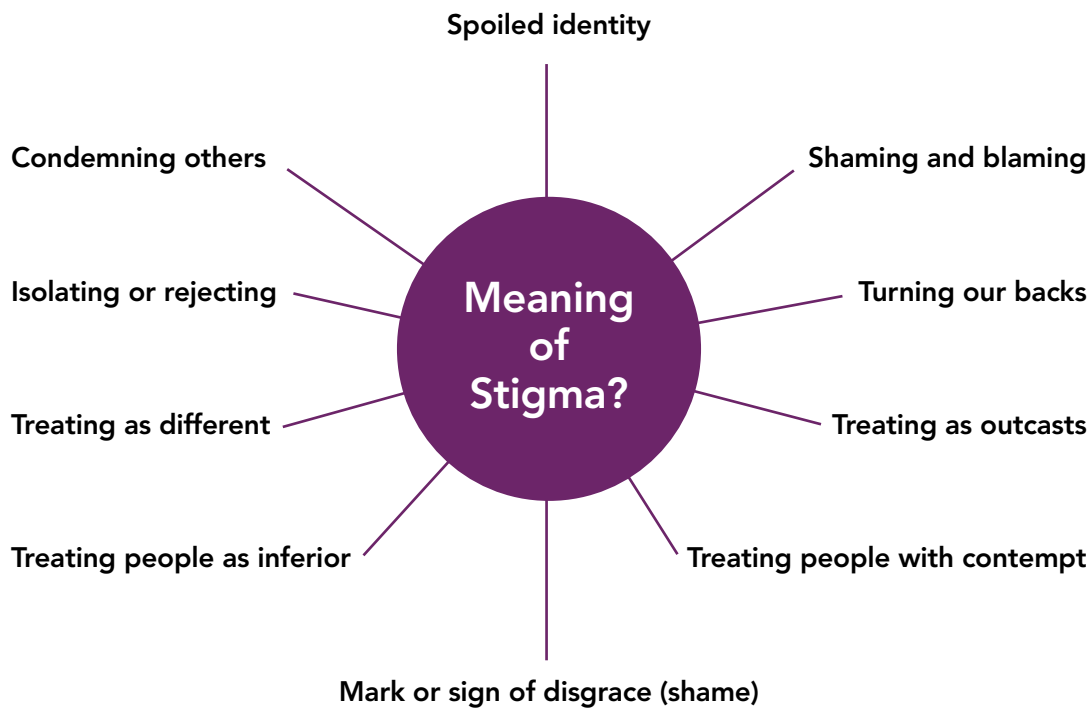
Why is stigmatizing others a problem?

- Animals and birds that look beautiful are valued more than those that are ugly, but some animals and birds that are rejected are also useful to society.
- Stigmatized people may be viewed as bad by society, but they all make a contribution in building a better world, so they should be accepted.

Why is it important to learn more about and take action against HIV stigma?

- Stigma is a major factor in the HIV epidemic. Fear of stigma means people don't get tested and disclose their status, which leads to further transmission of HIV.
- Stigma results in people living with HIV being discriminated against and not getting access to health and other services.
- People blame people with HIV as immoral or bad, rather than focusing on how to help them stay healthy and prevent HIV from being transmitted to others.
- Caring for and supporting people living with HIV (the opposite of stigma) helps to stop HIV spreading, because it encourages them to practice safer sex.

4. MEANING OF STIGMA: Ask – *What do you think is the meaning of stigma?* As participants give their ideas, record them in a circle diagram like the one below. Then present and discuss the summary on the following page.



5. SUMMARY

- We have been socialized to stigmatize others – to judge or devalue them. We are often not aware that we are stigmatizing.
- **Stigma** is when we look down on another person as being bad in some way; we assign negative labels to the person (e.g., “promiscuous”) and don’t value him/her.
- **Discrimination** is the action resulting from stigma when a person is treated differently (e.g., fired from work, kicked out of accommodation or school, stopped from attending meetings, not allowed to use the village well).
- **Stigmatization is a process:**
 - a) *We identify and name the differences* in someone;
 - b) *We make negative judgments* about a person – “he has been promiscuous;”
 - c) *We isolate or judge/ridicule the person* – separating “him” from “us”; and
 - d) The person who is stigmatized (isolated and judged) *loses status*.
- Stigma and discrimination **result in great suffering**. People get hurt!
- **Stigma is viewed at present as something normal – as something not to be taken seriously.** People are not aware of how it affects people living with HIV and how it affects the HIV epidemic.
- **HIV stigma is WRONG – it is NOT ACCEPTABLE!** HIV stigma hurts people living with HIV and drives the epidemic underground. Those stigmatized become silent and don’t disclose their status to others – and as a result spread HIV.

A2. Naming HIV Stigma Through Pictures

Facilitator’s Note: This exercise helps participants to “name” HIV stigma impersonally – saying that stigma happens, but not yet saying “we are the stigmatizers.”

The pictures for this exercise can be used in different ways. In the process described below, pictures are handed out to pairs of participants to analyze. Another option, for a literate group, is to tape the pictures, along with flipchart paper, on the walls of the training room and ask participants to move around the room writing their comments regarding each picture.

We also have found that the pictures can be used by participants as a stimulus for discussing stigma with their families, neighbors and friends – a good form of follow-up. So we recommend that you make photocopies and hand them out to your participants.

“Everyone in the village liked this man. He was always so cheerful and good to people. But when he got sick, they stopped visiting him. A few came, but this was just to see this new disease called ‘AIDS.’ He was kept in a back room and people forgot about him. There were lots of rumors flying around the village about his ‘immoral behavior’ when he had worked in Kolkata. And when he died, no one went to the cremation. People were scared they would breathe in the fumes from the cremation fire and get HIV.”

(Rural medical practitioner’s [RMP] story that emerged out of this session during the SVTH project.)

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

- a) Identify different forms of stigma in different contexts; and
- b) Identify how stigma affects people living with HIV and their families.

Time: 1 hour

Materials and preparation: Stigma Pictures in Annex 5 (A1 to A24), displayed on the wall.

■ Steps:

- 1. NAMING STIGMA (Picture-Discussion):** Divide into pairs. Ask each pair to select two pictures. Ask them to discuss, *What do you see in the picture? How does this picture show stigma?*
- 2. REPORT BACK (Circle):** Ask each participant to hold up one picture for everyone to see and explain its contents. Record points on flipchart. For each picture, ask, *How do you think this makes the person who is stigmatized feel?*

Sample Responses:

Picture A3 – Two men gossiping about another man

One man is sitting alone while two other men are gossiping about him. He looks sad. They know that he has HIV so they are making fun of him, rather than supporting him.

Picture A4 – Father, mother, and children being thrown out of house

The owner is kicking an HIV-affected family out of his house. The family looks lost and miserable – they don't know where they will go.

Picture A6 – Man sitting all alone on a bed

This man has been isolated – put into a room on his own and forced to stay there all alone. He has no visitors. No one is there to comfort or help him. He looks abandoned.

Picture A7 – Health worker meeting with the family – positive woman is sitting alone

The health worker is consulting the family about an HIV-positive family member but she is left out of the meeting. When you get HIV, you are seen as useless and left out of family decision-making.

Picture A8 – Man outside counseling room, saying, "What am I going to do now?"

He is worried about his situation. He is worried that he may be rejected by others once they find out that he is HIV-positive. What will people say or do? He looks desperate and confused.

Picture A12 – Man is fired for being HIV-positive

The man has been fired from work in the factory. He is not sure what he is going to do. He looks depressed – this may lead him to commit suicide.

Picture A13 – Doctor talking to nurse beside patient's bed

The doctor and nurse are keeping a distance from the patient and gossiping about him. Excessive use of gloves and mask makes the patient feel rejected.

Picture A20 – Children playing, one girl left out of the game

The children exclude one girl from the game. Secondary stigma – she is stigmatized because her parents have HIV. Other parents may have told them not to play with her.

3. PROCESSING: Ask–

- a) *What are the major forms of stigma?*
- b) *Why are people stigmatizing people suspected to have HIV?*
- c) *How did it make the people who are stigmatized feel?*
- d) *Have we seen examples of stigma in our own communities?*

4. SUMMARIZE: Refer back to the pictures to make some of the following points:

- We have been socialized to stigmatize others – to judge or devalue them. We are often not aware that we are stigmatizing.
- **Stigma** is when we look down on another person as being bad in some way; we assign negative labels to the person (e.g., "promiscuous") and don't value him or her.
- **Discrimination** is the action resulting from stigma, when a person is treated differently (e.g., fired from work, kicked out of accommodation or school, stopped from attending meetings, not allowed to use the village well).

■ The main **FORMS** of stigma include:

- **ISOLATION & REJECTION** – Physical separation from family, friends and neighbors. Person living with HIV may be forced to stay alone in a separate room and use separate utensils. Based on ignorance and fear of HIV infection. Example: neighbors not attending the cremation of a person suspected to have died of AIDS out of fear that the smoke would carry HIV.
- **SHAMING AND BLAMING** – Gossip, name calling, insulting, belittling. Based on moral views. Shame people for assumed bad behavior.
- **TREATING PEOPLE AS USELESS** – People living with HIV may be excluded from decision-making, assumed to no longer be able to make a contribution to family.
- **SELF-STIGMA** – People living with HIV stigmatize themselves in reaction to stigmatization from society. They accept the blame and rejection of society, and end up isolating themselves.
- **STIGMA BY ASSOCIATION** – The family of a person living with HIV is stigmatized by the community – their family reputation is affected. RMPs and other health workers are stigmatized as “AIDS doctors.”
- **SECONDARY STIGMA** – Some individuals (e.g., women, *dalits*, widows) are already stigmatized and discriminated against. Having HIV adds another layer of stigma.

■ Some of the **EFFECTS** of stigma are:

- Shame, humiliation and loss of self-esteem;
- Feelings of sadness, loneliness, rejection, hopelessness, worry and self-doubt;
- Feelings of uselessness and inability to contribute;
- Stress, depression, suicide and alcoholism;
- Shame (loss of status) to family;
- Violence and other conflict;
- Discrimination – person living with HIV is kicked out of family, job, organizations, etc.;
- Denial, which stops people from getting tested or seeking services and support; and
- Silence – people living with HIV do not disclose their status and may pass HIV to others.

■ **Action Ideas:**

- a) **Take the pictures home and discuss** them with family members and friends. Help others see what HIV stigma means in our lives – how it happens and how it hurts people.
- b) **Discuss** – *What can you do to stop HIV stigma?*

Examples: Treat people living with HIV with the same respect as anyone else. Avoid using words that hurt people.

A3. How It Feels to be Stigmatized (Reflection Exercise)

Facilitator’s Note: This exercise is one of the most important because it draws on personal experiences to bring out the feelings of being stigmatized. The exercise requires a lot of trust and openness within the group, so it should not be done at the start of the training. Wait until participants are comfortable with each other, so that everyone can talk openly about their experience and how it made them feel. The facilitators can help participants get started by sharing their own stories and feelings first.

Set a quiet, serious tone for the exercise. Try to minimize outside interference. Keep the door closed so that no one can come in and disturb the group’s concentration.

Sharing one’s story is voluntary. No one should be forced to give their story.

Encourage group members to listen carefully to each other’s stories.

The exercise can be very emotional and painful for some participants. Participants are being asked to think and talk about strong feelings. You should be ready to deal with the emotions raised. (See the Introductory chapter for suggestions on how to do this.)

“The exercise helped me understand how it feels to be stigmatized. I reflected back on my own experience of being stigmatized as a widow when I was very young. How I cried! I remembered the emotion of being rejected and blamed as a widow – something which was very painful to me at the time.” (TBA participating in the SVTH project)

Some trainers have combined this exercise with the reflection on violence (module B3) – thinking of experiences of being abused or beaten. The choice of combining these exercises or treating them separately is up to you. The advantage of combining the two issues is that they are often closely linked. The disadvantage is that most of the stories end up focusing on violence and not enough attention is given to stigma.

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

- a) Describe some of their own personal experiences concerning stigma; and
- b) Identify some of the feelings associated with being stigmatized.

Time: 1–2 hours

■ Steps:

1. OUR OWN EXPERIENCE OF BEING STIGMATIZED (Individual Reflection): Ask participants to **sit on their own** at a distance from other participants. Then say – *Think about a time in your life when you **felt isolated or rejected** for being seen as different from others – or when you saw other people treated this way.* Explain that *this does not need to be examples of HIV stigma* – it could be any form of isolation or rejection for being seen as different. Ask them to consider, *What happened? How did it feel? What impact did it have on you?*

2. SHARING IN PAIRS: *Share with someone with whom you feel comfortable. If you prefer to remain silent, this is okay too. There is no pressure on anyone to share.* Help participants pair off if they are having difficulties.

3. REPORT BACK: Invite participants to share their stories in the large group. This is not compulsory – people will share if they feel comfortable. You may choose to use your own story first to break the ice. As the stories are presented, ask – *How did you feel? How did this affect your life?*

Sample Responses:

Experiences of being stigmatized

Caste discrimination. Experience of being widowed. Women being rejected by their husbands. Having a different dialect. Dressing differently. Skin disease resulting in being shunned.

How did you feel when you were stigmatized?

Depressed. Rejected. Judged. Outcast. Lonely. Second class citizen. Pushed down. Unaccepted. Useless. Failure. Hated. Discredited. Misunderstood. Teased. Insulted.

4. PROCESSING: Ask – *What did you learn about stigma from this exercise? What feelings are associated with stigma?*

5. SUMMARIZE:

- This exercise helps us get an inside understanding of **how it feels** to be stigmatized – shamed or rejected.
- The feelings of being stigmatized are very painful. People get badly hurt.
- The feelings of being stigmatized last a long time.
- Stigma destroys people’s self-esteem. People begin to doubt and hate themselves. They feel very alone at a time when they really need the support and company of other people.
- This exercise helps put us into the shoes of people living with HIV. It helps us understand how painful it is to be stigmatized. People living with HIV go through this experience every day of their lives, and it is very demoralizing.

■ Action Ideas:

Talk with friends or family members about what you have learned about stigma. Get them to talk about their own experience of being rejected as a way of helping them understand how it feels to be stigmatized.

Stories and Experience of Being Stigmatized

1. I was widowed at 25. I am now 56. When I was widowed, I already had four children – the oldest age 10. Everyone told me, “How can you raise four children on your own?” This made me feel very bad. I told myself, “Why do people tell me I’m helpless? Why can’t I educate my own children?” So instead of allowing this stigma to demoralize me, it challenged me to do something. I worked very hard at dress-making to earn extra money to put my children through school. And later I became a TBA, but the stigma did not stop. On my first delivery, the owner of the house said, “Oh, look at you, a widow coming to my house to deliver – this is a bad omen!”

2. When I was small, my brother and I used to play with two children in our area, both of them from *dalit* families. One day my father came home and found us playing with them. He shouted at them and kicked them out of our house. This made me cry. I felt very bitter, I was so ashamed. This girl was my best friend. My brother and I did not accept this treatment. When my father was not around we would still go and play with them.

3. I have long hair and used to tie it in a ponytail, wrapped in a dhoti. One day on the bus schoolchildren sat behind me and pulled my hair. This made me feel very bad. They made me feel different because of my hair.

4. I married a man from another area, where the accent is quite different. When I first moved in with his family, I found it hard to understand their accent and they used to tease me about my accent, always imitating some of my words. So I felt very isolated in this household – they made me feel different from the others because of my language.

5. When I was 18, I decided to leave home, find work and survive on my own. I went to a bigger city and tried to find work. People said, “You look well fed, too spoiled to be able to do manual labor.” So no one hired me. I then tried to get work as a security guard, but no one hired me – they said I had no experience. So again I failed to find work. Demoralized I returned home, feeling I was a failure.

6. As women we are stigmatized from the day we are born to the day we die. As a child I was always treated as if I was nothing – my brothers always got more love and better treatment. When I became a teenager, my life stopped – I was pulled out of school and sent to work in the fields . . .

7. As *dalits* we are branded as outcasts. We are treated as being inferior and as a danger to other people. People don’t mix with us, don’t eat with us, don’t marry us, don’t accept us – we have to live separately in our own colonies.

A4. How It Feels to be Stigmatized (Testimonials)

Facilitator's Note: We consider this exercise to be very important. In it, two or three people from the Network of People Living with HIV address the health workers and answer their questions. Hearing first-hand about the lives of people living with HIV and how they are treated by their families, workmates, communities and health workers helps to make stigma real for health workers.

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

- a) Name some of the forms of stigma experienced by people living with HIV; and
- b) Describe the feelings of being stigmatized.

Time: 1 hour

Materials and preparation: Invite guest speakers (people living with HIV) and brief them beforehand on how to give their testimonies. Ask them to:

- *Talk about your own life and the life of your family before and after getting HIV. Talk about how you were treated in the family, in the community and in health facilities once people discovered you were HIV-positive – and how it made you feel.*
- *If possible use your own stories to **get health workers talking about their own experience with stigma** – examples they have they seen or heard about stigma.*

■ Steps:

1. TESTIMONIES: Ask each speaker to tell his or her story and invite participants to ask questions to clarify the story. Focus on the experience of the speakers, but also encourage participants to respond to the stories with their own examples of stigma in the community or health settings. *Have you seen or heard of things like this?*

See example of a testimony on the next page.

2. PROCESSING: Ask–

- a) *What were the main forms of stigma identified in the stories?*
- b) *What should/would be your responsibility and response, as health care providers, in similar situations?*

Sample Responses: Stigma and discrimination in the story (on the following page)

Stigma in the family

- Person living with HIV is verbally abused by other family members – mother-in-law blames her for her husband's infection.

Stigma in the community

- Neighbors gossip once they discovered she had HIV.
- People stopped buying goods from the family shop.
- Neighbors stopped their children playing with her son.

Stigma in the health facility

- No confidentiality – letting other staff and patients know her status.
- No proper counseling – no comfort, encouragement or reassurance.

3. SUMMARIZE:

- This exercise helps us understand **how it feels** to be stigmatized. The feelings of being stigmatized are very painful. People get badly hurt.
- Some people living with HIV say that health workers are afraid that treating them will lead to HIV infection. As a result, health workers minimize contact with patients who they suspect have HIV.
- Some HIV-positive patients think that health workers judge them – blame them for getting HIV through “bad behavior.”
- These two things – isolation and blame – **make people living with HIV feel like outcasts**. This has a **serious effect on their psychological health**.
- **Stigma destroys the self-esteem of people living with HIV**. They begin to doubt themselves. They feel very alone, confused and demoralized at a time when they really need the support and company of other people.
- While taking the necessary precautions to protect their own safety, health workers **need to focus on the well-being of their patients and take the feelings of people living with HIV into account**.

Example – a composite story based on the real experience of people living with HIV

I got married when I was 16. Soon after we were married, my husband left to work in Kolkata. He stayed there for eight years, returning once or twice a year to see the family, and make me pregnant. During the last part of his stay he began to get sick. Eventually he was kicked out of his job and he returned home. At first he didn't tell me what was wrong with him, but I suspected he might have this new disease called “AIDS.” He got sicker and sicker and eventually he died.

I was pregnant at the time and went to the health center for a check-up. They asked me to do a blood test – and then told me I was HIV-positive. They told me with very little counseling and support. And after telling me the results, no one told me what to do, how to cope with this new situation. I was shocked and confused and angry – I didn't know what to do. This was the first time for me to find out that my husband had infected me.

Everyone at the health center seemed to know my HIV status. They looked at me in a funny way and kept their distance. Sometimes I had to wait for a long time. But they helped me deliver the baby.

I returned home to find other problems. My neighbors started to gossip about me and my mother-in-law began to tell stories about me. She blamed me for infecting her son. This made me feel very depressed.

I started a sewing business to bring in extra income. At first I got customers but when people found out about my situation they stopped coming. My business suffered badly. Some people even blamed me, saying I had got HIV as a sex worker and had infected my husband.

The one good thing about my life was my baby. He was a very healthy boy – born without HIV – and he made my life worthwhile. When he was older, I sent him to school, but other children refused to play with him and he had to sit separately in class. He does not have HIV but he is suffering just like me – people say he is an AIDS child!

A5. Stigma and Violence in Different Contexts

Facilitator’s Note: This activity, which uses rotational brainstorming, is especially good for workshops that bring together different types of health workers.

Rotational brainstorming requires literacy skills, so to complete this activity with groups including TBAs you may need extra recorders (one recorder per group). At each flipchart the recorder reads out the points already written by other groups and asks the group to add new points.

The choice of combining stigma and gender violence within a single exercise or treating them separately is up to you. In our experience it is better to deal with them separately when training TBAs; otherwise it is too overwhelming. On the other hand, combining the two issues in a single exercise helps bring out the close links between stigma and gender violence.

During the group reports, debrief on the health facility and workplace contexts last. This provides a link to the next module on “Stigma in the Workplace.”

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

- a) Identify different forms of stigma and violence that take place in different contexts; and
- b) Work out solutions to stop stigma and gender violence.

Time: 1–2 hours

Materials and preparation: Put up flipchart paper on different walls of the room, with a context written on each sheet: Home, Community, Market, School, Health Facility and Workplace.

■ Steps:

1. ROTATIONAL BRAINSTORMING (Small Groups): Divide into six groups and assign each group to a topic. Ask each group to write down on the flipchart **forms of HIV stigma and gender violence that occur in their context**. (Ask them to start writing their first thoughts immediately, not stand talking for a long time without writing.) After three to four minutes shout “CHANGE” and ask groups to move to the next topic and add points. Continue until each group has contributed ideas to every context.

2. REPORT BACK (Rotational): The whole group moves around the room, looking at one topic at a time. Ask one participant to read out the points quickly.

Option: Another way to report back is to ask each group to return to the flipchart where they started and prepare a presentation. This would include presenting the main points and doing a drama.

Sample Responses: Identifying forms of stigma and gender violence

Home

- No respect or love. Family members stop touching or comforting HIV-positive family members.
- Isolation – hide people living with HIV in back room – separate bed, blankets, clothes, plates, food.
- Some people living with HIV are kicked out of the house and forced to move to another place.
- Hide people living with HIV from neighbors. Stop them going outside so neighbors won't see them.
- HIV-positive women are prevented from having contact with their own children.
- Loss of place and recognition within family. Excluded from family decision-making.
- Verbal abuse – insults, belittling and blame, e.g. *"Why did you bring shame on the family?"*
- Viewed as burden on family. Treated as useless – no longer able to contribute to the family.
- Women are the first blamed for bringing HIV into the home and abused verbally and physically.
- Property grabbing by relatives – women lose out. Resulting poverty.
- Family shame – family honor/reputation ruined – self-stigma by family.
- Wife blamed for not raising (HIV-positive) child properly. Often leads to violence.
- Stigma at home is very painful. This is the place of last resort. If your own family stigmatizes you, you have nowhere else to go.

Community

- Verbally abuse people living with HIV – call them "promiscuous." Whispering and finger-pointing.
- Neighbors isolate or shun people living with HIV – they stop visiting the family and sharing food.
- Neighbors only visit as voyeurs to see how thin the people living with HIV are or how the skin looks.
- They stigmatize the family. Blame family for low morals – not raising their child properly.
- Don't allow their children to play with children from the HIV-affected family.
- Refuse to provide services, e.g. washerman will not wash the family's clothes, barber will not cut the hair of a person living with HIV.
- People living with HIV are prevented by community members from attending functions.
- When a person dies from AIDS, community members refuse to take the body for the cremation and to attend the cremation.
- Sexual harassment and abuse of women and teenage girls.

School

- Children who have HIV-positive parents are stigmatized by other children – prevented from playing with them or taunted and teased.
- These children are given separate places in the classroom.

Market

- People stop buying products from someone suspected to be HIV-positive – say goods are contagious.
- Teasing and gossip, e.g. *"Her husband died recently from AIDS."*
- Isolation – stay away from the seller.
- Loss of respect, erosion of morale and business collapses.

Workplace

- Gossip and isolation toward someone suspected to be HIV-positive.
- Forced to take HIV test and then fired from job.
- Loss of status/reputation – viewed by everyone as unreliable.
- Sexual harassment and abuse of women and teenage girls.

Health facility

- Staff are suspicious of anyone who seems to have AIDS symptoms – fear of getting infected.
- Isolate people living with HIV – forced to stay in separate room. Keep food and utensils separate.
- Insults – blame him for getting HIV through promiscuous behavior, i.e. sleeping with sex workers.
- Neglect. Minimize touching of HIV-positive patients. Treat them last and provide "half treatment."
- Overprotection – wear gloves to examine HIV-positive patients. Maintain distance in giving injections.
- Breach of confidentiality – hospital staff tell other patients. Whispering. Gossip.
- RMPs and other health workers are stigmatized – called "AIDS doctors."
- Cases of battered women are treated as "accidents," not cases of violence.

3. PROCESSING – SOLUTIONS: Ask, What can we do to **stop** HIV stigma and gender violence?

Sample Responses:

- Change our own attitudes and language toward people living with HIV and women – stop “blaming and shaming” and using words such as “promiscuous.”
- Stop using negative words when we talk about people living with HIV or women.
- Educate others on how stigma and gender violence feel and why they are wrong.
- Speak out against stigma and violence toward women.
- Get the community to name HIV stigma and gender violence as problems.
- Provide up-to-date information about HIV and AIDS so that people no longer isolate people living with HIV out of fear of casual contact.
- Stop family members from isolating family members with HIV within the home.
- Stop family members from abusing women (physical, emotional, sexual or economic).
- Treat positive people like you would treat other people – no difference!
- Offer kindness, support, comfort and good listening to people living with HIV and battered women.
- Encourage people living with HIV to use available services, such as antiretroviral treatment, preventing parent-to-child transmission treatment and medical care.
- Encourage women to report violence to police and get police to treat cases seriously.
- Empower women and people living with HIV with assertiveness skills.
- Provide legal services for women and people living with HIV.
- Encourage people living with HIV to be involved in family and community gatherings.
- Introduce new practices in health facilities, e.g., no separate rooms or seating for people living with HIV.
- Treat cases of battered women differently – as cases of violence, not “accidents.”

4. SUMMARY:

- Stigma and gender violence are **everywhere** – homes, communities, health facilities, workplaces, markets, etc.
- Stigma takes two major forms:
 - a) **Rejection and isolation** – people are rejected because others fear getting infected (or they self-impose isolation from fear of other people knowing).
 - b) **Shame and blame** – people are judged, condemned, belittled, mocked – often based on the assumed sexual behavior of a person who has HIV.
- Other forms of stigma include:
 - c) **Self-stigma** – people living with HIV blaming and isolating themselves.
 - d) **Stigma by association** – families and health workers associated with people living with HIV are stigmatized.
 - e) **Secondary stigma** – some individuals are already discriminated against (e.g., women, *dalits* and widows). HIV adds another layer of stigma.
- Violence takes four major forms – **physical, emotional, sexual and economic**.
- **Emotional violence is similar to stigma** – women are blamed and shamed (verbally abused) for being a burden on the family, not having children, etc.

- **STOPPING STIGMA AND VIOLENCE** will take a huge effort by everyone. **The starting point is to change ourselves** – change the way we think, talk and act toward people living with HIV and women. We have to personalize the issue to see that **we** have to do something to change things.
- **Open your mind. Lose your prejudices. Respect differences.**
- After we have changed ourselves, **we can start to educate and challenge others.** It takes courage to stand up and challenge others when they are stigmatizing people living with HIV or abusing women – but this is one of the most important ways to stop stigma and violence. Breaking the silence and getting people talking openly is the first big step.

■ **Action Ideas:**

- Talk with your family, friends and clients **about HIV stigma and gender violence, and how they both hurt people and cause the virus to spread.**
- Get community leaders **to speak out against stigma and violence. Help everyone make these problems visible and unacceptable.**
- Reach out to, accept and support people living with HIV and abused women. **Once they feel accepted, they will be more open to discussing their situation with others and accessing services.**

A6. Naming Stigma in Our Own Workplace

Facilitator's Note: In this module participants look at how they, as health workers, stigmatize people living with HIV, and what they can do to change these practices.

The health workers explained during the pilot project that people living with HIV rarely come to them for medical help. TBAs, for example, said that they had not yet delivered babies for a positive mother. This module helped participants understand that people living with HIV will not come to them for help unless they show that they will provide treatment fairly and without stigma.

Because every health setting produces different forms of stigma, you should adapt this module to suit each of the target groups – rural medical practitioners, traditional birth attendants and community health workers (auxiliary nurse midwives and multi-purpose health workers).

"If an HIV-positive woman asks us to deliver her baby, we should never refuse. After all we are all mothers – we cannot leave her for her own destiny."

"One should be near a person at the time of birth and death, so we are going to help deliver babies for any woman who comes to us."

"From now on we are going to touch our HIV-positive patients. If we touch them, then only others will believe and behave."

(TBA comments from SVTH project)

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

- a) Describe how they stigmatize people living with HIV or people suspected to have HIV in their own working context – and how it affects their HIV-positive clients; and
- b) Take responsibility for changing the way they relate to people living with HIV.

Time: 2 hours

Materials and preparation: Pictures A13 to A15 (Annex 5), taped to the wall.

■ Steps:

1. NAMING STIGMA IN OUR WORKPLACE (Picture Discussion & Brainstorm):

Ask–

- a) *What forms of stigma do you see in the pictures?*
- b) *What other forms of stigma take place in health care settings? How does this affect people living with HIV?*
- c) *How are YOU treating clients whom you suspect have HIV? Do you treat them in a different way than other patients?*
- d) *What fears do you have about providing services to people living with HIV?*

Sample Responses:

Forms of stigma toward people living with or suspected to have HIV

- Avoid touching patients and minimize contact when checking symptoms.
- Force HIV-positive patients to sit in a separate area or on a separate bench.
- Judgmental – “*You guys play these dirty games – you deserve to get AIDS!*”
- No proper counseling – no comfort, encouragement or reassurance.
- Break confidentiality – gossip about people living with HIV to patients or community.
- Refer them to private testing centers – and get a commission. (Extra financial burden on patient, who could get free testing at an Integrated Counseling and Testing Center.)
- Reject clients suspected to have HIV, giving as an excuse that they don’t know how to treat this disease.
- Charge extra fees for treating people living with HIV – “risk allowance.”

How stigma affects people living with HIV

- Makes them feel unwanted and demoralized – lose their self-esteem.
- May avoid going to health workers for help, fearing that they will be treated badly.

How are you treating HIV-positive clients?

- We have treated them in an aggressive or impersonal way, showing very little concern.
- We do not have many patients who are HIV-positive.
- We refer them to other health workers.
- We have very little experience working with HIV-positive patients.

Fears about treating HIV-positive patients

- We are afraid we may get infected while we are checking their symptoms.
- We fear our businesses will suffer if our other patients see us treating the HIV-positive patients.

2. NAMING STIGMA IN OUR WORKPLACE (Story):

As an alternative or additional activity, read or act out the following story:

In one village, a father gets HIV and eventually dies. His wife becomes very sick, but her son makes no attempt to get her treatment. Dayamani, a TBA, hears about the situation and comes to visit, even though neighbors tell her this is dangerous. After talking with the woman, she tells the family that she is going to take the woman for treatment. But the family and neighbors try to stop her. She refuses to listen and takes the woman to the hospital. At the hospital, the doctor scolds her for bringing the woman and sends her to the outpatient unit for first aid. Dayamani then takes the woman home. When she returns to her own home, household members stop her from entering her house until she has had a bath and washed herself completely.

Then ask–

- What forms of stigma took place in this story? How do you think the woman with HIV felt?*
- Have you had similar experiences in trying to treat people living with HIV? If so, what happened?*

3. CHANGING OUR TREATMENT OF PEOPLE LIVING WITH HIV (Paired Role Play): The exercise below is designed for RMPs. You should adapt it for the other health workers.

Tell participants, *“We are now going to practice how to change the way we relate to people living with HIV and AIDS.”*

Step 1 (Clinic Situation): *We are first going to imagine that a man who suspects he has HIV comes to get help at your clinic. Everyone stand up and find a partner. A is the RMP, B is the client. In each pair agree on who is A and who is B. (Wait until they decide.) The situation you will play is: B arrives at A’s clinic and asks A to help him – B has been having lots of diarrhea. PLAY!*

Let the plays run for three minutes. Then shout *“Stop!”* and invite one pair to show their play to the group. At the end lead the following discussion:

- a) Ask the group, *What happened? How did the RMP deal with the client?*
- b) Ask the client, *How did this approach make you feel?*
- c) Ask the group, *What other approach might be used to make him feel better?*

Sample Responses:

a) What happened? How did the RMP deal with the client?

- He kept at a distance, showing his fear of the patient.
- He was very cold and refused to touch the patient.

b) Client – How did this approach make you feel?

- I felt he was shunning me. I felt very bad and demoralized and wanted to leave.

c) What other approach might be used to make the client feel better?

- Welcome the client with a warm smile and kind words.
- Sit closer to the client and ask him questions about his health.
- Ask questions to get him talking.

Use the suggested approaches (Question C) as the basis for a new role play, building on the first one. Ask the person who suggests the improved approach to take over the role of RMP, while the original person continues to play the role of the client. Then play the scene again, and afterwards debrief how it went – *Did the new approach work? How did it make the client feel? What made the difference?*

Continue this process until the group has agreed on a good strategy to respond positively to the client.

Step 2 (Family Situation): If there is enough time, try out the following situation, using the same pairs as in Step 1: *We are now going to look at a new situation, where a woman comes to ask the RMP to visit her sick husband, who is thin and has a high fever. Change the roles. The person who was the RMP now becomes the woman. The other partner plays the RMP. Now play out the new situation. PLAY!*

After three minutes shout *“Stop!”* and ask one pair to show their play to the group. Debrief and continue to use role play and discussion to work out approaches to deal with this new situation.

4. CHANGING OUR TREATMENT OF PEOPLE LIVING WITH HIV (Group Role Play):

As an alternative to #3, divide participants into two groups. Ask one group to develop a role play showing a negative, stigmatizing approach used by a health worker interacting with an HIV-positive client, and ask the other group to develop a role play showing a positive, supportive approach. Then ask both groups to perform their plays and discuss.

- a) *What happened in each role play?*
- b) RMP: *Why did you treat the patient like that? (e.g., fear)*
- c) Patient: *How did it make you feel?*
- d) *What approaches should be used to deal with an HIV-positive client?*

5. PROCESSING: Ask–

- a) *What approaches can we use to build good relations with an HIV patient?*
- b) *What approaches can we use to help a family accept the new situation and take responsibility for caring for the family member with HIV?*
- c) *How can we support people living with HIV to cope with stigma?*

Sample Responses:

Approaches for building good relations with an HIV patient

- Treat patients with HIV the same way you treat other patients.
- Empower/encourage the patient to talk – to explain how she or he is feeling.
- Touching patients with HIV (to check their symptoms) is okay. Touching is important because people living with HIV rarely get touched (because of the fear within family/ community).
- Be reassuring. Say things like *“Don’t worry – we can do something. People may tell you your life is over, but there is a new medication called antiretroviral therapy that can help you. If you look after yourself, you can live a long life.”*
- Tell the patient how to get tested and how it will help.
- Advise on how to get support from others. Encourage disclosure to a trusted family member or friend.
- Provide basic information on antiretroviral treatment and how it can be obtained.
- Help him focus on the positives, e.g. *It is important to stay alive for your children.*

Approaches for dealing with the family

- Help the family focus on the health situation and avoid *“shaming and blaming.”*
- Provide basic information on HIV and AIDS and clear up misconceptions.
- Help the family accept responsibility for caring for the person with HIV.

6. SUMMARY:

We should STOP:

- Sending clients with HIV away and refusing to help them (because we fear getting HIV from them or fear that we will lose our other clients);
- Breaching confidentiality – telling other clients about our patients with HIV;
- Separating patients – putting people living with HIV in a separate room/space; and
- Charging people living with HIV extra for services.

We should START telling our patients with HIV about:

- When and how to disclose to family and/or friends to get support;
- Why, where and how to get Integrated Counseling and Testing;
- How to avoid transmitting HIV during childbirth through Preventing Parent-to-Child Transmission (PPTCT) programs;
- The meaning of a CD4 test; and
- When and how to obtain antiretroviral treatment.

We should develop a **CODE OF PRACTICE** to treat people living with HIV in a **stigma-free, accepting way. They deserve our respect and support.**

■ Action Ideas:

Talk with other health workers and clients about what you can do to de-stigmatize your practice. How can you change the setup in your clinic to make it stigma-free? How can you educate your clients who do not have HIV so they are more supportive toward clients with HIV?

Meet with the RMP Association or other groups of health professionals to develop a **CODE OF PRACTICE** on how to treat people living with HIV in a stigma-free, accepting way. Encourage all health workers to sign it.

Example of what the “CODE OF PRACTICE” might look like:

This is the code of practice drawn up by the RMP Welfare Association of Ichchapuram
We will follow this code of practice and live by it on a daily basis:

We will treat people living with HIV with love and give them courage.

We will touch people living with HIV and make them feel comfortable.

We will use disposable syringes for every patient.

We will not show any discrimination to people living with HIV. We will treat all patients equally.

We will give people living with HIV good suggestions, courage and ideas to help them live a healthy life.

We will not disclose the status of HIV patients to others.

We will not organize separate rooms at clinics for HIV patients.

We will not charge HIV patients more than other patients.

We will raise the awareness of our communities on stigma, discrimination and gender-based violence.

A7. Stigma Walk – Mapping Stigma in a Health Facility

Facilitator’s Note: This module is an option to use along with A6 and is used to identify different forms of stigma in a health center. Staff walk through different rooms or spaces in their facility to observe how health workers interact with patients. This provides a non-threatening way for health staff to learn how patients (including those with HIV) perceive practices at the facility, and which practices are potentially stigmatizing.

Objective: By the end of this session, participants will be able to identify potential forms of stigma in each area of the health facility.

Time: 1 hour

Materials and preparation: Meet with the head of the facility beforehand to get permission to use the space. Explain the purpose of the “walk” and offer to debrief him or her afterwards on the forms of stigma found in the center. Try to minimize defensiveness and allay fears about criticism by clarifying that the aim is to find ways to improve relations with clients.

■ Steps:

1. INTRODUCTION: Explain the purpose of the walk and discuss with participants which issues should be explored during the walk (e.g., body language or words used by health staff to patients, separate spaces for patients with HIV, special codes used to identify HIV patients, use of Universal Precautions, etc). Decide on the locations to be visited. For a community health center, for example, you might visit the operating room, consulting room, wards, labor room, dispensary, injection room, dressing room, Integrated Counseling and Testing Center (ICTC), medical lab, X-ray room and incinerator. You might invite community leaders or some patients to join you for the walk.

2. STIGMA WALK: Divide into two groups for the walk and assign one facilitator to accompany each team. Ask each group to visit each room, make notes on what they observe, and hold short discussions with the staff or patients who are there.

3. REPORT BACK: At the end of the walk, reconvene and ask groups to report on their findings. Taking one room at a time, ask one group to report, and then ask the other group to add missing points. The second group can report first on the next room, and so on.

Sample Responses:

Integrated Counseling and Testing Center: Avoid touching patients. Excessive use of gloves. Treat them from a distance. Inform other staff of their status. Call them “AIDS people.” Give reports to them in anger. ICTC staff are stigmatized by other staff – one staff member writes HIV to identify staff who belong to this unit.

Outpatient Room: Patients gossip about other patients while sitting on the bench. Stigma here is directed to people they *suspect* have HIV, e.g. with symptoms of thinness or skin rashes.

Patients’ Ward: Separate wards, or separate beds within the ward. Some patients have asked to be moved or discharged once they learn they are sharing a room with an HIV patient.

Operating Room: Show difference in surgery process for patients with HIV. Excessive use of gloves (double gloves for every operation). Charge HIV patients more.

Labor Room: Minimize contact. Talk in codes. Doctors don’t do delivery for HIV-positive mothers, they ask nurses to do it for them; senior nurses pass responsibility to junior nurses; and junior nurses delegate this work to class 4 employees.

Dressing Room: Staff in this room give material to HIV patients and ask them to do the dressing themselves.

Dispensary: Make HIV patients wait a long time. Minimize contact.

Lab: Disclose their status to others. Scold and insult them. Serve them last.

4. PROCESSING:

Make a diagram of the health center and record the stigma in each area.

Break into small groups and discuss what can be done to create a stigma-free facility.

Sample Responses: How to create a stigma-free facility

- Stop separating HIV patients within the wards.
- Avoid stigmatizing or coded language for people with HIV.
- Do not violate confidentiality; do not gossip.
- Provide counseling and encouragement.
- Treat patients living with HIV like other patients.
- Tell them about how they can live a positive life, e.g. early treatment of opportunistic infections, a healthy diet, etc.
- Tell them about antiretroviral therapy and how to access antiretroviral drugs.
- Use disposable syringes consistently.

■ Action Ideas:

Decide how the group will address each recommendation generated, including:

- a) Who will do each activity;
- b) By when; and
- c) What indicators will show that the problem has been solved.

A8. How Health Providers Are Stigmatized

Facilitator’s Note: This exercise looks at how health workers are stigmatized for treating people suspected to have HIV. This is a real issue facing health workers; some RMPs have lost clients as a result.

In the pilot project, doing this module encouraged RMPs to start talking about the need for educating the larger community about stigma. They said that *“unless we change the environment that we work in – the thinking of our communities toward people living with HIV – we will continue to lose our clients, and people living with HIV will continue to live in fear and isolation. To break the stigma in the villages we need to work together with other health workers to change the community’s attitudes.”*

“I am a bachelor. It is difficult for me to find a wife because I am viewed as a health worker dealing with HIV.” (Lab technician)

“It’s true – I did lose clients in that village when I started to treat people living with HIV. But I began to talk to people and help them understand HIV and little by little they began to come back to me and use my services. The workshops taught me to stop fearing contact with people living with HIV and that I must serve them, no matter how it affects my business. If all RMPs stand together and make a commitment to serve people living with HIV, then we can bring a change. Even RMPs who have not gone through [this training] process are willing to learn from us and start treating people living with HIV.” (RMP)

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

- a) Describe how they are stigmatized for treating people living with HIV and how it affects them; and
- b) Work out a strategy for coping with this situation and countering stigma.

Time: 1 hour

■ Steps:

1. NAMING THE STIGMA WE FACE AS HEALTH WORKERS (Story Discussion):

Read the following story:

One RMP has a good practice and a good name in the village and is always available to help people. One day a man who was HIV-positive came to him for treatment. The man told the RMP that his wife had died of AIDS and that he was weak and suffering from fever. The RMP gave him some medication and followed up with visits to the man’s house to check on his progress. But the other villagers started to gossip about this patient – accusing him of killing his wife. They also began to talk about the RMP. They suspected the RMP was using the same medical instruments to treat the man and other people, and they worried that they would also become infected. So they stopped going to him for treatment.

Ask–

- a) *What happened in the story?*
- b) *What stigma do you face as a health worker who treats clients with HIV?*
- c) *How do you feel about this? How does this affect you?*
- d) *What can you do?*

Sample Responses:

Stigma faced by RMPs for treating clients with HIV

- RMPs who treat people living with HIV are teased as “AIDS doctors.”
- Relatives of RMPs tell them not to treat patients with HIV.
- Some clients who hear that a RMP is treating patients with HIV ask him to stop.

How does stigma affect RMPs?

- If many people with HIV come to them for treatment, they may lose other clients.

What can RMPs do about this situation?

- We should educate the community so they stop stigmatizing people living with HIV and RMPs who treat HIV patients.
- We need to change the public mindset – help people understand that:
 - a) People living with HIV are not dangerous; and
 - b) RMPs will not become infected by providing services to HIV-positive patients.
- We can't do it alone. If we all work stand together against stigma, we can help to break it.
- If we all adopt a common approach, and all agree to provide services to people living with HIV, then public attitudes will change and we will build acceptance.

2. SUMMARY:

- **Health workers themselves face stigma** for treating clients with HIV.
- To counter stigma, we need to **educate the community**:
 - a) **Clear up misconceptions** about HIV; and
 - b) Help people understand how **stigma can be hurtful** to people living with HIV, to health workers and to the community.
- **Working together** with other health workers and adopting a common approach will help us change public attitudes and build public acceptance.

■ **Action Ideas:**

- **Talk with your family, friends, and clients** about HIV stigma and how it both hurts people and causes the virus to spread.
- **Get community leaders** to speak out against stigma. Help everyone make the problem visible and unacceptable.
- **Reach out to, accept and support people living with HIV.** Once they feel accepted, they will be more open to discussing their situation with others and accessing services.

A9. Forms, Effects and Causes of Stigma – Problem Tree

Facilitator’s Note: In the earlier modules participants have analyzed the forms and effects of stigma. This exercise reviews forms and effects and looks at the causes of stigma.

This activity uses the “problem tree”—a method that describes the forms, effects, and causes of stigma by comparing them to the trunk (the forms of stigma), branches (effects), and the roots (causes) of a tree. Participants write each form, effect, or cause on a card and tape the card at the appropriate level of a tree diagram.

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

- a) Describe different forms of stigma and how stigma affects people; and
- b) Identify some of the root causes of stigma.

Time: 1–2 hours

Materials and preparation: Draw a large tree diagram on flipchart paper, with the “Effects,” “Forms” and “Causes” labeled at appropriate levels (see below). Write one example of the type of response expected at each level on a card and tape the cards at their respective levels.

Location	Part of Tree	Feature	Examples
Top	Branches	EFFECTS	loneliness
Middle	Trunk	FORMS	name calling
Bottom	Roots	CAUSES	lack of knowledge

■ Steps:

1. CARD-STORMING: Divide into pairs. Hand out cards and markers. Ask pairs to write points on forms, effects and causes – one point per card – and then tape them at the appropriate level of the tree. Remind them to consider HIV stigma as it affects various groups: people living with HIV, their families and health care providers.

Cluster common points and eliminate repetition.

2. EFFECTS: Divide into small groups and ask each group to analyze the effects of stigma on a specific group, e.g., men, women, children, etc.

*Group A: If the person stigmatized is a **woman** – what are the effects on her?*

*Group B: If the person stigmatized is a **man** – what are the effects on him?*

*Group C: If the people stigmatized are **children** – what are the effects on them?*

*Group D: If the **entire family** is stigmatized – what are the effects on them?*

*Group E: If **health providers** are stigmatized – what are the effects on them?*

*Group F: What is the effect of HIV stigma on the **epidemic**?*

3. CAUSES: Continue the same process in the same groups. Ask groups to analyze the causes of stigma for their group (women, men, children, etc.) and identify **possible solutions**.

Sample Responses:

Effects of stigma

PERSONAL – Shame. Isolation. Withdrawal. Loneliness. Loss of self-esteem. Feel unproductive. Self-blame. Loss of hope. Stress. Alcoholism. Depression. Suicide. Death. Anger. Violence. Kicked out of home. Fired from work. Forced to leave community. Drop out of school. Fear of disclosure. Avoid getting tested and using AIDS services.

FAMILY – Family quarrels, mutual blame and conflicts. Family members leave/get kicked out of home. Divorce or separation.

COMMUNITY – Loss of productivity as people living with HIV are fired from work or forced to leave the community.

EPIDEMIC – Spread of infection. Fear makes people refuse to have HIV test – they prefer not to know.

Forms of stigma

SHAME & BLAME – Name calling. Finger pointing. Belittling. Scolding. Spreading rumors. Gossiping.

ISOLATION – Rejection. Neglect. Separation of blankets, utensils, etc. Hiding in back room.

SELF-STIGMA – Blaming and isolating oneself. Giving up on oneself. Withdrawal from activities.

STIGMA BY ASSOCIATION – Family and friends of people living with HIV and health staff are also stigmatized.

Causes of stigma

MORAL JUDGMENTS – View that people living with HIV are sinners, promiscuous. Breaking social norms. People's beliefs about pollution, contagion, impurity.

FEAR AND IGNORANCE – Lack of knowledge and misconceptions about HIV transmission leads to fear about getting HIV through casual contact – people isolate and reject others. Fear of infection, fear of the unknown, fear of death.

GENDER AND POVERTY – Women and poor people are more stigmatized than men and rich people.

SECONDARY STIGMA – Women, mobile workers (e.g. sex workers, truckers, migrant laborers), backward castes are already stigmatized – so they get easily blamed.

APPEARANCE – The physical appearance of people living with HIV, e.g. thinness, skin rashes, is used as a basis for stigmatizing.

MEDIA IMAGES – Images of horrible death in the media make people scared of people living with HIV.

A10. Effects of Stigma and Gender Violence

Introduction: This exercise can be used after doing the problem tree (A9), which also deals with effects (but not in the same detail). The overall aim in focusing on effects is to help people see the importance of stopping stigma and gender violence.

Objective: By the end of this session, participants will be able to identify the effects of stigma and gender violence on different groups and institutions.

Time: 1 hour

Materials and preparation: Put up blank sheets of flipchart paper on different walls of the room, with a target group written at the top of each sheet – People Living With HIV, Family, Community, Women, Men, Children and Health Services.

■ Steps:

1. HOW STIGMA AFFECTS DIFFERENT GROUPS (Rotational Brainstorming): Divide into groups and assign one target group to each. Ask groups to brainstorm—*How does stigma affect your target group?* – and record. Ask participants to look for both *immediate effects* – shame, isolation, depression, hiding one’s status; and *larger effects* – loss of jobs, dropping out of school, suicide, etc. After three minutes shout “*Change!*” and ask groups to move to the next topic and repeat the process. Continue until each group has contributed to all seven topics.

2. HOW GENDER VIOLENCE AFFECTS DIFFERENT GROUPS (Rotational Brainstorming): The same exercise can be done on gender violence. Use the following target groups: Women, Family, Community, Children and Health Services.

Sample Responses: Effects of HIV stigma and gender violence

	HIV STIGMA	GENDER VIOLENCE
People living with HIV	Rejection – chased away by family and friends. Dumped at back of house. No longer contribute to family's income so feel useless. Resort to secrecy – hide status. Low self-esteem. Loss of hope. Loss of social status and self-esteem. Depression. Suicide. Loss of job. Blamed for behavior – “promiscuous.” Take risks and become reckless. Scared to tell others, get tested, and get help/services/support.	
Family	Shame, disgrace, loss of reputation/honor. Rejected by community. Secrecy – hide person living with HIV so neighbors can't see. Concerned about how other people will see/judge them. Deny that there is a problem. Family conflicts – blame each other for loss of family reputation. Stigma reinforces existing power relations – wife blamed for not raising child properly. Family disintegration. Divorce or separation. Children dumped with relatives. Loss of income when breadwinner dies. Property grabbing.	Family disintegration and breakdown in communication. Climate of fear. Children become depressed and silent. Less productivity and income.
Community	Finger-pointing and discrimination among community members. Destroys relationships. Rumors about AIDS used as a weapon to shame other families. Isolate/shun families perceived to have AIDS. Conflict and disunity. Community organization weakens. Loss of breadwinners.	Neighbors talk about the family, and this hurts their social status. No understanding between husband and wife – more scope for HIV to enter the marriage.
Women	Self-blame and denial. Low self-esteem. Blamed for bringing HIV home. Breakup of marriage – separation or divorce. Kicked out of house. Kept away from children. Husband finds another wife. Property grabbing. Loss of income/support. Extra burden of caring for HIV-positive husband. Avoid getting tested or seeking treatment.	Injuries, disfigurement, miscarriages, trauma. Stress. Poor physical and emotional health. Feel belittled and worthless. Chronic fear and self-isolation. Loss of sense of control over life. Anxiousness, depression, feeling suicidal. Weakened ability to negotiate safe sex. May get HIV from husband through forced sex. Reduced ability to work and generate income.
Men	Loss of employment. Loss of face. Feel useless. Rejection by women. Loss of manhood. Associated with promiscuity. Withdrawal from social contact. Avoid getting tested or seeking treatment.	
Children	Isolated. Lose their friends. Forced to sit separately from other students in school. Kicked out of school. Kept at home. Not allowed to play with other children.	Psychological problems and effects on school performance. Girls grow up believing violence is a norm and with low self-esteem. Boys see violence as a way to deal with conflict – may be violent to future partners.
Health Services	AIDS services and programs are stigmatized. People living with HIV don't use AIDS services (testing, counseling, treatment, PPTCT, opportunistic infection treatment). Discrimination against health staff. Heavy workloads, burnout and fears cause health workers to desert AIDS work.	Gender violence is treated as a norm – no effort by health care workers to solve this problem.

3. REPORT BACK: Ask the groups to present the main points from each topic and then ask for clarifications and additions. Note common or unusual points.

4. PROCESSING: Discuss–

a) *What are the differences in the effects on different groups?*

b) *What are the common effects across all players?*

If there is enough time, ask groups to discuss how to stop or reduce stigma in relation to different categories of stigmatized groups (i.e., women, men, children, etc). Assign each group to focus on one category.

5. SUMMARY: Stigma has a range of different effects – on people living with HIV, their families, communities and health institutions.

- Stigma and gender violence divide families and communities – they create conflict and breakdown in communication.
- Stigma and gender violence can result in economic losses, making families and communities poorer.
- The shame of stigma affects everyone – the person living with HIV, his family, the community, and even health workers who care for him.
- Gender violence harms women, families, children and communities, and puts women and men at greater risk of HIV infection.
- Stigma results in denial – people refusing to admit that there is any problem. Gender violence is also often denied or viewed as a norm, rather than a problem that must be dealt with.

A11. Effects of Stigma on the HIV Epidemic

Facilitators' Note: This can be used as a stand-alone exercise, or it can be added onto the problem tree exercise (A9) to take the effects discussion further.

Objective: By the end of this session, participants will be able to identify the effects of stigma on the HIV epidemic.

Time: 1 hour

■ Steps:

1. STIGMA AND THE HIV EPIDEMIC (story): Read the following story.

Raju was a carpenter from Andhra Pradesh. He worked for 10 years in Kolkata, returning three times a year to see his family – his wife Lakshmi and two sons. While he was in Kolkata his wife gave birth to a girl and another boy. After awhile Raju started to suffer from a constant fever and extreme tiredness. He went to the hospital where he was given a blood test. They told him in a brutal way that he had HIV – no other advice, he was just told to go home. When his employer discovered he was HIV-positive, he was fired. He found it difficult to get other work, so eventually he returned to his village. When he arrived home, he told no one. He didn't want to face any more shame. Lakshmi asked him what was wrong, but he kept silent. He survived for one more year before dying. During this year one of his sons started to get chronically sick, too. After he died, Lakshmi went for an HIV test and learned that she was HIV-positive.

Discuss–

- a) *What happened when Raju's status was disclosed in the hospital and his workplace?*
- b) *Why did he not tell his wife?*
- c) *What are the consequences of Raju not disclosing his HIV status?*

2. Ask the group to construct a positive story – which shows how HIV can be stopped. In the new story, Raju gets HIV but from that point on people deal with the situation in a positive, more supportive way.

3. SUMMARY:

■ Fear of stigma stops people who are living with HIV from:

- a) **Disclosing to their partners;**
- b) **Accessing treatment** (antiretroviral therapy or treatment of opportunistic infections);
- c) **Using other services** – for example a pregnant woman living with HIV is discouraged from making use of the PPTCT program; and
- d) **Disclosing and getting counseling, care and support.** They refuse to acknowledge that they or anyone in their family has HIV. As a result they avoid the stigma, but they remain sick, silent and alone.

■ Fear of stigma keeps HIV and AIDS underground!

- If on the other hand, people living with HIV are **treated with kindness, support and care**, they will be more likely to disclose to their families and take precautions in their sexual relationships.

A12. When HIV Enters the Home – Stigma and Violence

Facilitator’s Note: This exercise helps participants understand the impact of HIV entering the home. It works well as a combined module, since both stigma and gender violence can occur when the family discovers that one member has HIV.

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

- a) Analyze the impact of HIV and AIDS on the family; and
- b) Explore ways that the community can provide families with better support.

Time: 1–2 hours

Materials and preparation: Using the Family Cards (Picture Set C in Annex 5), make up family sets, varying the family structure and number of children in each set. In each family, draw a colored dot at the back of one character. This dot will indicate that the character is living with HIV or AIDS. Put the dot on a different family member in each group.

■ Steps:

1. STIGMA AND VIOLENCE IN THE FAMILY (Trios): Divide into groups of three and give each group a “family” (envelope of cards). Then explain the exercise:

Step 1: Before HIV Enters: Make up a story about your family–

- a) *What are the family members doing in terms of work and/or study?*
- b) *How are family relations – any problems? (e.g. alcohol, violence, sexual affairs)*
- c) *What are the family’s hopes or plans for the future?*

Step 2: HIV Enters the Family: Ask each group to turn over their cards to see which card has the dot on the back. This family member has HIV. Discuss–

- a) *What happens when the family finds that one member has HIV?*
- b) *What forms of stigma and violence might happen?*
- c) *How would this affect the family?*

2. REPORT BACK: Ask each trio to give a brief report.

Sample Responses:

- Women are at huge risk if they disclose their status to husbands.
- Emotional violence – wife accused of bringing HIV home (i.e. other partners) or blamed for not raising their (HIV-positive) child properly/morally.
- Physical violence – women get beaten by their husbands or parents-in-law.
- If wife gets HIV, she loses her right to property and her right to her children.
- Double standard – if the wife gets HIV, the marriage collapses and she is kicked out. If the husband gets HIV, the marriage stands and his wife is expected to care for him.
- Person with HIV becomes isolated within home – separate room, bed, food, utensils.
- Family disintegration – conflicts, communication breakdown, separation, divorce.
- Family shame and loss of honor. Denial – try to hide the problem from neighbors.
- Children affected – forced to leave school, start to work, etc.
- Women’s burden caring for positive family members – increasing costs and workload.

3. PROCESSING: Ask–

- a) *Why was there such a big change in the family once one member became HIV-positive?*
- b) *How are women treated compared to men?*

4. SUMMARY:

Women face severe violence (physical, emotional, economic) and stigma when HIV enters the home. They are blamed and verbally abused for bringing HIV home. They are chased from the household and sent back to their relatives. Their property is grabbed. Their children are taken away from them. When they become sick, they are abandoned and left on their own.

5. PROBLEM SOLVING: Discuss with the whole group–

- a) *How can families cope better with this situation?*
- b) *What can we do to minimize the impact on women?*
- c) *How can the community support families with HIV? What local institutions can support these families?*

Sample Responses:

Family coping mechanisms

- Stop the shaming/blaming and verbal abuse toward HIV-affected family members.
- Treat HIV-affected members in the same loving way other family members are treated.
- Help the family deal with the sense of shame and stigma they feel.
- Teach family members about HIV transmission to help overcome their fears of infection.
- Treat HIV like other diseases, such as cancer or high blood pressure, which are often fatal but for which we have coping mechanisms.
- Create a supportive environment for the person living with HIV.
- Give the person living with HIV responsibilities and encourage him or her to continue working.
- Stop the isolation of positive family members (e.g. putting them in a back room, making them use separate plates, etc.).
- Stop violence (physical and emotional) against women.
- Promote a positive attitude, e.g., *It's not how he got it, but what we can do now.*
- Allow normal life to continue, e.g. children should not be stopped from studying.
- Share the caring work among all family members.

How to minimize the impact on women

- Help everyone understand that HIV and AIDS is *not* a “woman’s disease.” Many women are faithful, but their husbands bring HIV home.
- Teach women about their sexual rights.
- Make men aware of gender violence.
- Empower women with assertiveness skills.
- Form women’s groups and encourage women to support each other.
- Let people know about the Domestic Violence Act (see Annex 4) and push the government to enforce it.
- Encourage women to report violence cases to the police and get the police to treat these cases seriously.
- Provide legal services for women.
- Provide counseling for couples.
- Address problems of excessive drinking.

Community support for battered women and families affected by HIV and AIDS

- Get the community to name stigma and gender violence as problems, and to take action that addresses the root of the problems.
- Get community leaders to speak out against stigma and violence.
- Get the community to support HIV-affected families.
- Give exemptions to HIV-affected families for water fees, school fees, etc.
- Stop property grabbing.
- Provide a neutral person to help mediate conflicts.

■ Action Ideas:

Discuss with friends or your peer group how to reduce stigma and violence within and against families living with HIV. How can community members support each other and in this way reduce stigma and violence?

Example of story (exercise 1)

There are nine members in the family: grandfather (65), grandmother (60), father (45), mother (35), three boys (17, 5 and 1) and two girls (13 and 9).

The father is a mechanic who works in Kolkata. His wife takes care of her parents-in-law and her own children, and does all the housework. She also works as a daily paid agricultural laborer. The oldest boy studies at intermediate level and tutors other children to earn money. The eldest girl studies in 8th class and takes tailoring classes. Her younger sister also studies.

Family's hopes: to educate their children so the boys can get good jobs and the girls can marry good boys; to construct a nice house for themselves; and to earn more money to live comfortably.

The family is close and loving. There is no alcoholism and no violence. Even though the husband is away from the family, he is not a promiscuous man.

The older girl frequently gets sick so the family takes her to a doctor who says she has HIV. The father puts her in a room and asks her if she has had sexual relations with a boy. He assumes she did, so he beats her up. (Some time ago, she had received a blood transfusion with contaminated blood – that is how she got infected.)

Her brother finds out and beats her up too out of shame. Her father and grandparents scold her mother, saying that the mother failed to raise the girl properly. The husband goes out and gets drunk and then beats his wife. He stops working out of depression.

The father stops the older girl from going to school. He assumes she contracted HIV through "bad behavior," so he also stops the younger girl from going to school.

Their biggest worry is that their family honor will be destroyed once people find out they have a person living with HIV in their family, so they keep it a secret and get her married.

Violence increases in the family, especially toward the mother and daughter. The husband becomes alcoholic and the feeling of love and affection disappears.

Suspecting that there is something wrong with the family, the neighbors and relatives begin to behave differently. They keep their distance.

Effects: The family feels depressed. The girl feels like ending her life, with the thought that she is suffering even though she had not done anything wrong.

A13. Women's and Men's Life Cycles – Stigma and Violence

Facilitator's Note: This session analyzes life cycles as the basis for comparing the impact of stigma and violence on women and men.

Quotes from TBAs in SVTH Project

"A women endures stigma and violence from the day she is born until the day she dies."

"As a girl is growing, stigma and violence towards her is also growing."

"Being born a girl is a big mistake – they are needed when they are young, and they are rejected when they are old."

"Husbands have sex with other women, but this is not taken seriously; his sins are washed off like he has taken a bath. But with women it's a serious matter!"

"Men are stigmatized and sometimes beaten if they make a mistake, but women are stigmatized and beaten, even if they make no mistake."

"Men do wrong, but society says that women are responsible for their wrong."

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

- a) Identify stigma and violence at different stages in a man's and a woman's life cycle; and
- b) Recognize how women face far more stigma and violence than men – and how this increases their vulnerability to contracting HIV.

Time: 1–2 hours

Materials and preparation: Life Cycle cards (Picture Set D)

■ Steps:

1. CARDSTORM: Divide into groups. Give half the groups women's life cycle cards and the other half men's life cycle cards. Then ask each group to write forms of stigma or violence that occur at each stage of the life cycle on blank cards.

Sample Responses:

Stage	Woman	Man
Pre-birth	If parents find out from an ultrasound that the baby will be a girl, they may abort.	
Birth	Parents feel unhappy, unlucky, guilty if baby is girl. Have small celebration. If she is pretty, everyone will love her, but if not, she will get no attention or affection. Don't like to spend money on female baby after 21 days.	Parents happy/proud with male child—maintains family line. Big celebration. Looked after with lots of affection. If mother dies during childbirth, he will be cursed/blamed for "killing mother."
Childhood	Little appreciation from family. Allowed to attend school, but after school given big workload, caring for younger siblings. Eats leftover food along with mother. If a girl gets lots of food and matures quickly, her parents will then have to arrange for her marriage, so they deprive her of good food.	Male child – good luck. Treated with respect as if he is a prince. No housework – after school plays with friends. Given good clothing and best food.
Teenage	Rules/restrictions – "Don't talk to boys," "Don't talk too loud," "Don't make demands." If she breaks the rules, she gets beaten. Menstruation starts: not allowed to cook, pray or go to temple. Forced to leave school and find wage labor. Sexually harassed at work, harassed by parents at home. Seen as burden by parents: want to get rid of her by getting her married. If she does not marry a good boy with a low dowry, her parents will curse her.	If he studies well, he is respected. If he does poorly in his studies, he is beaten and forced to leave school and find wage labor. If he talks to girls, he will be scolded – "remember – you are a man, not a woman." If he does not get work, he will be blamed for being lazy. If he acquires bad habits such as drinking or chasing women, parents will curse and beat him for giving bad name to the family.
Middle Age	Has to earn wages and care for her family. Big workload, low consumption – eats last. If she does not obey husband or run the house properly, beaten by husband. Sexual harassment at work. If she has no children, she is stigmatized as "barren;" if she has a baby girl, she will be blamed. If her daughter has a poor marriage, she will be blamed. If her son gets HIV, she will be blamed. If her husband dies, she loses community respect.	If he gets work and looks after his parents and family, he will be respected. If not, his parents will criticize him. If he drinks, curses and beats his wife, or has affairs and gets sexually transmitted infections (STIs), he will be stigmatized by the community. If there are no children, he is not stigmatized as barren. He is only blamed for his own behavior, not for that of his family.
Old Age	No respect – viewed as a burden, waste of food. Family members wait for her to die. No one gives her attention or listens to her. Kept hidden and isolated. Daughter-in-law curses her. Beaten by her children.	Some grandfathers are respected by their families. In other cases they are neglected and cursed by the children. Some grandfathers are beaten for revealing their family secrets.

2. REPORT BACK: Review and quickly check that people agree with the points made by each group.

3. PROCESSING: Discuss–

- What are the differences between men's and women's life cycles? Why?*
- Why do women face more stigma and violence than men?*
- How does this make women more vulnerable to getting HIV and AIDS and worsen the epidemic?*
- How are stigma and gender violence connected?*

Sample Responses:

Differences between men's and women's life cycles: Double standard

- Women are stigmatized and subjected to violence from their birth to the day they die.
- They are even cursed and violated (aborted) in the womb if fetus is found to be female.
- Girls and women are cursed for being born, being a burden, having no children, etc.
- Boys are regarded as good luck and given special treatment – good clothes and food.
- Girls are given housework, while boys are allowed to play with their friends.
- Parents make a big fuss if their son is sick, but don't worry if their daughter is sick.
- Girls are kicked out of school in their teens, while boys are allowed to continue schooling.
- Girls are controlled through rules/restrictions, while boys are given more freedom.
- Girls are regarded as a burden to the family and married off as quickly as possible.
- Women are blamed/stigmatized for everything – having no child, having girl babies, “not raising her children properly” (if son gets HIV or daughter gets poor marriage).
- If the husband gets AIDS, the wife is expected to remain quiet, stay in the marriage and care for her husband. If the wife gets AIDS, the husband “has the right” to divorce her and grab all the property, leaving her with nothing.
- It is accepted that married men will have sex with other women (especially if they are away from home). The wife, however, is expected to sleep only with her husband.
- Violence occurs at all stages in a woman's life – pre-birth (aborted), childhood (from parents), marriage (husband), workplace and old age (beaten by children).
- Men face much less violence. They get beaten for misbehaving (e.g. drinking or chasing girls) and ruining the reputation of the family.
- Men are stigmatized for making a mistake, women even if they make no mistake.

Why do women face more stigma and violence?

- Male dominance.
- Cultural attitudes – lack of respect for women. Women are stigmatized as inferior, “bad luck,” “a burden.”
- Violence against women is regarded as acceptable – a normal thing. Men think they have the right to beat their wives.
- Poverty and unemployment make stigma and violence against women worse.

How does this make women and men more vulnerable to getting HIV?

- Because of the fear of being stigmatized and beaten, women who suspect they have HIV hide their symptoms and avoid getting tested. Without being tested, they cannot access HIV services such as treatment or counseling.
- Because of the same fear, women avoid disclosing to their husbands/partners. This increases the chances of HIV spreading.
- Because of the fear of violence, women who suspect their husbands are sexually promiscuous cannot ask them to practice safe sex. This increases their vulnerability to getting HIV.
- Women are vulnerable to getting HIV because of their vulnerability to other forms of violence such as rape in the workplace or from survival (commercial) sex.

How are stigma and violence connected?

- Women are stigmatized (not respected) and these negative attitudes are expressed in the form of violence – both verbal abuse and physical abuse.

4. SUMMARIZE drawing on the points in the box and then say: *Given the high levels of stigma and violence faced by women, we need to change our behavior – to give women more respect, support and encourage them, and stop all forms of gender violence.*

OPTION: Extra session with female health workers on specific forms of stigma faced by women.

If you have time, you could add an extra step when conducting this module with the TBAs and other female health workers to address their own experience as:

- a) Widows;
- b) Women who don't have children, or don't have boy-children; or
- c) Women who are unmarried or divorced.

If you can help female health workers think through these experiences, it can help them get a better sense of how it feels to be stigmatized as a person living with HIV.

Encourage them to reflect on their own experiences and then share with one another.

Sample Responses:

Stigma toward widows

- Viewed as a source of bad luck, especially if people see a widow by accident.
- If a widow touches water, she spoils it – no one will drink the water.
- Widows cannot enter the house.
- Widows are excluded from marriages and functions.
- Sometimes her children want her to die quickly.

Stigma toward women without children

- Lots of pressure to do prayers to make sure she gets pregnant and has a child.
- People stop her coming into contact with children – bad omen.
- If she is childless, the husband might get another wife.
- Inauspicious to see her face in the morning.

Stigma toward divorcees

- Viewed as breaking culture, disrespecting customs, being anti-man.
- She doesn't know her role in society, doesn't respect her parents.
- Viewed as bad woman who is only interested in extra-marital relations.
- Viewed as a threat to other women – she will steal their husbands.
- Threats – you will face lots of problems, anybody can rape you.
- "You need to stay under a husband's protection."

A14. Comparing AIDS, Cancer, Leprosy, TB, etc.

Facilitator’s Note: This exercise is good to use with health workers because it builds on their knowledge of different diseases.

“No patients are blamed for getting high blood pressure, diabetes, or cancer, so why are we blaming AIDS patients?” (TBA participating in SVTH project)

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

- a) Compare HIV and AIDS with other diseases that have been connected with stigma; and
- b) Help participants view HIV and AIDS as they do any other manageable disease.

Time: 1 hour

Materials and preparation: Draw the matrix (below) on sheets of flipchart paper.

■ Steps:

- 1. INTRODUCTION:** Explain that the aim of this exercise is to compare HIV stigma with the stigma around other diseases.
- 2. MATRIX ANALYSIS:** Divide into groups of three to four people and give each group a copy of a blank matrix on flipchart paper. Ask the group to complete the matrix. Show them how to get started and then leave them on their own.
- 3. REPORT BACK:** Ask each group to tape its matrix on the wall and then ask participants to compare the results.

Sample Responses:

DISEASE	STIGMA STATUS – 30 YRS AGO	REASONS	STIGMA STATUS – PRESENT	REASONS
Leprosy	High stigma – forced to live in separate colonies.	Fear contagion. Not curable, no medicine.	Less stigma – no longer stay in separate colonies.	Medicine is now available and more awareness, yet still a contagious disease.
TB	High stigma, patients abandoned.	Fear of contagion. TB patients seen as half dead – so isolated.	Some stigma because of fear of contagion.	Associated with AIDS – associated stigma. Medicines available – can be cured.
Cancer	Some stigma.	Medicine not available. Seen as deadly disease.	No stigma.	Deadly disease <i>but no association with sex</i> . Not contagious. Can be treated but may not be curable.
High Blood Pressure			No stigma.	Medicines available. Seen as manageable. Not contagious.

DISEASE	STIGMA STATUS – 30 YRS AGO	REASONS	STIGMA STATUS – PRESENT	REASONS
Diabetes		Not curable – need for continuous medication.	No stigma.	Not curable, but medicines are available and no association with sex. Not contagious.
STIs	Some stigma.	Association with sex.	Not much stigma.	Medicines available and can be cured.
HIV and AIDS			High stigma.	Associated with sex Deadly disease Fear of contagion
Mental Illness	High stigma.	Not curable.	High stigma because of shame.	Not curable, though can be managed.
Malaria	No stigma.	Not contagious. Medicine available.	No stigma.	Not contagious. Medicine available and can be cured.

4. PROCESSING: Ask – Why are some illnesses stigmatized more than others?

5. SUMMARY:

- HIV and AIDS has the highest level of stigma because:
 - a) It is associated with SEX (main source of HIV transmission) – and sex, along with death, is a major taboo. People living with HIV are shamed because it is assumed they got HIV through immoral (sexual) behavior. (TB patients are not shamed – they are seen as unlucky, as getting TB through chance).
 - b) At present there is NO CURE – it is perceived as a deadly disease. (Antiretroviral therapy, however, makes it possible to rebuild the immune system and live a long life).
 - c) AIDS is seen as CONTAGIOUS (like TB or leprosy, which are communicable diseases spread through the air) – even though it is *not* contagious through casual non-sexual contact.
- In comparison, cancer is an incurable disease (like AIDS) but it is not contagious and it is not associated with sex – so it has no stigma associated with it.
- TB is curable (even for AIDS patients) but is somewhat stigmatized because it is contagious and is associated with AIDS (many AIDS patients also have TB). TB is more contagious than HIV but it is less stigmatized, because it is curable and not associated with sex.
- Leprosy is stigmatized because it is a disfiguring disease. Lepers are stigmatized because of their appearance. Similarly, patients in advanced stages of AIDS are stigmatized because of unsightly sores or rashes.

“Before when lepers died, they buried them, rather than cremating them, saying they are the devotees of Shiva.” (RMP participating in SVTH project)

- Mental illness is stigmatized because the symptoms are viewed as abnormal.
- One indicator that AIDS is heavily stigmatized is that people refer to it indirectly – instead of saying “AIDS,” they say “this thing,” “that disease,” “that four-letter word.”

A15. Review – Ten Questions on HIV Stigma

Facilitator’s note: This exercise can be used at any time in the training program. It is simply a series of questions to help participants review the main issues covered in this chapter.

Objective: By the end of this session, participants will have reviewed what they have learned about HIV stigma.

Time: 1–2 hours

■ Steps:

1. QUESTIONNAIRE: Hand out the following questionnaire or write the questions on a flipchart. Ask participants to complete the questionnaire. Then review the responses as a group.

QUESTIONNAIRE

1. What is the meaning of STIGMA?
2. HOW do people stigmatize people living with HIV? What are the FORMS of stigma?
3. WHY do people stigmatize people living with HIV?
4. How does it FEEL to be stigmatized?
5. What are the EFFECTS of stigma on people living with HIV and their families?
6. What are the EFFECTS of stigma on the HIV EPIDEMIC – and WHY?
7. How have HEALTH WORKERS been stigmatizing people with or suspected of having HIV and AIDS?
8. How can we STOP stigma in our HEALTH PRACTICE?
9. How can we STOP stigma in our FAMILIES AND COMMUNITY?
10. Why does AIDS have a much stronger stigma than cancer or TB?

Chapter B: Gender Violence – Naming & Owning the Problem

■ Introduction

This chapter looks at the problem of GENDER VIOLENCE. It helps participants see that:

- Gender violence exists;
- It is harmful to women, families and communities; and
- It fuels the HIV epidemic.

The aim of this chapter is to get health care providers to:

- Recognize gender violence as a problem;
- Become committed to stopping gender violence;
- Agree on a protocol to prevent gender violence;
- Develop new skills and approaches for treating abused women;
- Learn the skills for counseling abused women; and
- Stop gender violence in their own homes.

Many health care providers do not recognize gender violence as a problem. They view it as a norm – something that is acceptable. They believe that a husband has a right to beat his wife. During the baseline study for this program, roughly one-quarter of the rural medical practitioners (RMPs) said that violence is justified if the husband suspects his wife is unfaithful; if the wife refuses to have sex or asks him to use a condom; or if she burns food. RMPs and other health workers may not realize that beating affects a woman's health, both physically and psychologically.

One RMP, when asked about gender violence, responded by saying, “Why are you wasting my time asking these questions? Men beating their wives is normal, an everyday occurrence. Why are you worried about it?”

It will not be easy to change the behavior of RMPs and other health workers on this issue. In our initial workshops, we found that the RMPs were **discussing** the issue of violence, but not **internalizing** the learning. They talked about violence as if it were an academic topic, rather than something with which they had direct experience. Listening to the traditional birth attendants’ (TBA) stories about their own experiences of violence, however, made a difference. The TBAs talked from the heart, and this helped to change the RMPs’ views and behavior.

“I used to hit my wife, but now I know this is wrong and talk to my wife rather than hitting her. I have learned to control my temper – my own way of thinking has changed, I now tell myself that beating is wrong.” (RMP)

“I have changed the way I treat women who have been beaten by their husbands. Now if I see gender-based violence I feel responsible, and talk to husbands who have been violent and counsel them.” (RMP)

“In my street one widow had a relationship with one neighbor. Another neighbor forced her to stand in the road, and insulted her. I went out and said, ‘Why are you insulting her like this in public. This is wrong.’ She understood that I was supporting her.” (RMP)

“If women do not speak out about being beaten, violence will continue to grow. Women cannot simply ‘live with it.’ To bring change, women have to speak out – and support each other in challenging violence. To bring a change, women should be brave and bold!” (TBA)

Step-by-Step Approach for Looking at Violence

This chapter will introduce violence on a gradual, step-by-step basis. The sequence will be:

Step 1: Violence in the community

Step 2: Violence in the health workers’ practice

Step 3: Violence at home (personal level)

This approach will familiarize participants with gender violence in a gradual, non-threatening way. The first step will introduce gender violence impersonally. Health workers will name violence as **something that happens in their communities**, without focusing on their own records as possible perpetrators. Next, health workers will look at how they deal with cases of battered women **in their practice** – with the aim of changing how they deal with these cases. Finally, once they are more open and committed to changing community norms around violence, they might be willing to talk about and change **their own behavior** in their families, for instance agreeing to stop beating their wives.

Special Note

Talking about gender violence can be very upsetting for some people who have been directly affected by abuse. Read the notes on handling feelings in the Introduction. When discussing this issue, make sure participants are as comfortable as possible. Some sessions may need to be done in groups separated by gender.

Introduce two ground rules:

- a) Everyone has the right to participate at his or her own level of comfort. Everyone has the right to pass at any time.
- b) Everyone should honor confidentiality within the group.

One additional resource for this chapter is **Fact Sheet No. 12**, which deals with gender violence and HIV.

■ Modules

- B1. Naming Gender Violence Through Pictures
- B2. Forms, Effects and Causes of Violence – Problem Tree
- B3. How It Feels to Be Abused – Reflection Exercise
- B4. Violence in the Workplace – How We Respond to Cases of Battered Women
- B5. Gender, Violence, and HIV and AIDS
- B6. How to Mobilize the Community to Stop Gender-Based Violence
- B7. Sexual Rights and Responsibilities

Also see the following modules, which deal with gender violence:

- A5. Stigma and Violence in Different Contexts
- A10. Effects of Stigma and Gender Violence
- A12. When HIV Enters the Home – Stigma and Violence
- A13. Women’s and Men’s Life Cycles – Stigma and Violence

B1. Naming Gender Violence Through Pictures

Facilitator's Note: This exercise is designed to introduce the issue of gender violence and start exploring its effects and causes.

Don't waste a lot of time making long lists of forms of violence. It is more important to focus on the effects of violence and the "why?" behind it.

The one who gives birth is the mother.
The one who gives love and affection is the sister.
The one who cares for others is the wife.
Why so much violence against women?
If there are no women – all is darkness.
(Poem written by one of the TBAs – translated from Telugu)

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

- a) Identify different forms of gender violence; and
- b) Describe how violence affects women, their families and the HIV epidemic.

Time: 1 hour

Materials and preparation: Display VIOLENCE PICTURES (B1 to B14) on the wall.

■ Steps:

1. NAMING GENDER VIOLENCE (Picture-Discussion): Divide into groups and assign each group four pictures, one from each of the four categories of violence (physical, emotional, economic, and sexual). Ask each group to discuss:

- a) *What **forms of violence** do you see in your pictures?*
- b) *How would it make the woman in each situation **feel**?*
- c) *What **effect** would the violence have on the women and their families?*

2. REPORT BACK (Round Robin): Put a card for each category – PHYSICAL, EMOTIONAL, ECONOMIC and SEXUAL – along the top of the wall. Ask each group to tape their pictures under the appropriate categories, and then talk about one picture at a time. Record discussion points on a flipchart. For each picture, have the group explain: *What is the impact? How does the person abused feel?*

Sample Responses:

No.	Description
B1	Husband beating his wife with a stick. (Physical)
B2	Drunken man threatening wife with bottle in front of children, who are crying. (Physical)
B3	Family throwing oil over daughter in law – dowry killing. (Physical)
B4	Landlord beating laborer with stick. Laborer has to accept this humiliation. (Physical)
B5	Abortion – killing an unborn female child. (Physical)
B6	Woman belittled by husband in front of her parents. (Emotional)
B7	Woman shamed/stigmatized for not having children. (Emotional)
B8	Eve teasing – youth on motorbike harass a young woman. (Sexual)
B9	Man takes money away from wife by force. (Economic)
B10	Husband wastes family money on card playing. (Economic)
B11	Property grabbing – woman forced to put thumb print (i.e., give up legal title to land or property). (Economic)
B12	Incest – father/uncle forcing daughter to sleep with him. (Sexual)
B13	Man raping woman – hand covering mouth. (Sexual)
B14	Marital rape – the husband is forcing his wife to have sex. (Sexual)

3. PROCESSING: Discuss–

- a) *How does violence make women **feel**?*
- b) *What would be the **effect** of the violence on women and the family?*
- c) ***Who** faces more violence – men or women?*
- d) *What are the **causes** of violence against women?*
- e) *How does violence against women put women and men at **risk of getting HIV**?*
- f) *What can we do as health workers to **reduce** violence against women?*

Sample Responses:

Feelings: Bad. Sad. Fearful. Belittled. Worthless. Angry. Confused. Depressed.

Effects: Injuries, disfigurement, miscarriages, trauma. Women feel belittled and worthless. Self-blame. Poor self-esteem. Fear and isolation. Anxiousness, depression, suicide. Weakened ability to negotiate safe sex. May get HIV from husband through forced sex. Reduced ability to work and generate income. Divorce or breakup of marriage. Children affected – become fearful and depressed. Drop out of school and seek wage labor. Sons learn violence and disrespect toward women.

Who faces more violence? Women.

Causes:

- Gender inequality – unequal power relations between husbands and wives.
- Men want to dominate women and use force to maintain their control.
- Women are taught to be submissive to their fathers, husbands and their sons.
- Women are taught to accept and not question their husbands' word or behavior.
- This inequality allows men to treat their wives with contempt – leads to violence.
- Women treated as inferior/subservient to men – makes them vulnerable to abuse.
- Men think it is acceptable to express anger through physical and emotional violence.
- Common view that husbands beating wives is acceptable – a form of “discipline.”
- Poverty makes men insecure and more susceptible to the use of violence.
- Other triggers: Alcohol. Suspicion/jealousy. Wife “disobeying” husband. Preference for male children. Child marriages. Dowry system. Customs.

How does violence increase vulnerability to HIV?

- Fear of violence stops a woman from protecting herself from HIV and sexually transmitted infections (STIs). She is afraid she will be beaten if she refuses to have sex or asks her husband to use a condom.
- Fear of violence stops a woman telling her husband she has an STI or HIV. This fear stops her getting treatment for the STI, because she cannot do this without her husband's consent. And she continues having unprotected sex with her husband, who may then become infected with the STI or HIV.
- Sexual violence, which results in bleeding in the vagina and small internal cuts or sores, makes it easier for HIV to be transferred.
- A man having unprotected sex with his wife when he has an STI or HIV is a form of sexual violence. It means he is exposing her to the STI or HIV too.
- Women are vulnerable to getting HIV because of their vulnerability to rape in the workplace or in the community.

Solutions:

- Start with ourselves – change our own attitudes/behavior. Set a good example.
- Talk with family, friends, and clients and get community leaders to speak out against gender violence. Get people talking openly and make this problem visible.
- Help everyone – men, women and children – understand that gender violence is wrong.
- Stand up and challenge others when they “blame and shame” women.
- Raise men's awareness and encourage them to stop violence.
- Stop the stigma toward women and girls. Women should be respected.
- Reach out to abused women and support them. Once they feel accepted, they will be more open to discussing their situation with others and getting help.
- Educate women about their rights and how to get support when they are abused.
- Get women to work together and support each other.
- Build up women's solidarity and courage to challenge gender violence when it occurs.
- Encourage women to report violence to police and get police to treat them seriously.
- Get police to enforce the Domestic Violence Bill.
- Address problems of excessive drinking.
- Treat all children equally and educate girls.

4. SUMMARY:

- **Gender violence occurs at all stages in a woman's life** – pre-birth, childhood, marriage, workplace and old age.

"If one is born a woman, one definitely goes into a life of violence. A girl child undergoes violence at an early age and it never stops until the day she dies." (TBA)

- Gender violence takes **several forms** – physical, emotional, economic and sexual.
- Gender violence involves **abuse of power** – the man takes advantage of the woman because he is stronger.
- **Gender violence has a devastating impact on women.** Women get badly hurt **physically** – injuries, disfigurement, miscarriage, sexually transmitted infections (STIs), trauma and death. They also get hurt **emotionally** – they feel belittled and worthless, become fearful and anxious, and lose self-esteem and sense of control over their lives. They lose out **economically** – their income and property is grabbed, they are overworked in the house and in the fields.
- Gender violence **destroys relationships, women's productivity and health**, and the health of the family and community.
- Gender violence often occurs along a continuum, with men starting off by abusing their wives verbally, then starting to slap them, and moving to severe forms of battering. Evidence shows that many women suffer through a long-term, violent relationship and in spite of severe, regular beatings are often reluctant to get out of the relationship.

"Men are not born violent. They learn to be violent, so we can help them unlearn violence." (TBA)

- **Gender violence makes women and men more vulnerable to HIV infection.** Fear of violence prevents women from negotiating safe sex (asking husbands to wear a condom), and this fear also prevents them from disclosing to their husbands if they think they are HIV-positive. They also are subject to coercive sex which makes them vulnerable to HIV infection.
- At present, **gender violence is viewed by society as something normal – as something not to be taken seriously.** It is viewed as a "domestic affair" – a husband simply disciplining his wife. Consequently, it is rarely reported to the police. When violence cases are taken to doctors, they are reported as "accidents" rather than as a form of violence.
- **Gender violence is WRONG – it is against the law!** There is no acceptable form of violence. Even a slap is violence!
- **Women have the right to be safe from violence**, including forced sex and economic violence.
- **Gender violence must be challenged.** If women accept or adjust to the violence, it will never stop. To bring about change, they need to speak out and support each other in challenging violence. To bring change, they need to be brave and bold.

Special Note: Some participants may not at first accept that gender violence is a problem. For example, in one of our workshops a TBA said that violence is justified – that women provoke violence by spending lots of money or making their husbands angry by disobeying them. We challenged her, not by saying she was wrong, but by asking her to reflect on her own experience as a woman and as a wife. This approach worked. Eventually she started to talk about her own experience and admitted that all women faced unjustified violence in their homes from their husbands.

Other tips for the facilitator:

- Provide **statistics** on the amount of violence in your area.
- Hand out copies of the **Domestic Violence Act** (see Annex 4) and explain the main points.
- Prepare a wall display of **stories** and photographs on gender violence taken from local newspapers.

B2. Forms, Effects and Causes of Violence – Problem Tree

Facilitator’s Note: This exercise is similar to the Problem Tree analysis on stigma in Chapter A (module A9). The aim is to get participants to analyze the forms, effects and causes of gender violence.

In this exercise, participants write points on cards and tape them on the wall diagram to make a “problem tree,” showing forms of violence (main trunk), effects (branches), and causes (roots). Then points are reviewed and more analysis is done on the effects and causes.

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

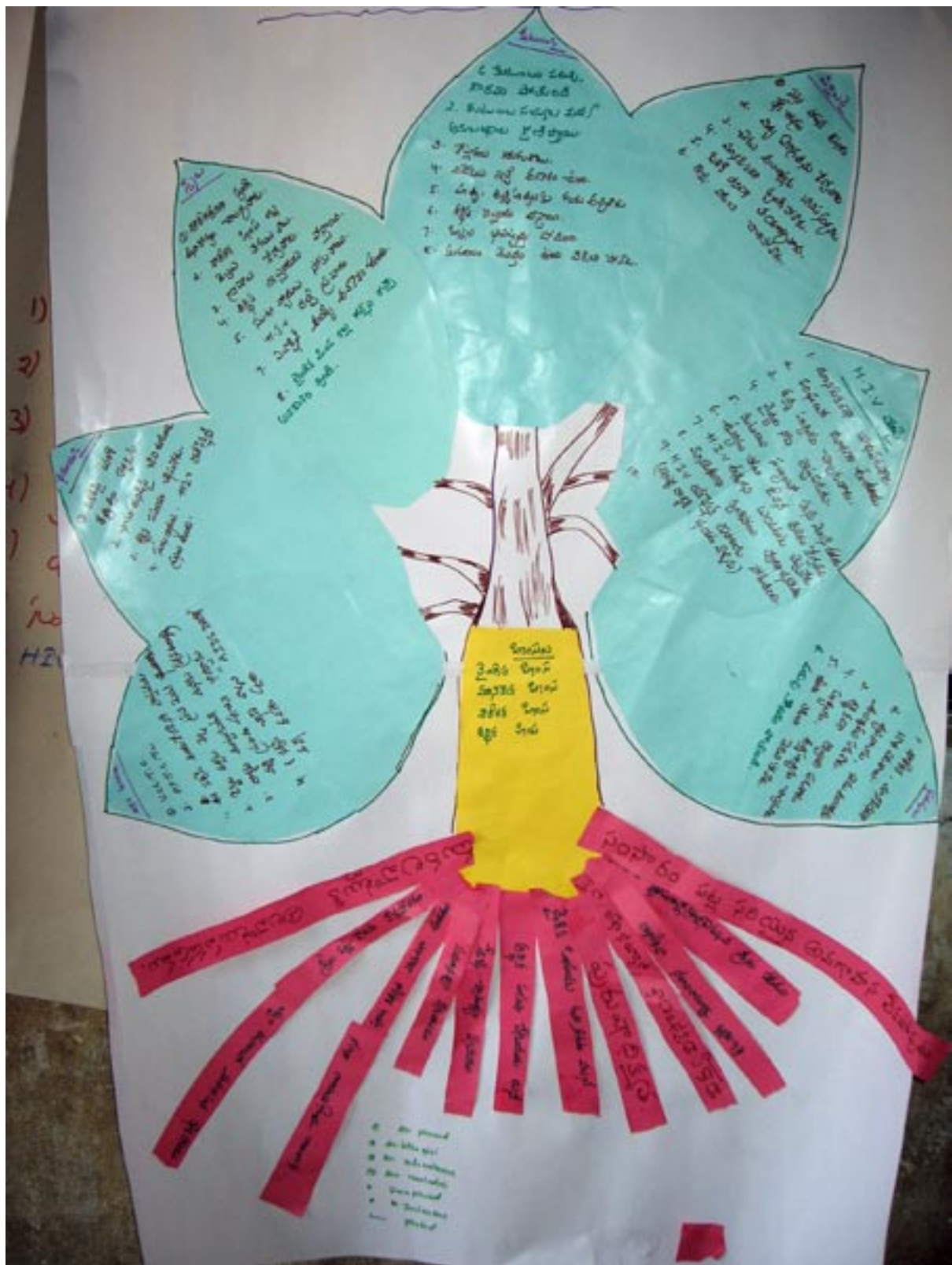
- a) Identify different forms of gender violence and how violence affects people; and
- b) Identify some of the root causes of gender violence.

Time: 1–2 hours

Materials and preparation: Draw a large tree diagram on flipchart paper, with the “Effects,” “Forms” and “Causes” labeled at appropriate levels (see below). Write one example of the type of response expected at each level on a card and tape the cards at their respective levels.

Location	Part of Tree	Feature	Examples
Top	Branches	EFFECTS	loss of self-esteem
Middle	Trunk	FORMS	physical violence (e.g., beating)
Bottom	Roots	CAUSES	male domination

Problem tree drawn by participants in pilot workshop.



■ Steps:

1. CARD-STORMING: Divide into pairs. Hand out cards and markers. Ask pairs to write individual points on forms, effects and causes of violence – one point per card – and then tape them at the appropriate level of the tree.

Debriefing: Review one level at a time. Cluster common points and eliminate repetition. Give each set of common points a category title, e.g. "PERSONAL," "FAMILY," "COMMUNITY," etc. When reviewing "Effects," help participants see two levels of effects – immediate impact on women (e.g. injuries, fear), and spin-off effects (e.g. reduced productivity).

2. PROCESSING – Causes and Solutions: Ask the following questions to probe deeper into the root causes of gender violence and elicit possible solutions:

- a) *What are the root causes of gender violence?*
- b) *Why are women not reporting cases of violence to the police?*
- c) *How can we solve this problem and reduce the incidence of gender violence?*

Sample Responses:

Forms of violence

PHYSICAL VIOLENCE – Slapping. Punching. Hitting with weapon. Kicking. Choking. Scratching. Pulling hair. Biting. Cutting. Burning. Stabbing. Throwing petrol or acid into face. Forcing wife to abort. Dowry killings.

EMOTIONAL VIOLENCE – Insults. Belittling. Scolding. Suspecting. Threatening. Shaming/blaming wife for: having no children, having girl child, not raising children properly. Threats when wife questions husband's extramarital affairs.

ECONOMIC VIOLENCE – Women and girls overworked. Husbands grabbing wives' income. Dowry harassment. Forcing wife to do work against her will. Husband wasting family money (e.g. drinking, playing cards).

SEXUAL VIOLENCE – Rape. Forced sex within marriage. Sexual teasing and coercion at work places or schools. Incest.

Effects

PERSONAL – Injuries. Disfigurement. Miscarriages. Exposure to STIs and HIV. Feel belittled/worthless. Shame. Fear. Isolation/withdrawal. Loss of self-esteem. Self-blame and denial. Loss of sense of control over life. Stress. Anxiousness. Depression. Feeling suicidal. Reduced ability to work and generate income.

FAMILY – Breakdown in communication and trust. Family conflicts and divorce. Children become fearful or depressed – leave school. Property grabbing. Financial problems. Family loses respect.

COMMUNITY – Neighbors talk about the family – this affects family's social standing within the village. Disruption of community life.

HIV EPIDEMIC – Wife cannot negotiate safe sex. More vulnerable to getting HIV. Fear of disclosure if she gets HIV. Avoids getting tested and using AIDS services. Spread of infection.

Causes

- Gender inequality – unequal power relations between husbands and wives.
- Men want to dominate women and use force to maintain their control.
- Inequality allows men to treat their wives with contempt – leads to violence.
- Women are not respected and recognized by society – they are stigmatized.
- Men think it is acceptable to express anger through physical & emotional violence.
- Women treated as inferior/subservient to men – makes them vulnerable to abuse.
- Women are taught to be submissive to their fathers, husbands and sons.
- Common view that husbands beating wives is acceptable – a form of "discipline."
- Women lack decision-making and financial power and do not control property.
- Other triggers: Alcohol. Suspicion/Jealousy. Wife "disobeying" husband.
- Poverty makes men insecure and more susceptible to the use of violence.

Why are women not reporting cases of violence?

- They fear that if they report the violence, it will continue or get worse.
- They fear they will lose economic support and be kicked out of the home.
- They fear that reporting the violence will bring shame/dishonor on the family.
- They fear that if they report the violence, no one will listen.
- They have been taught to stay silent – to protect the family secrets at all costs.
- They are not aware of their rights and accept gender violence as a norm.

What can we do individually and collectively to reduce violence?

- Educate men, women and children that gender violence is wrong.
- Help them understand the effects of violence on the family.
- Educate women on how to get support when abused.
- Help women develop the courage to tell others when they have been beaten.
- Encourage women to report cases of violence to the police.
- Get the police to enforce the Domestic Violence Law.
- Form women's groups and encourage women to support each other.
- Get the community to name violence as a problem and to stop it.
- Educate the community that the sex of a child is determined biologically, by chromosomes.
- Empower women with assertiveness skills.
- Provide legal services for women.
- Educate children on violence so they don't become violent when they grow up.
- Provide counseling for couples and address problems of excessive drinking.
- Discourage early marriages.

3. SUMMARY:

- The main CAUSE of gender violence is that **men use violence to exert control over their wives or partners.**
- The main SOLUTION is to **empower women to stand up to this violence** (in appropriate ways) and to get **community support for their empowerment.**
- Women, when beaten, often refuse to report the violence. They are worried about triggering further violence or shaming their family, so they remain silent.
- Women have been socialized to be submissive to their husbands and not to question the husbands' behavior. They have been taught to bottle up the problems of the family and protect the family secrets at all costs. This is why they remain silent after being beaten.
- Men have been socialized to be domineering – to be “laws unto themselves” and to treat women with contempt, rather than respect. They treat their wives as their property: they feel they own their wives, so they have a right to do anything to them without being questioned.
- Men feel that it is acceptable to express their anger through intimidating, verbally abusing or beating their wives. They think this is their right.
- All forms of gender violence – physical, emotional, economic or sexual – are wrong and need to be stopped, rather than hidden or condoned.
- The violence may be triggered by jealousy, alcohol, “talking back” or arguments over money, but these are not valid reasons for violence. Violence is wrong.
- Unless something is done, the men will continue to batter their wives, knowing that no action will be taken.
- If women are seriously injured, we (health workers) need to do more than patch them up and send them home.

B3. How It Feels to Be Abused – Reflection Exercise

Facilitator’s Note: This session will help participants understand violence on a **feelings** basis, rather than on a theoretical basis. **It may trigger strong emotions.** You should be ready to deal with these emotions. Read the note in the introductory chapter about how to manage feelings.

“During this exercise TBAs reflected on very painful experiences in their lives. They talked about being beaten or emotionally abused by their husbands without reason. They felt very bad and some cried. But they supported each other and we helped them to cope with the pain and learn from these experiences. We explained that our aim was not to remind them of painful moments in their lives, but to bring about awareness and look for ways to change things.” (Trainer in the Reducing Stigma and Violence Toolkit for Health [SVTH] pilot workshop)

Some trainers have combined this exercise with the reflection on stigma (module A3) – thinking of experiences of being stigmatized. The choice of combining these exercises or treating them separately is up to you.

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

- a) Describe some of their own personal experiences of being subjected to violence; and
- b) Identify some of the feelings of having been beaten or verbally abused.

Time: 1–2 hours

■ Steps:

1. OUR OWN EXPERIENCE OF BEING SUBJECTED TO VIOLENCE (Individual Reflection): Ask participants to sit on their own at a distance from other participants. Ask participants to close their eyes, and then say: *Think about a time in your life when you were **beaten up or subjected to continuing verbal abuse**. What happened? How did it feel? What impact did it have on you?*

2. SHARING IN PAIRS: *Share with someone with whom you feel comfortable. If you prefer to remain silent, this is okay too. There is no pressure on anyone to share.* Help participants pair off if they are having difficulties.

3. REPORT BACK: Invite participants to share their stories in the large group. This is not compulsory – people will share if they feel comfortable. As the stories are presented, ask – *How did you feel? How did this affect your life?*

Sample Responses:

Experiences of Being Subjected to Violence

Beaten by parents for doing something wrong. Beaten by husbands. Verbal abuse and teasing. Men controlling the family income.

How did you feel when you were subjected to violence?

Hurt and confused – didn't understand why I was being beaten. Feeling afraid. I couldn't defend myself. How could he do this? It made me feel so small. Sad. Inferior. Useless. Rejected. Shame – my children were watching. Wanting to be understood, listened to. Hatred.

4. PROCESSING: Ask – *What did you learn from this exercise about your own experience of being subjected to violence?* If the experiences are very painful, get participants to share in pairs.

5. SUMMARIZE:

- This exercise helps us see **how it feels to be beaten or emotionally abused**.
- **Violence is humiliating, painful and terrifying.** People get badly hurt and the feelings last a long time. The feelings are so powerful that some of us can even remember how it felt being beaten more than 30 years ago!
- **Violence destroys people's self-esteem.** People begin to doubt themselves. They feel belittled and worthless.

■ Action Ideas:

Talk with friends or family members about what you have learned about violence.

B4. Violence in the Workplace – How We Respond to Cases of Battered Women

Facilitator’s Note: This exercise is designed to get health workers to look at how they deal with cases of battered women who come to them for help. Before the training, some health workers may treat a case of battering as an accident. This module is designed to show them practically how they should respond to this kind of case.

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

- a) Describe how they currently deal with cases of battered women;
- b) Recognize that gender violence is a health problem and a human rights problem;
- c) Agree that the current response of some health workers – treating violence as a domestic matter to be settled at home – is wrong;
- d) Work out a new approach for dealing with these cases; and
- e) Understand the protections offered to women by the Domestic Violence Law.

Materials and preparation: Copies of the Domestic Violence Law, (Annex 4) to be distributed to participants.

Time: 2 hours

■ Steps:

1. **INTRODUCTION:** Facilitate a discussion on the following questions:

- a) *What do your patients seek treatment for?* [Possible responses: fever, headache, diarrhea, vomiting, stomachache, injuries, fractures]
- b) *When you say “injury,” do women or men come with the most injuries?* [Women]
- c) *What kind of injuries?* [Injuries caused by beatings by husbands, e.g. head injuries, internal pains, cuts, bruises, broken bones, damaged teeth, etc.]
- d) *When women who have been beaten ask for help, how do you deal with them?*

Use this as the starting point to introduce the role play.

2. **CURRENT SITUATION (Role Play):** Organize a role play to show the current situation.

A health worker is treating a woman who has been beaten badly by her husband. The health worker is very cold, disbelieves the woman and questions her about her behavior (implying that she is responsible for provoking the violence). He refers to the violence as an “accident,” and provides no counseling or legal advice. At the end, he sends her home, saying she “should go home and be a good wife.”

At the end of the role play, discuss the following questions:

- a) *What happened in the role play?*
- b) *Do you agree with how the health worker treated the woman? If not, why?*
- c) *How did the woman feel?* (question to the “battered woman” in the role play)
- d) *How should health workers deal with cases of battered/abused women?*

Sample Responses:

What happened?

- The health worker was very cold, unwelcoming and disbelieving.
- He was judgmental. He blamed the woman, saying she had done something to make her husband beat her.
- He kept using the word “accident” – he does not view violence as a problem.
- He told her that it was her duty to obey her husband.
- He sent her home, telling her to “be a good wife.”
- He does not see that beating affects a woman’s health – physical and psychological.
- He did not probe the source of the violence or offer counseling/support to the woman. He made no effort to help find a long-term solution.

How should health workers deal with cases of battered women?

- Don’t overreact or look shocked. Show her you believe what she is telling you.
- Let the woman talk about her feelings and listen to her.
- Give the woman your full attention and stay calm, reassuring and non-judgmental.
- Tell her that:
 - a) You will treat her information in confidence – you will not tell other people.
 - b) She is brave to talk about her problem. It is sometimes difficult to talk about these things – sometimes it feels easier to stay silent and suffer.
 - c) The violence by her husband is wrong. No one has the right to beat another person, no matter how angry he is.
 - d) Getting beaten is not her fault. She is not to blame. She did not ask to be beaten.
- After she has explained her situation, get her to talk about what to do next. Be realistic and do not frighten her.
- Don’t tell her what to do. Help her consider her options, but empower her to make her own decision.
- DO NOT question her about her behavior (which “may have triggered the abuse”).
- DO NOT tell her to “go home and be a good wife.”
- DO NOT call the husband to hear his side or try to counsel them as a couple.

3. COUNSELING PRACTICE (Paired role playing and stop start drama): Divide into pairs. Ask one person in each pair to play the health worker, the other person to play the battered woman. Ask pairs to play for 4–5 minutes. Then shout “Stop!” and ask one pair to show their play at the center. At the end of the play ask the group, “*What happened? How did the health worker deal with the woman? How did it make the woman feel? What other approaches might be used?*” Invite the person who suggests a new approach to take over the health workers’ role and replay the scene – and then debrief at the end. Continue this process, with new approaches being tried out in each subsequent role play.

Sample Responses: Possible approaches used by the health worker

- Comfort the woman and assure her she is in good hands. Get her to sit down.
- Talk to her in a way that builds her confidence to explain what has happened.
- Ask simple, open questions and get her talking.
- Check symptoms while at the same time asking questions, e.g. ask about her children.
- Get her to talk about her family first, and then ask, "And how did this happen?"
- Ask – "Why did he do it? How often has he done this? After beating you, what does he do? Does he repent? Did he come with you? Do you have a support system – do you talk about this with any family member? Do you talk to your husband?"
- Tell her husband that this was a criminal act and that he could be thrown into jail.

4. CURRENT SITUATION AND COUNSELING PRACTICE (group role play option):

As an alternative to steps 2 and 3, divide participants into two groups. Ask one group to prepare a "negative" role play showing a health worker who is *not* supportive of a battered woman, and ask the second group to develop a "positive" role play of a health worker who counsels the woman and takes up the issue of battering.

Once the two plays have been performed, ask participants to compare the approaches used in the two plays and discuss best practices for counseling a woman.

5. SUMMARY: Review the recommended approaches to caring for battered women:

- **Welcome the woman and make her feel comfortable. Treat her with respect.**
- Meet with her on her own **without her husband** and help her decide what she wants to do. Don't try to counsel the couple together and "negotiate violence." This is totally inappropriate when one partner dominates the other.
- Give her time to tell her story and express her feelings. Let her do the talking.
- Give her your full attention and listen attentively. Remember – a good counselor has big ears, big eyes, and a **small mouth**.
- Listen to and believe what she has to say. **She needs a friendly, supportive ear, not a challenging or accusing response. She needs help, not disbelief or hostility.**
- Build on her strengths. **Compliment her on what she has achieved so far, her coping strategies and survival skills, e.g., coming to see you.**
- **Don't question her behavior.** Focusing on her behavior will not solve the problem – the problem is the husband's controlling behavior.
- Tell her that:
 - You will treat her information **in confidence** – you will not tell other people.
 - She is **brave to talk about her problem**. It is sometimes difficult to talk about these things – sometimes it feels easier to stay silent and suffer.
 - **The violence is wrong.** No one has the right to beat another person.
 - **Getting beaten is not her fault.** She did not ask to be beaten.
 - **Her feelings** of love, anger, betrayal, hope, fear, sadness **are all normal**.

- After she has explained her situation, **get her to talk about what to do next**. Be realistic and do not frighten her.
- Help her plan for her safety. Discuss options to prevent violence, including:
 - Leaving her husband;
 - Getting support from others (e.g. community leaders, relatives, friends) to change the husband's behavior;
 - Addressing triggers that result in violence, such as alcohol abuse; and
 - Going to the police to take legal action.
- **The woman herself will decide if she wants to press charges**. Many women want to end the violence, but maintain the relationship. If she leaves her husband, she might lose her home, economic support and children. This is a difficult choice.
- **Some health providers may refuse to take responsibility** for this type of case, saying "*It is not a health issue.*" Gender violence, however, is a health issue – it results in injury, chronic health problems and even death. If a woman reports her case and you see her injuries, you are legally obliged to help get it reported to the police.

B5. Gender, Violence, and HIV and AIDS

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

- a) Explain why gender violence increases women's vulnerability to HIV; and
- b) Identify strategies for countering gender violence.

Time: 1 hour

■ Steps:

1. VIOLENCE AND HIV (Story-Discussion): Divide into two groups. Give each group one of the stories below and ask them to:

- a) *Read the story.*
- b) *Discuss the violence and how it affects vulnerability to HIV.*
- c) *Change the story so that the women are less vulnerable to HIV.*

Story A: The husband is alcoholic, goes out every night and has many other sexual partners. He beats his wife regularly and sometimes forces her to have sex. If the wife complains to her husband about his girlfriends or asks him to use condoms, he responds with more beating.

Story B: A young man is influenced by his friends to take up excessive drinking and sex with many women. Even though he knows the risks of getting HIV, he does not use condoms. After some time he tests positive for HIV but does not disclose his status to anyone, nor tell his partners. He continues to have unprotected sex.

Sample Responses:

Story A:

The husband drinks lots of alcohol and has sex with many other women. He beats his wife regularly. Out of the fear of being beaten, his wife agrees to have sex with him, even though she knows he has been sleeping with other women. This puts her at risk of getting HIV.

How to change the story so she is less vulnerable?

- The main solution is to empower women to stand up to violence.
- Educate the woman about HIV and how she is at risk.
- Encourage her to join a group and get support from other women.
- If she shares her problems and gets support from others, her husband may listen.

2. PROCESSING: Ask – *How does gender violence increase a woman's risk of getting HIV?*

3. SUMMARY:

- **Men having sex with their wives when the men have STIs or HIV is a form of sexual violence.** If a man who has STI symptoms has unprotected sex with his wife, he knows he is probably giving her the STI too. He may also be HIV-positive, since STIs and HIV go closely together. If he is HIV-positive and has sex while he has open sores or a discharge on his penis, the risk of giving HIV to his wife is greatly increased.

- **Fear of violence can prevent a woman from protecting herself from HIV or STIs.** She is afraid she will be beaten if she refuses to have sex or asks her husband to use a condom, even if she knows he has been having sex with other women or that he has HIV or STIs.
- **Fear of violence can stop a woman from telling her husband she has a STI or HIV.** As a result, she does not get treatment for the STI, because she cannot see a health provider without her husband's consent. She will also continue to have unprotected sex with her husband, and is likely to give him the STI or HIV.
- **Sexual violence, which involves forced sex, increases the risk of HIV transmission.** Sexual violence results in bleeding in the vagina and small internal cuts or sores that make it easier for the virus to be transferred.
- Women are vulnerable to getting HIV because of their vulnerability to **rape in the workplace or in the community.**
- **Women's fear of violence, which limits their control over their sexual lives, is a major factor in the growing spread of HIV in India.**
- **Women face severe violence when HIV or STIs enter the home.** They are the first to be blamed for getting HIV, even if the husband is the carrier. They are beaten, chased from their homes and dumped with relatives. Their property is taken from them. When they become sick, they are abandoned and left on their own. (For more detail on the effects on women of HIV entering the home, see module A12).

See Factsheet #12 for more information on gender violence.

B6. How to Mobilize the Community to Stop Gender-Based Violence

Facilitator’s Note: This module provides practical ideas on how to mobilize the community to act against gender violence. It grew out of the ideas and experience of the health workers during the trial workshops. They said, “It is not enough for us to be more aware of gender violence. We can’t act alone; we need to involve others. Gender violence is a societal problem and we need to wake up the community to see it and take action. Right now it is hidden – so it is our job to break the silence.”

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

- a) Raise the awareness of the community about gender violence; and
- b) Encourage community leaders to name gender violence as a problem and lobby to stop it.

Time: 1 hour

■ Steps:

1. INTRODUCTION (Stories or Role Play): Read and discuss with participants, or perform as role plays, the following real stories described by health workers:

Story 1. One woman came to my clinic for help. She reported that she had been beaten by her husband. I treated and counseled her, and the next day I went to her house to counsel her husband. When I arrived, he got angry and accused me of having a sexual relationship with his wife. (RMP)

Story 2. One woman was beaten badly in front of her house, and everyone knew about it. But the other women did nothing. They were too scared to do anything. I was the only one to go and talk to her. (TBA)

Discuss:

- a) *What happened in the two stories? Why?*
- b) *What can we do as health workers to get the whole community to address the problem of gender violence?*

Sample Responses:

What happened?

Story 1: If the RMP acts alone on the issue, he will be accused of having an affair. The only solution is for him to work together with other health workers and build the support of the whole community for change.

Story 2: The TBA on her own could console the woman but not bring about change. To address gender violence effectively she needs to get all the women involved in challenging it and calling for change.

How to mobilize the community for change?

- Start with ourselves – change our own attitudes and behavior first. Then we can be good role models for other people.
- Help everyone (men, women and children) understand that gender violence is wrong.
- Get people to recognize the impact of gender violence on the family, including both women and children.
- Talk with family, friends and clients about gender violence.
- Encourage community leaders to speak out against gender violence. Get people talking openly and make this problem visible.
- Stand up and challenge others when they “blame and shame” women. Stop the stigma toward women and girls. Teach respect for women.
- Educate women about their rights and how to get support when they are abused.
- Reach out to and support abused women. Once they feel accepted, they will be more open to discussing their situation and getting help.
- Get women to work together and support each other. Teach them assertiveness skills and build up their courage to speak out against gender violence.
- Encourage women to report violence cases to the police and get the police to treat these cases seriously. Provide legal services for women.
- Get the police to enforce the Domestic Violence Bill.
- Raise men’s awareness and encourage them to stop violence.
- Provide counseling for couples.
- Address problems of excessive drinking.
- Discourage early marriages.
- Educate the community that having baby girls should not be stigmatized. Neither parent controls the sex of the child; this is determined by chromosomes.
- Treat all children equally and educate girls.
- Educate children on violence so they don’t become violent when they grow up.

B7. Sexual Rights and Responsibilities

Facilitator’s Note: This exercise helps women understand that they have sexual rights, and helps men understand that that it is their responsibility to value women’s sexual rights. Improving the understanding of sexual rights and responsibilities will give women more control over sex and reduce the risk of getting HIV.

Objective: By the end of this session, participants will be able to describe their sexual rights and responsibilities and how exercising these will affect their lives.

Time: 1 hour

■ Steps:

1. GENERAL AND SEXUAL/FAMILY RIGHTS (Brainstorming): Explain that we all have a) *rights*, e.g. the right not to be controlled by others, the right to be treated fairly; and b) *responsibilities*, e.g. to provide for the family, obey laws, etc.

Ask participants to brainstorm:

- a) *What are our general rights – and responsibilities?*
- b) *What are our sexual/family rights – and sexual/family responsibilities?*

Sample Responses:

Rights: Live. Work. Education. Have property. Get married. Have a family. Get medicine. Get respect. Vote. Equal opportunity.

Responsibilities: Support the family. Work for the family. Protect own and family’s health. Educate the children. Avoid infecting others with STIs. Avoid bad habits.

Sexual or family rights:

- Choose one’s marriage partner. Decide when (at what age) to get married.
- Control one’s own body. Decide when and how to have sex.
- Say no to sex.
- Say no to certain forms of sex. Woman can say no to sex when partner has had alcohol.
- Say no to sex when the partner has an STI.
- Have a say in family planning method, and in number of children to have and how spaced.
- Ask one’s partners to use condoms and to go for an HIV test.
- Question a husband if he has a sexual relationship with other women.

Sexual or family responsibilities:

- To be understanding, live together and take care of each other.
- Listen to the partner about family/sexual matters (e.g. using condoms).
- If partner says “No,” partner should respect and understand the other’s decision.
- If one partner is infected with an STI, he or she is responsible to go for treatment.
- Responsibility to tell the other partner if she or he has an STI or HIV.
- Listen to the partner if she or he wants to delay having another child.
- Look after the other partner when she or he is sick.

Processing: Ask – Do women have these sexual rights? In practice, are women able to exercise these rights?

Sample Responses: (Taken from a pilot TBA workshop)

Our husbands have the power to veto everything. They decide, and we have to follow.
I disagree – culture is changing, women now are more educated and making decisions. They have the right to decide things – and some men are listening.
A girl who is being forced into marriage has the right to talk to her parents and refuse.
Some children are now marrying on their own, without their families interfering.

2. VIOLATION OF SEXUAL RIGHTS (Case Studies)*: Divide into two groups and give each group one of the case studies on the following page. Ask each group to discuss the questions at end of each case study and write up the answers on flipchart paper.

3. PROCESSING: Ask–

- a) *What did we learn from these two stories?*
- b) *Why are women denied their sexual rights?*
- c) *Why are men not practicing their sexual responsibilities?*
- d) *What happens if women are denied their sexual rights?*
- e) *What happens if men do not practice their sexual responsibilities?*
- f) *How can we ensure that women exercise their sexual rights and men live up to their sexual responsibilities?*

Sample Responses:

Why are women not exercising their sexual rights?

- Women are not aware of their sexual rights.
- Many women have been socialized to believe they have to obey what men tell them. For example, if their husbands ask for sex, they cannot say “No.”
- Because sex is taboo, there is very little education for women about their sexuality.
- Fear of violence prevents women from exerting their sexual rights.

Why are men not practicing their sexual responsibilities?

- Men have been socialized to dominate women and treat them with contempt, rather than respect. They treat their wives as their property: they feel they own them so they have a right to have sex with them any time they want, without being questioned.
- Men are not aware of their sexual responsibilities and women’s sexual rights.
- Alcohol is an excuse for men to abuse their power over women.

What happens if women do not exercise their sexual rights?

Poor sexual health. More vulnerable to getting HIV and STIs. Bearing many children affects their health. Stress and mental health problems. Loss of self-esteem.

What happens if men do not practice their sexual responsibilities?

They are more likely to get infected with HIV/STIs, and pass HIV and/or STIs to their wives. They are more likely to destroy their families

How to ensure women exercise rights and men practice their responsibilities?

- Educate men and women about their sexual rights and responsibilities.
- Help men see they are enjoying sexual rights but not practicing sexual responsibilities.
- Help women realize that they have sexual rights and need to demand them.

*This exercise was adapted from **Men as Partners: Training of Life Skills Educators** (Engender Health)

■ CASE STUDY 1: GENDER VIOLENCE

Chandamma is very nervous. Today it is her husband's pay day. It is very dark outside. Her husband should have been home by now. He had been paid that day, and she had hoped he would return with his salary so they could buy food for the children. She knew he was wasting the money with his friends, but there was nothing she could do.

She remembered what happened last month at this time. He came home late and woke her up and pulled off her sari. He smelled of alcohol. She did not want to have sex with him, she was afraid of getting pregnant again, and she did not feel well. When she tried to tell him to stop, he yelled at her and began to beat her, and forced her to have sex. He told her that he was her husband and she could not say no to him.

Discussion Questions:

- 1) *What do you think about this situation? Whose rights were violated?*
- 2) *Does a man have the right to have sex with his wife whenever he wants?*
- 3) *Does a woman have the right to refuse to have sex with her husband?*
- 4) *What can a wife do if she does not want to have sex?*
- 5) *How can a wife protect herself from physical violence?*

■ CASE STUDY 2: HIV

Sharat works at the mines a long way from his village, but today he is coming home. He comes home to see his wife every six months. While at the mines he stays with his friends and whenever he wants sex, he goes to sex workers.

Sharat is feeling worried. He has developed a skin rash and thinks he got it from a sex worker. Before leaving the mines he saw that she was very sick. His friend who also visited the sex worker had died after becoming sick and losing a lot of weight.

Discussion Questions:

- 1) *What, if anything, should Sharat tell his wife before he has sex with her?*
- 2) *When he has sex with her, should he wear a condom?*
- 3) *Does his wife have a right to know that he has sex with sex workers?*
- 4) *Does Sharat have a right to have sex with his wife if she does not want to?*

Chapter C: Shame and Blame – Stigma & Emotional Violence

■ Introduction

Because sex is the main route for HIV transmission in India, people assume that people living with HIV contracted the virus through immoral behavior. They think that getting HIV means a person has sinned – and so they shame and blame people living with HIV.

Gender violence also takes the form of shaming and blaming. Women often are mocked and told they are worthless. Women are blamed for being burdens on the family, not following their husbands' instructions, failing to produce male children, killing their husbands (in the case of widows) and many other things. This emotional abuse is often more painful than physical violence.

This chapter will explore shame and blame – stigma and emotional violence. It will show how shame and blame are connected to our ideas about sex and gender, and how they hurt people living with HIV and women.

If you have AIDS, you *die twice*. The first thing that kills you is being lonely when everyone discriminates against you, even your family members. The second one is the actual death.

(Quote in *Understanding and Challenging HIV Stigma: Toolkit for Action* – the original African stigma-reduction toolkit).

■ Modules

- C1. We Are All in the Same Boat – Elimination Games
- C2. Stigma in the Center (Game)
- C3. Things People Say About People Living with HIV, Sex Workers, Truck Drivers, etc.
- C4. Judging People – Occupation Cards
- C5. People Living with HIV Have Rights and Responsibilities
- C6. Blaming Women
- C7. Women’s Vulnerability to HIV – Problem Tree
- C8. Breaking the “Sex” Ice

C1. We Are All in the Same Boat – Elimination Games

Facilitator’s Note: This is a warm-up exercise to introduce the idea that we are all affected by HIV. It can be based on any competitive game that eliminates players when a person makes a mistake. This form of exclusion is a metaphor for stigma, and will be used to trigger discussion on how it feels to be excluded from the group.

Objective: By the end of this session, participants will recognize that everyone is at risk of getting HIV.

Time: 15 minutes

■ Steps:

1. WE ARE ALL IN THE SAME BOAT (Game + Discussion): Facilitate the elimination game (example described below). Then discuss, *What does the game mean?*

GAME – “IN the river, ON the bank”

Ask players to stand in a line, all facing the same direction. Then explain:

*Where you are standing is the bank. When I say, “**IN** the river,” you should take one step forward. If, however, I say “**ON** the river,” you should not move. When I then say, “**ON** the bank,” you should take one step back to our starting point here “on the bank.” If, however, I say “**IN** the bank,” you should not move. If anyone makes a mistake, she/he will be eliminated from the game.*

Then start the game. Give the commands quickly. If anyone makes a mistake, ask him/her to leave the game. After a few minutes, stop and debrief.

Other games that can be used include IDLI-DOSA-PURI or SIMON SAYS (see Annex 3 for more game ideas).

2. DEBRIEFING: Ask–

- a) *Those who were kicked out of the game – how did you feel?*
- b) *Those who were not eliminated – how did you feel?*
- c) *What can we learn from the game about stigma?*

Sample Responses:

Those kicked out of game – how did you feel?

Why me? Anger. Confusion. Embarrassment. I felt I had made a little mistake – didn't know why I was being kicked out. Why can't you give me another chance? I felt others were laughing at me. I felt all alone. I felt good when others were eliminated – and then I was not alone. I wanted others to fail – then they would feel the same and join me in the "loser" category.

Those who remained in the game – how did you feel?

I felt very nervous. I kept watching others to see if they would make a mistake.

Yes, I did laugh – it was a natural response – it was a very competitive situation and when someone makes a mistake, you laugh to relieve the tension.

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 (stigmatized) feel bad.
- Laughing at others making mistakes can be interpreted as a form of blaming.
- Laughing at the behavior 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 socialized.
- It is easy to make a mistake in the game and in real life, e.g. not using a condom or taking risks in our sexual behavior.
- Those who were still in the game were watching and judging other's behavior – this is just like the way we stigmatize.

3. SUMMARY:

- People may 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 affects everyone.
- Stigmatizing others **makes us feel superior to others**. It makes us feel that WE are right and THEY are wrong.
- Yet, as this game shows us, "**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. All of us are at risk of getting HIV so there is no point stigmatizing or blaming those who are already affected. We could join them any day!
- **Don't point fingers at anyone**. As you point one finger toward others, four fingers are pointing back toward you – you are blaming yourself.

C2. Stigma in the Center (Game)

Facilitator’s Note: This exercise is a quick game to introduce the idea of the “shaming and blaming” dimension of stigma. It shows that stigma is not faced only by people with HIV – we are all the center of negative attention at different points in our lives.

This exercise could also be linked to “How It Feels to be Stigmatized” (Module A3).

This exercise is adapted from a game developed by Gill Gordon for the *Youth Drama Guide on Sexual and Reproductive Health* (International HIV/AIDS Alliance, 2007).

Objective: By the end of this session, participants will be able to describe how it feels to be stigmatized, and how it feels to stigmatize others.

Time: 1 hour

■ Steps:

1. STIGMA IN THE CENTER (game and discussion)

- a) Ask the group to stand in a circle.
- b) Then say, *Those who have ever been stigmatized because they are. should go into the center of the circle.* (Describe a feature that applies to you, the facilitator, e.g., “too short,” so that you also go into the center of the circle.)
- c) Once those “stigmatized” are in the center (along with you), say, *Hug the others who have been stigmatized for being. (too short). Remember – you are not alone. Now, look at the rest of the group who are standing in the outer circle.*
- d) Ask the outer circle – *Have you stigmatized someone for this reason? Why?*
- e) Repeat steps b through d, giving other ways in which a person might be stigmatized. Examples: being fat, having a dark complexion, being a certain caste, being a widow, being single/unmarried, having no children, etc. As the last example, use “being a health worker who works with people living with HIV.”

2. PROCESSING: Ask–

- a) *What are some other ways that people are stigmatized?*
- b) *How did it feel to be stigmatized?*
- c) *What did you learn from the game?*

Sample Responses:

Ways that people are stigmatized: Being tall. Being too loud/noisy. Being migrant worker. Doing jobs that are seen as “dirty.” Being lower caste. Having visible illness. Drinking alcohol. Being seen as promiscuous. Not practicing one’s faith.

How did it feel to be stigmatized? Scared at first. People were looking at me and laughing at me. Feeling targeted, others were pointing fingers at me. I’m happy I was not alone. I didn’t want to go into the center, so I remained quiet.

Learning: Stigma does not apply just to people living with HIV. We are all stigmatized in some ways. If we were alone in the circle, it would feel worse. Some of us will hide certain information to avoid being stigmatized.

3. SUMMARY

- We have **all experienced stigma** for some reason or another.
- Being stigmatized can be **frightening and painful**.
- **Having the support of others** can make the experience easier.
- Some of us will **hide certain information** to avoid being stigmatized.

C3. Things People Say About People Living with HIV, Sex Workers, Truck Drivers, etc.

Facilitator's Note: This exercise is called "Things **People** Say about People Living with HIV, Sex Workers, Truck Drivers, etc." This phrasing allows participants to express their own stigmatizing labels for other groups while attributing them to "the people."

The aim of the exercise is to understand how hurtful these words can be and how they can affect the morale and health of the person stigmatized. We ask participants, "If you – or your daughter – were called these names, how would you feel?"

The words produced can be strong and abusive, so you should manage this exercise carefully. Select categories that do not apply to the participants. We have already removed the categories "dalits" and "widows," which we felt were potentially hurtful to participants.

Throughout this exercise you should make it clear that these words are being raised **not to insult people, but to show how these stigmatizing words hurt.**

The initial warm-up game also requires some sensitive facilitation. Some participants might find it hard to accept certain roles (e.g. sex worker), even in the context of a game. One solution is to assign yourself the role of "sex worker" to help break the ice.

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

- a) Identify labels used by people to stigmatize people living with HIV and other stigmatized groups; and
- b) See that these words HURT.

Time: 2 hours

Materials and preparation: Set up flipchart stations – blank sheets of flipchart paper on different walls of the room, with the following titles at the top of each sheet: People living with HIV, Sex Workers, Truck Drivers, Lepers, Migrant Workers and Beggars. Provide markers at each station. Then set up chairs in a circle so that each participant has a chair (and no chairs are left empty).

■ Steps:

1. WARMUP – SWITCHING CHAIRS (game): Have everyone sit in a chair. Allocate roles to each person going around the circle – "Person living with HIV, sex worker, truck driver, leper, migrant worker, beggar" etc. Continue until everyone has been assigned a role. Make sure everyone knows his or her new identity. Then explain how the game works:

I am the caller and I do not have a chair. When I call out the names of roles, for instance "People living with HIV" and "sex workers," all people assigned these roles have to stand up and run to a new chair. I will grab one chair. The person left without a chair becomes the caller, and the game continues.

Tell the new caller that she or he can call out any of the role names – either a single name or several names.

Debriefing: Ask – *How did it feel to be called a person living with HIV or a sex worker?*

Explain that these labels have a strong moral tone. This affects how people would feel about assuming these labels.

2. THINGS PEOPLE SAY ABOUT . . . (Rotational Brainstorm): Divide into six groups based on the roles assigned for the game, and ask each group to go to its flipchart station (e.g., those assigned the “leper” role in the warmup game go to the “leper” station). Ask each group to write on the flipchart all the things people say about those in their assigned group. After two minutes, shout “CHANGE” and ask groups to rotate and add ideas to the list at the next flipchart station. Continue until each group has contributed to all six flipcharts.

Sample Responses:

THINGS PEOPLE SAY ABOUT . . .

People living with HIV: Promiscuous. Sinners. Irresponsible. Walking graves. Cursed. They got what they deserved. Useless. AIDS untouchable. Unlucky.

Sex workers: Whores (moonda). Bitches (veshya). Highway girl. Overnight girl. Promiscuous. Sinners. Immoral. Cursed. Women without shame. Like money.

Truck drivers: Promiscuous. HIV carriers. Multiple sex partners. Sex crazy.

Lepers: Sinners. Untouchable. Keep separate from community.

Migrant laborers: Coolie. Homeless. Dirty. Always roaming. HIV carriers.

Beggars: Dirty. Nasty. Bad smell. Lazy. Thieves.

3. REPORT BACK. Bring the group into a semi-circle and ask one person to read the words in each of the lists. Then discuss:

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

b) *What would you **do** if you were called these names?*

Sample Responses:

How would you feel if you were called these names?

Ashamed. Embarrassed. Hurt. It makes me very sad. I wish I could die. Bad. Humiliated. Hopeless. Angry. Rejected. Unfairly treated.

What would you do if you were called these names?

I would hide so I wouldn't have to face this kind of rejection.

I would lose confidence and stay away from people.

4. SUMMARIZE:

- We are socialized or conditioned to judge other people. We judge people based on **assumptions about their behavior**.
- **Sex is a taboo** – it is regarded as something shameful that we should not talk about. So people who have sex frequently are assumed to be shameful.
- **People living with HIV, sex workers, and truck drivers** often are labeled as sexually immoral. They are called “promiscuous,” “sinners,” “irresponsible.”
- **Migrant laborers, lepers and beggars also** are judged with insulting words – “dirty,” “untouchable,” “HIV carriers,” etc.
- People affected by HIV stigma, e.g. sex workers, are often **already stigmatized before they get HIV**. They have the least power to resist or challenge stigma.
- **When we stigmatize, we stop dealing with people as human beings**. Using mocking or belittling words gives us a feeling of power and superiority and we forget people’s humanity.
- **We attribute characteristics to a group and everyone who belongs to that group**. We assume that all members of the group have the same characteristics, e.g. all truck drivers are promiscuous.
- All of these labels are **generalizations** that have no validity – we simply assume that “the other people” are “dirty, lazy, promiscuous.”
- **Stigmatizing words are like a knife – they have tremendous power to hurt, to humiliate and to destroy people’s self-esteem**.
- **So how should we treat people living with HIV?** We should give them: a) respect and affection; b) support and encouragement; and c) space, place and recognition in society. If we treat people living with HIV well, their increased sense of self-worth will help them to live a longer and better life. But if we treat them badly, they will die quickly – not from the illness alone, but from the shame, isolation and rejection they feel. And if we treat them badly, they will remain quiet about their status – which will result in HIV being passed to others.
- **Why do we condemn some groups and accept others?** You may disagree with the behavior of some people, but that does not give you the right to belittle them. Try to put yourself in the shoes of other people – how would you feel if you were called these names? You must try to empathize as though they were your son or daughter.

C4. Judging People – Occupation Cards

Objective: By the end of this session, participants will be able to analyze why we judge people unfairly according to occupation.

Time: 1–2 hours

Materials and preparation: Write the names of the six categories – HIGH BLAME, LOW BLAME, NO BLAME, HIGH RISK, LOW RISK and NO RISK – on cards, and tape the cards to the wall. Tape the Occupation Cards (Picture Set F) to a different wall.

■ Steps:

1. JUDGING PEOPLE (Picture study in pairs): Divide group into pairs. Ask each pair to select one occupation card and discuss:

- a) *Who is this person in the picture?*
- b) *How would you or the community judge this person (high blame, low blame or no blame)? Why?*
- c) *What risk does this person have of getting HIV (high risk, low risk or no risk)? Why?*

Sample Responses:

Occupation	Blame	HIV risk
Sex worker	High. Immoral/promiscuous. Spoils families.	High. Sex with many partners.
Truck driver	High. Travels extensively. Away from family.	High. Lots of sex without condoms.
Sweeper	High. <i>Dalit</i> – no respect. Cleans toilets – dirty.	High. Sex with many partners.
Barber	High. Low caste – low respect. Seen as dirty profession.	Low. However, uses same knife for everyone so could help to spread HIV.
Washerman	Medium. Low caste – low respect.	Low.
Tailor	High. Not much respect for job.	Low. No travel – no sex relations.
Police	High. Corrupt. Use money for sex workers.	High. Sex with many partners
Teacher	Low. Respect because he teaches the children.	Low.
Doctor	Low. Respect him because he treats patients.	Low.

2. REPORT BACK: Ask each pair to hold up its picture and give a report.

3. PROCESSING – ask:

- a) *How does the community judge people?*
- b) *What assumptions do we make about people?*
- c) *If you were shamed and blamed like this, how would you react?*

Sample Responses:

How does the community judge/what assumptions do we make?

- The doctor and teacher were given a positive rating because of their occupation – viewed to be sexually responsible and role models in society.
- The others were shamed and blamed because a) they were assumed to have many sexual partners, or b) they are from a low caste.
- Mobility was the main factor in determining who was considered to be in the high-risk group. Mobile workers included sex workers, truck drivers, migrant laborers, masons, fishermen and mechanics. These workers are morally condemned because they are assumed to be sexually promiscuous.
- *Double stigma:* Some groups of people are already stigmatized for coming from a certain caste, e.g., sweepers, fishermen, rickshaw pullers, agricultural laborers. These groups face double stigma if they are assumed to be promiscuous.

How would this shaming make you react?

Feel bad and lose one's sense of self-worth. Affects willingness to disclose and get tested. Because of the fear of stigma, people are not willing to disclose their status to others. If they disclose their status, they know they will be stigmatized – this is why they keep things hidden.

4. SUMMARY: *It is not WHO you are, but WHAT you do!*

- We make judgments or assumptions about other people's behavior based on their **occupation or their perceived sexual behavior – but without knowing them personally**. In making these assumptions we often generalize, e.g., saying that all people in a certain occupation are promiscuous. This, of course, is wrong: you may be a truck driver, but this does not mean that you are promiscuous.
- We stigmatize or condemn people without knowing their actual behavior. **We often believe or assume the WORST about other people. For example, women who work as dancers are assumed to be sexually active because of their occupation, but this assumption may be wrong.**
- We say people from low castes should not be given respect, yet people in these groups make important contributions to our society. **They should be accepted and respected, not stigmatized** for coming from a lower caste.
- Stigmatizing others through shame and blame is not acceptable. We are **all at risk** of getting HIV, so **we should stop judging other people**. We are all sexual beings. We are all vulnerable.
- Tape the cards for high-risk groups (e.g. sex workers, truck drivers) on the wall and explain:
There are an estimated 53 million people in India living with HIV, including 200,000 sex workers and 175,000 truckers. This means 52,620,000 people who are not sex workers or truckers have HIV. HIV is now affecting the general population, not just high-risk groups. We cannot continue to blame sex workers and truckers as if they are the only people with HIV – they are only a small fraction of those with HIV.
- Stop blaming people living with HIV and help to normalize HIV and AIDS. Get people to regard people living with HIV as **people with an illness, not people guilty of bad behavior**.

■ EXTRA PROCESSING ON JUDGING – IF YOU HAVE TIME

Facilitator’s Note: These additional exercises will help participants bridge general discussion about how “the community” judges others to their own more personal experiences with judging and being judged.

1. HOW DO WE JUDGE? (Buzz Groups): Divide into pairs and ask each pair to discuss:

*HOW are people living with HIV judged? What are they **blamed** for?*

Sample Responses:

BLAME: Promiscuous behavior. Spread of HIV. Climate of fear. Bringing shame to the family. Burden on the family – money and workload.

2. WHY DO WE JUDGE? (Buzz Groups): Divide into pairs and ask each pair to discuss:

Look at your own judging behavior and consider, “WHY do I judge others?”

Sample Responses:

Why do I judge others?

- Helps to make me feel better or superior.
- Helps to increase my power and control over others.
- Helps to keep me separate from others.
- By judging others I can maintain the status quo in the community.
- Projection of my own fears – I judge in others things I don’t like about myself.
- My religion teaches me to judge, to point out the sin in others.

3. WHEN DOES JUDGING HURT? (Buzz Groups): Explain that we all judge – it is a normal human activity and we all do it. Then divide into pairs and ask each pair to discuss:

When does judging HURT people?

Sample Responses:

Judging HURTS when it:

Demoralizes. Makes people feel small/stupid. Makes people isolate themselves. Destroys confidence. Reinforces self-stigma.

4. HOW TO BREAK OUR JUDGING HABITS (Buzz Groups): Explain that we all have a habit of judging others. Divide into pairs and ask each pair to discuss:

- a) *In what situations do you shame and blame others?*
- b) *What can you do to change this habit?*

5. SUMMARY:

- Stigmatizing others makes us feel superior to others. It makes us feel that WE are right and THEY are wrong. Yet we may be vulnerable to judging and stigma ourselves.
- We should aim to accept rather than judge or condemn others. For example, we may not agree with the lifestyle of a sex worker, but we should not reject or condemn her.
- Whether or not we agree with other people, we do not have the right to judge them. We should **treat them as human beings**. To stigmatize is to wipe out a person's humanity and treat him or her as having no value.
- We should treat those living with HIV as people with an illness, **not** people guilty of bad behavior.

C5. People Living with HIV Have Rights and Responsibilities

Facilitator’s Note: This module looks at how the rights of people living with HIV are violated. People with HIV are kicked out of jobs and accommodation, have to leave their families, and get separated from their children. We suggest you use Module B7 on “Sexual Rights” before you do this module. B7 introduces the concept of “rights.”

We also suggest you invite a representative from the Network of People Living with HIV in your area to join you for this session.

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

- a) Recognize that people living with HIV and AIDS have rights and responsibilities;
- b) Recognize that the rights of people living with HIV and AIDS often are denied; and
- c) Agree on how the family and community can reaffirm those rights.

Time: 1 hour

■ Steps:

1. RIGHTS AND RESPONSIBILITIES OF PEOPLE LIVING WITH HIV: Divide into two groups and ask each group to brainstorm two lists – RIGHTS and RESPONSIBILITIES of people living with HIV.

Ask each group to present its lists. Then discuss–

- a) *Which rights should families provide?*
- b) *Which rights should society provide?*
- c) *What are the effects on people living with HIV of being denied these rights?*
- d) *What happens if people living with HIV are unable to meet their responsibilities?*
- e) *How can we as health workers help to ensure these rights and responsibilities are met?*

Sample Responses:

Rights

Be respected. Be loved. Be included in family discussions/decision-making. Feel needed. Have friends. Get married. Have food. Have clothing. Have shelter. Have sex. Have children. Get medical care. Have property.

Responsibilities

Be open to advice. Help out in the house when you can. Avoid infecting others. Help make income when you are well. Talk to other family members about protecting themselves. Practice safe sex.

2. SUMMARY:

- We need to recognize that people living with HIV have rights, including the right to have sex, the right to get married, the right to have work and the right to have friends.
- If we do not give people living with HIV their rights, the result will be depression, loss of health, financial loss and people dying early.
- If people living with HIV are denied their rights, they may not be able to meet their responsibilities, including the responsibility to help protect others from infection.
- We need to ensure that people living with HIV are involved in making decisions about their lives, even when they get sick. They are still capable.
- People living with HIV need to understand the stresses of their illness on a family. These stresses mean that all their needs may not always be met.

■ Action Ideas:

Talk at home with other family members about their ideas on rights and responsibilities.

C6. Blaming Women

Facilitator's Note: This exercise is designed to show how women are more stigmatized than men. It should be used after the Life Cycle Exercise (A9), which identifies the different forms of stigma faced by women.

Objective: By the end of the session, participants will be able to recognize that women face greater stigma than men do, and that this stigma increases the impact of HIV on women's lives.

Time: 1 hour

■ Steps:

1. CAUSES OF STIGMA TOWARD WOMEN (Brainstorm): Ask participants to brainstorm the causes of stigma faced by women. Record each "cause" on a card and tape on the wall.

Sample Responses:

- Viewed as inferior.
- Being a burden on the family.
- Having no children – being "barren" (assumed that it is the woman's fault).
- Having only girl children – associated with tensions around dowry.
- Not raising children properly.
- Being a widow – surviving her husband.

Ask – *What is the effect of all of this stigma and emotional violence on women?*

2. WHO GETS BLAMED FOR BRINGING HIV HOME – THE MAN OR WOMAN? Ask participants to read the following case study.

A woman lost her son through AIDS. When she discovered what had happened, she at first blamed her son's wife. She accused her daughter-in-law of killing her son and kicked the young woman out of her house. Later, when she learned more about HIV and AIDS, she took her daughter-in-law back and began to take her for regular checkups at the hospital.

Discuss–

- a) *What happened in the story?*
- b) *Why did the woman blame her daughter-in-law?*
- c) *What happens when AIDS enters the home? Who is more likely to get blamed – the wife or the husband? Why?*

5. SUMMARY:

- Women, who are already stigmatized for being women, are more vulnerable to HIV stigma – they are more likely to be blamed for bringing HIV into the household.
- A woman is more likely to be chased from the household, sent back to her own family or abandoned when sick.
- Women are also more vulnerable to violence when they disclose they are living with HIV.
- Women living with HIV are vulnerable to poverty resulting from separation or divorce and property grabbing.

C7. Women's Vulnerability to HIV – Problem Tree

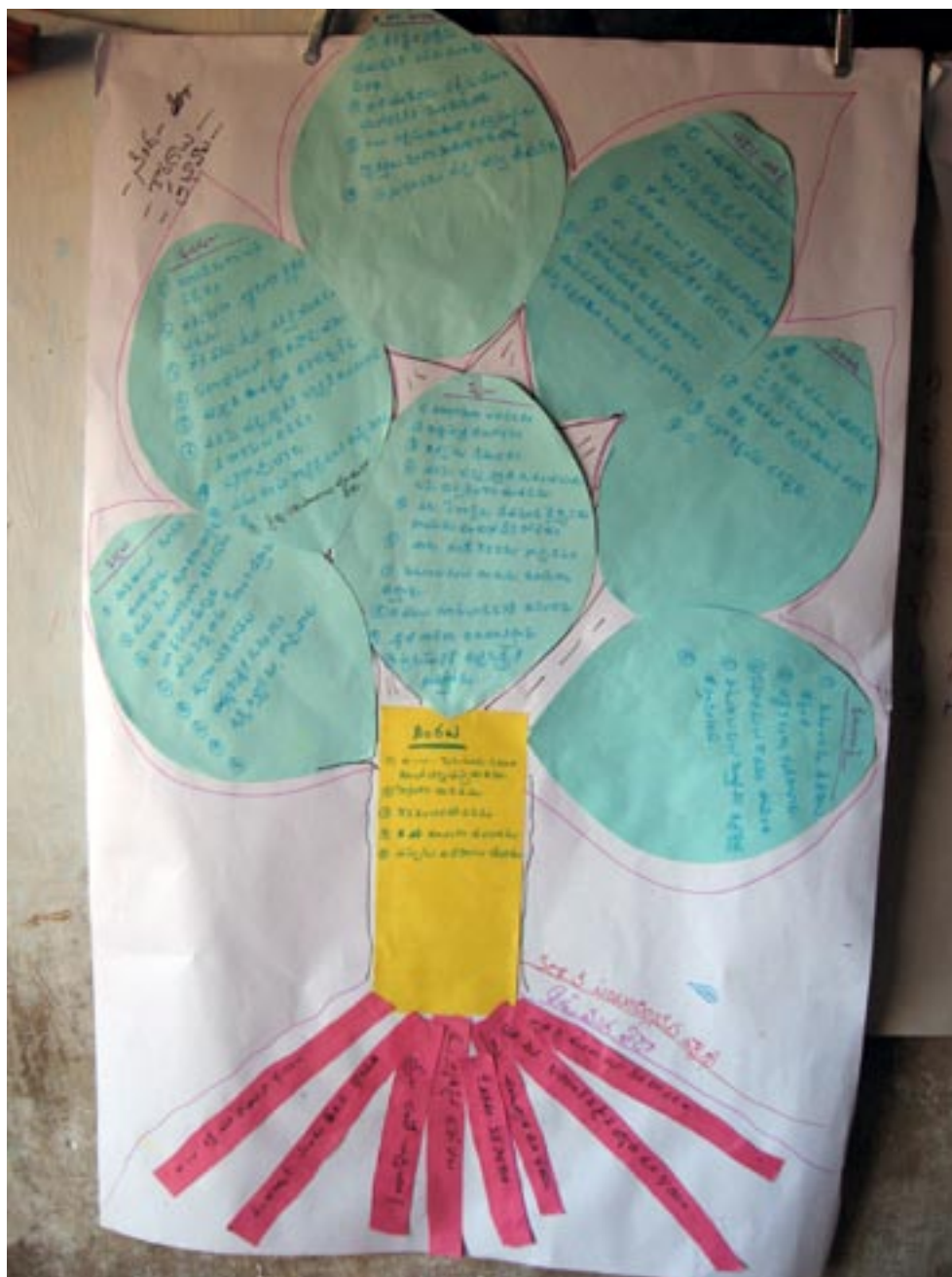
Objective: By the end of the session, participants will be able to explain why women are particularly vulnerable to getting HIV.

In this exercise, participants write points on cards and tape them on the wall diagram to make a "problem tree," showing effects (branches) and causes (roots) of women's vulnerability to HIV.

Time: 1 hour

Materials and preparation: Draw a large tree diagram on flipchart paper, with the "Effects" and "Causes" labeled at appropriate levels (see below). Write one example of the type of response expected at each level on a card and tape the cards at their respective levels.

Problem tree drawn by participants in pilot workshop.



You will also need copies of Fact Sheet 1a – Why Women Are More Vulnerable to HIV – to discuss and hand out to participants.

■ Steps:

1. **CARD-STORMING:** Divide into pairs. Hand out cards and markers. Ask pairs to write individual points on the effects and causes of women’s vulnerability to HIV – one point per card – and then tape them at the appropriate level of the tree.

Sample Responses:

Effects

Women are blamed for infecting their husbands. Gender violence. Women kicked out of their homes. Women getting sick and seeking treatment. Women transmitting HIV to their babies.

Causes

Gender inequality. Lack of control over sexual decision-making. Fear of violence prevents women from negotiating safe sex and protecting themselves against HIV. Marriage is a risk factor – women cannot refuse to have sex with their husbands, even if they know husbands are having sex with other women. Acceptability of men having other sexual partners. Sexual violence – forced sex in marriage or rape in the community. Women’s lack of knowledge that they are at risk. Biological vulnerability – women get HIV and STIs during sex twice as easily as men. Poverty – women forced into survival sex work.

2. **DEBRIEFING:** Review one level at a time. Cluster common points and eliminate repetition. Ask participants to add to the diagram by digging deeper to explore additional roots or additional effects.

3. PROCESSING – Causes and Solutions:

- a) *Which root causes can we address? What can we do?*
- b) *How can we address the effects?*

4. **SUMMARY:** Give a summary of the main points in the fact sheet.

C8. Breaking the “Sex” Ice

Facilitator’s Note: Many of us have been socialized to avoid talking about sex, yet this talk is important if we are to change the impact of HIV.

Objective: By the end of the session, participants will be able to explain how comfortable they are in talking about sex and related issues with different people.

Time: 1 hour

■ Steps:

1. ASSESSMENT DIAGRAM: Ask each participant to make the diagram below, showing their level of comfort in talking about various topics to different categories of people.

Sample Responses: (Responses given by traditional birth attendants [TBAs] during the pilot workshop)

Relation	Violence	Stigma	Sex	HIV/AIDS
Spouse	50%	25%	50%	100%
Brother	50%	50%	0%	100%
Sister	100%	100%	50%	100%
Daughter	100%	100%	50%	100%
Son	50%	100%	0%	100%
Father	50%	50%	0%	100%
Mother	50%	50%	0%	100%
Friend	50%	50%	50%	100%
Neighbors	50%	50%	50%	100%

2. DEBRIEF: Review and discuss the results:

- a) *What did we learn?*
- b) *Which relationships are particularly difficult?*
- c) *What stops us from talking about these things?*

3. SUMMARY:

To educate our children and others about HIV and AIDS, we will need to be able to talk with them about sex, including safe sex and the use of condoms. We will need to become more comfortable with these topics. Some of us find it difficult to talk to our daughters or – especially – our sons on these issues, but we will need to learn how.

If we are to become more effective in our own relationships, we will need to be able to negotiate with our marriage partners. We will need to learn how to talk about sex and our sexual needs.

Chapter D: More Understanding and Less Fear

■ Introduction

“One day I went to visit a family with my sister. While we were there I asked for water. The father gave me a glass of water, but my sister stopped me from drinking it. This confused me and really upset the man. We said nothing about it, but when we left my sister told me that people suspected he had AIDS, and touching the glass might have given me AIDS.”

This story is an example of fear-based stigma. The man offered some water, but it was rejected out of fear of getting HIV. This rejection was a form of stigma.

This chapter will address **fear and lack of understanding** in relation to HIV and AIDS. The fear has two dimensions: a) fear of a disease that has no cure and results in what the media have painted as an agonizing, horrific death; and b) fear of getting infected through “**casual contact**” with people who have HIV. The second fear is the major focus of this chapter – the fear that people can get infected through sharing the same space, dishes, towels and toilets with a person living with HIV.

This chapter will also address the way people respond to this fear by restricting contact with people living with HIV. This practice is seen as a form of **prevention – a strategy to protect people from getting HIV**. Some families force HIV-positive family members to eat and sleep separately, or take their children away, thinking that this will minimize HIV transmission. People think they are doing the right thing, but this response has no medical justification and represents a **major form of stigma**. It makes people living with HIV feel like outcasts in their own homes.

The baseline study conducted for the Reducing Stigma and Violence Toolkit for Health (SVTH) project shows that health workers have some information about HIV and AIDS, but it is incomplete and often incorrect:

- Most health care workers know that unsafe sex and blood transfusions are possible sources of HIV, but have limited understanding of parent-to-child HIV transmission;
- Many do not know the difference between HIV and AIDS, the progression of HIV in the body or the symptoms of AIDS;
- Many do not know that opportunistic infections (such as TB) can be successfully treated for a person living with HIV;
- Many do not know that HIV cannot survive outside the body, resulting in misconceptions that HIV can be transmitted through sharing food, dishes, bedsheets and clothes, and through mosquito bites;
- Most know the symptoms but not the names of different sexually transmitted infections (STIs), nor how STIs make people susceptible to getting HIV; and
- Many are afraid of getting HIV when providing certain services to their patients, such as taking blood samples, suturing or administering an IV drip.

Seventy percent said they did not treat people living with HIV because of fear of infection. They **know a little but not enough** to deal in a rational way with their fears about AIDS.

This chapter will help teach the basics on HIV transmission so that health workers have the information and understanding needed to overcome fears about getting HIV through casual contact. At the same time it will help them see that keeping people living with HIV at a distance and restricting social contact is stigmatizing.

This chapter also will challenge the view that a positive HIV test result means instant death. Being told that you will die quickly demoralizes those who have HIV, which ultimately produces the expected result – they give up on themselves and die, not because of the virus but because they lose hope. This chapter will provide information on HIV progression in the body, options for treatment, and strategies people living with HIV can use to lead long and productive lives.

Earlier approaches to teaching about HIV and AIDS were fear-based and used one-way communication. This increased people's fear, but failed to give them knowledge to deal effectively with HIV and AIDS in their daily lives. Instead, this chapter will show you how to create a safe space for people to discuss their fears, concerns and questions about HIV and AIDS. It will provide correct information using discussion-based methods that allow participants to internalize the new information, discuss it with their peers, connect it to their own ideas and experience and apply it to their own lives.

■ Educational process in this chapter:

1. Create safe opportunities for participants to **raise all the fears and questions they have about HIV and AIDS**, addressing in particular: a) HIV transmission through non-sexual casual contact; and b) What happens to a person after becoming HIV-positive. Get participants to identify situations where they are afraid of getting HIV and why they think this is a high-risk situation.
2. **Assess participants' knowledge level about HIV and AIDS:** Find out what they know, what they don't know, their beliefs and their misconceptions.
3. **Provide information to negate people's specific fears and misconceptions about getting HIV through casual contact.** Challenge misconceptions. Help participants fully understand how HIV is transmitted and how to make informed decisions when faced with different risk situations.

4. **Provide information on progression of the illness and treatment for people living with HIV** to counter views that people living with HIV will die immediately.
5. **Use a practical and participatory learning process**, which will allow people to internalize the information by discussing it with their peers, connecting it to their own ideas and experience and applying it to their own practice as health care providers.
6. **Analyze and challenge myths**, e.g. "A man can cure HIV if he sleeps with a virgin."
7. **Emphasize common sense around hygiene**. Example: we would not share razors or toothbrushes with other people; and we would not drink from a cup or eat from a plate that has blood on it. This is simple common sense.
8. **Emphasize that sex is the main route for HIV**: Explain that even though we are discussing non-sexual (casual) contact, people's biggest risk of getting HIV is by having unprotected sex. **HIV IS TRANSMITTED MAINLY THROUGH SEX.**

This chapter should be used along with the FACT SHEETS provided in Annex 1. Photocopy the fact sheets and give them to participants.

■ Modules

D1. Assessing Knowledge and Fear Levels

- Option A – Brainstorming What We Know about HIV and AIDS
- Option B – Listing Things We Want To Know about HIV and AIDS
- Option C – Individual Quiz: What Do I Know about HIV and AIDS?
- Option D – Risk Continuum
- Option E – Listing Fears and Myths

D2. Basic HIV and AIDS Knowledge

D3. HIV Transmission and Prevention Game

D4. Fears about Non-Sexual Casual Contact

D5. Non-Sexual Casual Contact Game

D6. Knowledge About Living with HIV and AIDS

D7. Countering Myths and Misconceptions

Individual Quiz: What Do I Know about HIV and AIDS?

D1. Assessing Knowledge and Fear Levels

Facilitator's Note: This module assesses participants' knowledge of basic HIV and AIDS facts and uncovers gaps in their understanding. This will help to establish a baseline to build on, and identify specific points of misunderstanding or fear that underpin stigma.

There are five OPTIONAL METHODS for this assessment. Select the one that best fits your situation.

Objective: By the end of this session, participants will be able to identify what they do and do not know about HIV and AIDS.

Time: 1 hour

■ FIVE OPTIONAL METHODS TO ASSESS KNOWLEDGE

Choose one of these exercises only. Use the fact sheets as a resource for answering questions or areas of confusion.

■ A. Brainstorming What We Know About HIV and AIDS:

Put up sheets of flipchart paper on the walls and write these topics at the top of each sheet (one topic per sheet):

- a) Difference between HIV and AIDS
- b) How HIV is transmitted
- c) Parent-to-child transmission
- d) Symptoms of AIDS
- e) HIV prevention
- f) Opportunistic infections caused by HIV
- g) STIs
- h) HIV testing
- i) Antiretroviral (ARV) treatment
- j) What precautions do you use in your clinic/practice to prevent HIV transmission?

Divide into pairs and ask participants to walk around and write down, for each topic: a) what they know about the topic; and b) any questions, concerns or fears. Then, as a group, review each sheet and respond to questions, concerns or misinformation.

■ B. Listing Things We Want To Know About HIV and AIDS:

Divide into pairs. Hand out five blank cards to each pair. Ask pairs to write on each card something they want to know about HIV and AIDS and tape the cards on the wall. Eliminate repetition. Then discuss each of the questions, with participants contributing their ideas. Help to sort out fact from misinformation.

Examples of questions from a workshop with registered medical practitioners (RMPs) and traditional birth attendants (TBAs)

Where and when did HIV first occur? What is the difference between HIV and AIDS? What are the symptoms of HIV and AIDS? How does HIV spread? Can you get HIV through washing the clothes of people living with HIV? How long after sex does it take for AIDS symptoms to appear? What is the life cycle of HIV and AIDS? In what part of the body is HIV found? What body fluids have high a concentration of HIV? How would a mother know that she may have HIV? How can an HIV-positive mother avoid infecting her unborn baby? What precautions can people living with HIV and their families take? What precautions can health providers take when treating people with HIV? What is ARV treatment? Where can ARV drugs be found? What food and nutrition is needed by people living with HIV? What services are provided by Integrated Counseling and Testing Centers? What is the impact of HIV and AIDS on people who have it? What diseases are spread through sexual contact?

■ C. Individual Quiz – What Do I Know About HIV and AIDS?

Hand out the quiz attached at the end of this chapter. Then discuss the questions where most participants are confused about the responses.

■ D. Risk Continuum

Materials and preparation: Write up on cards the 16 “Ways In Which HIV May Be Transmitted” listed below – one card for each activity. Then, write on cards the three risk categories – “HIGH RISK,” “LOW RISK” and “NO RISK” – and tape them across the wall to create a risk continuum.

Activity:

Hand out the activity cards to participants and ask them to tape each card under the appropriate position on the risk continuum. Then discuss their choices.

Ways in Which HIV May Be Transmitted – Correct Responses

HIGH RISK	Many sexual partners. Sex without a condom. Blood transfusion. Using unsterilized needles/razor blades.
LOW RISK	Parent-to-child transmission. Breastfeeding. Using condoms.
NO RISK	Non-penetrative sex. Kissing. Shaking hands or touching. Bathing people living with HIV and AIDS. Cleaning up spilled blood. Sharing cups. Sharing sheets/towels/clothing. Using toilets. Mosquito bites.

■ E. Listing Fears and Myths (Card storm)

Put up two title cards on the wall – “FEARS” and “MYTHS.” Divide into pairs and hand out blank cards and markers. Ask participants to write down their fears about HIV and AIDS, or myths they have heard about HIV and AIDS, one on each card, and tape the cards to the wall. Discuss as a group, helping to answer questions and counter misinformation.

Sample Responses:

Fears about HIV and AIDS	Getting HIV from clients. Getting HIV during deliveries. Dying slowly, painfully and alone. Being stigmatized. Losing friends. Abandoned by family and friends. Getting HIV through attending a funeral of a person who died of AIDS-related complications.
Myths about HIV and AIDS	AIDS only affects sex workers and truck drivers. Men can cure AIDS by sleeping with a virgin. Herbal medicine can cure HIV. Men can prevent HIV by washing their private parts with lime after intercourse. The partner who falls sick first is the person who got infected with HIV first – who “brought HIV into the family.” If one partner is HIV-positive, the other must also be HIV-positive. You can get HIV from a mosquito bite. If you urinate in the same place that a person living with HIV has urinated, you will get HIV. Using condoms makes women barren.

D2. Basic HIV and AIDS Knowledge

Facilitator's Note: This module builds on the assessment of existing knowledge (module D1), and will vary according to the target group. For example, many health center staff have already had training on HIV and AIDS, so they will need less briefing on this subject than RMPs and TBAs will. Build on the participants' specific knowledge and correct the misperceptions of your target audience.

We recommend three approaches for delivering basic information on HIV and AIDS:

1. Ask local doctors to give presentations on the basic facts. Inviting local doctors to provide this information has a number of advantages:
 - a) It helps ensure that the information is factually correct;
 - b) It responds to the demand from health workers (especially RMPs) to be briefed on technical matters by qualified doctors;
 - c) It helps to strengthen relations between doctors and other health workers – a form of collaboration that is crucial in an effective response to the epidemic; and
 - d) It provides an opportunity to brief the doctors on the strategy and activities for stigma reduction and involve them in this campaign.
2. Make use of other resource persons or educational materials available in your area, e.g. speakers from the Network of People Living with HIV, or flipcharts and pamphlets provided by the State AIDS Control Societies.
3. Photocopy and hand out the fact sheets in Annex 1.

Meet the doctors or other invited resource persons beforehand to brief them on the participatory approach used in the training, provide them with the assessment information and go over their presentations.

Objective: By the end of this session, participants will have a much stronger knowledge of the basic facts on HIV and AIDS.

Time: 2 hours

Steps: Specific content to be chosen by the trainers, based on gaps identified in the knowledge and fears assessments (module D1).

Example (technical content delivered to RMPs during pilot training program)

HIV basics: History of HIV. What is HIV? AIDS? Difference between HIV and AIDS?

HIV transmission facts: Bodily fluids and levels of concentration. How HIV is transmitted – and ways it cannot be transmitted. Parent-to-child transmission.

Other relevant facts: Symptoms of AIDS. How to prevent HIV infection. Different types of testing. Links between STIs and HIV. Opportunistic infections. Universal precautions.

D3. HIV Transmission and Prevention Game

Facilitator's Note: This game demonstrates how people might be exposed to HIV in a community and how they can use different approaches to prevention.

The initial explanation is very important so that everyone understands that this is a game – it does not imply that anyone has HIV.

In one SVTH pilot workshop where this game was played, 90 percent of the people were exposed to HIV in round one, but only 30 percent in round two. This means that if many people protect themselves (as in the game), we could reduce HIV transmission significantly.

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

- a) Explain how HIV is and is NOT transmitted; and
- b) Assess the value of strategies for preventing HIV transmission.

Time: 2 hours

Materials and preparation: Prepare a slip of paper for each participant. Most should be blank, and a few should have "X" written on them. Fold the papers to hide the "X" before handing them out. You will also need a supply of plastic bags.

■ Steps:

1. INTRODUCTION: Explain the following – *This is a game to show how HIV spreads. The roles that people play are decided by chance. The game does not imply that anyone in the group has or doesn't have HIV.*

2. ROUND ONE (game): Conduct the first part of the game, issuing the following instructions:

- a) *Take one piece of paper, but don't look at it until I tell you to.*
- b) *Walk around the room and when I clap, shake hands with **one person** and **remember their name**. [WALK – CLAP – FIRST SHAKE].*
- c) *Now walk again and when I clap, shake hands with a **new person** and remember their name. [WALK – CLAP – SECOND SHAKE].*
- d) *Now walk again and when I clap shake hands with a **new person** and remember their name. [WALK – CLAP – THIRD SHAKE].*
- e) *Look at what is written on your slip of paper.*
- f) *Those who have an "X" on your paper come forward. These people have HIV infection **in the game**.*
- g) *Those who shook hands with "X" on the first round, come and sit in the middle.*
- h) *Those who shook hands with "X" in the second round or with any of those sitting in the middle, come and sit in the middle.*
- i) *Those who shook hands with "X" in the third round or with any of those sitting in the middle, come and sit in the middle.*

3. DEBRIEFING – Ask:

- What is the handshake pretending to be? [*Sexual intercourse. Emphasize that you cannot get HIV through shaking hands.*]
- How many people have been exposed to HIV through “shaking hands?” [All those sitting in the middle.]
- Explain that HIV can spread silently through the community because at first it shows no symptoms and stays in the body for life.

4. ROUND TWO (game): Explain – We will now play the game again. This time you can **make a choice to protect yourself from getting HIV.**

Ask – How can you protect yourself from getting HIV?

- A) Abstinence – No shaking hands
- B) Having sex with one partner who does not have HIV and only has sex with you – only shaking hands with the same person (for all three rounds)
- C) Having sex only using condoms – shaking hands with plastic bag (condom)
- D) Having sex without intercourse – fingertip shaking

Ask participants to decide what approach they will use, but not to tell anyone yet. To make sure that all of these approaches are used, tell them to close their eyes and raise hands for A-B-C-D. If any of the approaches have not been chosen, ask a few participants to switch.

Allow participants who want them to come forward and take plastic bags.

Shake up the papers and hand them out again. Tell people not to look at their papers.

Repeat the instructions for the three rounds (Step 2 above), emphasizing that **participants should choose their own actions and not necessarily listen to the facilitator’s instructions.** (Example: if the instruction says, “shake hands with a new person,” participants who are using approach B ignore those instructions.)

Repeat as in Round One to find out how many people are infected this time.

- a) *Those who have an “X” on their paper, come forward and sit in the middle.*
- b) *Those who shook hands with an “X” on the first round should come and sit in the middle, unless either of them was wearing a plastic bag.*
- c) *Those who shook hands on the second round with a person now in the middle should join the people in the middle, unless either of them was wearing a plastic bag.*
- d) *Those who shook hands on the third round with a person now in the middle should join the people in the middle, unless either of them was wearing a plastic bag.*

5. DEBRIEFING: Ask–

- *How many people have been exposed to HIV in this round?*
- *Those sitting on the outside – what were you doing during the game?*
- *What were the people who refused to shake hands doing? (Not having sex) Are they infected? (Not unless they had an “X.”) Who used this approach? (Show of hands) How did other people feel when these people refused to shake hands?*
- *Did people using the plastic bag get infected? (Not unless they already had HIV. Explain that anyone who had an “X” was already infected, whatever their behavior, but they could prevent infecting others if they abstained or wore a condom). Who used this approach? (Show of hands) How did you feel when you “shook hands” using the bag? Did anyone say anything or laugh or go to another person? How do people feel about it now?*
- *What happened to those who shook hands with the same person all the time?*

Sample Responses:

- If they shook hands with a person with a condom, they will not be infected.
- If neither of them had HIV and they only shook hands with each other, they will not be infected.
- If the person they shook hands with had HIV or they had HIV, both will be in the middle.

Ask – Which people did not get exposed to HIV during the game?

Sample Responses:

- Anyone wearing a bag over their hand (condoms)
- Anyone who refused to shake hands (abstinence)
- Anyone who shook hands with the same person throughout if that person did not have HIV (being faithful)

6. SUMMARY:

- To be safe when you are having sex only with each other, you should know that you are both free of HIV, or use condoms until you have a test.
- If your partner has HIV, having sex only with that person will not protect you unless you use condoms.
- People with the “X” who used a plastic bag all the time or refused to shake hands will not have infected anyone or been re-infected.
- People living with HIV can protect themselves from re-infection and protect their partners from getting HIV by enjoying sexual activities without intercourse or intercourse with condoms.

D4. Fears about Non-Sexual Casual Contact

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

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

- a) Name their fears in relation to specific forms of contact with people living with HIV; and
- b) Explain why HIV cannot be transmitted through non-sexual casual contact.

Time: 1–2 hours

■ Steps:

1. FEARS ABOUT NON-SEXUAL CASUAL CONTACT (Card storm): Divide into pairs and ask – *What fears do you have about non-sexual casual contact with people living with HIV at work or in other situations?* Ask pairs to write single points on cards and tape on the wall.

Sample Responses:

- Accidents – getting HIV through an accidental needle prick.
- Contact with the blood of a HIV-positive woman while delivering her baby.
- Contact with the blood of an HIV-positive patient while suturing.
- Infecting other people through food cooked by a person living with HIV.
- Helping to lift an injured person living with HIV who has open sores on his body.
- Using a public toilet that has been used by a person living with HIV.
- Sharing dishes, utensils, etc. with a person living with HIV.

Then ask participants to **prioritize** – *Which of these fears should we focus on? Which are your biggest fears?*

2. ANALYZING THE FEAR: Take one fear at a time and ask the pair that raised the fear to explain the reasons behind it.

Sample Responses:

- **Public toilet:** A man living with HIV sits on a toilet, his sweat gets onto the seat, and the next person who sits on the seat comes into contact with the sweat – and through this acquires HIV.
- **Contact through food:** A woman living with HIV cooks food for her family. While cooking, she cuts her finger. The blood gets into the food and through the food into the mouths of her family, who then get HIV.
- **Carrying injured person:** While carrying the person, the carrier comes into contact with the person's blood from an open cut and gets HIV.

Then respond to each of these statements, using information drawn from Fact Sheet 2 on Quality, Quantity and Route of Transmission. Hand out and discuss the fact sheet.

Examples of Responses by the Trainer

- **Public toilet:** There is no HIV in sweat, so one cannot get HIV by coming into contact with sweat. There are only small quantities of HIV in urine or feces, and HIV does not survive once it is outside the body.
- **Contact through food.** HIV cannot survive outside the body, so even if the blood gets into the food, the HIV would die as soon as it is exposed to air. In addition the heat of the cooking would kill the HIV.
- **Carrying injured person:** While carrying the injured person the carrier might come into contact with the person's blood and get HIV. There is a slight chance of this, but it is unlikely for the same reasons given above: HIV does not survive very long outside the body.
- **Needle prick or contact with blood during delivery or suturing:** All of these are possible ways that HIV might be transmitted. A needle prick would allow HIV to go directly into one's body – one of the conditions for getting HIV. The other forms of contact could lead to infection only if the health worker has an open cut. In this case HIV could attach itself to the mucous membrane.

3. SUMMARY

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

- There must be enough **QUANTITY** of the virus in body fluids. HIV is found in large quantities in blood, semen, vaginal fluids, and breast milk – so in these fluids there is a risk of transmission. HIV is found in small quantities in saliva, vomit, feces and urine; and not at all in sweat or tears – so in these cases there is no risk.
- There must be enough **QUALITY** – the virus must be **STRONG ENOUGH**. HIV does not live on the surface of the skin, it lives inside the body. HIV cannot survive outside the human body. It starts to die as soon as it is exposed to air.
- HIV must have a **ROUTE OF ENTRY** through the skin into the bloodstream of the uninfected person:
 - Through a vein (e.g. a needle injection, which puts infected blood directly into the blood of the uninfected person);
 - Through the lining of the anus or vagina, or through sores on the penis; or
 - Through open cuts in the skin.

Our body is a closed system. Healthy skin is an excellent barrier against HIV. HIV cannot pass through unbroken skin. Even if skin is broken, HIV cannot pass through it very easily.

D5. Non-Sexual Casual Contact Game

Facilitator’s Note: This is an adaptation of the Risk Continuum Exercise used in many AIDS education workshops and in module D1, option D. The aim here is to get at participants’ actual beliefs, as opposed to what is accepted as “correct knowledge.” Naming the forms of casual contact that really scare participants serves as a starting point for helping to address these deep-seated fears.

Objectives: By the end of this session, participants will be able to name their own fears in relation to non-sexual casual contact with people living with HIV.

Time: 1 hour

Materials and preparation: Write up on cards the forms of non-sexual contact listed below – one card for each activity. Then, write on cards the three risk categories – “HIGH FEAR/DISTRUST,” “LOW/NO FEAR/DISTRUST” and “REAL RISK” – and tape them across the wall to create a continuum.

■ Steps:

1. FEAR AND DISTRUST (Continuum Exercise): Hand out cards and ask each person to place the card under the category that represents their own position.

Sample Responses: (these sample responses do *not* correctly identify genuine risks; the point of the exercise is to uncover participants’ fears)

High Fear/Distrust	Medium or Low Fear/Distrust	REAL RISK
Accidents	Shaking hands	
Cuts	Hugging	
Sharing utensils	Toilet seats	
Washing person living with HIV		
Sharing food/eating together		
Sharing cup		
Person living with HIV prepares food		
Carrying dead bodies to cemetery		
Deep kissing		

2. TASK GROUPS: Divide into groups and assign each group one or more of the forms of casual contact listed under HIGH FEAR/DISTRUST. For each activity, ask the groups to:

- Discuss – *Why do people think that this activity may lead to HIV infection?* Ask them to explain how people think HIV is transmitted in this situation.
- Prepare a presentation to challenge this misperception, based on the Fact Sheet on Quality, Quantity and Route of Transmission.

3. REPORT BACK: Ask each group to give their presentation. Ask the other participants to play “devil’s advocates” by pretending they don’t trust the information presented and challenging the presentation.

D6. Knowledge About Living with HIV and AIDS

Facilitator's Note: This module is designed to challenge the view that a positive HIV test result means instant death. If people living with HIV are told they will die quickly, it demoralizes them and produces the expected result – they give up on themselves and die, not because of the virus alone, but because they lose hope.

This module provides information on HIV progression in the body, options for treatment, and how people living with HIV can lead long and productive lives.

We suggest inviting an experienced resource person (a speaker from the Network of People Living With HIV) to deliver this information, and supplementing his or her presentation with the Fact Sheets on Opportunistic Infections (#6), Antiretroviral Treatment (#8) and Care and Support for People Living with HIV (#11).

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

- a) What happens to a person who is living with HIV (progression of illness, longevity, etc);
- b) Antiretroviral treatment; and
- c) Basic information on positive living.

Time: 1 hour

■ Steps:

1. **YES OR NO (Quiz):** Ask participants to complete the quiz below.

If a person is HIV-positive–

- Does the person have AIDS?
- Is the person's life over?
- Will the person be dead in two years?
- Will the person be infectious to other people?
- Is there any medicine she or he can take?
- Will other people be able to tell if the person has HIV?
- Should the person give up his/her job?
- Should she or he stop doing physical work, such as farming?
- Is the person's sex life over?
- Can the person have children?
- Can the person take part in family decision making?

2. REPORT BACK: Review each of the questions and agree on the correct information.

3. OPTIONAL ACTIVITY (Card storm): Divide into pairs and hand out cards. Ask pairs to write on cards all the things they have heard about what happens to people once they have tested positive, and to tape the cards to the wall. Cluster common points and review the list. Explore the thinking behind any misconceptions and the effect they may have about people living with HIV. Clarify questions and uncertainties.

4. TESTIMONY: Invite a person living with HIV to talk to the group about his or her own experience and answer questions.

5. SUMMARY: Many people think that an HIV-positive test result is an immediate death sentence. They think that a person who tests positive will get sick quickly and die. Believing this, they give up on people living with HIV and treat them as a drain on the family. This stigmatization – being told you are no longer part of the living – hurts and demoralizes the person living with HIV. If not stopped, it produces the expected result: the person living with HIV gives up and dies, in large part due to loss of hope.

Getting HIV does not mean instant death.

- HIV and AIDS are not the same. A person can have HIV and live for 10 or more years before the immune system is affected and AIDS develops.
- If the person living with HIV lives positively and takes care, she or he can lead a long life.
- Most opportunistic infections, including TB, can be treated and cured.
- Treating opportunistic infections quickly will help to prolong lives.
- People living with HIV can continue to work and lead productive lives.
- Antiretroviral treatment slows down progression of the illness and increases immunity.

D7. Countering Myths and Misconceptions

Objective: By the end of this session, participants will be able to assess a number of beliefs that affect people's attitudes toward HIV and AIDS.

Time: 1 hour

■ Steps:

1. WARMUP – WHISPERING GAME: Ask 10 participants to form a line and ask the other participants to observe. Whisper a message to the person at one end of the line. Have this person whisper the message to the next person, and so on down the line. The person who receives the message at the end of the line writes it on the flipchart. Then display the original message. Alternatively, ask each "whisper" to be spoken aloud so those watching and those who have already passed the message can hear how it gets distorted – but ask players further down the line to cover their ears so they don't hear the message until it is their turn.

Discuss–

- a) *What happened as the message got passed along?*
- b) *Why did the message change?*
- c) *How could participants ensure that it is passed along the line unchanged?*
- d) *What does this game tell us about communication?*

Summarize – *The game shows how information is distorted as it is passed from one person to another. The same is true about beliefs on HIV and AIDS. These ideas are also distorted as they are communicated from one person to the next.*

2. INTRODUCTION (Brainstorm): Divide into pairs and ask pairs to brainstorm beliefs around HIV and AIDS (or use the list of myths generated in Module D1, Option E).

Sample Responses:

AIDS only affects sex workers and truck drivers. Men can cure AIDS by sleeping with a virgin. Herbal medicine can cure HIV. Men can prevent HIV by washing their private parts with lime after intercourse. The partner who falls sick first is the person who got infected with HIV first – who "brought HIV into the family." If one partner is HIV-positive, the other must also be HIV-positive. You can get HIV from a mosquito bite. If you urinate in the same place that a person living with HIV has urinated, you will get HIV. Using condoms makes women barren.

Task Groups: Divide into task groups. Ask each group to select one of the beliefs and try to explain it.

- a) *Where does this belief come from?*
- b) *What are some of the reasons or thinking behind the belief?*
- c) *How does this belief lead to HIV stigma?*

Sample Responses:

“Sex with a virgin cures HIV.” Men use this belief to justify having sex with young women and avoid safe sex practices. It puts young girls under tremendous pressure – and increases their risk of getting HIV from older men.

“Whoever gets sick first gets the blame.” This belief is often used by men to shift the blame of who infected whom to their wives. In reality, there is no way to know who was infected first because the period of time that elapses between contracting HIV and showing AIDS symptoms varies from person to person.

3. PROCESSING: Ask – *How can we change or challenge these beliefs?*

Individual Quiz: What Do I Know about HIV and AIDS? 50 True or False Questions

What is HIV and AIDS?

1. HIV is the same thing as AIDS. There is no difference.
2. AIDS is a punishment from God for promiscuous people.
3. HIV is a virus that destroys the immune system.
4. HIV needs to penetrate the skin or mucous membranes to cause HIV infection.
5. HIV is most commonly spread through vaginal fluids, blood, breast milk and semen.
6. HIV can be spread through sweat, urine, tears and saliva.
7. HIV can live for a long time outside the body.
8. AIDS is the condition of the body when its immune system has become weak.

What is the cause of HIV? Who spreads HIV?

9. Sex workers are largely responsible for spreading HIV.
10. Eighty-five percent of people who are infected with HIV in India got it through sex.
11. HIV can be transmitted when two people share needles during drug use.
12. All babies born to HIV-positive mothers are infected with HIV.

Who is at risk of getting HIV and AIDS?

13. HIV is a problem only in the towns, not the rural villages.
14. HIV only affects young people. Adults over 30 cannot get HIV.
15. Married people cannot become infected with HIV.
16. You can get an STI or HIV the first time you have sex.
17. More than ninety percent of women in India who have HIV were infected by their husbands.
18. Anal sex has a higher risk of HIV transmission than vaginal sex.
19. If you stick to only one partner, you cannot get HIV.
20. People with STIs have a higher risk of getting HIV than people who have no STIs.
21. If you are fit and healthy, you will not become infected by HIV.
22. Women are safe from HIV so long as they use the birth control pill.
23. Women are at greater risk than men of getting HIV through heterosexual sex.
24. The risk of clinic staff getting HIV from needle pricks is very low – only 0.3 percent.

One CAN get HIV from:

25. Sharing food, drinks or cutlery with an HIV-positive person.
26. Using the same toilet as an HIV-positive person.
27. Bites from mosquitoes.

One CANNOT get HIV from:

28. Breast milk from an HIV-positive mother.
29. Donating blood if sterilized instruments are used.
30. Sharing toothbrush with an HIV-positive person.

Appearance of HIV:

31. You can tell that a person has HIV by just looking at him or her.
32. A person can have HIV for two to 10 years before becoming sick with AIDS.
33. Some people have HIV but do not know they have it.

Signs and symptoms of AIDS

34. Swollen glands, weight loss, diarrhea and skin problems.
35. Burning pain when urinating and sores on the genitals.
36. Getting opportunistic infections such as TB, pneumonia, diarrhea and skin cancer.

HIV and AIDS can be cured by:

37. Having sex with a virgin.
38. Some RMPs and doctors.
39. There is no cure for AIDS.

You can prevent yourself getting HIV by:

40. Not having sex (abstinence).
41. Choosing healthy-looking partners.
42. Using condoms during sex.

Sexually transmitted infections (STIs):

43. You always know if you have an STI.
44. If STI symptoms go away, you are okay.
45. One out of 10 people with an STI has HIV.
46. A woman living with HIV can infect her partner more easily during her period.

People with HIV can live normal lives for as long as possible if they:

47. Practice safe sex to minimize the amount of HIV in the body.
48. Stop working immediately.
49. Get treatment for opportunistic infections as early as possible.
50. Eat well, avoid alcohol and tobacco and avoid stress.

WHAT IS HIV AND AIDS?

1. HIV is the same thing as AIDS. There is no difference.

FALSE. HIV and AIDS are different. HIV is the virus that causes AIDS. HIV attacks and destroys the body's immune system over a period of time. Once the body is weak, the person begins to suffer from illnesses such as diarrhea or TB. When these illnesses begin to appear, we say the person has AIDS. AIDS is the result of the worsening of HIV infection.

2. AIDS is a punishment from God for promiscuous people.

FALSE. AIDS is a disease, not a punishment. If we blame or stigmatize people for getting HIV, we are destroying their self-esteem and making their condition worse.

3. HIV is a virus that destroys the immune system.

TRUE. One type of white blood cell is the CD4 cell. These cells are a crucial part of the body's immune system – the system that protects us against sickness. The CD4 cells are like a fence around the body, protecting the body from diseases. They attack germs that get into the body so that we do not get sick. When HIV enters a person's bloodstream, it attacks, enters and destroys the white blood cells so that the white blood cells cannot do their work of keeping the body healthy. Germs then take advantage of the weakened immune system and attack the body.

4. HIV needs to penetrate the skin or mucous membranes to cause HIV infection.

TRUE. HIV found in the blood, semen or vaginal fluid of an HIV-positive person has to get inside the body and into the bloodstream of the other person to be transmitted. The skin is normally a barrier to this type of penetration, but breaks in the skin such as cuts, sores and ulcers, can allow the HIV virus to pass through and get into the bloodstream. HIV can pass through the skin on the genitals – penis, vagina, or anus – during sex, because the skin here is much thinner and has small openings where HIV can pass through. Infections in the genital area (e.g. sexually transmitted infections, or STIs) provide an easy way for HIV to enter the bloodstream. This is why people with STIs are at higher risk of getting HIV than other people.

5. HIV is most commonly spread through vaginal fluids, blood, breast milk and semen.

TRUE. HIV is found in *large quantities* in vaginal fluids, blood, breast milk and semen, and therefore most likely to be spread through these fluids.

6. HIV can be spread through sweat, urine, tears and saliva.

Answer: False. HIV is found in *tiny amounts* in saliva, tears, vomit, feces and urine, but **not** enough for there to be any risk of transmission, unless blood is present. HIV is *not found at all* in sweat.

7. HIV can live for a long time outside the body.

FALSE. HIV is a very fragile virus that cannot live outside the body for a long time. It starts to die the minute it is exposed to air. It does not live on the surface of skin – it lives inside the body.

8. AIDS is the condition of the body when its immune system has become weak.

TRUE. AIDS is the advanced stage of HIV when HIV has weakened the body's immune system. With advanced HIV disease, opportunistic infections cause disease because the HIV-positive person's immune system has been weakened.

WHAT IS THE CAUSE OF HIV? WHO SPREADS HIV?

9. Sex workers are largely responsible for spreading HIV.

FALSE. India has an estimated 53 million people living with HIV and AIDS, including 200,000 sex workers and 175,000 truckers. This means there are 52,625,000 people with HIV or AIDS who are not sex workers or truckers. This shows that HIV is now affecting the general population, not just populations at high risk. So we cannot continue to blame sex workers or truckers as if they are the only people with HIV – they are only a small fraction of those with HIV.

10. Eighty-five percent of people who are infected with HIV in India got it through sex.

TRUE. Sex is the main form of HIV transmission in India.

11. HIV can be transmitted when two people share needles during drug use.

TRUE. Sharing needles during injection drug use carries a high risk of HIV transmission. Infected blood is easily passed from one person to another via an infected needle or other equipment used to inject drugs.

12. All babies born to HIV-positive mothers are infected with HIV.

FALSE. The majority of babies born to HIV-positive mothers will **not** be infected. If preventive measures are not taken, roughly one-third of HIV-positive mothers will pass the virus to their babies. The more HIV is present in the mother's blood, breast milk and other fluids, the higher the chance of HIV transmission to the baby. The amount of HIV depends on the stage of the illness. Soon after a person is infected with HIV, there is a lot of virus present in blood and bodily fluids because there are no antibodies to fight it. As the immune system develops antibodies, levels of the virus will drop for a while. Later, if the person gets sick with illnesses caused by HIV, the amount of virus goes up again. When the person becomes very ill (having AIDS) the amount of virus is very high, and HIV can easily be passed on. This means that if a woman becomes infected at the time when she is pregnant or breastfeeding, then the chances of that baby getting infected are higher. It also means that if a woman gets pregnant or breastfeeds when she is showing signs of AIDS, then the chances of that baby getting infected are high.

WHO IS AT RISK OF GETTING HIV AND AIDS?

13. HIV is a problem only in the towns, not the rural villages.

FALSE. HIV is present in both towns and villages in India.

14. HIV only affects young people. Adults over 30 cannot get HIV.

FALSE. HIV is found in adults of all ages. While young people are more likely to get HIV because of more high-risk behavior, HIV affects all age groups. Fifty percent of all HIV infections happen among people between the ages of 15 and 25.

15. Married people cannot become infected with HIV.

FALSE. Being married does not prevent HIV. A woman may be faithful, but her husband may be having sex with other women. For many women, marriage is a **risk factor** for getting HIV, because they cannot refuse to have sex or ask their husbands to use condoms, even if they know their husbands have been unfaithful or already have HIV or STIs.

16. You can get an STI or HIV the first time you have sex.

TRUE. While it is estimated that only one percent or fewer of sexual exposures lead to transmission, it only takes one sexual encounter to get HIV. You have the same chance of getting HIV any time you have unprotected sex.

17. More than ninety percent of women in India who have HIV were infected by their husbands.

TRUE. The vast majority of women in India who have HIV were infected by their husbands. Most of them were infected by their husbands without knowing they were at risk.

18. Anal sex has a higher chance of HIV transmission than vaginal sex.

TRUE. Both anal and vaginal sex are unsafe. Both the vagina and the rectum are lined with a mucous membrane, which tears easily during sexual intercourse and allows HIV to pass directly into the bloodstream. Anal sex has a higher risk of HIV transmission because the anus is not as elastic as the vagina and sexual activity can cause tearing and bleeding in the anus.

19. If you stick to only one partner, you cannot get HIV.

FALSE. Your partner may not be faithful to you – or she or he may have had sexual partners before meeting you who were HIV-positive.

20. People with STIs have a higher risk of getting HIV than people who have no STIs.

TRUE. Having an STI increases the risk of getting HIV. STIs produce sores in the genitals that make it easier for HIV to pass into the bloodstream during sex. The prevention and early treatment of STIs will reduce the spread of HIV.

21. If you are fit and healthy, you will not become infected by HIV.

FALSE. It does not matter how healthy you are, anyone can get HIV.

22. Women are safe from HIV so long as they use the birth control pill.

FALSE. Birth control pills prevent pregnancy, but they do not prevent HIV.

23. Women are at greater risk than men of getting HIV through heterosexual sex.

TRUE. Women get HIV and other STIs during sex twice as easily as men. There is a higher concentration of HIV in semen than in vaginal fluids. Also, the woman's vagina has large areas of exposed and sensitive skin that can develop small tears during sex. This allows HIV and other STIs to enter the woman's bloodstream. Semen stays longer in the vagina after sex, increasing the risk of transmission. In contrast, the penis has a small surface area in contact with vaginal fluids for a shorter time, and men can more easily wash off vaginal fluids after sex. This is why women face much greater risk of getting HIV through sex. Young women are particularly vulnerable to HIV infection through penetrative sex, because their sexual organs are still not fully developed and are more vulnerable to tearing.

24. The risk of clinic staff getting HIV from needle pricks is very low – only 0.3 percent.

TRUE. The risk of HIV infection from occupational exposure is very low – about 0.3 percent for a needle stick injury and 0.1 percent from splashing of blood on nose, mouth or eyes.

ONE CAN GET HIV FROM:

25. Sharing food, drinks or cutlery with an HIV-positive person.

FALSE. HIV is found only in blood, semen and vaginal fluids, and has to get inside the body and bloodstream of another person to spread. HIV cannot survive outside the body. These are the two reasons why HIV does not spread through sharing food, drinks or cutlery (or shaking hands, sharing rooms or clothing, or using the same toilet).

26. Using the same toilet as an HIV-positive person.

FALSE.

27. Bites from mosquitoes.

FALSE. The blood containing the virus goes into the mosquito's stomach where the virus is digested and killed. Mosquitoes only suck blood; they do not inject it into people. HIV is very rare among children ages 5–15, even though this age group is often bitten by mosquitoes.

ONE CANNOT GET HIV FROM:

28. Breast milk from an HIV-positive mother.

FALSE. Babies can get infected with HIV when the mother is breastfeeding. The chances are higher if the mother has a high level of virus in her blood while she is breastfeeding. If the mother has cracked nipples or painful swelling of breasts through mastitis, or if the baby has thrush or sores in the mouth, the risk of transmission becomes higher.

29. Donating blood if sterilized instruments are used.

TRUE. You cannot get HIV through donating blood using sterilized instruments.

30. Sharing toothbrush with an HIV-positive person.

TRUE. No one can get infected from sharing a toothbrush. But for reasons of hygiene it is better not to share toothbrushes.

APPEARANCE OF HIV

31. You can tell that a person has HIV by just looking at him or her.

FALSE. There are no symptoms to show that one has HIV. You can only know for sure from an HIV blood test. Most people who have HIV do not show any signs of illness for years. However, the virus remains in the body and can be passed on to other people. People with HIV look ill only when they have AIDS.

32. A person can have HIV for two to 10 years before becoming sick with AIDS.

TRUE.

33. Some people have HIV but do not know they have it.

TRUE. UNAIDS estimates that 90 percent of people with HIV are not aware of it. People can carry the virus for many years without knowing they have it, because there are no signs. They can look and feel entirely healthy before developing any symptoms of AIDS.

SIGNS AND SYMPTOMS OF AIDS

34. Swollen glands, weight loss, diarrhea and skin problems.

TRUE.

35. Burning pain when urinating and sores on the genitals.

FALSE. The above symptoms are the symptoms of some STIs, but not AIDS.

36. Getting opportunistic infections such as TB, pneumonia and skin cancer.

TRUE.

HIV AND AIDS CAN BE CURED BY:

37. Having sex with a virgin.

FALSE. Virgins do not have any power to heal HIV-infected individuals. This myth puts young girls at more risk of getting HIV.

38. Some RMPs and doctors.

FALSE. Some RMPs claim they can cure HIV or AIDS, but none of these claims are true.

39. There is no cure for AIDS.

TRUE. There is no cure or vaccine for HIV infection. There are drugs (ARVs) to slow down the production of the virus in an infected person, and there are other drugs to control opportunistic infections, but these do not cure AIDS. They can only postpone symptoms or death. After infection, HIV remains in the body for life.

YOU CAN PREVENT YOURSELF GETTING HIV BY:

40. Not having sex (abstinence).

TRUE.

41. Choosing healthy looking partners.

FALSE. There is no way to tell through looking whether a partner has HIV.

42. Using condoms during sex.

TRUE.

SEXUALLY TRANSMITTED INFECTIONS (STIS):

43. You always know if you have an STI.

FALSE. Some people who get STIs have no symptoms at first. It is harder for women to know that they have an STI than men. Roughly 60 percent of women have no noticeable discharge, and it is rare for a woman to develop an infected urethra that causes burning while urinating. Other symptoms may be hidden in the vaginal canal. As a result, many women do not find out they are infected with STIs until they develop pelvic inflammatory disease.

44. If STI signs go away, you are okay.

FALSE. The symptoms may go away, but the STI will remain. If it is not treated, it will continue to harm the body, and can leave both women and men infertile. Infection can be passed on to unborn babies, leading to miscarriage, stillbirth, handicaps or death. The infection also can be transmitted to other people.

45. One out of 10 people with an STI has HIV.

TRUE.

46. A woman living with HIV can infect her partner more easily during her period.

TRUE. Menstrual blood from HIV-infected women contains the HIV virus, putting partners at higher risk if they have penetrative sex during this time.

PEOPLE WITH HIV CAN LIVE NORMAL LIVES FOR A LONG TIME IF THEY:

47. Practice safe sex to minimize the amount of HIV in the body.

TRUE. This is important not only to stop the transfer of HIV to others, but also to minimize re-infection – getting infected by others who are HIV-positive. When the virus replicates in the body, it changes, so any HIV-positive person may have many variations of the virus. The body's immune system has to adapt to fight off each form of the virus, which puts further strain on the immune system. If two HIV-positive people have unprotected sex, they may reinfect each other with all the different forms of the virus that either may have. This will put more strain on their immune systems and increase their viral loads.

48. Stop working immediately.

FALSE. People living with HIV and AIDS should not be forced out of work. Many of them are still strong enough to hold down a job and earn some income. Working is also an important basis for morale. People with HIV can live for many years before coming down with AIDS symptoms, so they should be allowed to continue to work.

49. Get treatment for opportunistic infections as early as possible.

TRUE. Most of these infections can be prevented or treated with medication, and this can help to improve the quality of life and delay the onset of AIDS. People living with HIV and AIDS should be encouraged to be proactive in preventing and treating opportunistic infections. The earlier they get treatment, the better chance their body has of fighting off the disease.

50. Eat well, avoid alcohol and tobacco, and avoid stress.

TRUE. The body needs nutritious foods to build it up, give it energy and make it stronger so that it can fight some infections and sicknesses. Alcohol and cigarettes can damage the body's ability to fight off diseases, so stopping or reducing their consumption can help to keep the body strong.

Chapter E: Moving to Action

■ Introduction

When a community accepts an atmosphere of HIV stigma and gender violence, it results in fear, distrust, social disharmony and the spread of HIV:

- People living with HIV will not get tested, or will not disclose their status to their partners – so HIV will continue to be spread;
- People living with HIV will not access HIV and AIDS services – and so they will suffer physically and psychologically;
- Women will not communicate with their husbands about their fears, will not report cases of violence and will become more vulnerable to HIV infection; and
- Families and the community will not provide the support and care that people living with HIV and battered women need.

The main causes of stigma and gender violence are:

- **Ignorance and fear about HIV infection** – not knowing how HIV can spread;
- **Judgmental attitudes** – shaming and blaming others, e.g. saying that all people living with HIV are promiscuous and deserve to die; and
- **Gender inequality** – men want to dominate women and use force to maintain control.

Stigmatizers and violent men need to be shown how harmful their actions are – and how they **cause HIV to be spread**. We need to create a community in which people are willing to talk openly about HIV and AIDS and gender violence; people are not afraid to get tested for HIV; and women are not afraid to communicate to their husbands and report cases of violence. **This chapter will look at strategies for educating and challenging all of us to stop stigma and gender violence.**

Some of the earlier modules include ACTION IDEAS – suggestions for practical activities that participants can do at home. For example, after Module A2 participants are asked to take the stigma pictures home and show them to family members and neighbors. Talking with others helps to see what is involved in challenging stigma and gender violence and build up the courage to do it.

The modules in this chapter – MOVING TO ACTION – get participants thinking more deeply about concrete strategies for action. These modules assume that participants have already discussed stigma and violence and are committed to doing something to change things. This chapter helps to:

- **Bring together everything participants have learned** about stigma and violence;
- **Build up commitment to change things** – to stop stigma and gender violence;
- **Focus on what we can do to change** as individuals, groups and communities; and
- **Agree on goals and how to achieve them.**

■ Key Messages

- **We are all responsible for challenging HIV stigma and gender violence.** We can all play a role in educating others and advocating new attitudes and practice.
- **Be a role model.** Apply what you have learned in your own life. Think about the words you use when talking about people living with HIV and women and try to speak and act supportively.
- **Share what you have learned.** Tell others what you have learned to get them talking about stigma and violence and how to change it.
- **Encourage community leaders to speak out** about HIV and AIDS and to condemn stigma and gender violence.
- **Encourage people living with HIV to speak out** to help others understand how it feels to be the object of stigma. Help ensure that their voices are heard.
- **Challenge stigma and violence when you see them in your homes, workplaces and communities.** Speak out, name these problems, and let people know that stigma and violence hurt.
- **Talk openly about AIDS without fear** to help people see that this is not a shameful thing that has to be hidden. Talking openly about AIDS will also empower people living with HIV and help relieve some of their self-stigma.
- **Avoid using stigmatizing words.** Instead of saying “victims” or “sufferers,” use positive words such as “people living with HIV.” Talk about “us,” not “them.”
- **Facilitate discussion with family, friends and neighbors on stigma and violence:** What are the most common forms of stigma and violence in your community? What perpetuates these abuses? What can be done to change things?
- **Develop a protocol** to describe the changes you want to see in your own practices as health care providers.
- **Act against stigma and violence as a community.** Help your community to agree on one or two practical things they can do to do to bring about change.
- **Saying “stigma and gender violence are wrong” is not enough.** Help people move to action – agree on what needs to be done, develop a plan and then implement it.
- **Think big but start small. Act now!** Have a big vision – but start with something small. And don’t wait!

Things You Can Do Yourself

- Watch your own language and avoid stigmatizing words.
- Visit and support people living with HIV and their families.
- Encourage people living with HIV to use available services.

Things You Can Do To Involve Others

- Use informal conversations as opportunities to talk about stigma and violence.
- Use the stigma and violence pictures from this training to get people talking.
- Use real stories to put stigma and violence into a practical context.
- Challenge stigmatizing words when you hear them – get people to think about how their words can hurt.
- Help normalize HIV and AIDS. Get people to regard people living with HIV as “people with an illness,” not “people with bad behavior.”
- Encourage people to talk openly about their fears and concerns about HIV and AIDS, and correct myths and misconceptions.
- Form women’s groups and encourage women to support each other.

Things to Get the Community Talking About and Acting Against Stigma

- Organize testimonies by people living with HIV or their families about their experience.
- Conduct a language watch, in which school children or youth groups identify stigmatizing words used in the community through a “listening survey.”
- Make a community map of stigma and display it at a community meeting place.
- Do a community walk to identify points of stigma in the health center.
- Use a youth group drama based on real examples as a trigger for discussion.
- Have youth or children draw pictures and use them as a starting point for discussion.
- Hold community meetings to discuss what has been learned from the above methods and make decisions about what the community wants to do (e.g., agreeing on a code of conduct, specific support to HIV-affected families, etc.).
- Organize training workshops on stigma for community and peer group leaders.

■ Modules

- E1. “A Community Free of Stigma and Violence”
- E2. Action Planning I
- E3. Action Planning II
- E4. Mobilizing Community Action Against HIV Stigma and Gender Violence
- E5. Ten Steps for Moving to Action
- E6. How Have Our Attitudes Changed? (Monitoring)

Auxiliary Skills

- E7. How to Support Disclosure by People Living with HIV
- E8. Confidentiality
- E9. Positive Living

E1. "A Community Free of Stigma & Violence"

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

- a) Develop a vision of a community without stigma and violence; and
- b) Identify specific initial activities toward that vision.

Time: 2 hours

■ Steps:

1. A WORLD WHERE THERE IS NO STIGMA AND VIOLENCE (Picture-storm): Divide into pairs and hand out cards. Ask pairs to draw pictures and words describing "a world where there is no stigma and no violence." If there is time, have them draw a "BEFORE" and "AFTER" picture – the world as it is with stigma and violence; and then the world as it might be without stigma and violence.

2. PROCESSING: Ask–

- a) *What does the future world look like? What has changed before and after?*
- b) *What can we do to build this kind of world?*
- c) *What are the obstacles? What are the supporting factors?*
- d) *What are the first steps in bringing about change?*

Sample Responses:

Future vision

- People living with HIV being accepted and supported. People living with HIV playing an active role in educating others. People with HIV living longer lives.
- Women have equal rights to men. Women are not subjected to violence. Women feel safe in the community and in their own homes. Problems and conflicts are resolved through discussion, not violence.

What can we do to build this world?

- Educate men to live as equals with women and to stop gender violence.
- Educate the community to stop shaming and isolating people living with HIV.
- Get health workers and community leaders to model/promote the new behaviors.
- Increase understanding and reduce fears about HIV and AIDS.
- Get the community to work together in addressing HIV and AIDS.

First steps in bringing about change?

- Change the way health care workers address people living with HIV and battered women.
- Change our own attitudes and language.
- Provide information on how HIV is spread to reduce fears about infection.
- Speak out against stigma and violence toward women and people living with HIV.
- Encourage people living with HIV to use available services, e.g. integrated counseling and testing centers (ICTC), prevention of parent-to-child transmission (PPTCT), etc.
- Get women to report violence to police and get police to treat cases seriously.
- Empower women and people living with HIV with assertiveness skills.
- Provide legal services for women and people living with HIV.
- Encourage people living with HIV to get involved in educating the community on HIV and AIDS.
- Change practices in clinics, e.g., no separate room or seating for people living with HIV.
- Treat cases of battered women as cases of violence, not "accidents."

E2. Action Planning I

Facilitator’s Note: In this module, health providers apply what they have learned in the training to propose actions they can take in their work contexts. This exercise could work well in a joint workshop with different types of health care providers.

Objectives: By the end of the session, participants will begin developing practical strategies for overcoming HIV stigma and gender violence.

Time: 2 hours

■ Steps:

1. WHAT DID WE LEARN FROM THE TRAINING? (Small Groups): Divide into groups, by category of health worker (registered medical practitioners [RMPs], traditional birth attendants [TBAs], etc.) if it is a joint workshop. Ask each group to discuss and prepare to report back on what they have learned from the training and how they have applied it in their lives:

- a) New knowledge and awareness;
- b) New attitudes; and
- c) Behavioral changes, both personal and professional.

Sample Responses:

Knowledge:

- HIV is not a dreadful disease – it is manageable.
- How HIV is transmitted and not transmitted, and our misconceptions answered.
- People living with HIV face stigma everywhere – home, market, clinic and workplace.
- Women face more stigma than men – and also face gender violence.
- How violence makes women more vulnerable to getting HIV or sexually transmitted infections (STIs).
- People living with HIV have rights and responsibilities.

Attitudes:

- Should treat HIV patients with respect and affection.
- Should recognize that gender violence is wrong.
- Gender violence is not a family problem, it is a social problem that we should all try to deal with.

Behavior change – personal

- No longer isolate people living with HIV. We support and encourage them.
- Share our learning with family members, neighbors, women’s groups, etc.

Behavior change – professional

- Refer women suspected to have HIV to ICTC and PPTCT.
- Use new syringes for every patient, and gloves while dressing wounds of all patients.
- Tell HIV patients that HIV is a manageable disease and give them courage.

Counsel and treat women who have been beaten by their husbands.

- Encourage people living with HIV to join a support group.

2. REPORT BACK: Ask each group to give a report.

3. JOINT ACTION PLANNING: Ask each group to develop an action plan for working together to reduce HIV stigma and gender violence.

Sample responses:

- Joint village meetings and rallies to raise community awareness.
- Encourage all health workers to follow the code of conduct.
- If any health worker identifies a major problem involving stigma and discrimination, she or he will report to the whole group, and the group will provide support to solve the problem.
- Challenge any health worker who discriminates against an HIV patient.
- Form village committees to reduce stigma and gender violence.

4. REPORT BACK: Ask each group to give a report.

E3. Action Planning II

Facilitator's Note: This module starts by getting health workers to name and propose solutions to specific forms of stigma or gender violence within their workplace. It then asks participants to develop strategies for challenging HIV stigma and gender violence as individuals. Like module E2, this exercise could work well in a joint workshop with different types of health care providers.

Objectives: By the end of the session, participants will further develop practical strategies (which they started working on in module E2) for overcoming stigma and gender violence.

Time: 2 hours

■ Steps:

1. SOLUTIONS AS HEALTH PROVIDERS (Small Groups): Divide into groups, by category of health care provider if it is a joint workshop. Ask each group to discuss—

- a) *What forms of stigma or violence do you see in your own context/institution?*
- b) *Which of these forms of stigma or violence are the biggest problems in your context?*
- c) *What are some possible solutions to these problems? Identify two or three new things you would like to do to put an end to HIV stigma and gender violence.*

2. REPORT BACK: Ask each group to give a report.

Sample Responses:

PRIMARY HEALTH CENTER OR COMMUNITY HEALTH CENTER

Forms of stigma

- Force HIV patients to sit in a separate area or on a separate bench.
- Avoid touching patients and minimize contact when checking symptoms.
- Excessive use of gloves when examining HIV-positive patients.
- Delegate the task of delivering the babies of HIV-positive mothers to junior nurses.
- Avoid dressing the wounds of HIV patients. Give the dressing to the patients and tell them to do it themselves.
- Break confidentiality – gossip about people living with HIV to patients or community.
- Judgmental – blame people living with HIV for getting infected through promiscuous behavior.
- No proper counseling, comfort, encouragement or reassurance.
- Reject clients suspected to have HIV.
- Stigmatize staff who work in departments (e.g. ICTC) that focus on HIV.

Strategies to combat stigma and gender violence

- Stop separating HIV patients within the wards or putting them on separate benches.
- Avoid stigmatizing or coded language for people with HIV.
- Do not violate confidentiality.
- Learn skills to handle patients with sensitivity. Treat all patients with respect.
- Provide counseling and encouragement and tell people living with HIV how they can live a positive life through early treatment of opportunistic infections, healthy diet, etc.
- Tell them about antiretroviral (ARV) therapy and how to access ARV drugs.
- Deal with cases of battered women in a new way – provide counseling, support and advice on how to report cases of violence.

REGISTERED MEDICAL PRACTITIONERS

Forms of stigma

- Minimize contact when checking symptoms.
- Force patients who are living with HIV to sit in a separate area.
- Judgmental.
- No proper counseling of people living with HIV or battered women.
- Gossip about people living with HIV and women.
- Refuse to treat patients with HIV.
- Refer people living with HIV to private testing centers to get commission.
- Charge extra fees to treat people living with HIV.

Strategies to combat stigma and gender violence

- Provide counseling and support to people living with HIV and battered women. Be reassuring.
- Tell people living with HIV how they can get tested.
- Tell women how they can report cases of abuse.
- Advise people living with HIV on how to access other services.
- Encourage clients living with HIV to disclose to a trusted family member or friend.
- Provide basic information on ARVs.
- Help people living with HIV focus on positive living.
- Help the family focus on the health situation and avoid “shaming and blaming.”
- Help family accept they have a health problem and accept responsibility to care for the relative living with HIV.
- Provide basic information on HIV and AIDS and clear up misconceptions.

TRADITIONAL BIRTH ATTENDANTS

Forms of stigma

- Avoid doing deliveries for women suspected to have HIV.
- Do nothing to counsel women who have been beaten.

Strategies to combat stigma and gender violence

- Refer pregnant women to ICTC for counseling and testing.
- Be more supportive of people living with HIV.
- Counsel and support women who have been beaten and help them take up their cases.

3. INDIVIDUAL ACTION (Buzz Groups): Divide into pairs, mixing different types of health provider in each pair, and ask: *What can you do as an individual to get people thinking and talking about stigma and gender violence?*

4. REPORT BACK (Round Robin).

Sample Responses:

- Change our own attitudes and language toward people living with HIV and women – stop blaming and using words such as “promiscuous.”
- Be a good role model. Show in words and actions that we are no longer stigmatizing people living with HIV or condoning gender violence.
- Educate others on how stigma and gender violence feel and why they are wrong.
- Speak out against stigma and violence toward women.
- Get the community to name stigma and gender violence as problems.
- Encourage people to talk openly about their fears and concerns about HIV and AIDS.
- Provide up-to-date information about HIV and AIDS so that people no longer fear casual contact and isolate people living with HIV.
- Stop family members from isolating family members with HIV within the home.
- Stop men from abusing women (physical, emotional, sexual or economic).
- Treat positive people and women like you treat other people – no difference!
- Offer kindness, support, comfort and good listening to people living with HIV and battered women.
- Encourage people living with HIV to use available services, such as antiretroviral treatment, preventing parent-to-child transmission and medical care.
- Encourage women to report violence and get the police to treat cases seriously.
- Empower women and people living with HIV with assertiveness skills.
- Encourage people living with HIV to be involved in family and community gatherings.
- Treat cases of battered women as cases of violence, not “accidents.”
- Show the stigma and violence pictures and discuss them with neighbors.
- Use stories about people living with HIV or battered women for discussion.

5. CODE OF PRACTICE (Brainstorm): Ask the group to brainstorm a list of DOs and DON'Ts – a code of practice to stop stigma and gender violence.

Sample Responses:

DO	DON'T
<ul style="list-style-type: none"> ■ Speak out about stigma and violence when they occur. ■ Let people know that stigma and violence hurt. ■ Encourage people to talk openly about their fears and concerns about HIV. ■ Correct myths/misperceptions about AIDS. ■ Provide a caring ear to people living with HIV and to women. ■ Visit people living with HIV and abused women at home. ■ Encourage people living with HIV to use AIDS services. ■ Get women to report cases of violence. 	<ul style="list-style-type: none"> ■ Judge or condemn people living with HIV or women. ■ Use stigmatizing words. ■ Isolate or reject people living with HIV. ■ Assume people living with HIV can do nothing. ■ Tell people living with HIV they should <i>not</i> have sex, <i>not</i> have children, <i>not</i> do things. ■ Say husbands have a right to beat wives. ■ Tell women to solve problems at home. ■ Say women should keep gender violence secret.

E4. Mobilizing Community Action Against HIV Stigma and Gender Violence

Facilitator’s Note: This module grew out of some of the activities health workers carried out on their own following the pilot training. Participants realized that to have the greatest impact, they would need to change the overall environment – to get the whole community to address the problem of stigma.

This module discusses ways that health workers can plan and organize community mobilization campaigns on HIV stigma and gender violence.

Do not push the health workers to organize this kind of campaign before they are ready. Let the decision to organize community action emerge out of the discussion, so they own it.

Objective: By the end of the session, participants will have developed a strategy for involving the community in discussions on HIV stigma and gender violence.

Time: 1 hour

■ Steps:

1. WHY COMMUNITY MOBILIZATION? (Story): *This is the real story of one TBA who took action against stigma and discrimination in her own village.*

Two years before the training I knew of a family in my village who had a household member with HIV. The husband was very sick, with vomiting, diarrhea, and rashes all over his body, and he was getting treatment from RMPs and doctors. Villagers used to look down on him and curse him, saying he was a bad man for getting infected by sex workers. His family was also stigmatized. His son had to sit alone in the school classroom and was not allowed to eat with other students. No one visited the family, and neighbors used to complain about water from the bathroom passing in front of their houses, fearing they would get HIV. The wife worked alone in the fields – no one offered to help. The local teashop kept a special cup just for the wife.

During the training, I learned to overcome my fear about HIV. I learned that one could not get HIV through sharing food or talking with people living with HIV. I also learned that it was wrong to stigmatize people living with HIV. I decided to visit the husband. I found him all alone – no one visited him. He seemed very angry, so I counseled him and went with him to the government hospital, where he took an HIV test that confirmed he was HIV-positive. These results were a bitter disappointment. He had already spent lots of money on medication and this was the final blow. He could no longer bear the stigma, and four days later committed suicide.

Just before he died, I went to the school to stop the stigma toward his son. I talked to the teachers and the students about isolating the boy and making him feel bad. After this visit they treated him better – just like other children.

I also took the wife for testing and counseling at the ICTC. Her HIV test result was positive.

After the husband died, no one came forward to perform the death rituals, so I performed some of these rites. I told the relatives that this disease would not affect them through touch, and they then came to help with the rites. I also took the four children to be tested. Luckily their results were all negative.

I met with one RMP from the same village and we decided to raise the issue of stigma with the whole community. We first talked to the *sarpanch* and explained how the stigma had resulted in suicide. He agreed to help organize a community meeting. We decided to hold it on a Sunday, when everyone could attend. The RMP talked to the other RMPs at one of their association meetings and they all agreed to help. We prepared invitation cards and invited everyone to attend – teachers, children, women, youth members, *angawadi* workers and village elders. One other TBA and I mobilized the women and teenage girls, and the RMP mobilized the men.

We held separate meetings for the two language groups in our village – Telugu and Oriya. The meetings were held at the center of the village and more than 100 people attended each meeting, including the man's wife. I talked about how I had lost my fear of HIV. Several RMPs also talked about HIV and AIDS, how HIV is spreading, how HIV is not transmitted through casual contact and how stigma is fueling the epidemic. The RMPs also explained the code of conduct they had prepared to guide their own treatment of people living with HIV. We talked about how the family had been stigmatized, and how this had resulted in suicide. The villagers agreed that this kind of stigmatization should stop.

The community now has stopped isolating and condemning this family. Some neighbors visit the home, and children visit to watch TV and play with the children. Some neighbors help the wife with agricultural work and they have stopped keeping a separate glass in the tea shop.

2. DEBRIEFING: Ask–

- a) *What happened in the story?*
- b) *How did the TBAs and RMPs organize the community meeting?*
- c) *How can we, as health workers, change the attitudes of the community?*

Sample Responses:

What happened in the story?

- The TBA visited the man living with HIV and counseled him.
- She took him to the government hospital for HIV testing and treatment.
- She washed his body and prepared him for the cremation.
- She educated the man's family members to stop fearing HIV.
- She went to the school to get the teachers to stop stigmatizing the boy.
- She organized a meeting with the whole village to raise the issue of stigma and help people see why it is wrong to stigmatize people living with HIV.

How did the TBAs and RMPs organize the community meeting?

- The TBA and RMP first met with the *sarpanch* to get his support.
- The RMP invited the other RMPs to help organize the meeting.
- They organized separate community meetings for the two language groups.
- They sent out invitations to a broad cross-section of groups.
- They took turns explaining the issues, e.g. HIV transmission, stigma.
- They explained the code of conduct on how to treat people living with HIV.
- They discussed a real case of stigma in the community and its impact.
- The meeting culminated in a decision by the community to stop stigma.

How to change the attitudes of the community?

- Set a good example to others through our own behavior: stop isolating and shaming people living with HIV and provide them support and encouragement.
- Use real cases of stigma, such as the one in the story, to raise the issue.
- Talk to our own families and neighbors and help them understand that they should stop fearing contact with people living with HIV.
- Organize community meetings to raise the issue of stigma with the whole community.
- Show the stigma and violence pictures and discuss them with neighbors.
- Organize a regular system of support visits to AIDS-affected households.
- Organize house-to-house visits to raise everyone's awareness.
- Organize a Stigma Walk or Community Mapping exercise.
- Organize awareness activities in the schools, e.g. art or drama competition.

3. SUMMARY: Health workers cannot organize against stigma on their own. They need support from others to make a real impact. If everyone works together in organizing community meetings, people will listen and dramatic changes can result.

E5. Ten Steps for Moving to Action

Objective: By the end of the session, participants will be able to work out a detailed strategy for taking action against HIV stigma.

Time: 3 hours

■ Steps:

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

1. SITUATION ANALYSIS: Ask – *What is the current situation in the community regarding HIV stigma? What forms of stigma are common in the community? What background factors influence stigma?*

Sample Responses:

- Lots of secrecy and silence around sex and AIDS – people find it difficult to talk.
- Denial that AIDS is a problem.
- AIDS-affected households are the target of gossip and name-calling.
- Lots of hidden conflicts between different households.
- High levels of fear and hopelessness.
- Low knowledge about HIV and AIDS, and fear of infection.
- High levels of poverty.
- Young women at high risk – coercion, poverty and limited control over sexuality.
- Poorly run and equipped health services, and lack of trust in health services.

2. VISION: Ask – *What will the situation in our community look like in two years time after our anti-stigma program?*

Sample Responses:

- More openness in talking about sex and AIDS.
- Villagers helping each other in caring for people living with HIV and AIDS.
- Less gossip and name-calling toward families affected by HIV and AIDS.
- More knowledge about transmission and less fear about casual contact.
- More hope – less feeling of fatalism and paralysis.
- More trust in and use of health services.

3. ACTIVITIES: Ask – *What activities will you carry out to reach that goal?*

Sample Responses:

- Training workshops for community and peer group leaders and people living with HIV and AIDS.
- Community and peer group meetings and awareness-raising in schools.
- Community participatory education on new facts about HIV and AIDS.
- Data gathering and analysis – community mapping, stigma walk.
- Mini-campaigns on specific issues, e.g. stop stigma against widows.
- Home visits and support for AIDS-affected households.

4. PRIORITY ACTIVITIES: Ask – *Which activities are the most important?*

5. RESOURCES: Ask – *What resources do we need to do these activities?*

6. OBSTACLES: Ask – *What might get in the way of our activities?*

Sample Responses (obstacles):

- Resistance from temple and mosque.
- Apathy and sense of fatalism – people feeling they cannot do anything.
- Poverty – people too busy just trying to survive.
- People resorting to faith healers and other solutions.

7. INDICATORS: Ask – *What things will show that we have been successful?*

Sample Responses:

- More people visiting each other and providing support/comfort.
- People living with HIV and AIDS have more say in family decision-making about their care.
- More openness in discussing issues around AIDS and sex.
- Increased use of health services.
- Increased knowledge that HIV cannot be transmitted through casual contact.
- Exemptions from water fees and other fees for AIDS-affected households.
- Couples living with HIV planning for the future of their children.
- Fewer AIDS orphans dropping out of school.

8. SUMMARY:

- Review handout on “Ten Steps for Moving to Action.”
- Each small group now has a plan. The next step is to put the plan into action!

Handout: Ten Steps for Moving to Action

Step	Examples
1. Where Are You Now? (Situational Analysis)	This helps you to look at what is currently happening around stigma. You can ask: "How have things been in the past?" and "How are they now?" "Where is the stigma in the community or workplace?" etc.
2. Where Do You Want To Be? (Vision)	How would things look if you could really make a difference? Make a "vision" of the future in which there is reduced stigma.
3. How Will You Get There? (Activities)	What kind of activities can you do to help reduce stigma? Brainstorm all your ideas – practical new actions to solve the problem.
4. Where Will You Start? (Prioritize)	What are the most feasible actions to start with? What is the most important action?
5. What Do You Need? (Resources)	Identify any resources, skills or training that will help with your action – and any partners who can help. Don't stop at this point even if you have no funds.
6. What Might Get In The Way? (Obstacles)	Identify any obstacles that might prevent your action from being successful. Try to strategize on how to overcome these obstacles.
7. How Will You Know That You Are Successful? (Indicators)	Decide how you will measure your success. Identify "indicators" or signs that will show you that stigma is reduced, e.g., are more people talking openly about testing?
8. Action	Start the activities you have planned. Assign tasks to specific people.
9. Monitoring	Check how you are doing and whether anything is changing.
10. Replan	Make changes to your plans based on what you learn from the monitoring.

E6. How Have Our Attitudes Changed? (Monitoring)

Facilitator's Note: This activity is carried out toward the end of the training program as part of the monitoring and evaluation process. Participants identify their own changes in attitudes and behavior regarding HIV stigma and gender violence. Encourage participants to assess themselves as honestly as possible.

Objective: By the end of this session, participants will have documented how their attitudes have changed in relation to HIV stigma and gender violence.

Time: 1 hour

■ Steps:

1. INDICATORS OF DE-STIGMATIZATION AND DECLINING GENDER VIOLENCE: Ask—

- a) *If stigma has declined significantly, what would be the indicators?*
- b) *If gender violence has declined significantly, what would be indicators?*

Sample Responses: Indicators for de-stigmatization

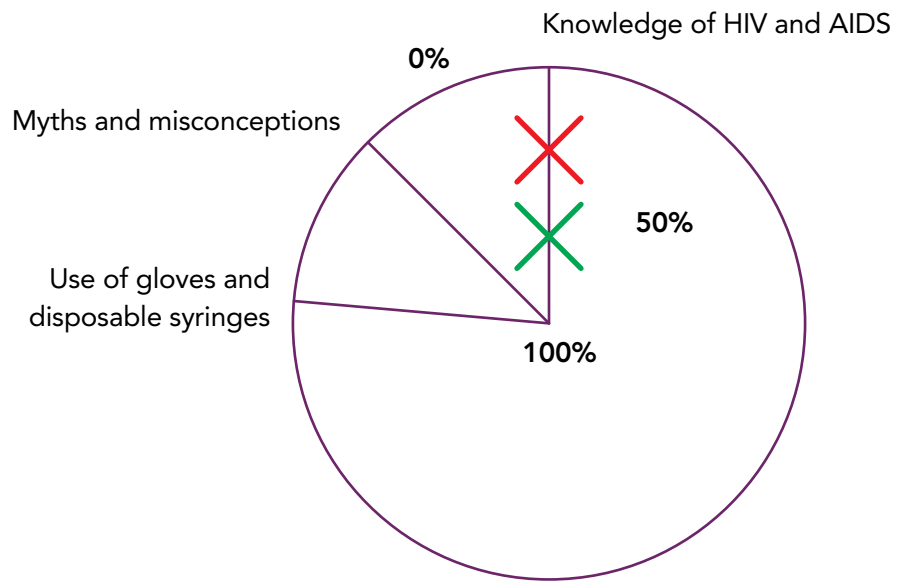
- Increased knowledge of HIV and AIDS
- Declining myths and misconceptions
- Increased use of gloves and disposable syringes
- Increased acceptance of people living with HIV

2. SHOWING CHANGES (Group Work): Divide into small groups and ask each group to prepare two circles, one representing attitudes in relation to stigma, and the other representing attitudes in relation to gender violence.

Ask the groups to draw spokes in each circle to represent each of the indicators listed in Step 1. The edge of the circle represents NO progress toward de-stigmatization or declining gender violence (e.g., total rejection of people living with HIV), and the center of the circle represents COMPLETE de-stigmatization and lack of gender violence (e.g., total acceptance of people living with HIV). (See figure below for stigma example.)

Give each group two colored markers (e.g. one black, one red) and ask them to mark on each indicator spoke their attitudes and behavior **before** (color one) and **after** (color two) the training.

Changes in Stigmatizing Attitudes and Behaviors (Sample Responses):



Auxiliary Skills

■ Introduction

Health care providers need more than basic knowledge on HIV and AIDS. They also need to develop technical skills to become “HIV competent.”

This section will cover a few technical topics that closely overlap with stigma and gender violence: supporting disclosure, confidentiality and positive living. Information on other technical areas, including HIV testing, ARVs, opportunistic infections, Universal Precautions, PPTCT, nutrition, etc., is available through the State AIDS Control Society and other AIDS organizations. Some of these topics are also covered in the fact sheets in Annex 1.

■ Modules

- E7. How to Support Disclosure by People Living with HIV
- E8. Confidentiality
- E9. Positive Living

E7. How to Support Disclosure by People Living with HIV

Facilitator’s Note: ICTC staff are often too busy with test-related counseling to be able to provide ongoing supportive counseling, including helping people living with HIV disclose to their partners and families.

Because RMPs and TBAs are very close to their clients, they are often among the first to know that a person is HIV-positive. As a result, they need to develop skills to help people living with HIV tell their families.

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

- a) Describe why it is important for people living with HIV to disclose their status to family members, and the potential difficulties involved in disclosure; and
- b) Develop strategies for helping people living with HIV prepare for disclosure.

Time: 1 hour

Materials and preparation: Picture A10 (Man returning home with HIV test result)

■ Steps:

1. WHY DISCLOSE? Ask – *Why do you think it is important for people living with HIV to disclose their status to other family members or close friends?*

Sample Responses:

Reduce the stress of coping alone. Help them access care and support. Help protect themselves and others from HIV infection. Stop rumors and suspicion and the stress of keeping a secret.

2. HOW TO DISCLOSE (Picture-Discussion): Show the picture and discuss in pairs:

- a) *What do you think is happening in the picture?*
- b) *What are the risks involved in disclosing to family members?*
- c) *What are the possible consequences of non-disclosure?*

Sample Responses:

Risks involved in disclosure

Violent reaction – physical or emotional violence. Shame, blame and rejection. People may use this information against him. Loss of support.

Possible consequences of non-disclosure

Family and friends may not provide the support he needs and he will have to deal with everything on his own. Risk of HIV infection – placing others at risk, particularly sexual partners. Lack of care – he may be unable to access medical care or counseling if he is not open about his status. Suspicion – family members may be suspicious of his actions because they do not understand his HIV status.

3. DISCLOSURE PRACTICE (Paired Role Playing): Explain that the aim is to learn about the issues involved in disclosure through role playing. Have participants pair off and ask the partners to decide on their roles. One will play a person living with HIV, and the other will play a family member (the pair should also decide on the relationship between the two, e.g. son and mother, or wife and husband). Then shout "Play." After a few minutes, shout, "Stop" and ask one pair to show their role play in the center of the circle. Then debrief: *What approaches did you use in disclosing your status?*

Sample Responses:

Woman telling her mother

- Selected a suitable place and time (e.g., children asleep).
- Broke the news slowly – started off saying she had gone to the clinic for a check-up; then said her friend had been tested for HIV; then said she decided to get tested too.
- At each point in the story she stopped to check on awareness and reaction of her mother before proceeding.

Brother telling his sister

- Chose the right time (e.g., evening after children are asleep).
- Starting statement – "I wanted to talk to you because I know you can support and help me."
- Why did you select sister? She knows about HIV – she would be sympathetic.

Wife talking to husband

- Best timing – early morning at home. Why? Want to keep it short and let him think about it, and then have a second meeting with him later.

3. PROCESSING: As a group, brainstorm a set of strategies for disclosing successfully.

- Select the right person to disclose to – someone who will be sympathetic.
- Start with relatives with whom you are close.
- Find a time when it is easier for people to concentrate.
- Find a place where there will be no interruptions.
- Ask for help, support and advice.
- Share your burden. Be aware that it is a struggle, not easy, stressful.
- Remember it is hard news to tell and hard news to hear.
- Go slowly and check on the reaction at each stage.
- Do it gradually – if you get a supportive response from the first person, you can try a second person. Support gives you the courage to continue.

4. SUMMARY: When a person discovers he has HIV, he faces a difficult decision about whether to tell anyone. There are real advantages to disclosure, but the person living with HIV should take time to think through whom to disclose to, how to do it and how to deal with any negative consequences.

A health care provider can help the person living with HIV think through these issues – making sure it is what the person wants to do and helping him or her plan how to disclose. This process would include helping the client to:

- Decide if she is emotionally ready to disclose. Does she understand the full implications of disclosure? Has she considered the reactions of different family members?
- Decide whom she should disclose to. It may be easier to start with close and trusted family members.
- Think about the likely response, including negative reactions.
- Develop a plan and practice how to disclose status.
- Identify sources of support (support groups, counselors).
- Discuss partners who need protection from infection.

E8. Confidentiality

Facilitator's Note: The case studies in this exercise have been borrowed from Horizons/Population Council and SHARAN, *Training Manual for Sensitizing Health Care Workers on HIV and AIDS*, Washington: Population Council, 2002 (page 28).

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

- a) An individual's right to confidentiality; and
- b) The potential effects of a health worker violating confidentiality.

Time: 1 hour

Steps:

1. WHAT IS CONFIDENTIALITY? (Brainstorm): Ask – *What is the meaning of confidentiality?*

Record the group's ideas and then clarify its meaning.

2. ROLE PLAYS: Ask participants to act out the following role plays:

Role Play A: Ramu, a 30-year-old factory worker, was suffering from TB that was resistant to normal medication, so he came to the hospital for an HIV test. The doctor admitted him and, after taking consent, sent his blood for an HIV test. The result of the HIV test was relayed back to the head nurse in the ward in an ordinary, unsealed form. All the nurses, and the ward boys who delivered the test result, found out that Ramu was HIV-positive.

Discuss–

- a) *How do you think Ramu felt when all the health workers knew his status?*
- b) *How could confidentiality of the test result have been maintained?*
- c) *What should be done to ensure confidentiality of the result?*

Role Play B: Ramu's test result has come to the ward. The head nurse informs all the sweepers to be careful. Ramu's case sheet is marked prominently saying "HIV-positive" in red, and his bed is shifted to the verandah near the toilet. During the rounds, the head doctor announces Ramu's status loudly in front of all the other patients.

Discuss–

- a) *How do you think Ramu felt? What was wrong with the way his case was handled?*

3. SUMMARY:

What is Confidentiality?

- Confidentiality is about sharing sensitive information – such as a person's HIV status—with only those who really need to know. The person most affected by the information – the person with HIV – is the owner of the information. Others must respect his or her wishes about sharing it.
- Each person who has HIV should be encouraged to disclose this information to those whom they trust will treat this information with respect – but the person has the right to control who gets this vital information.
- **Every person has the right to confidentiality** – the right to decide what aspects of his or her life are private and what can be made public. This includes the right to confidentiality with regard to a person's HIV status.

- A health worker may discover things about a patient, such as HIV status, that are considered private. The health worker should keep this information confidential.
- The health worker should protect the information provided by a patient and not disclose an illness to any third party. Whatever is discussed between the health worker and patient should remain a private issue between the two of them.

Why Confidentiality?

- If a health worker breaks confidentiality, she or he puts the patient at risk of being rejected by the family and facing other forms of stigma and discrimination.
- The health worker builds a relationship of trust with the client by agreeing to keep information confidential.
- If a person feels his or her HIV status will remain confidential, he or she will be more likely to seek counseling, testing, treatment and support.

What Happens if Confidentiality is Not Respected?

Failure to defend the right to confidentiality will drive the HIV epidemic underground:

- People suspecting they have HIV will be afraid to be tested because they fear that the information will be released to the public and they will be victimized.
- People needing health care will be afraid to disclose all the facts of their health status, and as a result not get the best treatment for their condition.
- People living with HIV will suffer in silence and HIV will continue to spread.

Voluntary Disclosure

WHO encourages **voluntary disclosure** of HIV status:

- It respects the dignity and autonomy of those affected;
- It maintains confidentiality;
- It benefits the individual, his or her sexual partners and family; and
- It leads to greater openness in the community about HIV and AIDS.

Partner Notification

Confidentiality means that the person who provides the test result tells the result only to the patient tested. However, sometimes an HIV-positive person chooses not to tell his or her partner. Does the spouse have the right to know?

The main arguments in favor of partner notification are:

- The partner may not yet be infected. The risk of infection is very high unless condoms are properly used all the time. The partner has the right to know the information as it may be life-saving.
- The partner has the right to know that she or he may already have HIV infection, so she or he can seek a test and treatment as needed.

The arguments against partner notification include:

- Patient confidentiality must be upheld. If this is not guaranteed, some people will be deterred from seeking treatment.
- Giving the partner information in the absence of any other support merely creates anxiety and conflict and may do nothing to reduce sexual risk, particularly for women.

WHO encourage **partner counseling**, which is based on **informed consent** of the client and maintains **confidentiality** of the client, where possible. HIV counseling and partner counseling programs should encourage and support people living with HIV to notify and counsel their partners. These steps involve:

- Repeated efforts to persuade the client to counsel partners;
- Informing the client that partner counseling will occur;
- Keeping his or her name confidential if possible; and
- Ensuring social and legal support for the client and other relevant parties (spouses, partners and family members) to protect them from any physical abuse, discrimination and stigma that may result from partner counseling.

E9. Positive Living

Facilitator’s Note: Health care providers need to develop the skills and confidence to provide people living with HIV with comprehensive care that will enable them to take control of their lives and health care. Positive living not only helps people with HIV live longer and healthier lives, it can help to prevent the further spread of HIV.

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

- a) Understand the importance of positive living; and
- b) Identify some of the main features of positive living to support people living with HIV.

Time: 1 hour

Materials and preparation: Leaflets, brochures and other resources on aspects of positive living (nutrition, hygiene, safe sex, etc.)

■ Steps:

1. WHAT IS POSITIVE LIVING? (Card storm, small groups and presentations): Divide into pairs and ask pairs to brainstorm (on cards) all the things they know are involved in positive living. Cluster the cards according to categories.

Then divide into groups, one group per category. Ask each group to research their topic and prepare a short (five minute) presentation. Give them enough time to prepare (e.g., between training sessions). Provide them with the materials you have gathered, but also tell them to try to present new information that the group may not know about.

Sample Responses: Categories of positive living

Food and nutrition. Hygiene. Emotional health/spiritual support. Exercise. Safe sex.
Early medical care. Treating opportunistic infections. Reducing alcohol intake.

3. EMOTIONAL HEALTH (discussion and role play): Ask–

- a) *What do people living with HIV need to feel good about themselves?*
- b) *Why is “feeling good” (emotional health) important for leading a long life?*
- c) *What might prevent people living with HIV from feeling good?*

Then ask participants to act out the **role play** below.

At the market, a person living with HIV is shunned by the other traders, who gossip openly about him being “promiscuous.” He returns home, where he pours out his heart to his brother, talking about his frustration and feeling of rejection. He blames himself, saying he was “reckless and therefore deserves to be treated like this.”

Discuss in pairs and then share–

- a) *What happened? Who is stigmatizing? Why?*
- b) *How does this treatment affect the emotional health of the person living with HIV?*
- c) *What are the indicators of self-stigma?*

Sample Responses:

- Stigmatization by traders – shunning, refusing service, gossiping.
- Effects – loss of self-esteem and confidence.
- Indicators of self-stigma – blames himself for his situation, accepts that he “deserves to be treated like this.”

Brainstorm with the whole group–

How can people living with HIV cope with stigma?

Sample Responses:

- Understand and accept one’s situation as a person living with HIV.
- Socialize. Join a support group.
- Ongoing supportive counseling from family, friends or health professionals.
- Talk openly with close friends and family about your situation. If they continue to gossip, tell them: *“I already told you my status and you’re still talking. What’s new?”*
- Continue being productive. Do things that build confidence and self-esteem.
- Focus on positive goals, such as *“I want to stay alive for my children.”*
- Deal with negative anger.
- Transform anger into assertiveness – *“Stop treating me like this. I don’t deserve it.”*

4. SAFE SEX (Picture-discussion + mini-lecture): Explain the link between physical and emotional health and the importance of staying healthy by practicing safe sex. Emphasize that people living with HIV have the right to have sex – but they should practice safe sex.

Pass around a picture (showing a couple in bed) – then **discuss**–

What happens if a person living with HIV is re-infected/exposed to more HIV?



Explain that even if one has HIV, safe sex is still important because it is possible to get re-infected, which would increase the amount of HIV in a person’s system.

5. SUMMARY: Health care providers can support people living with HIV and encourage positive living. This will help patients:

- Understand how to better cope with HIV and AIDS;
- Take control of their lives and health care; and
- Live longer and healthier lives.

People living with HIV need comprehensive care. Medical treatment (ARVs and treatment of opportunistic infections) is important, but it is only part of the solution. Medical treatment needs to be linked to and supported by other forms of care and support, such as counseling, advice on nutrition, and information about safe sex, exercise, alcohol intake, etc. in order to be effective.

Comprehensive care includes:

- Diagnosis and treatment;
- Referral and follow-up;
- Counseling; and
- Support to meet psychological, spiritual, economic, social and legal needs.

Annex 1: Fact Sheets

The following 13 fact sheets can be used for your general reference as you conduct your training. Several fact sheets also are used in conjunction with various modules.

Fact Sheet 1: HIV and AIDS: The Basics

Fact Sheet 1a: Why Are Women More Vulnerable to HIV than Men?

Fact Sheet 2: QQR: A Tool for Understanding HIV Transmission

Fact Sheet 3: Frequently Asked Questions (FAQs) about HIV and AIDS

Fact Sheet 4: HIV Testing: Voluntary Counseling and Testing

Fact Sheet 5: Sexually Transmitted Infections (STIs)

Fact Sheet 6: Opportunistic Infections (OIs)

Fact Sheet 7: Tuberculosis (TB)

Fact Sheet 8: Anti-Retroviral (ARV) Therapy

Fact Sheet 9: Parent-to-Child Transmission (PTCT)

Fact Sheet 10: Universal Precautions

Fact Sheet 11: Care and Support for People Living with HIV

Fact Sheet 12: Gender Violence: What Is It? What Can We Do?

HIV and AIDS: The Basics

■ What is HIV?

HIV stands for **H**uman **I**mmunodeficiency **V**irus.

- **Human** – HIV only affects human beings; it needs a human host.
- **Immunodeficiency** – HIV creates a deficiency within the body's immune system, making it more open to disease and infection.
- **Virus** – HIV is one of a family of viruses known as "**retroviruses**."

■ What is AIDS?

AIDS stands for **A**cquired **I**mmune **D**eficiency **S**yndrome.

- **Acquired** – Not born with; something that a person gets from someone else.
- **Immune** – The body's immune system, which fights off germs.
- **Deficiency** – The immune system is not working properly to fight off disease/infection.
- **Syndrome** – A set of illnesses that attack the body when its immune system is weak.

■ What is the Difference between HIV and AIDS?

- HIV is the **virus that causes AIDS**. It develops in the body over a long period of time and slowly destroys the body's capacity to fight infection and disease.
- AIDS is the **advanced stage of HIV infection** when HIV has destroyed the CD4 cells, which protect the body's immune system. The body is then susceptible to opportunistic infections, including tuberculosis (TB), septicemia, pneumonia and fungal infections.

A person infected with HIV can remain healthy for many years with no physical signs or symptoms of infection. A person who has the virus but no symptoms is "**HIV-positive**." People living with HIV often do not know that they have the virus.

When a person living with HIV begins to get sick and develop opportunistic infections, she/he is said to have AIDS. "**AIDS**" is a clinical definition given to people with HIV who have a CD4 count of below 200. (A CD4 test counts the number of CD4 cells, which are infection-fighting blood cells that the HIV virus attacks and kills.)

■ How Does HIV Harm the Body?

CD4 cells protect our bodies. These cells attack germs as part of the body's immune system. When a person is infected with HIV, the virus invades the CD4 cells and these cells can no longer keep the body healthy. Germs then take advantage of the weakened immune system and attack the body.

Most people who become infected with HIV do not notice that they have been infected. Soon after being infected, some people may suffer flu-like symptoms for a few weeks. Otherwise there are no signs of early HIV infection. However, the virus remains in the body and can be passed to other people. At this stage the person is HIV-positive but she/he does not have AIDS.

This weakening of the immune system takes place over a period of time. As the body weakens, it is attacked by diseases such as TB, pneumonia, cancer and meningitis – or “opportunistic infections.” When the body is too weak to fight these diseases, the person is said to have “AIDS” – a collection of diseases that attacks a person after HIV has made the body weak. When the body becomes extremely weak, the person can die.

■ Where Does HIV Come From?

Nobody knows where HIV came from, exactly how it works, or how to eliminate it from a person.

■ How is HIV Transmitted?

For HIV to spread, an HIV-infected person’s blood, semen or vaginal fluids has to get inside the other person’s blood supply. There are **three** ways that HIV is passed from human to human.

- 1. Sex:** If someone is HIV-positive, the virus can be passed from his or her infected blood, semen or vaginal fluids directly into another person’s bloodstream, through the lining (mucous membrane) of the vagina, penis or rectum. During sex, friction normally causes tiny scratches (or micro-abrasions) in these linings, and this is how HIV gets into the bloodstream. Sex is the most common form of transmission. Infections in the genital area (e.g. sexually transmitted infections) provide an easy way for HIV to enter the bloodstream.
- 2. Mother-to-child transmission:** HIV can be passed to a baby during pregnancy, delivery and breastfeeding. However, not all babies born from HIV-positive mothers will have HIV. About one-third of infants become infected with HIV if the mother has not been treated with anti-retrovirals, which are drugs that slow down the progression of HIV.
- 3. Blood transfusions and unsterilized equipment:** HIV can be transmitted by HIV-infected blood transfusions or contaminated injecting equipment (syringes/needles) or razors. People who inject drugs often get HIV because they share needles, which spreads the virus.

■ How is HIV Not Transmitted?

- **HIV cannot survive outside the human body.** The virus dies as soon as it is exposed to air. If it is exposed to heat (for example if someone bleeds into a cooking pot) it will die.
- **HIV cannot pass through the skin on the outside of your body unless there is an open cut**
- **HIV cannot be transmitted through saliva, tears, vomit, feces or urine**, although small amounts of HIV have been found in these fluids. HIV is not found in sweat.
- **HIV cannot be transmitted through unbroken skin or casual contact** such as touching someone with HIV, or something they have used (e.g., clothing); sharing cups, plates or utensils; or using the same toilet seats.
- **Caring for people living with HIV is not risky if the person follows sensible precautions** such as disposing of sharp needles safely and keeping cuts covered.
- **HIV is not transmitted by mosquitoes or other blood-sucking insects.** Most insects do not pass blood from one person to another when they bite humans. The malaria parasite enters the bloodstream in mosquito saliva, not blood.
- **HIV is not contagious: It cannot be transmitted by casual contact!**

■ How Can HIV Infection be Prevented?

- If you have sex with many partners or you are unsure of your partner's sexual relations, **always use or insist on a condom during sex.**
- **Protect yourself** from contaminated body fluids.
- **Use disposable syringes** obtained from a reliable source. Never reuse syringes.
- **Women who are pregnant or intending to get pregnant** should access prevention of parent-to-child transmission (PPTCT) services to prevent HIV transmission to the unborn child.
- **Before a blood transfusion**, insist on having blood that has been tested for HIV from a licensed blood bank. It is safer when someone you know donates blood for you.
- **Use sterilized instruments when piercing skin or sterilize the instruments yourself** by boiling for 20 minutes or rinse thoroughly using 1 percent bleach solution.
- **Medical professionals should follow universal precautions to protect yourself and your patients.** In addition, cover cuts and wounds with waterproof bandages. If you do not have a bandage, use a piece of clean cloth to cover wounds.

Why Are Women More Vulnerable to HIV than Men?

■ HIV Infection by Gender

Here are the statistics:

- In 2006, there were an estimated 2.5 million HIV-infected people in India. (National AIDS Control Organization)
- 51 percent of those infected were women, although some estimate that this percentage is higher.
- 95 percent of the infected women have not had any other partner than their husbands (even though many women are blamed for bringing HIV into the home).

■ Socioeconomic Reasons for Women's Vulnerability to HIV

There are a number of socioeconomic reasons why women are more vulnerable to HIV than men.

- **Fear of Violence.** Gender violence or the fear of violence limits women's control over their bodies and sexual lives and makes them more vulnerable than men to HIV. Women who fear violence find it difficult to negotiate safe sex and protect themselves against HIV and sexually transmitted infections (STIs). Sexual violence – forced sex by husbands or partners or rape by other men in the workplace or community – also increases women's vulnerability to HIV.

Fear of violence is one of the main reasons why women do not tell their husbands or partners that they have an STI or have tested positive for HIV. This fear also prevents them from getting treatment. They continue to have unprotected sex and pass the STI (or HIV) to their husbands.
- **Marriage.** Marriage is a risk factor for HIV. Many wives are at risk because of their husbands' high risk sexual behavior. The women are faithful, but their husbands are not. The husbands have sex with other women, bring HIV or STIs home, and do not tell their wives. Their wives cannot say "no" to their husbands wanting sex (or they will get beaten) so they end up having sex and getting HIV (and/or STIs).
- **Cultural practices.** Women also are vulnerable to HIV due to prevailing cultural norms that condone multiple sexual partners for men under certain circumstances. For example, when women decrease sexual activity during pregnancy or post-delivery, it is commonly accepted that men will have other sexual partners.
- **Poverty.** Poor women may be forced into sex work to survive, making them vulnerable to HIV infection and sexual violence.

■ **Biological Reasons for Women's Vulnerability to HIV**

Women have physical differences that increase their risk of getting HIV:

- **Women get HIV and other STIs during sex twice as easily as men.** Semen has a higher concentration of HIV than vaginal fluids. The woman's vagina has large areas of exposed and sensitive skin surfaces, which can develop small tears during sexual intercourse. This allows HIV and other STIs to enter the woman's bloodstream. Semen stays in the vagina after sex, increasing the risk of transmission. In contrast, the penis has a small surface area, which is in contact with vaginal fluids for a shorter time; men can more easily wash off vaginal fluids after sex.
- Men usually know when they have an STI, but women don't. It is difficult for women to detect that they have an STI because some symptoms do not appear in women and other symptoms may be hidden in the vagina canal. Women must depend on their husbands or partners to tell them they have an STI. This limits their ability to protect themselves against STIs, and having STIs increases their vulnerability to HIV. STIs produce sores or cuts in the vagina, which make it easier for HIV to pass during intercourse.
- During labor or delivery, women often get vaginal cuts or lesions, which makes it easier for HIV to get into their bodies and bloodstream.
- Teenage girls, whose vaginal tissue is not fully mature, are more likely to develop lesions during intercourse, increasing their vulnerability to HIV.

More attention should be given to address these particular vulnerabilities that women face.

QQR – A Tool for Understanding HIV Transmission

■ QQR – Quality, Quantity, Route of Transmission

HIV transmission depends on the **quality** of the virus, a large **quantity** and a **route of transmission**.

Quality: The quality of the virus must be strong. HIV does not live on the surface of the skin, it lives inside the body. HIV cannot survive outside the human body; it starts to die as soon as it is exposed to air. If it is exposed to heat (e.g., if someone bleeds into a cooking pot), it will die. The only place the virus can survive outside the body is in a vacuum (e.g., a syringe) where it is not exposed to air.

Quantity: The quantity of the virus in body fluids must be large enough to pose any risk. HIV is found in large quantities in blood, semen and vaginal fluids, and breast milk; these fluids have a greater risk of transmission. HIV is found in small amounts in saliva, vomit, feces and urine. HIV is not in sweat or tears. In these smaller amounts, there is no risk of transmission, unless blood is present.

Route of Transmission: HIV must get inside your bloodstream. Our body is a closed system. Healthy skin is an excellent barrier against HIV. HIV cannot easily pass through unbroken or broken skin. If you cut yourself, the blood flows outwards, away from the bloodstream. If you touch someone else's cut, blood will not swim into your bloodstream.

Common sense and daily hygiene can alleviate concerns regarding HIV transmission. For example, you wouldn't share a toothbrush if it was covered in blood; you would wash if you cut yourself; you would wear gloves or cover your hands if you are cleaning up someone's diarrhea.

These three conditions – **quantity, quality and route of transmission (QQR)** – explain why HIV cannot be transmitted by activities such as:

- Touching the skin or sweat of a person living with HIV;
- Changing the clothes of or serving food to a person living with HIV; and
- Taking the blood pressure of a person living with HIV.

■ Other Factors that Increase the Risk of Sexual Transmission

- **Viral load of infected person.** Higher viral load increases risk of HIV transmission. The highest viral loads occur at the initial stage of HIV infection and final stages of AIDS.
- **Presence of cuts or wounds.** Wounds or cuts on either partner increase the chance of HIV entering the bloodstream.
- **Presence of other sexually transmitted infections (STIs).** STIs cause sores or broken skin, making it easier for infected blood to get through the skin into the bloodstream.
- **Having sex during menstruation period or when a woman is bleeding.**

■ **The HIV Transmission Equation**

Human host with HIV – someone has to carry the virus to infect someone else

+

Body fluid that carries large amount of HIV – blood, semen, vaginal fluid, breastmilk

+

Opening into the bloodstream – needle holes or cuts/tears in the vagina and penis

+

Activity that can move these fluids between people – unprotected sex, sharing injection needles, breastfeeding, blood transfusion

= POSSIBILITY OF HIV INFECTION

Frequently Asked Questions (FAQs) about HIV and AIDS

■ Can you tell if someone has HIV by looking at him or her?

No. The only way to know if someone is infected with HIV is through a blood test. Most people living with HIV look healthy and do not have symptoms for many years. It is only at the end stages of HIV infection that people become ill, showing the signs and symptoms of AIDS.

■ Can mosquitoes transmit HIV from human to human?

No. HIV cannot live outside the human body. Mosquitoes do not inject blood into humans, they suck blood. (There is no "QQR" – see Fact Sheet 2.)

■ Can HIV be transmitted through razor blades or sharp instruments?

There is a slight risk if a razor is being used quickly to make incisions or cuts on many people one after the other without washing it. It is better – and more hygienic – to sterilize sharp instruments by boiling them, or to use new razors every time.

If a razor is being shared but it is covered in blood, you would probably not use it or you would wash it thoroughly.

■ Can I get HIV by touching someone who has open cuts and sores?

No. Unless someone is covered in blood and you are badly injured with open wounds, there is no risk. Your skin protects you. If you are bleeding, your blood flows outward, it does not suck things into your bloodstream! If you are caring for someone (with HIV or not) and she/he were bleeding, use gloves and wash well before and afterward.

■ Can I get HIV by cleaning up diarrhea of an HIV patient?

There is no risk. Diarrhea does not contain HIV, unless it has blood in it, and it would still have to get inside your bloodstream. Use gloves or cover your hands.

■ How long can you live if you get HIV?

This depends on many things. If you are healthy and can eat well and have lots of love and support, you can live for many years. If you can access anti-retroviral (ARV) drugs and take them consistently, you can live many years.

Remember that HIV and AIDS are different things. With HIV you have the virus but you are healthy. With AIDS, it means your immune system has become significantly weakened and you may have a number of opportunistic infections. It is important to treat these infections.

Finding out you are HIV-positive is not a death sentence.

■ Is it true that condoms are not really safe?

If used properly, condoms offer 98 percent protection against HIV (and pregnancy). The virus cannot pass through a condom. Make sure your condoms are not out of date, and store them in a cool place. Don't use vaseline or oil on them as this can make them break. Never use more than one condom at a time.

■ Is there any cure for AIDS?

There is no cure but treatments that slow down the impact of HIV are available. The combination of treatments is called anti-retroviral therapy, or ARV therapy. These treatments are widely available in Western countries, where most people no longer think that HIV means you will die. ARV therapy is becoming more available, cheaper and easier to access in India. Governments and drug companies are increasingly making ARVs available to everyone. In April 2004, the government started distributing free ARV therapy in six high prevalence states in India. In 2006, this effort was scaled up to all the states. However, the actual reach is still limited, with only 95,000 patients receiving ARV therapy in 2006 through public and private channels (for more on ARV therapy, see Fact Sheet 8).

■ Can a man cure HIV or STIs by having sex with a virgin?

No. A man will still have the virus in his body after sex and he will probably have infected the virgin as well.

■ Why can't a mother typically give HIV to her baby in the womb?

HIV is not passed from mother to baby because the blood of the mother and the blood of the baby are separate. Inside the womb the baby floats in a bag of water. The baby is attached to the woman's uterus by the placenta, a temporary organ. The baby does not come into contact with the mother's blood at all, except during delivery. The mother's blood is in her own blood vessels. Oxygen from her lungs and food (nutrients) from her stomach and intestines are brought to the womb by the mother's blood. The blood of the fetus (baby) is in its own blood vessels and these extend to the placenta. There are thin membranes that separate the placenta from the lining of the mother's womb. This prevents the mother's blood from mixing with the baby's blood, but allows oxygen and nutrients to pass from the mother's blood to the baby's blood.

HIV Testing: Voluntary Counseling & Testing

■ What is an HIV Test?

An HIV test determines if a person is infected with HIV. The test involves taking a sample of blood or urine from a person and then analyzing the sample in a laboratory.

The test checks for the presence of **HIV antibodies** in the person's bloodstream, rather than for the virus itself. The immune system produces antibodies to fight off HIV infection. If HIV antibodies are present, then the person is infected with HIV and she/he is HIV positive. If there are no antibodies, the person is not infected with HIV and she/he is HIV negative.

The most common HIV tests are:

- **Enzyme-linked immunosorbent assay (ELISA)** – Highly accurate, requires a confirmatory test using the Western blot;
- **Rapid serological tests** – Provide results in 30 minutes using simple procedures, requires a confirmatory test using the Western blot; and
- **Western blot** – Used to confirm positive results from the other two tests.

■ What is a “False Positive” Result? What is a “False Negative” Result?

A “false positive” result is when the result appears positive even when there are no antibodies in the blood. A “false negative” result is a negative result when the person is actually infected. A false negative can occur if a person is newly infected and not yet producing HIV antibodies. To protect against false positives and false negatives, HIV test results should be confirmed with other tests using another method.

■ What is the Window Period?

When a person is infected with HIV, it takes three months for his/her body to show detectable levels of antibodies. This length of time is called the “window period.” During this period, the test will not show the antibodies, and the results will appear as if the person is HIV-negative, even though she/he may have HIV. This is why a second test is needed three months after the first test.

■ What is Voluntary Counseling and Testing?

Voluntary counseling and testing (VCT) is a system of testing people for HIV while also counseling them so they know the full implications of being tested. VCT includes pre-test counseling, HIV testing, post-test counseling, and partner notification and follow-up/referral.

It is illegal to test a person for HIV without his/her consent. If an individual goes to the hospital or clinic for treatment, she/he must consent to all tests and treatment. It is a client's right to be asked to give, or refuse to give, consent for every medical test.

VCT provides information and benefits for those who test positive as well as those who test negative. VCT helps people deal with worries about their status, increases their perception of their vulnerability to HIV, promotes behavior change, facilitates early referral for care and support, and helps reduce stigma in the community.

■ What are the Conditions for VCT?

- **Voluntary** – Individual decides to take the test; no one coerces him/her.
- **Right to Counseling** – Those testing have the right to be counseled by a trained counselor.
- **Informed Consent** – Individual understands what is involved before deciding to take the test; a person cannot be tested without his/her knowledge.
- **Confidential** – Personal information disclosed to a counselor remains confidential.

■ What are the Advantages of Voluntary Counseling and Testing?

- VCT is the first step in the continuum of care: the entry point for prevention, treatment, support and care.
- If the HIV test result is positive, a person can:
 - Start to practice a healthy lifestyle to live a long life and delay the onset of AIDS;
 - Get early access to treatment, anti-retroviral therapy and prevent parent-to-child transmission;
 - Get access to counseling, support groups and social support services; and
 - Adopt safe sex practices and protect his/her sexual partners from HIV.
- If a person tests negative, he/she can change his/her practices to avoid being infected with HIV.
- If people are worried that they have HIV, they can put their minds at rest.
- If many people get tested, it can help to destigmatize HIV in the community.

■ What are the Disadvantages of Voluntary Counseling and Testing?

- Some people who test positive may not be able to cope with these results. Before taking the test, a person should think about how she/he will react to the results.
- Being classified as HIV-positive can lead to stigma, violence and discrimination (e.g., a person is ostracized by the family, kicked out of the house or abandoned by his/her partner).

■ What are the Steps in Voluntary Counseling and Testing?

VCT involves a number of steps including (1) deciding on whether to get tested, (2) whether to receive pre-test counseling, (3) going to get the test and (4) deciding whether to get post-test counseling.

1. Deciding to Get Tested

Most people with the HIV virus feel healthy, and they do not know that they have been infected. The only way to know if they are HIV-positive is to take an HIV test.

Reasons for taking a test might be that the person:

- Had unsafe sex or a condom broke
- Is thinking about getting married or having children
- Has a spouse/partner who tested positive
- Keeps getting sick and worries that she/he may have HIV

It is the client's decision to take a test. No one else can make him/her have the test.

2. Pre-Test Counseling

Pre-test counseling helps the client prepare for the HIV test.

Topics discussed can include:

- The procedure for HIV testing: how it is done, the meaning of positive and negative results;
- The client's reasons for being tested and deciding whether to take the test;
- The client's potential HIV risks and how to reduce their HIV risk; and
- The client's plan after test results are available (e.g., their reaction, how to tell a partner, how to get support, etc.).

3. Testing

If the client has decided to go through with the test, she/he provides a blood sample, which is then tested in a lab.

4. Post-Test Counseling

Post-test counseling helps the client deal with the results. The client talks with the same counselor about the results and what she/he will do next.

If the results are negative, the client will be asked to come back for another test three months later – at the end of the “window period.” She/he will also be encouraged to stay negative by reviewing his/her risks and how to minimize them.

If the results are positive, these results will be explained to the client. Positive results do not mean the person has AIDS or will die soon, only that she/he has HIV. Many people who test positive stay healthy for several years, even without treatment. The counseling session will also discuss what to do next:

- Who to tell about the results and how to do this;
- How to live a healthy life to delay the onset of AIDS;
- How to prevent infecting sexual partners with HIV;
- How to deal with opportunistic infections; and
- How to access treatment, including anti-retroviral drugs.

Women who test positive will be counseled on options available to prevent mother-to-child transmission of HIV.

■ Gender Violence and Partner Notification

The fear of violence may prevent women from negotiating safe sex, which puts them at risk of getting HIV from their husbands or partners. It also may discourage them from disclosing the results of the HIV test to their partners because this might lead to physical and emotional violence, separation and divorce, and loss of economic support. While disclosure is ideal to avoid spreading infection, the woman's safety from violence is the first priority. Counselors should take this into consideration when talking with positive women about their next steps, including when and how to tell their partners.

Sexually Transmitted Infections (STIs)

■ What are STIs?

STI stands for **sexually transmitted infection**. **STIs** are a group of infections that are passed from one person to another, mainly through sexual contact. Many STIs can be transmitted from a pregnant woman to her child during delivery. Some STIs can be passed through unclean injection needles, skin-cutting tools (such as razors) and blood transfusions.

Most STIs are easily treated and cured, but can be **very dangerous and even fatal if left untreated**. STIs can damage sexual organs and lead to infertility. Gonorrhoea, for example, can lead to Pelvic Inflammatory Disease (PID), which makes it impossible to have a baby. Some STIs can cause blindness, cancer and heart problems; others can lead to death.

Women get STIs (including HIV) twice as easily as men. The woman's vagina has a larger surface than a man's penis and vaginal walls have thin membranes that easily develop small tears through which STIs can pass.

It is also more difficult for women to know that they have an STI. Some STIs do not show symptoms at all and may be hidden in the vaginal canal. As a result women have to depend on their sexual partners to tell them they have an STI.

Having an STI increases the risk of contracting HIV. STIs produce sores in the genitals, which make it easier for HIV to pass into the bloodstream during sex. Prevention and early treatment of STIs will reduce the spread of HIV.

■ What are Common Types of STIs?

STIs include: chancroid (genital ulcer), chlamydia, gonorrhoea, genital herpes, genital warts, hepatitis B, syphilis and HIV.

There are two groups of STIs: (1) those caused by bacteria and which can be cured and (2) those caused by viruses, which cannot be completely cured.

STIs that **can be cured**: chancroid, chlamydia, gonorrhoea and syphilis.

STIs that **cannot be cured**: genital herpes, genital warts, hepatitis B and HIV.

■ What are the Common Symptoms of STIs?

Common symptoms in **women** are:

- Unusual or excessive discharge and smell from the vagina
- Burning pain when urinating
- Sores, bumps or blisters near or on the sex organs or mouth
- Burning or itching around the vagina
- Unusual itching around the sex organs, especially the pubic area
- Pain in the lower part of the abdomen
- Pain inside the vagina during sexual intercourse
- Unusual bleeding from the vagina when it is not the woman's regular monthly period
- Backache, fever and chills

Common symptoms in **men** are:

- Discharge from the penis
- Burning pain when urinating
- Sores, bumps or blisters on or near the sex organs
- Itching or irritation on or near the sex organs
- Unusual scratching around the genital area, especially around the pubic area

Sometimes, people who get STIs have no initial symptoms. The person feels healthy, but the STI germs are inside his/her body injuring his/her reproductive organs. The person can unknowingly pass an STI to someone. Even if symptoms appear to go away, the STI remains so be sure to seek out testing and treatment.

Women often have no visible symptoms, making it more difficult for them to know that they have an STI.

■ What are the Symptoms of Specific STIs?

Chancroid (genital ulcer): Sores on or around the genitals; sometimes the glands in the groin swell up and the sores may burst.

Chlamydia: Discharge from the penis or vagina, burning/pain when urinating; women have no symptoms.

Gonorrhea: Symptoms for men include discharge from the penis and pain when urinating. Symptoms in women include sores in the vagina; discharge and pain when urinating.

Genital herpes: Small painful blisters/ulcers on the genitals or mouth, itching or burning before the blisters appear. The sores can come back, particularly if you are feeling weak or tired, or have a vaginal infection.

Genital warts: Small and bumpy warts on the sex organs, which are painless but sometimes itchy. The warts grow around the genitals and can sometimes cause problems in passing urine. Women with untreated genital warts may be at increased risk of developing genital cancers.

Hepatitis B: Flu-like feelings, tiredness, jaundice, dark urine and light-colored stool.

Syphilis: Painless sore on the vagina or penis; a rash and flu-like symptoms. These signs disappear, but the disease is still growing in the body.

■ What Should You Do If You Think You Have an STI?

Go to a clinic and get tested and treated. Many STIs can be treated and cured with antibiotics. However, viruses like HIV, hepatitis B and genital herpes cannot be cured. Genital warts can be removed, but may return.

Patients should complete the full treatment. Otherwise the germs will stay in the body and make the person ill later on. The person can also transmit the disease to others. People who are treated for STIs should tell their most recent partners, so they can also be treated.

Opportunistic Infections (OIs)

■ What are Opportunistic Infections?

Opportunistic infections (OIs) are HIV- and AIDS-related illnesses caused by bacteria, fungi and viruses that take advantage of a weakened immune system. OIs would not normally cause illness in a healthy person, but can affect an HIV-infected person whose immune system has been weakened. Most OIs can be prevented or treated with medication, which can help improve the quality of life for a person living with HIV and delay the onset of AIDS.

There are more than 20 opportunistic diseases associated with AIDS, including tuberculosis (TB), diarrhea, pneumonia, bowel infection, Kaposi's Sarcoma, candidiasis, skin cancer and meningitis. An individual with an AIDS diagnosis may have two or more diseases at the same time.

When AIDS first appeared in the mid-1980s, many people living with HIV rapidly died from opportunistic infections because their doctors did not know how to treat and prevent these diseases in people with damaged immune systems. But as doctors learned how to prevent OIs with medication and how to recognize and treat these infections more effectively, people living with HIV began to live longer and longer.

■ Different Types of Opportunistic Infections

Tuberculosis (TB) is a lung disease that affects many people with HIV. It is preventable and curable. (Read the TB Fact Sheet for more details.)

Candidiasis is a fungal infection, commonly known as "thrush" in infants. It appears as white patches on the tongue and ulcers in the mouth. These patches are sometimes painful, making it difficult to swallow. This fungal infection can also affect the vagina, causing vaginal candidiasis. Symptoms include thick, curd-like vaginal discharge, painful intercourse and redness of the vaginal wall.

Kaposi's Sarcoma is a cancer commonly diagnosed in people living with HIV. Symptoms include dark skin lesions or nodules appearing on different parts of the body. It usually affects the skin, lymph nodes and the mouth. Lesions also can be found in the stomach and the lungs, causing severe breathing problems.

Pneumocystis Carinii Pneumonia (PCP) is an infection of the lungs that can cause severe pneumonia and results in difficult breathing, fever and dry cough. PCP is the leading cause of death of infants with AIDS in India.

■ How to Prevent or Treat Opportunistic Infections

- Maintain regular medical check-ups. Seek medical care at the first sign of sickness.
- Get plenty of rest, good food and nutrition, good hygiene, and avoid alcohol and smoking.
- Avoid infection: Many people fear getting infections from people living with HIV, but in fact they have more to fear from getting infections from "healthy" people.
- Access TB prevention therapy.
- Use available medicines to cure most infections or reduce the impact of the symptoms (e.g., reduce itchiness of skin rashes).

■ Medicine for Treating Opportunistic Infections

- Fluconazole is used to treat severe oral candidiasis or thrush infections. Thrush causes painful little white sores in the mouth.
- Acyclovir is used to treat herpes, which are painful blisters on the lips or genitals.
- Cotrimoxazole is an antibiotic given to people living with HIV whose CD4 count is below 200. This medicine helps to prevent PCP (Pneumocystis Carinii Pneumonia).

■ Other Common Symptoms of AIDS and What to Do

The most common symptoms of AIDS include: weight loss; fevers; breathing problems; digestive problems; and infections of the mouth, skin, and genital areas. Some of these conditions can be treated at home, with support from a health care provider.

Nausea and vomiting. AIDS patients often feel nauseous. Patients should keep their mouths clean by frequently rinsing with clean water and using a toothbrush to brush the teeth and tongue. Nausea can lead to vomiting, making them unable to eat. If the patient is vomiting, he/she should avoid fatty foods and not eat or drink fluids for one or two hours, then gradually increase intake of fluids.

Tiredness and weakness. People living with HIV often feel tired and should rest often. Help them do simple exercises, such as moving their arms and legs. If the patient is bedridden, encourage him/her to regularly move the arms and legs. Turn the patient every now and then. Keep him/her involved in daily home activities and help with daily needs, such as bathing and using the toilet.

Sore mouth and throat. This is a common problem among people living with HIV.

- Rinse patient's mouth with warm, clean water mixed with a pinch of salt
- For white patches in the mouth, give the patient a lemon to suck – but sometimes this may be too painful
- Apply gentian violet solution to sores on the lips
- Use soothing local remedies to help the patient relieve soreness

Pain. To help alleviate pain, give the patient two aspirin or paracetamol tablets every four hours. Make sure the patient does not have an empty stomach when taking aspirin or tablets.

Swelling. Raise the legs or the swollen part of the body on pillows and massage the sore muscle using some oil or soothing cream. Regularly move the patient to change positions.

Fever. Treatment for a fever can include:

- Removing unnecessary clothing and blankets
- Wiping the patient down with a wet cloth, or using a cold compress
- Getting the patient to drink lots of water or other liquids
- Using aspirin or paracetamol (two tablets every eight hours)

If the patient is too hot and the fever continues for a long time or is accompanied by stiffness, severe pain, confusion, yellow color in the eyes, sudden diarrhea or convulsions, seek medical assistance immediately. The fever may be caused by malaria.

Diarrhea. Diarrhea is very common in AIDS patients. The stools are very watery and sometimes contain blood. Patients suffering from diarrhea often get dehydrated. Treatment for diarrhea can include the following:

- Keep the skin clean and dry. Wash with clean water after each bowel movement.
- Treat dehydration with an oral rehydration drink. Add half a flat teaspoon of salt and eight flat teaspoons of sugar to one liter of cooled boiled water. Make a fresh mixture every day. If the diarrhea continues, get help from a health worker.
- Give the patient solid or starchy foods such as rice water.
- Don't feed patients food containing a lot of sugar, which can worsen diarrhea.

Skin Problems. Skin problems include rashes, itching, painful sores, skin dryness, slow healing wounds, boils and abscesses. Each problem may need a different treatment.

Itching. Keep cooling the skin with water. Apply lotions such as calamine. Keep the skin dry.

Wounds. Clean the wounded area with boiled, clean water. Cover with a bandage or cloth wrapped loosely around the wound. Put a warm compress of weak salt water on the wound four times a day (a teaspoonful of salt to one liter of clean water). If the wound is on the foot or leg, raise the affected area as high as possible and as often as possible. During sleep, rest the foot or leg on a pillow. During the day, try to raise the foot for five minutes every 30 minutes. Walking helps circulate blood. Standing or sitting with the affected foot down for long periods is harmful. When wounds are infected, seek medical attention immediately.

Bed Sores. Bed sores are caused by pressure on parts of the patient's body, which often results from lying in the same position for long periods. Bed sores often occur on the buttocks, elbows, hips, back and feet. Treat bed sores by doing the following:

- Get the patient out of bed as much as possible.
- Change the patient's position often, at least every two hours.
- Use soft bed sheets and padding, which should be hung daily to air out. Change sheets when soiled with urine, vomit or sweat.
- Straighten the bedding because lying on wrinkled bedding can hurt the skin.
- Put a cushion under the patient to support bony parts.
- Encourage the patient to eat well. Extra vitamins help to heal the sores.

Shingles. Shingles is a rash, blisters or sores that develop on the chest or back. It is very painful and itchy. Treat shingles by doing the following:

- Apply calamine lotion twice a day to relieve pain and itching.
- Keep sores dry and do not let clothing rub against them.
- Let the patient wear clean, loose fitting clothing.
- Relieve pain with aspirin or paracetamol.
- Bathe sores with clean water three times a day or apply gentian violet solution.
- Watch for signs of infected sores, such as redness or pus.

Boils and abscesses. These are painful, raised, red lumps on the skin that commonly appear on the groin, buttock, armpits and upper parts of the legs. Treatment can include the following:

- Wash boil and abscess with salt water (one teaspoonful of salt in a cup of clean water).
- Put a hot compress over the wound for 20 minutes four times a day. Be careful not to burn the patient.
- If the boil continues to grow, seek medical help.

Difficulties in breathing. People living with HIV often have infections in the lungs and experience chronic coughing and difficulties in breathing.

- Make the patient lie with pillows under his/her head, or with the head of the bed raised on blocks.
- Make the patient sit forward with his/her elbows on his knees or on a low table.
- Make sure someone is there to watch over the patient, as not being able to breathe could make him/her very frightened.

Coughing. If pain is felt in the chest or ribs during coughing, a pillow or hand should be held tightly over the area that hurts. This makes the cough less painful. Where possible encourage the patient to keep walking, turning around in bed or simply sitting up. This helps the lungs to drain. Give the patient a clean cloth to cover the mouth when coughing.

Tuberculosis (TB)

■ What is Tuberculosis (TB)?

Tuberculosis (TB) is a fatal disease of the lungs and other parts of the body caused by germs that create “holes” in the organs they affect. Most TB cases are pulmonary (lungs). TB can travel through the blood and attack other parts of the body, including glands, bones, brain, nervous system and spine.

■ How is TB Transmitted?

TB spreads through coughing, spitting or sneezing sputum (droplet nuclei) into the air. Not everybody who breathes in TB germs will get it. If people are healthy and strong, their body can fight the germs.

■ How Do You Know if You Have TB?

Some of the signs of TB include productive coughing (rather than a dry cough), feeling weak and/or tired, loss of appetite, not being able to sleep and, sometimes, night sweats. If you suspect that you have TB, you should go to your nearest clinic for some tests.

■ TB is Treatable and Curable

The treatment for TB involves taking a tablet every day for six months to one year. After the first two to three weeks of treatment, the patient is no longer infectious. Patients should complete the entire course of treatment; otherwise the TB germs can get stronger and medicine becomes less effective.

■ Do TB Patients Need to be Isolated?

No. Patients are no longer contagious after the first two weeks of treatment. As long as TB patients abide by their treatment regimes, they can eat, sleep and work with others. Special utensils or separate bedding are not necessary. During the first two weeks of treatment, the patient should take precautions to prevent spread of infection by keeping the house well ventilated, and covering their mouth when coughing.

■ What Is the Link between TB and HIV?

If you are infected with TB, it does not mean you have HIV or AIDS. However, if you are living with HIV, you may be more vulnerable to TB because your immune (defense) system may be weak.

If you are HIV-positive, you can take a course of treatment that will prevent you from getting TB. In many places these treatments are freely available.

If you are living with HIV and you do get TB, you can still cure the TB through treatment.

Anti-retroviral (ARV) Therapy

■ How HIV Makes the Body Sick

There are many different kinds of cells in our bodies. One is white blood cells, also known as CD4 cells, which are found in our blood. **White blood cells protect our bodies** by attacking germs that get into the body, keeping us from staying sick.

Once a person becomes infected with HIV, the virus begins to live and spread in white blood cells. **HIV attacks and damages the white blood cells** so that the blood cells cannot do their work of keeping the body healthy. Germs then take advantage of the weakened immune system and attack the body.

The weakening of the immune system takes place over a period of time. People who are infected with HIV do not die right away. A person living with HIV often feels perfectly healthy and feels no sign of sickness. But over time the immune system weakens. The body has to work harder to fight off other germs and diseases.

As the body gets weaker, it is attacked by different opportunistic infections, or AIDS-related diseases, including TB, pneumonia, bowel infection, cancer and meningitis. When the body is too weak to fight these diseases the person is said to have AIDS, a collection of diseases that attack a person after HIV has made the body weak. When the body becomes weak, the person can die.

■ What is Anti-retroviral (ARV) Therapy?

ARV therapy is a combination of medications – usually two or more – that **slow down the growth of HIV in the body**. ARV therapy helps to improve the immune system, helping the body protect itself against AIDS-related diseases. If the ARV therapy is properly taken, a person with HIV can live a healthier, more productive and longer life.

ARV therapy is not a cure for HIV or AIDS. The combination of medicine will reduce the amount of HIV in the body, but the virus is still in the blood. **ARV therapy is lifelong.** If people stop taking treatment, HIV will continue to grow and they will become sick again.

People taking ARV therapy need to **take their medications at the right time and in the right way each day**. If they stop or forget, HIV will become stronger and may become resistant to the medication.

ARV therapy is given to people who are HIV-positive but do not yet have AIDS and to people who have AIDS. **But not every HIV-positive person needs ARV therapy.** ARV therapy is only for those people whose immune systems have been seriously weakened by HIV.

Once a person discovers that he or she is HIV-positive, he or she should get tested to determine if ARV therapy is needed (when the CD4 count is low). A **CD4 count test** measures the amount of white blood (CD4) cells. When a person starts ARV therapy, tests will indicate how well the medicine is working by checking if the immune system is getting stronger. This is indicated through a **viral load test**, which measures the amount of HIV in the blood.

When people start taking ARV therapy, their bodies may react to the medicine. These **side effects** may include: stomach pain, nausea and vomiting, diarrhea, skin rash, excessive tiredness, headaches, tingling feeling in fingers and toes, and sleep disturbances. People should not stop taking the medicine when they have these side effects, but they should report them to their health care provider.

■ **Is ARV Therapy the Only Medication Available for People with HIV and AIDS?**

No. People living with HIV and AIDS often take other medications for opportunistic infections such as TB.

People taking ARV therapy should try to live **healthy and positive lives** to help the ARV therapy fight the HIV in their bodies. Things they can do include:

- **Eating good food and drinking plenty of liquids** to strengthen their bodies and keep up body weight. (People living with HIV lose weight as a result of opportunistic infections or lose nutrients because of diarrhea or vomiting.)
- **Being physically active.** People living with HIV will be healthier if they keep themselves busy.
- **Getting enough sleep and rest** to allow their bodies to recover.
- **Keeping their bodies and homes clean** to help reduce germs that can bring diseases.
- **Practicing safe sex (using a condom).** HIV-positive people can still pass HIV on to others, even if they are taking ARV therapy. By practicing safe sex, they not only protect their partner, but also protect themselves from getting re-infected and increasing the amount of HIV in the body.
- **Living with hope and getting emotional support from family and friends.** This helps people living with HIV feel loved, accepted and better about themselves, strengthening them to live longer and more productively.

■ **How Many Extra Years of Life Can ARV Therapy Give a Person Living with HIV?**

ARV therapy can allow most people to live up to 10 years longer, depending on how advanced the HIV infection had been when the ARV therapy was started. New medications are likely to increase this time period. Lifestyle, diet and adherence also will determine how well ARVs will work.

■ **How Is ARV Therapy Different from Other Medicine?**

It is like other medicine in that it has side effects. The difference is that it requires 100 percent adherence to prevent HIV from becoming resistant to medication.

■ **Why is Drug Resistance Such A Danger?**

In the case of ARVs, drug resistance is particularly dangerous because no other drugs are available to treat HIV and prolong life. A newly resistant strain of HIV could then spread to other countries. This is why the use of ARV therapy requires a lot of responsibility and commitment from everyone.

■ **Why Should People Living with HIV Stop Smoking and Drinking Alcohol?**

Smoking and drinking are bad for a person's health, and tobacco and alcohol break down a person's immune system.

Parent-to-Child Transmission (PTCT)

■ What Is Parent-to-Child Transmission (PTCT)?

When HIV passes from an HIV positive mother to her baby, this is sometimes called “mother-to-child transmission.” This wording has the limitation of singling out women as the carriers of HIV infection. Both parents produce a child and the responsibility of giving birth to a healthy baby lies with both of them. Men can take responsible steps to prevent PTCT and support women in making decisions around childbearing.

■ How Does the Baby Get Infected with HIV?

- **Babies may get infected with HIV while they are in the mother’s womb, though this mode of transmission is rare.** The baby’s blood (circulatory) system is separate from the mother’s system. The fetus is attached to the mother’s uterus by the placenta, which acts as a barrier between the mother and fetus. The mother’s blood carries nutrients to feed the baby after passing through the placenta. The placenta is meant to filter out bad things like infections, but this sometimes fails.
- **Babies may get HIV through direct contact with blood and fluids during birth.** Most HIV transmission occurs during labor and delivery. When the baby travels through the mother’s birth canal, the baby’s skin can get damaged, and HIV can be transmitted when the baby comes into contact with the mother’s blood. A delivery that causes a lot of bleeding from the mother through cuts or instruments used to help the delivery may increase the chances of the baby getting infected with HIV.
- **Babies may get infected with HIV when the mother is breastfeeding.** The chances of the baby getting infected are higher if the mother has a high level of virus in her blood while she is breastfeeding. If the mother has cracked nipples, painful swelling of breasts through mastitis, or if the baby has thrush or sores in the mouth, the risk of transmission becomes higher.

■ Why Do Some Babies Born to HIV-positive Women Get Infected and Others Do Not?

Roughly one third of HIV-positive mothers pass the virus to their babies. The more HIV is present in the mother’s blood, breast milk and other fluids, the higher the chance of transmitting HIV to the baby. The amount of HIV present varies depending on the stage of the illness. Soon after a person is infected with HIV, a lot of the virus is present in their blood and bodily fluids because there are no antibodies to fight it. Later, if the person gets sick with illnesses caused by HIV, the amount of virus goes up. When the person becomes very ill (with AIDS), the virus is very high and can easily be passed on. If a woman becomes infected while she is pregnant or breastfeeding, then the chances of that baby getting infected are higher. If a woman gets pregnant or breastfeeds when she is showing signs of AIDS, the chances are high that the baby will be infected.

■ How to Reduce Parent-to-Child Transmission

The most important way is for men and women to prevent HIV infection. Ideally, parents should be tested for HIV before planning a pregnancy. It is especially important to prevent HIV infection in the expectant mother during pregnancy and later when she is breastfeeding.

During pregnancy, some men may have sex with other women and become infected with HIV. When men resume sexual relations with the mother of their child, she is at risk of contracting HIV. If she becomes newly infected while breastfeeding, the baby is at a higher risk of contracting HIV because the amount of virus present in the blood and milk of the mother is relatively high at this point.

Men should support women during pregnancy, childbirth and breastfeeding. They can avoid infections by staying faithful and avoiding sex with other women. If they are not able to abstain from casual sex, they should practice safe sex and use condoms.

■ How to Minimize HIV Transmission During Childbirth

Most HIV transmissions occur at the end of pregnancy and during delivery. The following practices in childbirth reduce contact between the baby and the mother's fluids during childbirth:

- Women should go to the place of delivery early in their labor so they do not delay after their water has broken.
- Health workers should try not to manually rupture the membranes unless birth is imminent and not use forceps or other instruments during delivery unless the baby's life is in danger. Practices such as cutting the mother's vagina (episiotomies) should be avoided because they result in heavy bleeding for the mother.
- Health workers should routinely wipe out the mother's vagina with antiseptic lotions before delivering the baby. This should be done for all women in labor, whether they are HIV-positive or not.

■ How to Minimize HIV Transmission During Breastfeeding

Breastmilk provides babies with the best nutrition and protection from infection. All mothers are advised to do **exclusive breastfeeding** (feeding the baby only breastmilk) for the first four to six months. Feeding the baby anything besides breastmilk (e.g., cow's milk or other foods) can damage the lining of the baby's gut. If the mother is HIV-positive, the virus can infect the baby through the damaged lining. Babies who receive **mixed feeds** (mixing formula and breast milk or feeding with breastmilk and giving other fluids or solids) are more likely to become HIV-infected than those who receive exclusive breastfeeding or exclusive substitute feeds.

Exclusive breastfeeding is best:

- Give breastmilk only – no solids or other fluids, even water.
- Breastfeed for up to six months – then wean abruptly. After six months, stop breastfeeding completely and change to substitutes without any mixed feeding.

■ **Can Anti-retroviral Drugs be Used to Prevent Transmission of HIV?**

Yes. The ARV drug can be given to the mother twice daily starting from the 36th week of pregnancy and during labor. This short course of ARVs during pregnancy and delivery significantly reduces the risk of HIV transmission from parent to child.

Historically, the tendency has been to view the “mother” as simply a vehicle for producing a healthy baby, and efforts were directed mainly at providing ARV treatment to pregnant women to prevent HIV transmission to the baby. This view is now being challenged and defined in a broader way as a combined set of efforts to:

- Prevent HIV in the first place
- Prevent unintended pregnancies among HIV-positive women
- Prevent HIV transmission from HIV-positive women to their children
- Provide treatment, care and support for HIV-positive women

■ **What is the Effect of Anti-retrovirals on the Mother? Is There any Harm to the Child?**

The ARV slows viral replication and lowers the amount of virus in the body. This reduces PTCT and does no harm to the pregnant woman or her child. However, it does not treat the mother’s HIV infection. The whole purpose of using this drug is to reduce the risk of passing HIV to the child.

■ **What if a Woman Takes Anti-retrovirals for PTCT and Stops?**

When a mother takes ARVs for PTCT prevention her viral load will fall. This is how HIV transmission is prevented. When she stops taking it, her viral load will return to the level she had before she started taking the ARVs. Although the ARVs won’t deal with the mother’s HIV condition, it will not make it worse. It will not increase her viral load or further weaken her immune system.

■ **Is There a Risk of Drug Resistant HIV if a Pregnant Woman Takes ARVs?**

This risk is considered to be minimal when taking a short course of ARVs.

■ **Can a Mother Keep Taking Anti-retrovirals after the Baby is Born?**

Taking a single ARV is not effective in treating HIV. A combination of two and usually three ARVs is needed to treat HIV. Therefore taking a single anti-retroviral over the long term will not be of any benefit. This will also lead to drug resistance.

■ **Shouldn't HIV-positive Women be Discouraged from Having Children?**

It is generally accepted that it is every woman's right to decide for herself whether or not to have children. The responsibility of health workers is to provide HIV-positive women and their partners with comprehensive information about the risks associated with childbearing, the risks of parent-to-child transmission, and the additional burden on the family if the child is HIV-positive. But the final decision is the woman's, and she should not be pressured into not having children. Health workers should support whatever decision she makes.

■ **If a Pregnant Woman is HIV-positive, Shouldn't She Tell her Husband?**

Ideally, all people living with HIV and AIDS should disclose their status to their partners to prevent HIV transmission to an uninfected partner and to gain the partner's support. The couple should be encouraged to come together for counseling and the partner encouraged to seek voluntary testing and counseling to learn his status. However, some HIV-positive pregnant women will feel unable to discuss this with their husbands/partners. They may be worried that they will be blamed, beaten and abandoned. Their worries should be discussed, but the decision whether they disclose or not should be their own.

■ **What about Testing for Pregnant Women?**

The Government of India has adopted a policy of providing HIV testing to all pregnant women on an opt-out basis. This means that HIV testing is offered to all women who come to government clinics for antenatal services, but each woman has the right to decline testing.

Universal Precautions

■ What Are Universal Precautions?

Universal precautions are designed to help minimize the risk of HIV exposure for clients and staff in health care settings. Health care providers should follow them with every client, regardless of whether they think the client may be HIV-positive. This is important because it is impossible to tell who is HIV-positive based on appearance. Blood-borne infections that pose a risk to us go undetected and can be present in the blood of all persons. Diseases do not discriminate, and health care providers should not discriminate.

■ Universal Precautions in Health Care Settings

Use the following precautions to avoid injury and reduce the risk of infection:

Handwashing

- Wash your hands with soap and water after coming into contact with blood, body fluids and contaminated items, whether you have worn gloves or not.
- Wash your hands immediately after removing the gloves and between client contacts to avoid transferring micro-organisms among the clients.

Gloves

- Wear gloves when coming into contact with blood, body fluids and contaminated items.
- Put on clean gloves before touching eyes, nose, and mouth and non-intact skin.
- Put on a new clean pair of gloves between tasks or procedures on the same client after contact with blood or body fluids.
- Rinse gloved hands in 0.5 percent chlorine solution before removing the gloves.
- Remove gloves immediately before touching non-contaminated items and surfaces.
- If gloves are not disposable, wash and disinfect after use with each patient.

Note: Health care providers with open cuts or rashes should avoid direct client contact and should not handle contaminated equipment because breaks in the skin provide points for micro-organisms to enter the bloodstream and cause infection.

Eye Protection

Wear eye protection, face shield and mask to protect mucus membranes of the eyes, nose and mouth during procedures (e.g., during delivery, cutting of the umbilical cord) and client care activities that might produce splashes or sprays of blood or body fluids.

Protective Clothing

- Wear clean, non-sterile gowns to protect skin and prevent clothes getting soiled during activities that might produce splashes or sprays of blood or body fluids.
- If possible, use a plastic or rubber barrier (e.g., apron) to protect clothing if large amounts of soiling are anticipated (e.g., during delivery).
- Remove a soiled gown immediately, placing it in a designated container for decontamination, and wash hands.

Instrument Processing

- Decontaminate, clean, disinfect and/or sterilize the instruments using standard infection prevention procedures.
- Make sure that instruments are not used on another client before this processing has been done.

Handling Sharp Instruments

- Don't recap needles after use. This is the most common cause of needle stick injury.
- Don't bend, break or cut needles after use.
- Don't remove the needle from the syringe before disposal.
- Dispose of used needles in a puncture-proof container immediately after use.

If injured by a contaminated needle or sharp instrument, wash the area immediately with soap and water and then apply post-exposure prophylaxis (PEP).

Maintaining a Clean Environment/Waste Disposal

- Make sure that liquid waste is placed in a container with enough disinfecting solution to kill organisms.
- Make sure that all contaminated waste (e.g., bloody dressings, swabs, tissues, gauze, cloths soiled with body fluids, etc.) is placed in designated and clearly marked containers, collected and taken for incineration or other safe disposal.
- Immediately clean up surface spills of blood and body fluids with a disinfectant solution, such as 0.5 percent chlorine solution, and clean the area with detergent and water.

Handling and Processing Soiled Linen

- When handling linen soiled by blood or body fluids, wear gloves and place items in designated and clearly marked bags. If using a plastic bag, use double bags.
- Transport the soiled linen in a way that avoids puncturing the bag or loss of soiled items on the way to the laundry.
- Wash soiled linen using detergent and germicide following standard infection prevention guidelines.

Universal Precautions Summary

- Regard all blood, body fluids and objects as contaminated and infected.
- Follow the same precautions and procedures of cleanliness, sterility and hygiene that are followed for other viruses, (e.g., Hepatitis B).
- Avoid accidental exposure to areas with broken or cut skin, scratches, rashes, acne, chapped skin or fungal infections.
- Avoid accidental splashes of blood or body fluids, especially on eyes or mouth.
- Report needlestick injuries or accidental splashes to the clinic authorities.
- Dispose of all contaminated materials appropriately.
- Use gloves, masks and protective eye shields when coming into contact with blood or body fluids of the patients.

- Wash hands thoroughly with soap after coming into contact with blood and body fluids, before and after each procedure, and after removing gloves.

Remember–

- (1) Assume that blood and body fluids from all persons are infected with HIV, regardless of the known or supposed status of the person.
- (2) Universal precautions are intended to isolate the virus and body fluids, not the patient.

■ Health Care Providers Can Get HIV through Injuries on the Job

Health care providers can get HIV accidentally through injuries sustained on the job. Two types of injury can lead to HIV transmission:

- Needlestick injuries that pierce skin with contaminated needle or sharp instruments.
- Splashes on the nose, eyes or mouth by blood or body fluids from infected patients.

The risk of HIV infection from these forms of occupational exposure is very low:

- The risk from a needlestick or sharp instrument injury is around 0.3 percent.
- The risk from splashing blood or body fluids on nose, mouth and eyes is about 0.1 percent.

Nonetheless, health care staff need to avoid these forms of exposure.

Support staff who clean up and dispose of contaminated instruments are also at risk of getting HIV through their handling of these instruments.

■ Clients Can Get HIV When Health Care Providers Use the Wrong Practices

Clients also are at risk of HIV infection when health care providers do not clean their hands between clients, or use instruments that are not cleaned or sterilized properly. For example, health care providers may reuse contaminated needles, which have been rinsed in water between injections or the needle is changed but the syringe remains the same for many patients. Water will not kill the blood-borne micro-organisms, and syringes become contaminated because negative pressure is generated when the needle is removed, drawing up whatever blood is in the needle into the syringe. The acceptable standard is one sterile syringe and needle for each client.

■ Community Can Get HIV through Improper Disposal of Medical Waste

The community is also at risk of HIV infection from the poor disposal of medical waste, such as contaminated sharps, and other practices:

- Improper disposal of medical waste, including contaminated dressings, tissues, needles, syringes and scalpel blades. These items can be found by children or others scavenging in open dumps. Medical waste is often scattered on the ground in areas where adults and children travel, putting them at risk of infections and injury.
- Not providing information to family members who are caring for people living with HIV and AIDS on how they can protect themselves.

■ **Post-exposure Prophylaxis (PEP)**

Post-exposure prophylaxis (PEP) is the anti-retroviral (ARV) treatment provided to a health care worker following exposure to HIV.

The PEP procedure aims to reduce the chances of getting infected and involves the following:

Immediately Following Exposure:

- Report exposure to the relevant authority and treat the condition as an emergency.
- Immediately flush the injured area with running water.
- Wash your hands with soap and water.
- Where there is bleeding, allow the skin to bleed briefly.
- If the eyes or mouth were exposed to blood or body fluids, flush the area with lots of water. If the eyes have been affected, wash with clean water, saline or sterile irrigating solution.
- Provide counseling for the injured health care worker.
- Determine the HIV status of the source patient (using testing if necessary), following counseling and informed consent. If the source patient is HIV negative, there won't be a need to use ARVs.

If the Injured Health Worker Decides to Take PEP

- Start the ARV treatment as soon as possible after the injury (i.e., ideally within two hours and at most within 24 hours).
- Provide counseling.

Follow-up Care for Health Staff Taking PEP

- Organize regular testing for up to six months after exposure.
- Provide ongoing counseling and support to the health care worker as needed.

This document is based on information provided in: Reducing Stigma and Discrimination in Health Care Settings: Participants' Handbook and Trainer's Guide (EngenderHealth, 2007); Draft Training Manual for Sensitizing Health Care Workers on HIV/AIDS. (SHARAN and Population Council/Horizons, 2002).

Care and Support for People Living with HIV

■ Care and Support for People Living with HIV

People living with HIV and their families need care and support to face the challenges of HIV infection. They have many needs, which vary according to the stage of infection.

They need a comprehensive set of services as well as a continuum of care for prevention, care, treatment and support provided by the family, community and health workers who are working together in a coordinated response.

Comprehensive care responds to all the needs of a person living with HIV in a holistic way and goes beyond just medical treatment. It includes: diagnosis; treatment; referral and follow up; nursing care; counseling; advice on food and nutrition; ideas on income generation; and support to meet psychological, economic, social and legal needs.

Continuum of care means responding to the full range of care and support needs in different places – home, community, hospital – throughout the stages of the illness for a person living with HIV. Continuum of care involves a network of services provided by different players including families, community, health care workers, counselors and support organizations for people living with HIV. This continuum requires a good referral network and linkages between different players and different levels of care – hospitals, clinics, communities and homes. Different players have different roles (e.g., diagnosis and treatment by hospitals, care in the community provided by nongovernmental organizations (NGOs), and home-based care provided by families). Health care workers need to learn how to provide a broader range of services and be able to refer patients to other available services.

Care and support for people living with HIV can:

- Improve their quality of life
- Help keep them healthy and able to work as long as possible
- Build up their confidence and hope
- Decrease stigma and discrimination
- Help prevent the spread of HIV to other people

An HIV-positive person goes through a number of stages of illness. Care needs to be organized in relation to each stage. The five stages are:

- (1) Uninfected but at risk
- (2) HIV-positive with no symptoms
- (3) Early HIV disease
- (4) Late disease or AIDS
- (5) Terminal stage

■ Different Ways to Address Care and Support Needs

- Counseling and basic information
- Support groups and networks of people living with HIV
- Home-based care
- Community-based approaches and community mobilization
- Support for children orphaned by AIDS
- Clinical guidelines for individual patient management
- Improved access to essential drugs
- Hospital-based services for HIV and AIDS management
- Palliative and terminal care

■ Palliative Care

Palliative care is designed for someone who is dying. This includes psychological, emotional, spiritual and physical care of the person and the people close to that person (e.g., friend, spouse, family or partner).

Goals of palliative care:

- To provide the patient with as much control over their symptoms as possible.
- To keep the patient comfortable.
- To assist the person in coping with the impact of HIV infection.
- To help the person, their families and caregivers organize their lives.
- To prepare the person and their loved ones for death.

Palliative care begins when:

- Medical treatment is no longer effective.
- The person or relatives decide that they do not want to continue the treatment.
- The body's vital organs begin to fail.
- The relatives opt to have the patient discharged from the hospital or medical facility.

■ Terminal Care and Support

Most people living with HIV will require some form of terminal care. This can be provided either in the hospital, in a terminal care center or in the community and home with help and assistance. Care includes:

- Effective analgesia/pain relief;
- Management of distressing symptoms;
- Spiritual and emotional support for the dying person;

- Spiritual and emotional support for the caregiver and family;
- Training caregivers in basic skills, if care is managed at home; and
- Assistance with material needs.

■ **Signs of Imminent Death**

Some signs indicate death may be imminent, but these are general and will not apply to all people. In some cases, death comes unexpectedly. As death approaches, a patient's level of consciousness often decreases or she/he becomes unconscious. However, keep communicating to the person even if you get no response.

Breathing is often difficult, irregular and noisy. Sometimes a person might have trouble with mucus in the throat, which causes them to gurgle because they are unable to cough it out. The person's skin can become pale and cool, covered in perspiration, and their hands and feet turn blue. During this time, ensure that the person is comfortable.

■ **Support for Those Preparing for Death**

- Allow the person and his/her family to talk about how they are feeling.
- Enhance self-esteem by looking at life achievements and reflecting on past events.
- Accept people's feelings of anger, grief and other emotions and reactions.
- If the person asks, and having assessed what they want to know, describe what will happen as he or she nears death. Give reassurances about controlling the pain and symptoms resulting from the process of dying, where possible.

■ **Bereavement Counseling Principles**

- Help the survivor absorb the shock of the loss. One of the best ways to help the survivor is to talk about the loss. The counselor can encourage this.
- Ask questions such as, "Where did the death occur? How did it happen? Who told you about it? Where were you when you heard it?"
- Help the survivor identify and express feelings. Expressing feelings may be difficult for some people. Anger, guilt and sadness need to be addressed.
- When the deceased has a partner, help the person deal with the loss by facilitating his/her ability to live without the deceased. The counselor can help the person to learn coping and decision making skills so the individual will be able to take over the role of the partner.
- Facilitate emotional withdrawal and encourage the survivor, in time, to form new relationships.
- Provide time to grieve.
- Examine defenses and coping styles. It is important to examine coping styles and determine whether if these are healthy or unhealthy. The counselor can highlight the different coping skills and help the client to evaluate their effectiveness.

■ Effective Approaches for Care and Support

Comprehensive Care and Support

The comprehensive care concept covers medical treatment, nursing care, counseling and other social and psychological support for people living with HIV, their families and dependents.

- It requires establishing an effective mechanism for linkages between the different levels of care – hospitals, health centers, communities and homes – through a good referral network
- Using this model – integrated AIDS care as part of general health services – hospitals will provide diagnosis, clinical management and treatment of acute conditions, while care in general is intended to be provided in a community setting by NGOs and at home by the family members.

Comprehensive care consists of four interrelated elements:

1. **Clinical management** – early diagnosis and treatment and planning for follow up care of HIV related illness;
2. **Nursing care**- care to promote and maintain hygiene and nutrition, provide palliative care, educate individuals and families and practice infection control by observing universal precautions;
3. **Counseling** – psychological support, promoting positive living and helping individuals make informed decisions on HIV testing, planning for the future and behavioral changes and involving sexual partners in such decisions; and
4. **Social support**- information and referral to support groups, welfare services and legal advice for individuals and families, including surviving family members.

■ Communities

Communities have major roles to play in care and support of people living with HIV. Communities should organize care and support to people living with HIV and to their families and make full use of the existing programs from the government and NGOs in the health and social sectors.

Gender Violence: What Is It?

What Can We Do?

■ What is Gender Violence?

Gender Violence is when a man abuses or exerts his power to cause harm to a woman or girl. It is humiliating, painful and terrifying. The aim of the abuser is to intimidate, dominate and control the other person.

■ What Are Forms of Gender Violence?

Gender violence takes four forms:

Physical: Hitting, slapping, punching, kicking, scratching, choking, pulling hair, biting, stabbing or hitting with a weapon, cutting, burning, throwing objects, throwing gasoline or acid into face, forcing wife to abort a child, or dowry killings.

Emotional: Insulting; belittling; scolding; jealous suspicion; threatening; shaming and blaming the wife for having no children, having a girl, not raising children properly, etc. , or threatening the wife for questioning the husband's extra-marital affairs.

Economic: Controlling all household spending, withholding necessary household money, wasting family money (e.g., drinking, playing cards), preventing wife from earning money, forcing wife to do work against her will, grabbing the money she has earned, forcing a wife/daughter to do excessive work, or dowry harassment.

Sexual: Forcing a woman to have sex against her will (marital rape), forcing her to do oral/anal sex, inflicting pain during sex, preventing wife from using birth control, refusing to use a condom when wife has concerns about sexually transmitted infections (STIs) including HIV. Sexual violence also includes rape, sexual teasing and coercion at work places or schools, and incest.

■ What Are the Effects of Gender Violence?

Gender violence results in the following:

Physical: Cuts and bruises; broken bones and other injuries; chronic back or neck pain; beatings to the head, which may result in brain or eye damage or hearing loss; disability (e.g., loss of function of fingers, hands, legs); disfigurement; miscarriages; exposure and increased vulnerability to STIs and HIV.

Psychological: Feeling belittled or worthless; shame; fear; isolation; loss of self-esteem; self-blame and denial; loss of sense of control over life; stress; anxiousness; depression; sleeplessness; feeling suicidal.

Economic: Deprived of income and economic support; loss of property; reduced ability to work and generate income.

Effects on family: Family breaks up through desertion, separation, divorce, property loss; children are fearful of violence, unable to talk, depressed, drop out of school.

Effects on HIV Epidemic: Because of fear of violence, the woman cannot negotiate safe sex, so she cannot protect herself from getting HIV. She does not tell her husband if she discovers she has a STI or is HIV-positive. As a result she may get infected or she may infect her husband, and the HIV epidemic spreads.

■ What Are the Causes of Gender Violence?

The central cause of gender violence is **gender inequality**, or unequal power relations between men and women. Men have been socialized to dominate and control women; and women have been socialized to submit to men and not question male behavior. Women are treated with contempt, stigmatized as “inferior,” “bad luck” and “a burden.” Given this lack of respect, men feel they have a right to abuse women.

Some men treat women as property: They feel they own them so they have a right to do anything to them without being questioned. They also feel it is acceptable to express their anger through intimidation, verbal abuse or physical beating. Some men think that beating women is “a form of discipline.”

There are a number of “triggers” to gender violence, including poverty; alcohol; men’s insecurities and jealousies; perceptions that a woman is “talking back” or “disobeying”; arguments over money; an women’s perceived inability to bear male children, dowry pressures, etc.

■ Why Don’t Women Report Violence to Authorities?

Women don’t report violence to the police for the following reasons:

- They fear that if they report the violence, the physical violence will continue.
- They also fear they will lose economic support and be kicked out of the home.
- They fear that reporting the violence will bring shame on the family.
- They have been taught to stay silent and protect the family secrets at all costs.
- Women are not aware of their rights and have accepted gender violence as a norm.

■ Gender Violence, STIs and HIV

- Men who have sexually transmitted infections (STIs) like HIV and knowing this have sex with women are perpetuating a form of sexual violence. If a man who has STI symptoms has unprotected sex with a woman, he knows he is giving her the STI too. He may also be HIV-positive, since STI and HIV co-infection is relatively common. If he is HIV-positive and has sex while he has open sores or a discharge on his penis, the risk of giving HIV to the woman is greatly increased.
- Fear of violence prevents a woman from protecting herself from HIV or STIs. She is afraid she will be beaten if she refuses to have sex or asks the man to use a condom, even if she knows he has been having sex with other women or that he has HIV or STIs. So she finds it difficult to protect herself from HIV or STIs.
- Fear of violence stops a woman from telling a man that she has an STI or HIV. This fear stops her getting treatment for the STI from a health care provider, because she cannot do this without her husband’s consent. As a result she will continue to have unprotected sex with her husband and give him the STI or HIV.

- Sexual violence, which involves forced sex, increases risk of HIV transmission. Sexual violence results in bleeding in the vagina and small internal cuts or sores that make it easier for the virus to be transferred.
- Women are vulnerable to getting HIV because of their vulnerability to other forms of violence such as rape in the workplace or in the community.
- Women's fear of violence, which limits their control over their sexual lives, is a major factor in the growing spread of HIV in India.
- Women face severe violence when HIV or STIs enter the home. They are the first to be blamed and abused (for getting HIV) even if the husband is the carrier. Women are beaten, chased from their homes, abandoned to relatives, and lose their property. When women become sick, they are abandoned and left on their own.

■ Cycle of Domestic Violence

Domestic violence often follows a pattern. The man first abuses the woman verbally, starts to slap her, and then moves to battering. Following this there may be a "honeymoon" phase, when the husband is loving and kind. However, the cycle usually repeats itself.

■ Women's Response

Many women who suffer through a long-term, violent relationship are often reluctant to get out of the relationship. Men may threaten women to keep them from leaving. Women may feel unable to tell their relatives, fearing that they will be blamed or not taken seriously. Women also may fear losing their children or that the children will be harmed if there is an open conflict in the marriage. Women may not want to break up the family, admit the marriage has failed or they may simply have nowhere to go. Sometimes they have no choice but to stay in a violent relationship. But nobody chooses to be beaten.

■ How Does the Community View Gender Violence?

Gender violence can be seen as normal. Communities may believe men have the right to beat their wives as a form of discipline.

Health care providers may see gender violence as normal. They treat it as an "accident," rather than something they need to take action on.

Gender violence is perceived as a "domestic affair," which needs to be resolved at home, not taken to the police station. Communities often believe that women should not tell others about being beaten by their husbands.

■ Gender Violence is Wrong

- **Gender violence is painful and humiliating.** It destroys women's health and self-esteem, their productivity, and the health of the family and community.
- **Gender violence also fuels the HIV epidemic.** Women become silent out of fear and don't disclose their status to others – and in this way HIV keeps moving.

- **Gender violence not acceptable.** Even a slap is violence. Gender violence should be stopped, rather than accepted in silence.
- **There is no excuse for violence.** Nobody deserves to be beaten. Women have the right to be safe from all forms of violence.
- **Assault is a criminal offense.** People who beat women should be held accountable for their behavior.
- **Health providers should do more than patch women up and send them home.**

■ **What Can a Community Do to Fight Gender Violence?**

- Talk with family, friends and clients and encourage community leaders to speak out against gender violence. Get people talking openly and make this problem visible.
- Help everyone – men, women and children – understand that gender violence is wrong.
- Stand up and challenge others when they “blame and shame” women. Stop the stigma toward women and girls. Women should be respected.
- Reach out to abused women and support them. Once they feel accepted, they will be more open to discussing their situation with others and getting help.
- Empower women and educate them on how to get support when abused.
- Form women’s groups and encourage women to support each other.
- Encourage women to report violence to police and get police to treat them seriously.
- Get police to enforce existing laws on domestic violence.
- Address problems of excessive drinking.

■ **What Can Health Care Providers Do to Counsel Women who Have Been Abused?**

- Welcome the woman and make her feel comfortable. Treat her with respect.
- Meet with the woman without her husband and help her decide what she wants to do. Don’t try to counsel the couple together and “negotiate violence.” This is not inappropriate when one partner dominates the other.
- Give her time to tell her story and express her feelings. Let her do the talking.
- Give her your full attention and listen attentively. Remember – a good counselor has big ears, big eyes, and a small mouth.
- Listen to and believe what she has to say. She needs a friendly, supportive ear, not a challenging or accusing response. She needs help, not disbelief or hostility.
- Build on her strengths. Compliment her on what she has achieved so far, her coping strategies and survival skills such as coming to see you.
- Don’t question her behavior by asking questions such as “What did you do to make him so angry?” or suggest that her behavior provoked the violence. Focusing on her behavior will not solve the problem: The problem is with the man’s controlling behavior.

- Tell her:
 - a) You will treat her information in confidence, and you will not tell other people.
 - b) She is brave to talk about her problem. It is sometimes difficult to talk about these things – sometimes it feels easier to stay silent and suffer.
 - c) Violence is wrong. No one has the right to beat another person.
 - d) Getting beaten is not her fault. She did not ask to be beaten.
 - e) Her feelings of love, anger, betrayal, hope, fear, sadness, guilt are all normal.
- After she has explained her situation, get her to talk about what to do next. Be realistic and do not frighten her.
- Help her plan for her safety. Don't tell her what to do. Help her consider her options, but empower her to make her own decisions.
- The woman will decide if she wants to press charges. Many women want to end the violence, but maintain the relationship. If she leaves, she might lose her home, economic support and children so this is a difficult choice.
- Some health care providers may refuse to take responsibility for this type of case, saying "It is not a health issue." Gender violence, however, is a health issue – it results in injury, chronic health problems and even death. If a woman reports her case and you see her injuries, you are obliged to help get it reported to the police.

■ **How to Advise a Woman on Her Options**

- Discuss which trusted people might support her to cope with the situation.
- Discuss going to the police to take legal action.
- Discuss options to prevent or end the violence and help her decide on the best course of action. Her options might be:
 - Leave her husband and live with a supportive person.
 - Get support from others (e.g., community leaders, relatives, friends) to change the man's behavior.
 - Build the woman's support network to pressure the man to change.**
 - Address triggers that result in violence such as alcohol abuse
 - Support the woman to go to the police.
- Consider the pros and cons of each option. This will help the woman make an informed decision. Do not expect a quick solution to the problem of violence. It often takes time for a woman to work through her feelings and options.
- Support the woman to choose what action she wants to take.

Annex 2: Making Your Own Training Program

Sample Timetables for Different Types of Workshops

■ Introduction

This annex provides sample timetables for the following workshops:

- I. Nine-day Course for Registered Medical Practitioners (over several months)
- II. Nine-day Course for Traditional Birth Attendants (over several months)
- III. Four-day Workshop for Staff of a Community or Primary Health Center
- IV. One-day Joint Workshop for Health Workers (Action Planning)
- V. Three-day Community Workshop
- VI. Half-day Workshop for Policy-makers

Note: Some program timetables include medical topics, such as universal precautions, that have no corresponding toolkit module. We suggest you work with a qualified medical professional to prepare and deliver these modules.

I. Nine-day Course for Registered Medical Practitioners

Day	Modules Covered
1	Introduction to Stigma – Animal Cards (A1) Naming HIV Stigma through Pictures (A2) Assessing Knowledge and Fear Levels (D1)
2	Naming Gender Violence through Pictures (B1) How It Feels to Be Stigmatized – Reflection (A3) Basic HIV and AIDS Knowledge (D2)
3	Stigma and Violence in Different Contexts (A5) Comparing AIDS, Cancer, Leprosy and TB (A14) Fears about Non-sexual Casual Contact (D4)
4	Naming Stigma in our own Workplace (A6) How It Feels to be Abused – Reflection (B3) Technical Knowledge – Universal Precautions I
5	When HIV Enters the Home – Stigma and Violence (A12) Sexual Rights and Responsibilities (B7) Technical Knowledge – Universal Precautions (continued from day 4)
6	How Health Providers Are Stigmatized (A8) How It Feels to be Stigmatized – Testimonials (A4) People Living with HIV Have Rights and Responsibilities (C5)
7	Forms, Effects and Causes of Stigma – Problem Tree (A9) Violence in the Workplace – How We Treat Battered Women (B4) Counseling Skills
8	Women’s and Men’s Life Cycles – Stigma and Violence (A13) Forms, Effects and Causes of Violence – Problem Tree (B2) Technical Knowledge
9	How to Mobilize the Community to Stop Gender-Based Violence (B6) Action Planning

II. Nine-day Course for Traditional Birth Attendants

Day	Modules Covered
1	Introduction to Stigma – Animal Cards (A1) Naming HIV Stigma through Pictures (A2) Assessing Knowledge and Fear Levels (D1)
2	Naming Gender Violence through Pictures (B1) Stigma and Violence in Different Contexts (A5) Basic HIV and AIDS Knowledge (D2)
3	How It Feels to be Stigmatized – Reflection (A3) When HIV Enters the Home – Stigma and Violence (A12) Fears about Non-sexual Casual Contact (D4)
4	Things People Say about People Living with HIV (C3) How It Feels to be Abused – Reflection (B3) Forms, Effects and Causes of Stigma – Problem Tree (A9)
5	Judging People (C4) Gender, Violence, and HIV and AIDS (B5) Comparing AIDS, Cancer, Leprosy and Tuberculosis (A14)
6	Women’s and Men’s Life Cycles – Stigma and Violence (A13) Naming Stigma in our own Workplace (A6) Technical Knowledge – Universal Precautions I
7	Sexual Rights and Responsibilities (B7) Forms, Effects and Causes of Violence – Problem Tree (B2) Technical Knowledge – Universal Precautions (continued from day 6)
8	How It Feels to be Stigmatized – Testimonials (A4) Effects of Stigma on the HIV Epidemic (A11) People Living with HIV Have Rights and Responsibilities (C5)
9	Violence in the Workplace – How We Treat Battered Women (B4) Counseling Skills Action Planning

III. Four-day Workshop for Staff of a Community or Primary Health Center

Day	Modules Covered
1	Introduction to Stigma – Animal Cards (A1) Naming HIV Stigma through Pictures (A2) Basic HIV and AIDS Knowledge (D2)
2	Naming Gender Violence through Pictures (B1) How It Feels to be Stigmatized and Abused – Reflection (A3 and B3) Stigma Walk – Mapping Stigma in a Health Facility (A7)
3	Naming Stigma in Our Own Workplace (A6) Judging People (C4) Forms, Effects and Causes of Stigma – Problem Tree (A9)
4	Violence in the Workplace – How We Treat Battered Women (B4) People Living with HIV Have Rights and Responsibilities (C5) Action Planning

IV. One-day Joint Workshop for Health Workers

Note: After registered medical practitioners, traditional birth attendants and community health workers have completed their own trainings, this is a joint workshop for health workers to plan community education on HIV stigma and gender-based violence.

Day	
1	Sharing about the Impacts of the Training Analysis of Causes of Stigma and Gender Violence in the Workplace, Home, and Community – Possible Solutions Action Planning by Each Cadre (Solutions and Action Plans) Joint Action Planning – Planning Community Education Rallies to be Organized Jointly by Health Workers (with Network of People Living with HIV)

V. Three-day Community Workshop

Note: This workshop could be organized by health workers who were trained in the workshops described above.

Day	Modules Covered
1	Naming HIV Stigma through Pictures (A2) Stigma and Violence in Different Contexts (A5) Assessing Knowledge and Fear Levels (D1) Basic HIV and AIDS Knowledge (D2)
2	Fears about Non-Sexual Casual Contact (D4) Judging People (C4) When HIV Enters the Home – Stigma and Violence (A12)
3	Forms, Effects and Causes of Stigma – Problem Tree (A9) Effects of Stigma and Gender Violence (A10) and Effects of Stigma on the HIV Epidemic (A11) Action Planning

VI. Half-day Workshop for Policy-makers

Note: This workshop could be organized for senior government policy-makers to raise their awareness on HIV stigma and gender-based violence.

Day	Modules Covered
1	Naming Stigma through Pictures (A2) How It Feels to be Stigmatized – Testimonials (A4) Stigma and Violence in Different Contexts (A5) Forms, Effects and Causes of Stigma – Problem Tree (A9) Action Planning

Annex 3: Games for Training

■ Openers and Name Games

Write Your Name in the Air: Ask participants to write their name in the air – first with right hand; then left hand; and then both hands, elbow, nose, knee or foot.

Rhyming Names: Each person introduces him/herself with a “rhyming” adjective that starts with the same letter). Example: “I’m **Chandramma**” and I’m **Charming**” or “I’m **Harish** and I’m **Happy**.” As they say this, they can also mime an action that describes the adjective.

Throwing Names: Participants stand in a circle. Throw a ball to someone in the circle, saying his/her name as you throw it. The person who catches the ball throws it to another person and says his/her name, and so on. Once everyone has caught the ball, add extra balls so several are being thrown at the same time, following the same pattern.

Find Your Partner: Before the game starts, prepare a list of famous couples (e.g., Bill Clinton and Hillary Clinton, Mahatma Gandhi and Kasturba Gandhi) and write each name on a piece of paper. Stick each paper to the back of each participant. Tell participants who they are and ask them to find their partners. After pairs are formed, one partner will introduce his/her partner to the rest of the group.

Three Greetings and Run (Howdy, Howdy): Participants stand in a circle holding hands. The leader walks around the outside of the circle and touches someone on the back. The two people race around the circle in opposite directions. When they meet, they stop and greet each other three times. Then both continue going around the circle until they reach the empty place. Whoever loses walks around the outside and touches a new person and the game continues.

Groups Game: Explain that the purpose of the game is to get organized into different groups. Ask people to walk around and when the music stops, call out a type of group and ask everyone to join their group. Start with simple groupings to break the ice: two’s, four’s, eight’s. Then add other categories: “Gender, age, village, occupation, height, marital status, favorite food.” At the end bring everyone together into one big group and ask, “How did it feel to form into certain groups?” (e.g., some groupings are stigmatized, such as certain professions).

■ Paired Games

People to People: Divide into pairs. A caller shouts, “Front to Front,” “Back to Back,” “Foot to Foot,” and pairs are expected to follow directions. When the caller shouts “People to People” everyone finds a new partner. The person left without a partner becomes the new caller.

Mirror Image: Divide into pairs. Decide in each pair who is the mirror (B) and who is the person looking into the mirror (A). A initiates actions and B mirrors all the actions, including facial expressions. After a while, players reverse roles.

Leading and Guiding: Divide into pairs. In each pair, one participant puts on a blindfold. Her partner then leads her carefully around the area, making sure she doesn't trip or bump into other participants. After some time, the facilitator asks the pairs to swap roles. At the end, participants discuss how they felt when they had to trust someone else to keep them safe.

■ Games In a Circle

Passing Objects around Circle while Singing: Ask each participant to pick up any object (e.g., stone, pen, etc.) At an agreed signal, everyone starts singing a song and passing the objects around the circle to the rhythm of the song.

Clap Exchange: Send a clap around the circle (e.g., two hand claps then one double-handed clap with your neighbor). The neighbor repeats the same claps and passes it to the next person, and so on. Do this as fast as possible. Send many claps around the circle at the same time.

Mime the Lie: Walk into the circle and mime an action (e.g., swimming). The person next to you in the circle (B) asks, "What are you doing?" You respond, for example, "I am praying." Then B walks into the circle and mimes what you said you were doing (praying). When C asks what B is doing, B also lies, saying "I am jogging," and so the game continues until everyone in the circle has had a turn at doing one thing but saying they are doing something else.

Nodding Game: Usually, we nod our head when we say yes and shake it when we say no. In this game, we do the opposite: For yes, shake your head and for no, nod your head. Go to one participant and ask questions. If the answer is yes, the person should say yes by mouth and shake his head; if the answer is no, then he should say no by mouth and nod his head. If anybody makes a mistake, he becomes the person who asks the questions. This game shows that changing our behavior is not easy, but through practice we can learn new behaviors.

O Kovalamma! Go around the circle and ask each participant to say, "O Kovalamma," going round the circle, one at a time. Each person should say it with a different emotion (e.g., fear, anger, sadness, excitement).

Seven Clap: Ask participants to count around the circle (1, 2, 3, 4, 5, etc.) Don't say "seven" or a multiple of seven (e.g., 14) or any number that has seven in it (e.g., 17) but clap instead. If someone makes a mistake, the person drops out and you start the counting again from one.

Shopping List: One person starts by saying, "I am going to the market to buy fish." The next person says, "I am going to the market to buy fish and potatoes." Each person repeats the list and then adds an item. The aim is to remember all of the items that people before you have listed.

Sagidi Sagidi Sapopo: Teach a simple chant: "Sagidi Sagidi Sapopo." Everyone repeats the chant together until they find a rhythm. Each person looks at the person to their left while chanting. The leader starts the activity by doing a simple action along with the chant (e.g., touching chest, slapping thigh or putting hands in the air). Each time the group repeats the chant, the leader initiates a new action, while at the exact same time the person to the leader's right copies the leader's action from the last repetition. As the chant is repeated, each person copies the action of the person to his left, until everyone is doing a different action.

■ Communication Games

Muddling Messages (The Whisper): Participants sit in a circle. Think of a long message (e.g., “I’m going to go to the market to buy bananas, mangoes and a goat. Then I am going to meet my cousin for lunch.”) Whisper this message to the person to the right and continue around the circle. Once the message has been passed around the circle, ask the last person to say the message aloud. Compare the final message with the original version. Discuss the following questions: (1) Why did the message change? (2) How could people in the group have ensured that it was passed around the circle unchanged? (3) How does this game relate to communication in real life?

Pass the Picture: Ask five volunteers to leave the room. Those who remain draw a few pictures on a flipchart (e.g., a person, a house, a tree and some animals). Then hide the picture and ask the volunteers to return. One volunteer is shown the picture. The volunteer then describes the picture in words to the second volunteer, who in turn describes it to the third volunteer and so on. The fifth volunteer draws the picture on a new flipchart sheet as she understands it. She should receive no help from the rest of the group. When she has finished, compare it with the original picture. There should be some interesting differences.

Yes/No Game: Form two lines facing each other. Explain that one group is the “YES” group and can only use the word “YES.” The other group is the “NO” group and can only use the word “NO.” Each group should try to convince the other group of the truth of what they are saying, but can only use the one word, either “YES” or “NO.” After a minute or so, get the groups to swap roles, with the “YES” group saying “NO” and vice versa. After the game discuss the following question: “How did you feel doing this exercise?” Include comments on body language, use of attacking or avoiding stances, laughter, etc.

■ Cooperation Games

Knot: Form groups of eight people. Ask each group to stand in a tight circle. Each person reaches out and holds the hands of **two** other people across the circle, not the people on either side of him. He should **not** hold the hands of the same person; they should be two different people. This creates a “knot.” The aim is to untangle without letting go of hands until everyone is standing together in one circle. Talk about the experience after the game.

Tsunami: Draw five, non-overlapping circles with chalk on the floor, big enough to fit all participants. Give each circle, or “island,” a name. Then say that one island will be hit by a tsunami so those people will have to move quickly to another island. Allow the suspense to build, then call out the name of the island that will be hit. Participants run to the other islands. The game continues until everyone is squashed into one island. Afterwards, discuss the game with participants, focusing on cooperation (or lack of it) within the group.

Group Statues: Ask participants to walk around the room, loosely swinging their arms and gently relaxing their heads and necks. After a short while, shout out a word (e.g., “peace.”) The whole group must instantly strike a pose to show what the word means to them. Repeat several times.

■ Competitive Games

Tiger-Man-Gun: Divide into two teams. Introduce three symbols: (1) TIGER (action: claws raised in the air and a roar); (2) MAN (action: hands folded across chest); (3) GUN (action: hands pointing a gun). Then explain the scoring system: TIGER wins over MAN; MAN wins over GUN (MAN controls GUN); GUN wins over TIGER. Ask each team to secretly decide on their symbol. Then get the two teams to line up facing each other. At a signal, teams show their symbols. Announce the winner. Then ask teams to select another symbol (secretly), and the game continues.

Thread the Needle: Divide into two teams of equal numbers (no more than 10 people each). Ask teams to form a line and hold hands and then face the other team. Each team should number off. A leader shouts out two consecutive numbers (e.g., four and five), the fourth and fifth persons in each line hold his/her hands up high creating a hole. The rest of the team then “threads the needle” – moves through the gap – without dropping hands. Team members at both ends run through the hole (with other team members following) and back to their original position. The first team back in its original position without breaking the line wins. Repeat this several times. Ask one participant to be the judge.

Killer Wink: Ask someone to be the “killer” in advance of the game or through a piece of paper distributed to all participants (all papers are blank, except one paper that has “KILLER” written on it). Then explain the rules to all the players: The one killer murders people with a wink. Everyone should walk around the room in different directions, keeping eye contact with everyone you pass. When the killer passes you, he may wink at you. If he does you are dead, but wait a few seconds before dying so you don’t give away the killer’s identity. The killer should keep his winks secret to protect his identity. The game continues until someone guesses the killer.

■ Energizers

Fruit Salad: Set up the chairs in a circle so that there is one less chair for the number of people in the group. Then allocate fruit names to each participant (e.g., orange . . . banana . . . mango orange . . . banana . . . mango . . . orange . . .). Call one of the names (e.g., orange), and all the “oranges” have to stand up and run to another seat. As the caller, you also run and find a seat. Whoever is left without a seat becomes the new caller. When the caller shouts, “Fruit Salad,” everyone has to stand up and find another seat. If the room is hot, or if people are too old to run, ask participants to walk.

The Wind Blows For: Set up the chairs in a circle so that there is one less chair for the number of people in the group. Then shout, “The wind blows for. . . .” and add a descriptive phrase (e.g., “everyone wearing a watch.”) Everyone who is wearing a watch has to get up and run to another chair. As the caller, you also run and find a seat. Whoever is left without a seat becomes the new caller. Other examples include: “The wind blows for everyone who . . . has a beard, wears glasses, is single, is in love, ate too much for lunch!”

Touch Blue: Ask participants to walk around. When you shout “touch blue,” each player has to find something blue on another player and touch it. Then give other instructions: “Touch . . . someone with beard, wearing glasses, something yellow, someone wearing sandals, etc.” Each time, participants must touch what the leader calls out.

Pass the Action: Players sit in circle. “A” stands in the center of the circle. “A” walks toward “B,” using a specific action (e.g., hopping or walking with hands above the head). When she reaches “B,” “B” walks to the center of the circle using “A’s” action. When “B” reaches the center, he walks toward “C” using a new action or movement. The game continues until everyone has taken part.

■ Elimination (Stigma) Games

Many games “stigmatize” players by forcing them to drop out of the game for making a “mistake.” This represents a form of stigma. These games can be used to trigger discussion on how it feels to be excluded from the group. After playing, stop and ask those who were eliminated, “How did you feel when you were eliminated and left sitting watching the other players?”

Idli, Puri and Dosa: Explain the three actions: (1) IDLI (fingers pointing down), (2) PURI (fingers pointing up), and (3) DOSA (trace two circles in the air). Call out the words one at a time and ask participants to do the actions. Anyone who makes a mistake is out of the game.

ON the Bank – IN the River: Draw a line representing the river bank and ask participants to stand behind the line. When the leader shouts, “IN the river” everyone jumps forward over the line. When the leader shouts “ON the bank,” everyone jumps backwards over the line. If he says “ON the river” or “IN the bank,” participants who move have to drop out of the game.

Simon Says: Ask participants to find an empty space with enough room around them to swing their arms. When you say, “Simon says do this” and follow this by some movement or action (e.g., swinging your arms at your sides), the whole group should copy the action. When you say “do this” without including the words “Simon says,” participants should remain motionless (i.e., do not copy the action). Build up a rhythm of instructions using “Simon says” and then suddenly add a new action saying “Do this.” For example: “Simon says lift your right foot. Simon says put your hands over your head. Now lower your right foot.” Participants who copy your action when you do not say “Simon says” have to drop out of the game.

Forming Groups by Number: Call out different numbers at random – “2 . . . 5 . . . 3 . . . 4” – and ask participants to form groups according to the number called. After each number is called, participants will have to make a quick decision about who to join or who to exclude. Those who are not in groups of the correct size will have to drop out of the game. When several people have been eliminated, stop and discuss the game. Ask participants how they felt about being excluded from groups and being forced to drop out. Then relate this to their work with communities.

■ Guessing Games

Who Is the Leader? Participants are in a circle. Someone volunteers to leave the room. A leader is chosen. Her job is to lead the group in a series of rhythmic actions or movements that the whole group copies (e.g., clapping, raising hands over head, swaying back and forth, etc.) The volunteer then tries to guess who is leading the actions. The group protects the leader by not looking at her. The leader must change the action at regular intervals without getting caught. When the volunteer spots the leader, he joins the circle and the person who was the leader leaves the room while the group selects another leader.

Who Am I? One participant leaves the room while the others decide on his occupation (e.g., driver, politician, fisherman). When he returns, the others mime activities to help him guess his identity.

What Kind of Animal? Participants sit in a circle and pair off. Each pair secretly decides what type of animal they are. Two participants without chairs are the elephants: They walk around the circle calling the names of different animals. Whenever they guess correctly, the animals named have to stand up and walk behind the elephants, walking in mime. This continues until the elephants can guess no more. Then they call “LIONS,” and all pairs run for seats. The pair left without chairs becomes the elephants for the next round.

Who Has It? Participants sit in a circle while one person stands in the center. While he closes his eyes, participants pass a small object from person to person. The person at the center gives a signal, opens his eyes and tries to guess who has the object. He has three guesses. Meanwhile, the object continues to pass behind people’s backs.

■ Games to Divide Participants into Groups

Introduction: The methods below are fun ways of creating groups. At the same time they generate energy, enthusiasm and spirit for the small group activities which follow.

Love One: Cross your arms in front of you and say "This is LOVE ONE" and get all participants doing the same thing. Then say "LOVE TWO" and demonstrate; hold another person at the shoulders and ask the whole group to do the same thing (i.e., get into pairs holding each other by the shoulders). Then say, "LOVE FOUR" and get two pairs to combine into four people and ask the whole group to do the same thing. Then set up groups to fit your group size. If you want six in a group, say "LOVE ONE" . . . then "LOVE THREE" . . . then "LOVE SIX."

Animal Groups: This group divider requires slips of paper with a word on each slip: one slip for each participant. Prepare the slips of paper beforehand with the names of animals written on each slip (e.g., cat, dog, sheep, etc.). Make the same number of slips for each animal. Hand out the slips. Then ask everyone to stand and start making the sound of their animal and link up with others making the same noise to form a group (e.g., cat group, dog group, etc).

Occupational Groups: The same activity as ANIMAL GROUPS with occupations written on slips of paper (e.g., farmer, fisherman, driver, soldier). Group members find each other by miming the work done in their occupation.

Puzzle Groups: Give out picture puzzles, each cut into the number of pieces needed to make up a group. Group members find each other by matching their puzzles.

Annex 4: Overview of the Protection of Women from Domestic Violence Act 2005

This overview was prepared by Center for World Solidarity as part of the public awareness campaign on the Domestic Violence Act, which was passed in 2005.

Overview of the Protection of Women from Domestic Violence Act 2005 (PWDVA)

The origin of the Act lies in Article 15 (2) of the Constitution of India, which clearly says that “State can make special provisions for women and children” towards realizing the right to equality. This indicates the use of affirmative action to remedy a wrong. It is often said that India has several laws but they are not implemented. The problem, however, is not the lack of implementation, but the lack of a mechanism by which it can be implemented. Women have insufficient understanding of the law and lack of access to the courts. Hence it is necessary not only to enact a law but to provide the necessary infrastructural tools with which to access the law. The way of doing this is to put a mechanism in place in the law itself. In the Act, this has been done by creating the office of the Protection Officer and recognizing the role of the Service Providers. Affirmative duties have been imposed on the government to provide legal aid, medical facilities and shelter homes in the hope that women in distress be given all these facilities. The Act is a statement of commitment by the State that domestic violence will not be tolerated.

The framework and crucial aspects of this Act are as follows

The PWDVA is a civil law. While the objective of criminal laws is to punish the offender, a civil law is directed towards providing reliefs to the aggrieved party; in this case, the woman who faces violence at home.

Definition of “Domestic Violence”

The Act defines “Domestic Violence” for the first time in Indian law. It is a comprehensive definition and captures women’s experience of abuse and includes not only physical violence but also other forms of violence such as emotional / verbal, sexual, and economic abuse. It is based on definitions in international law such as the UN Declaration on Violence Against Women and a Model Code.

The Act recognizes domestic violence as a human rights violation. It recognizes a woman's right to live in a violence-free home. To realize this right, the Act recognizes a woman's right to residence and her right to obtain protection orders under the law.

The reliefs provided in the Act are meant to provide immediate relief in emergency situations

The Act does not make any changes in the existing personal law regime on family matters. The reliefs under the Act are in addition to existing laws and have been recognized with the objective of empowering a woman to tide over an emergency situation. Having obtained relief under the law, a woman can still go for relief under other laws later.

Access to justice and the availability of infrastructure

Recognizing that a woman requires assistance with legal procedures and other forms of support, the PWDVA allows for the appointment of Protection Officers, and recognizes the role of Service Providers in providing medical, shelter, legal, counseling and other kinds of support services. The Protection Officer is the person in charge to assist women to avail of these facilities as well as assist her in obtaining the appropriate order under the Act.

Procedures to obtain orders, reporting of violence and the consequence of breaching the obtained orders

The Act includes provisions for making Domestic Incident Reports which will serve as important records at the stage of evidence taking. The manner in which the applications for orders under the Act have also been mentioned in the Act. Finally, the Act provides that the breach of an order obtained is a criminal offence.

PWDVA

- It is a civil law for protection orders and not meant to penalize or punish
- It recognizes the right to residence of woman, It recognizes the right of the woman to live in a violence-free home and that she should not be facing violence
- It provides only temporary and emergency relief
- It is a law in response to the needs of the woman
- It has certain crossovers from civil to criminal law—so when the protection order or Magistrate's order is violated, criminal law will start

Procedures involved under the PWDVA

Step 1: Informing the Protection Officer: Any person who has reason to believe that such an act has taken place or is likely to take place can inform the Protection Officer.

Step 2: Aggrieved woman should be informed of her rights under the law: A police officer, Protection Officer, Service Provider or Magistrate who has received a complaint shall inform her of:

- Her right to make an application for obtaining relief by way of protection order, an order for monetary relief, a custody order, a residence order, a compensation order;
- The availability of services of the Protection Officers, Service Providers, including shelter homes, medical facilities, etc.
- Her right to free legal services under the Legal Services Authorities Act 1987; and her right to file a complaint under section 498 A of the Indian Penal Code.

Step 3: Making the Domestic Incident Report and other responsibilities of the Protection Officer: The Protection Officer makes a Domestic Incident Report to the Magistrate and forwards copies there of to the Police Officer in charge. She/he ensures that:

- The aggrieved person gets all the benefits mentioned.
- A list of all Service Providers is maintained and that the aggrieved person has access to counseling, shelter homes and medical facilities where required;

Step 4: Once the matter is with the Magistrate: The Magistrate shall fix the first date of the hearing, which shall not ordinarily be beyond three days from the receipt of the application by the Court, and shall endeavour to dispose every application within a period of 60 days from the date of the first hearing.

Step 5: Informing the respondent of the date of hearing: A notice of the date of hearing shall be given by the Magistrate to the Protection Officer who shall serve it on the respondent and on any other person as directed by the Magistrate within a maximum period of two days.

Step 6: Other options with the Magistrate: The Magistrate may

- Direct either of the parties, singly or jointly, to undergo counseling;
- Seek assistance of a person, preferably a woman, engaged in promotion of family welfare, for assisting him/her in discharging his/her functions;
- Conduct the proceedings in camera.

Step 7: Where does she stay in the meantime? Aggrieved person has the right to reside in a shared household, whether or not she has any right, title or beneficial interest in the house and shall not be evicted.

Step 8: How is she protected in the interim? The Magistrate, after giving both parties an opportunity of being heard, and satisfied that domestic violence has taken place, can pass a protection order or a residence order, direct the respondent to pay the aggrieved person monetary relief and in addition, can pass compensation orders, custody orders and ex-parte orders.

- The Magistrate shall ensure that a copy of any such order shall be given free-of-cost to the parties.

Step 9: What if the protection order is breached? If the protection order has been breached, it shall be punished with either imprisonment or fine or both.

Step 10: Who will ensure that all this is done? The Central and the State Government shall take measures to ensure that:

- Provisions of this Act are given wide publicity through media;
- Central and State government officers including police officers, members of the judicial services, etc., are given periodic sensitization and awareness trainings on issues addressed by this Act;
- There is effective coordination between the services provided by concerned Ministries and Departments dealing with law, home affairs, health and human resources, and that there is a periodic review of the same.

■ Rules

- This is a Central law and hence the Centre is framing the Rules—but the appointment of POs will be by the State Governments.
- The PO is the first point of contact for the woman—hence a very important cadre.
- The Rules specify the rights of the victim and the duties of the authorities under the Act.
- The Rules specify the procedure for exercise of powers under the Act including eligibility and appointment of authorities, manner of counseling, disposal of applications, service of summons etc.

■ Heads for which Rules are to be made listed under the Act

- Eligibility, appointment, terms and conditions of service etc. of the Protection Officer
- Form and manner of making a Domestic Incident Report
- Form and manner of making applications for protection order
- Duties of the Protection Officer
- Registration and regulation of Service Providers
- Form of making applications
- Means of serving notices
- Qualification and experience of counselors
- Form of affidavit to be filed by the applicant

■ Shelter and medical assistance to the aggrieved person

- The shelter homes and the medical facility are under a legal obligation to provide shelter or medical facility to the aggrieved person.
- Copy of medical examination report is to be provided free of cost to the aggrieved person.

■ Qualifications and appointment of Protection Officer under the Act

- Protection Officer either to be a government servant or a social worker working for women and child welfare, with a post graduate degree in Humanities or Law
- One or more Protection Officer within the jurisdiction of each Judicial Magistrate

■ Functions and duties of Protection Officer

- To inform aggrieved person of her rights under the Act
- To provide all forms and applications and assistance to the aggrieved person
- Make a safety plan and take adequate measures in view of the safety plan
- Enforce the orders of the Court as and when directed by the Court

■ **Service Providers include shelter homes, medical facilities and counseling services.**

- The Service Providers should be registered and fulfill the statutory requirements for running a medical facility or a counseling center, etc.

■ **Form and manner of making complaint—(Domestic Incident Report) and applications for relief under the PWDV Act**

- Complaints and applications under the Act can be made by filling in the prescribed forms.
- The forms can be availed of from any source including Service Providers, Protection Officers or Police Stations.
- The aggrieved person has a right to seek assistance for filling in the forms or filing the applications before the Court.
- The aggrieved person can also file the complaint or applications directly before the Court.
- In case the aggrieved person files the complaint or applications through the Protection Officer or a Service Provider, she has a right to receive a copy of the complaint or the applications free of cost.
- The service of the notice or summons shall be by handing over the same to the respondent or any male member of his family.
- The summons / notice can be delivered by registered post.
- Court can direct service in accordance with the Code of Criminal Procedure or the Civil Procedure Code or employ any other effective way of service in view of the facts and circumstances of the case.

■ **Appointment of counselors and counseling**

- The Court can direct counseling for an amicable of the matter by the parties.
- Counseling can be directed on admission of alleged misconduct and undertaking not to repeat the same by the respondent.

■ **Enforcement of orders passed under the Act and consequences of breach of protection order.**

- The breach of orders of the court under the Act shall amount to cognizable, non-bailable offence warranting immediate arrest and summary trial.

■ **Computerized user-friendly forms for making complaints and applications**

- The forms for making complaints and applications are in computerized format and user friendly.
- The aggrieved person can easily provide the required details.
- Filling in the forms will take care of all the legal requirements to be fulfilled by aggrieved person.

■ Important features

- POs will be appointed by State Government on deputation basis. Deputation will be on a voluntary basis and will be for a minimum of 3 years.
- Direct Incident Reports—DIRs have been simplified. POs should know how to document. NGOs might need training on how to document DIRs—to be used as evidence in Courts
- A woman need not always approach the PO—she can go to Court directly. She can also seek help of police, friend, NGO, Service Provider—but each of them should refer her to the PO. She/he then takes on the role of doing all the needful to provide the woman with immediate and emergency services.
- Letter of demand has been sent to Minister of State; Ministry of Women and Child Development
- Training and awareness sessions with the implementing State partners
- Building linkages with the State Gender Resource Centers
- Speedy implementation at all levels
- Introduction of the PWDVA as a part of the Course Curriculum at the school level
- Protocols for the various Ministries concerned with the delivery of services to women under this Act, including the Courts, are prepared and put in place.

■ Framework of the Rules

The broad categories under which the Rules for the Act have been framed are as follows:

Appointment and functions of the Protection Officer

Appointment of Protection Officers

There was a great deal of controversy relating to the appointment and the qualifications of the Protection Officer. The ideal situation would be to create a new cadre of paralegals to serve exclusively as Protection Officers. However it is not possible to put in place a new system in the Rules as such, since a 'new cadre' would require involvement of the Ministry of Personnel Affairs. Also, the question of whether responsibility of the new cadre will vest with the Centre or the State will arise since law and order is a State subject.

Hence, under Rule 7, it has been suggested that Protection Officers be appointed from a particular section of people who are already employed as government officials. These officials will be on deputation to serve exclusively as Protection Officers. Under the Rules, there is a mention of various departments and sectors from which such officers may be deputed. Emphasis has been given on voluntary deputations. Provisions for the appointment of persons employed in Non Governmental Organizations as Protection Officers have also been included. The issue that remains unresolved is who will be responsible for paying volunteers from the NGOs. If the remuneration is minimal, volunteers may be discouraged from applying to the post. As the State Government is responsible for the appointment of Protection Officers, this is a matter that will have to be put for its consideration.

Tenure of Protection Officers

Rule 8 provides for a minimum term of 3 years for serving as a Protection Officer.

Jurisdiction of Protection Officers

In Rule 8, it is made clear that there shall be not less than one Protection Officer for the area of a Judicial Magistrate. This provision also allows the State Government to appoint more than 1 Protection Officer, keeping in mind the area and the volume of the work involved.

Functions of the Protection Officer

Rule 21 enlists the functions of the Protection Officer. The primary function of the Protection Officer would be to protect the victim from any further act of domestic violence. The Protection Officer should serve as a liaison between the woman, police and the Service Provider. Caution must be exercised to ensure that the functioning of the Protection Officers do not impinge on the right to privacy and the autonomy of women complainants.

The duties of a Protection Officer have been divided into two parts:

Functions of the Protection Officer under the Act

On receipt of any complaint from an aggrieved person, the Protection Officer will have to make a Domestic Incident Report and forward it to the concerned authority for further action if the woman so desires.

- It shall be the duty of the Protection Officer to also assist the victim in
- making a complaint or an application under the Act,
- accessing legal aid and obtaining medical/shelter facilities,
- becoming aware of her rights, remedies and services available under this Act.
- receiving all possible assistance

Thus, the Protection Officer is the authority charged with the duty of doing everything possible to assist the woman in getting the remedies provided under the Act and live a life free of violence. The Protection Officer will be the interface between the victim and the Court, and between the victim and the police, the medical facility and the shelter home.

Functions of the Protection Officers under court orders

On receipt of an order from a Court, the Protection Officer can conduct a home visit, and can make appropriate enquiries regarding the salary, assets, bank accounts, and emoluments of the respondent liable to pay maintenance. The Court can also direct the Protection Officer to assist the aggrieved person in regaining the custody of her children and assist the Court in enforcement of the order passed.

It is an effort of creating a synergy between institutions of society, all of which are responsible for preventing violence against women, but till now have not performed the role that is expected of them.

Whereas there has been a challenge to domestic violence over the years from the civil society, there has been no institutional response to this. The Police, performing their role under Section 498 A, is not an institution to challenge domestic violence. There are no institutions charged with liaising between different institutions charged with the duty to combat domestic violence. Therefore, there is a need to create such institutions.

An apprehension was expressed that a woman should not be denied direct access to the Court. It was clarified that a woman can approach the Court directly and approaching a Protection Officer is purely optional for the woman and is voluntary.

Form and manner of making application for orders

Rule 12 states that on receipt of a complaint, the Protection Officer shall make a Direct Incident Report. An application under Section 12 shall be made in the format included in Form C in Schedule I. The Protection Officer shall assist her in making the application. Attached with the Rules are various forms for obtaining different orders (Forms E–Form J). Rules 14 to 20 state the various Sections under which these applications/forms are to be filed.

Registration and duties of Service Providers

The Rules provide for the registration of Service Providers. The important issue that arises in this regard is that if NGOs are not registered, does it mean that they cannot continue providing services to women facing domestic violence? This is not the case. All Service Providers can continue to perform all the functions they are at present performing without any need to register. Registration under the Act is purely voluntary for the Service Provider. The objective of providing for the registration of Service Providers is that if they are registered, then their records will have authenticity in the court of law. The record of a registered NGO and a Domestic Incident Report ('DIR') recorded by them will form part of the evidence or the previous history of violence in a court of law and will be very helpful in getting a protection order. Record keeping is, therefore, crucial. If the NGOs are registered, then the records maintained would be authentic records.

The status that is accorded to the NGOs will also give them the authority to insist that the victim be provided the facility offered by other registered Service Providers such as medical facilities and shelter homes. Minimum standards can be enforced in the facilities. What is required is a need to liaison between different institutions such as the police, legal authority, Service Providers etc. This role will be played by the Protection Officer.

Counseling process

Section 14 provides that a Magistrate can, at any stage of the proceedings, direct the aggrieved person and the respondent, either singly or jointly, to undergo counseling. Under Section 15, a Magistrate can requisition the services of a person engaged in "promoting family welfare" to assist him/her in discharging his/her functions. Both these provisions did not form part of the Draft Bill submitted to the Ministry. But since these provisions are present in the law, it becomes imperative to lay down a comprehensive procedure that ensures that these provisions will not be used against women in their struggle for justice. Hence, the format and manner in which the Rules have been formulated reflect this concern.

Stage at which a counselor can be appointed and the purpose of counseling

The first important step in this regard is that, Under Rule 35, counseling can be directed only after passing an order for interim relief. It has to be kept in mind that counseling can take place only in an atmosphere free of violence. Only once the violence stops can equality be restored and negotiations can take place on a level playing field. The purpose of counseling would be to tell the aggressor not to commit any form of domestic violence towards the complainant. To this extent, an undertaking may be obtained from the perpetrator. Rule 38 clearly lays down that that the perpetrator shall not be allowed to plead any justification for the alleged act of domestic violence during the process of counseling.

Appointment of counselors

Rule 33 refers to the appointment of counselors. The qualifications and disqualifications for the appointment to the position of counselors have also been provided in detail. The disqualifications include any form of association with either of the parties to rule out bias. Further, the

appointment of the counselor is subject to the consent of both the parties. Care must be taken to ensure that Protection Officers are not appointed as counselors under the Act.

Settlements arrived at during the process of counseling

Rule 39 provides that negotiations for a settlement can be initiated at the behest of the aggrieved person.

The aim of counselor would be to arrive at a settlement of the dispute by suggesting measures for redressing the grievances of the aggrieved person by taking into account the measures or remedies suggested by the parties.

During the course of counseling, Rule 40 provides that the counselor shall not be bound by the provisions in the Indian Evidence Act, 1872 or by the Code of Civil Procedure, 1908 or the Code of Criminal Procedure, 1973 and shall be guided by the principles of fairness and justice.

On arriving at a settlement, the counselor, under Rule 41, will record the terms of settlement and get the same endorsed by both the parties. The Court shall accept the terms only after it is satisfied subsequent to conducting a preliminary enquiry to rule out fraud, force and coercion. The Court will then record its reasons. Thereafter the Court can pass appropriate orders. Any orders in existence can be discharged if a proper and fair settlement has been arrived at.

If a settlement is not arrived at, the case will be continued with, and the record of the counseling proceedings shall not be deemed to be material on record for the purpose of the case.

Means of serving Notices

Rules 29–32 refer to the service of notice and summons. In these provisions, it is stated that notices shall be served at the place where the respondent is residing or where the respondent is employed. For any further process, the procedure as prescribed in the Code Of Criminal Procedure, 1973 or the Code of Civil Procedure 1908 shall be followed.

Enforcement of orders and breach of protection orders

Rules 44–50 refer to the procedure to be followed in cases where there is a breach of a protection order. An aggrieved person may report the breach of a protection order to a Protection Officer who shall then inform the concerned Magistrate or may directly make a complaint to the Magistrate. A simple affidavit by the woman that a particular Protection Order has been breached is enough to trigger off the procedures prescribed to address breaches. Section 31 of the Act provides that the breach of a protection order is an offence and shall be punishable with imprisonment of either one year and/or a fine. The procedure laid down in the CrPC shall govern arrest, summary trial, sentence etc

Safety Plan for the aggrieved person

Under Rule 23, it is also stated that on an application being moved under Section 12, the Protection Officer shall prepare a “safety plan” which shall include measures to prevent further violence after making an assessment of the dangers involved.

Annex 5: Pictures for Use in Toolkit Sessions

■ Introduction

The toolkit uses pictures as a major tool for training. Many of the modules are built around pictures that show different aspects of stigma and violence to trigger discussion.

The pictures show real life situations as a focus for discussion. Pictures are meant to stimulate interest, get participants talking and sharing ideas, and help illiterate participants to participate more effectively.

There are eight different sets of pictures:

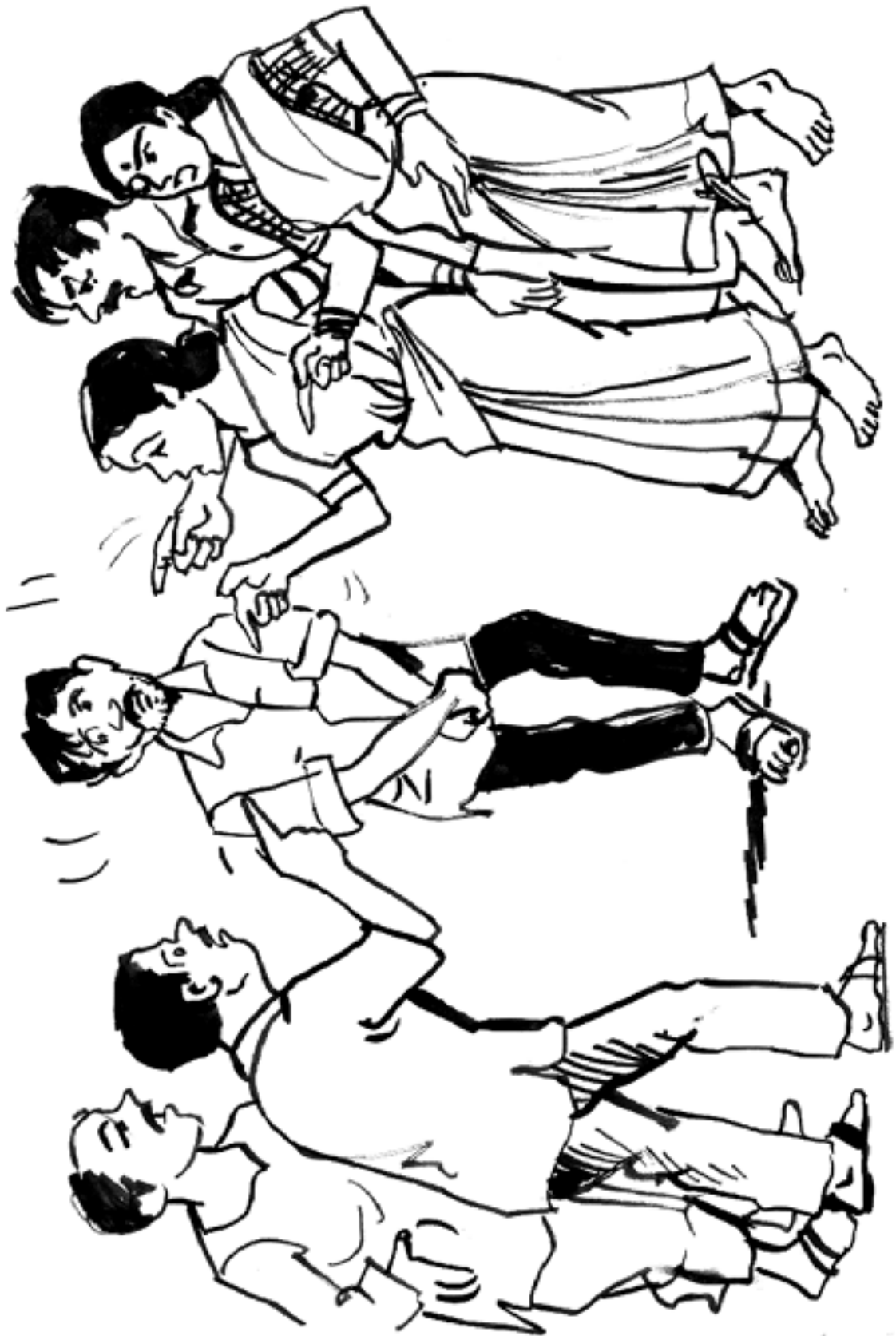
	Type	No. of Pictures	Description and Use
A	Stigma Pictures	24	Different scenes showing HIV stigma. Used as individual pictures or as a set in the module, "Naming Stigma" (A2).
B	Violence Pictures	14	Different forms of gender-based violence. Used as individual pictures or as a set in the module, "Naming Violence" (B1).
C	Family Cards	9	Men and women of different ages. Combined to create different sizes of families for use in the module, "When HIV Enters the Home" (A12).
D	Life Cycle Cards	10	Men and women of different ages. Used in the "Life Cycle" module (A13). (This set uses some of the same pictures used in the Family Cards.)
E	Casual Contact Cards	19	Different activities that people fear might lead to getting HIV. Used in the "Casual Contact Game" (module D5), where participants put cards into HIV risk categories.
F	Occupation Cards	16	Different occupations (e.g., farmer, sex worker, doctor, etc.). Used in "Judging People" module (C4). Used to assess who is more or less stigmatized and why; or used to create stories around how HIV affects different types of people.
G	Animal And Bird Cards	24	Different animals (16) and birds (8) used in introductory module on stigma (A1) in which participants select animals (or birds) they like or dislike.
H	Context Cards	6	Different contexts in which stigma or violence takes place (e.g., family, community, clinic, school, workplace, market). Used in the module, "Naming Stigma in Different Contexts" (A5).
	Total	122	

USE OF PICTURES: We suggest you photocopy and laminate these photos for frequent use. Use different colored paper to distinguish the different sets of pictures.

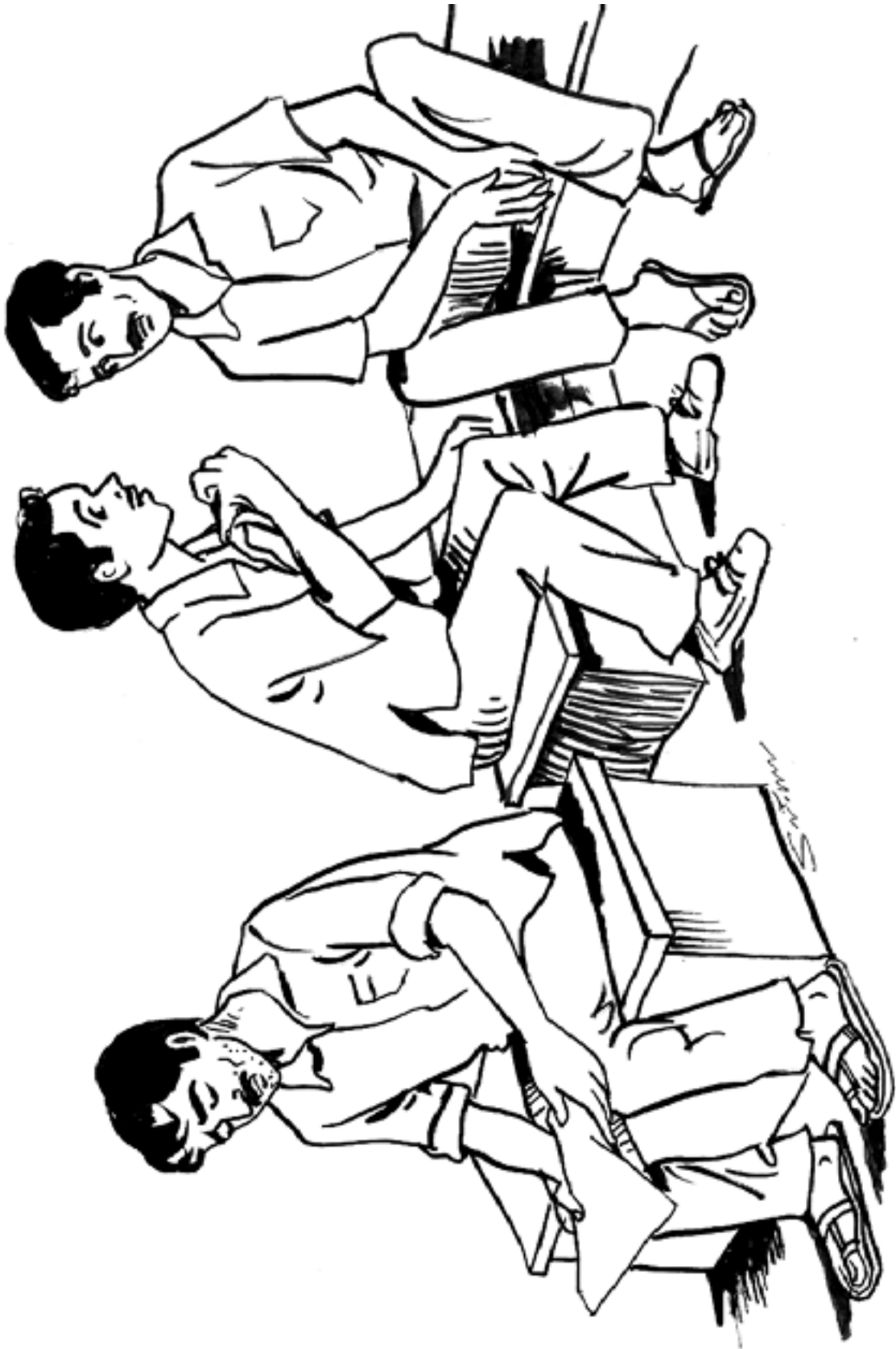
A. Stigma Pictures

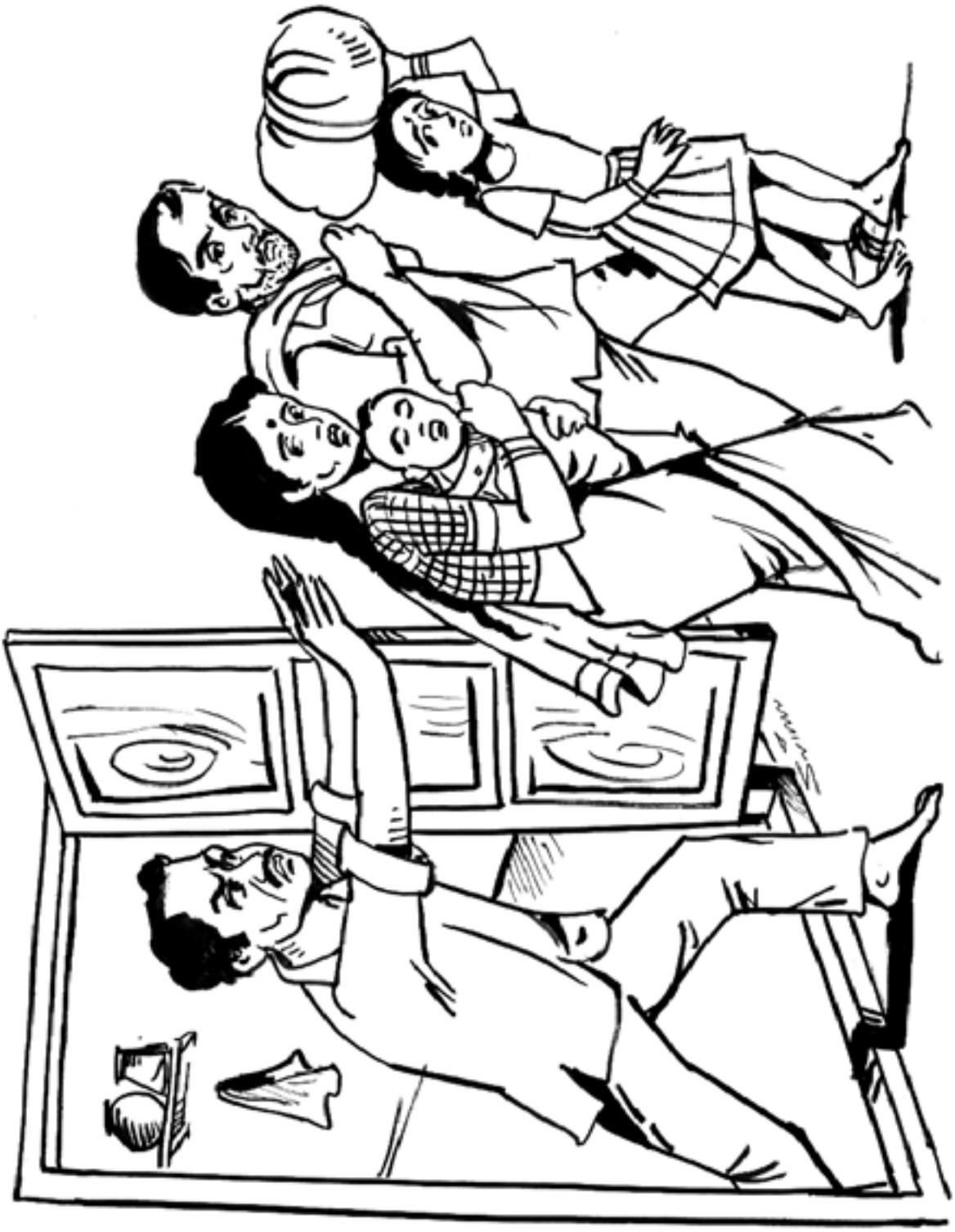
Description: These pictures show scenes of stigma or discrimination as a starting point for discussion. These pictures can be used as single pictures for a specific exercise or a full set of pictures used in the module, "Naming Stigma through Pictures" (A2).

No.	Title	Description
A1	Community finger pointing	Community members point fingers at one man
A2	Gossip 1	Two women gossiping about another woman
A3	Gossip 2	Two men gossiping about another man
A4	Kicked out of house 1	Family kicked out of rented house
A5	Kicked out of house 2	Pregnant woman kicked out of house by parents
A6	Isolation in the house	Man sitting all alone on his bed
A7	Left out of family decisions	Woman sitting alone, left out of family discussion
A8	Thinking about results 1	Man coming out of voluntary counseling and testing center with HIV test results
A9	Crying about results 2	Woman crying all alone about her HIV test results
A10	Returning with results 3	Worried man returns home with HIV test results
A11	Care and support	Wife caring for her sick husband
A12	Fired from work	Man being fired from his job
A13	Stigma in hospital/clinic 1	Doctor and nurse gossiping about patient
A14	Stigma in hospital/clinic 2	Nurse giving injection to patient from a distance
A15	Stigma in hospital/clinic 3	Patients and nurse scared by seeing HIV patient in hospital
A16	RMP refuses to help	Registered medical practitioner refuses to visit sick man (suspected to be HIV-positive)
A17	Fear of using common toilet	Men fear using public toilets along with HIV-positive man
A18	Crying for sick husband	Wife cries for sick husband
A19	Not allowed to go to mother	Father stops daughter going to her mother
A20	Isolation at playground	Three boys playing football; one boy is excluded
A21	Excluded from social event	Community celebration; one woman is excluded
A22	Stigmatized at the tea shop	Man arrives and customers stand up to leave
A23	Rejected at the water point	Line of women at public tap; one woman rejected
A24	Stopped from holding child	Woman prevented from holding her child

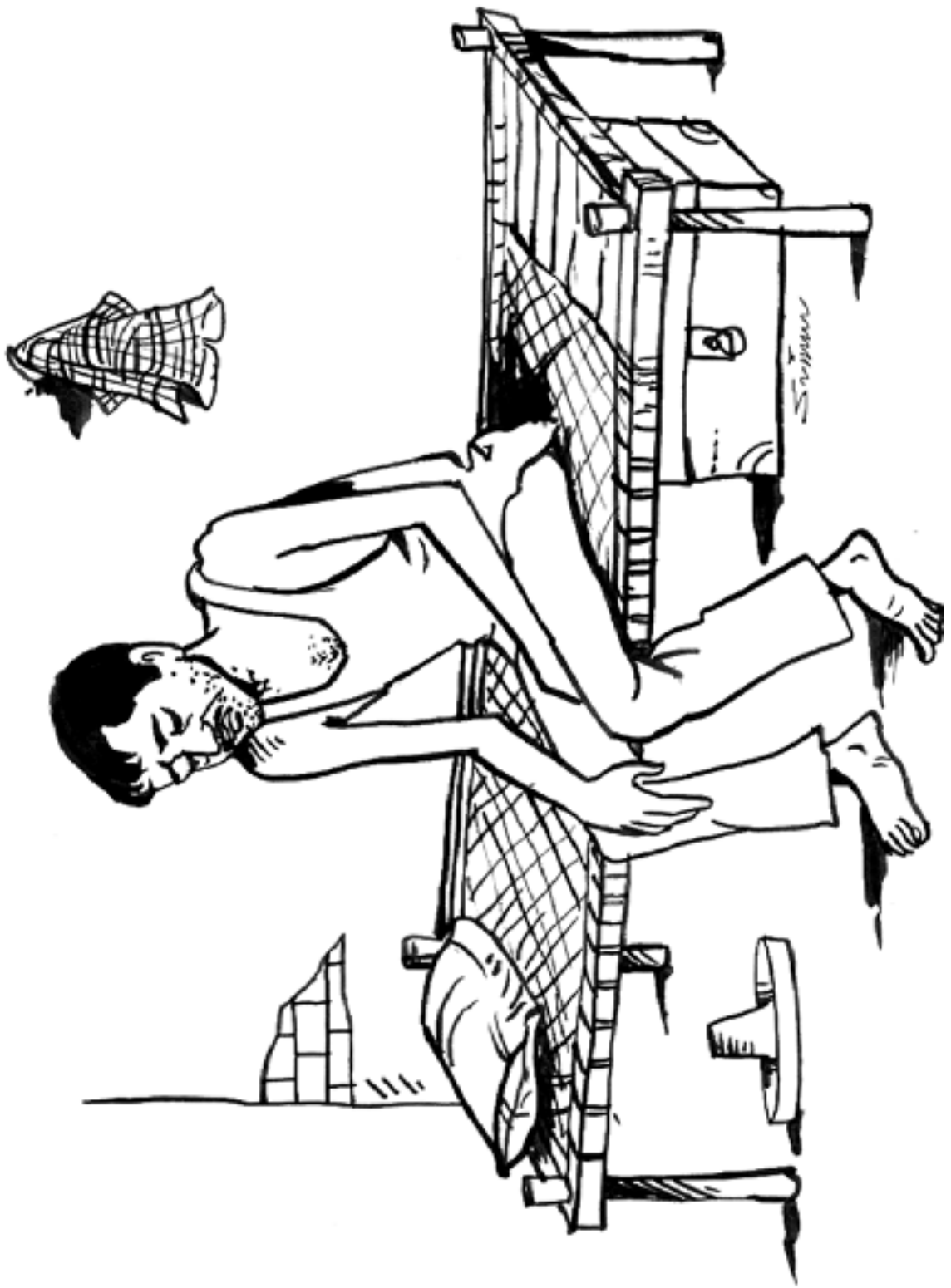




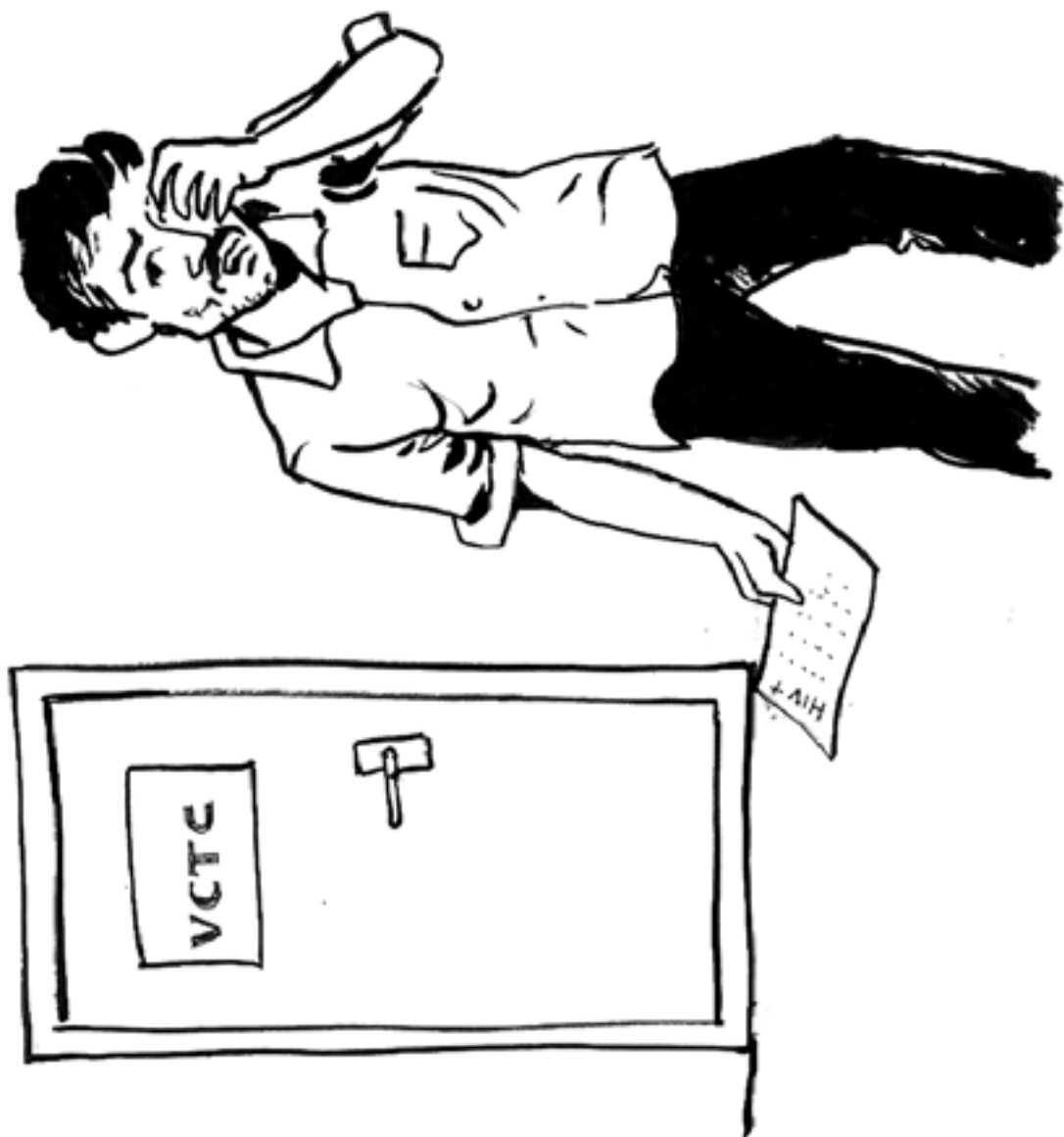




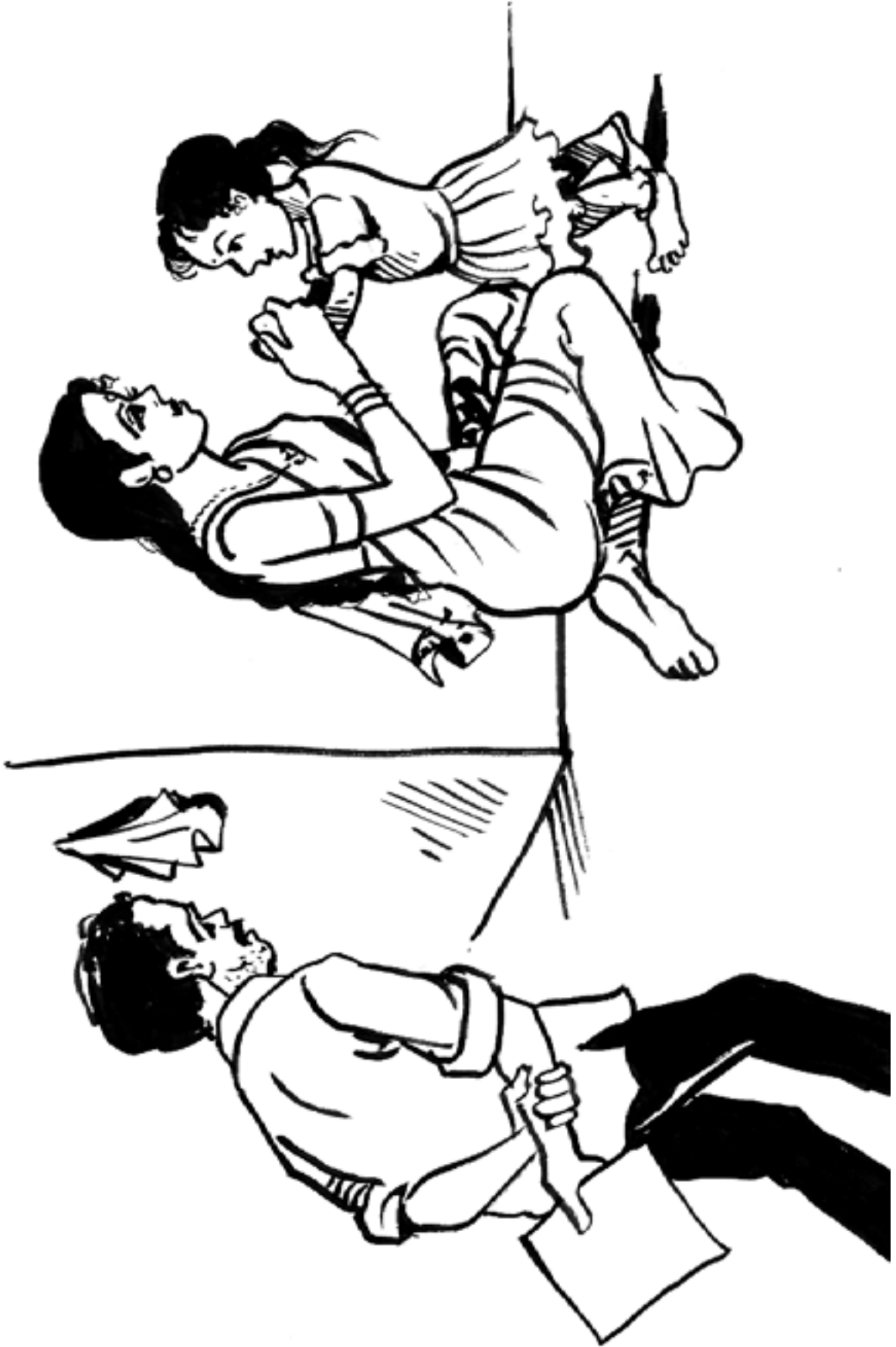










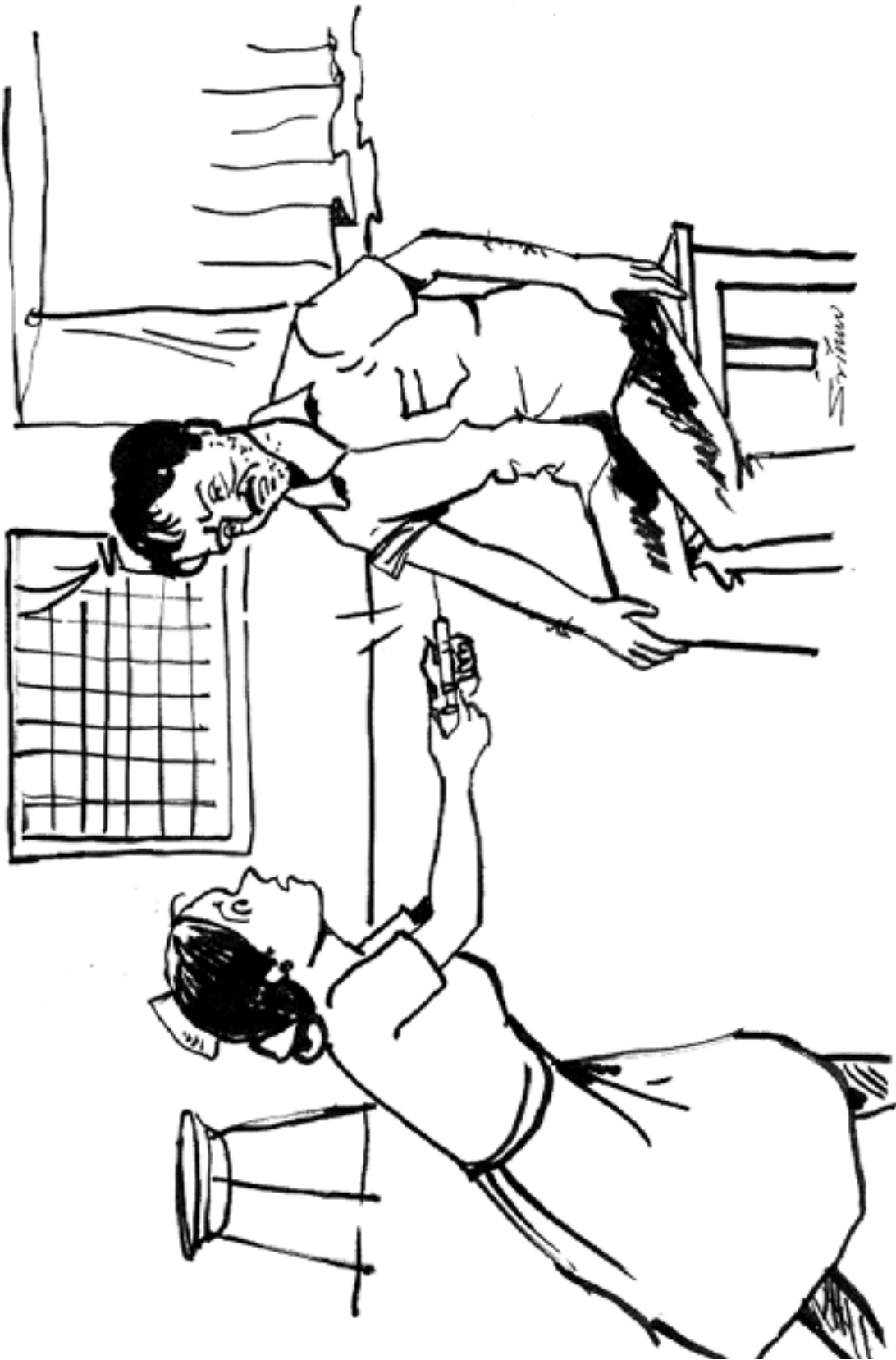




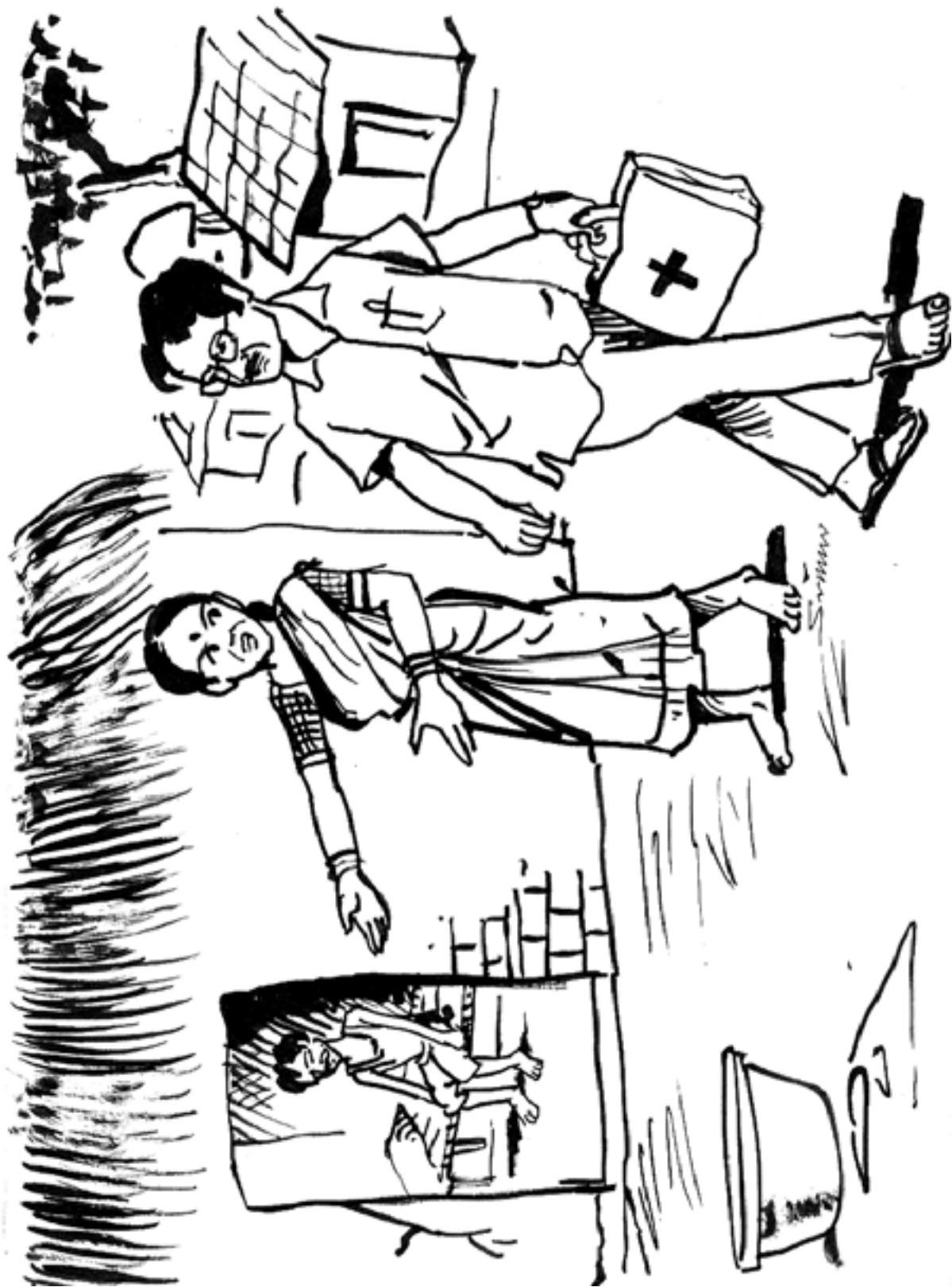


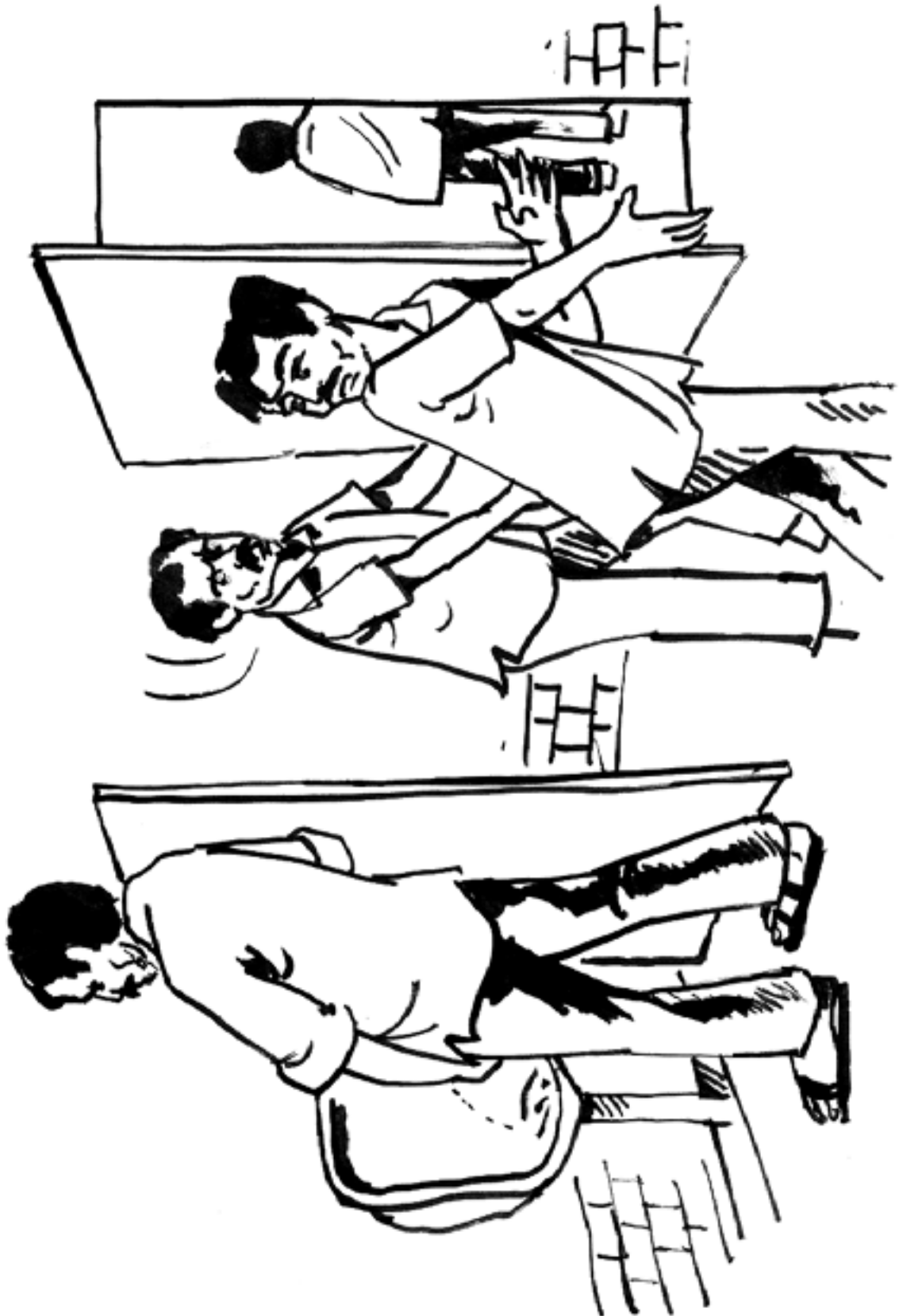
A12



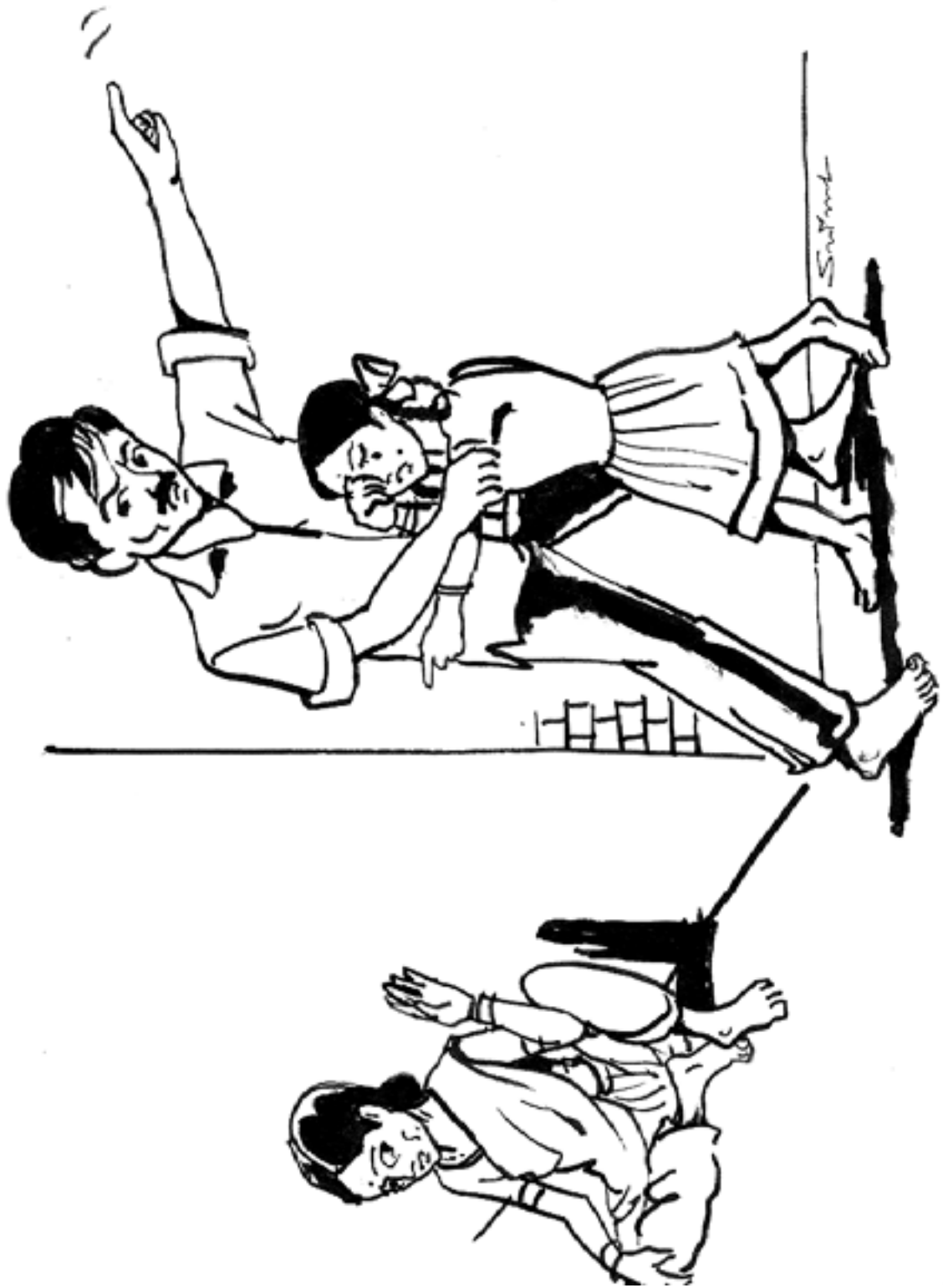


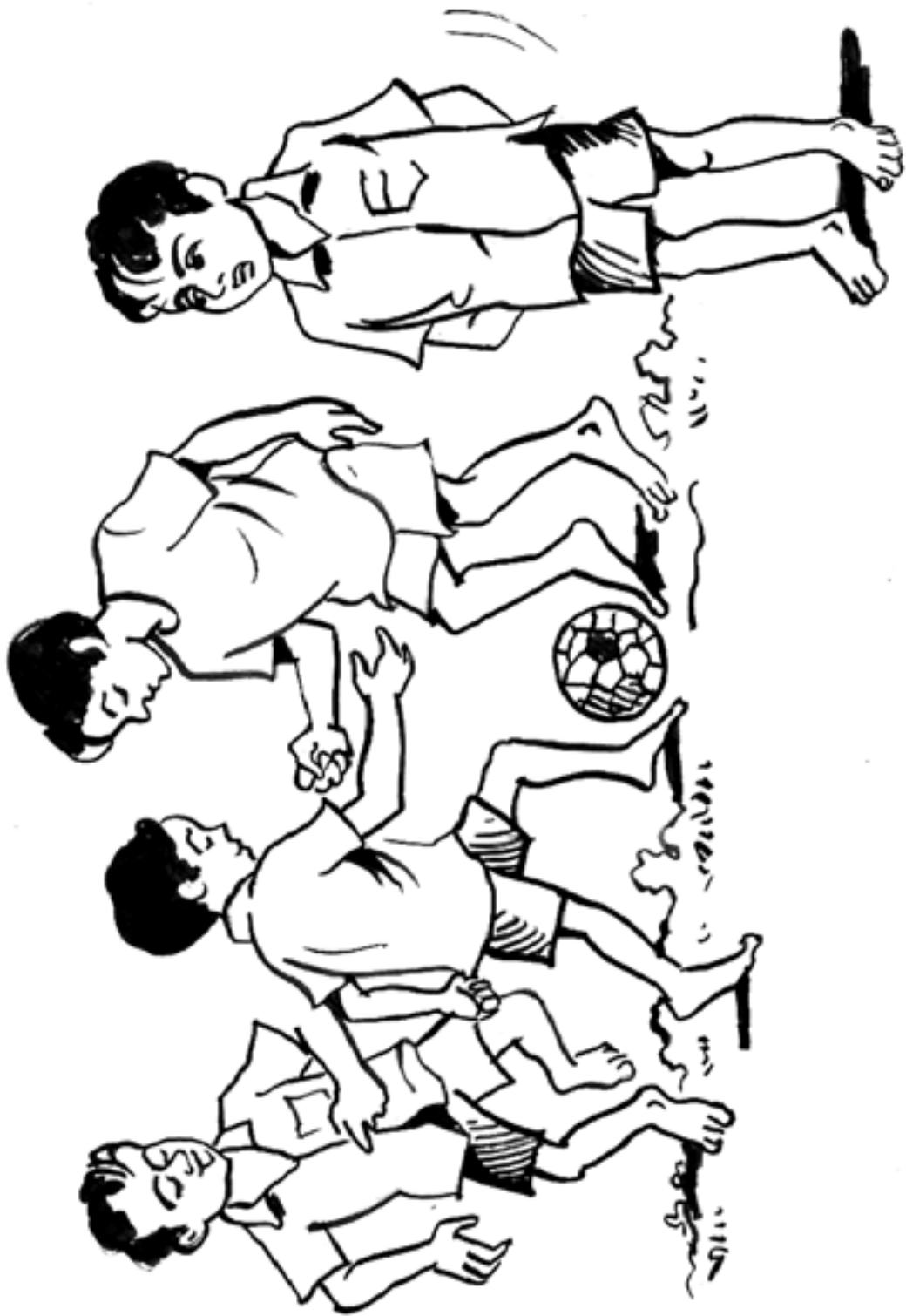




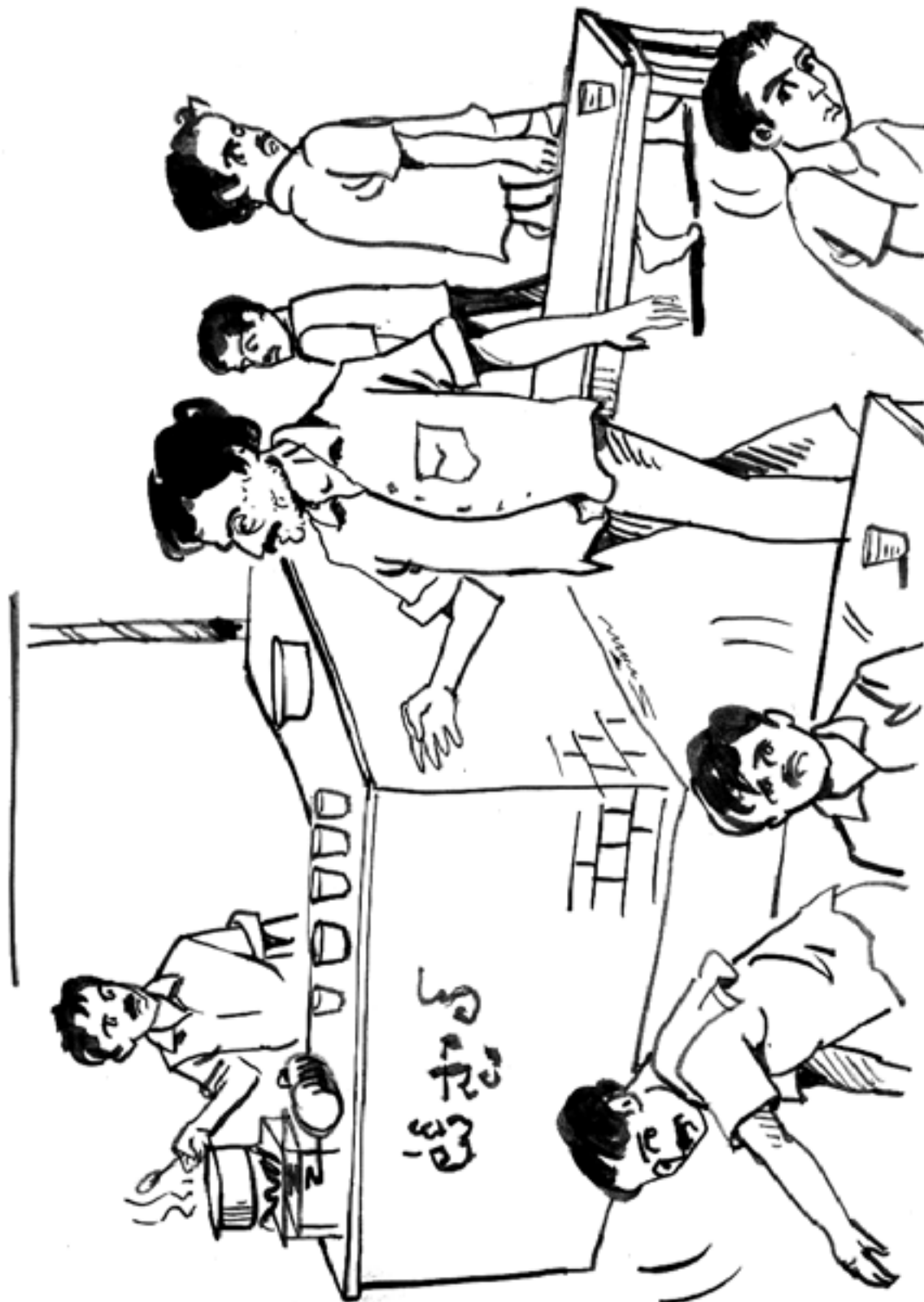


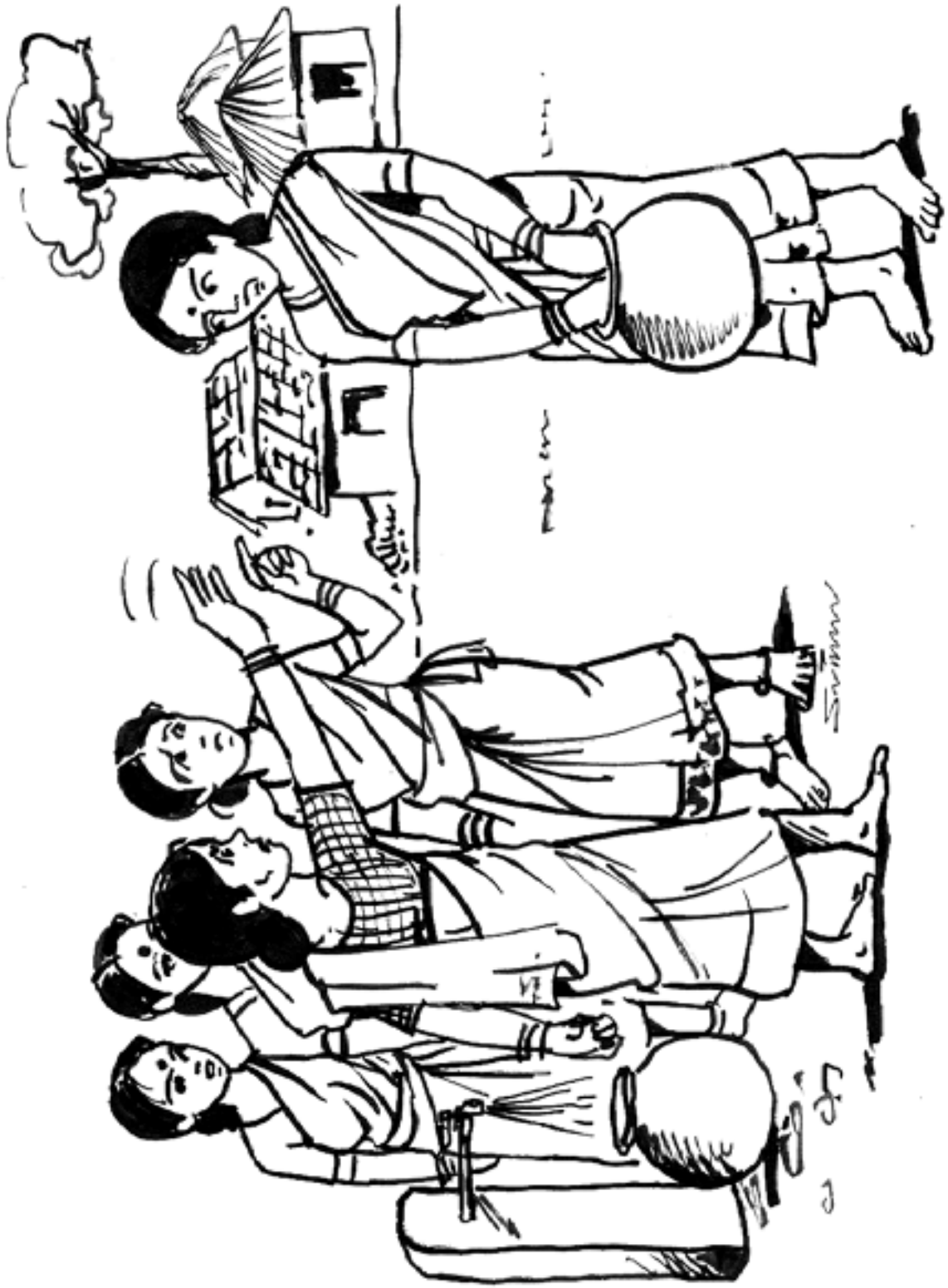










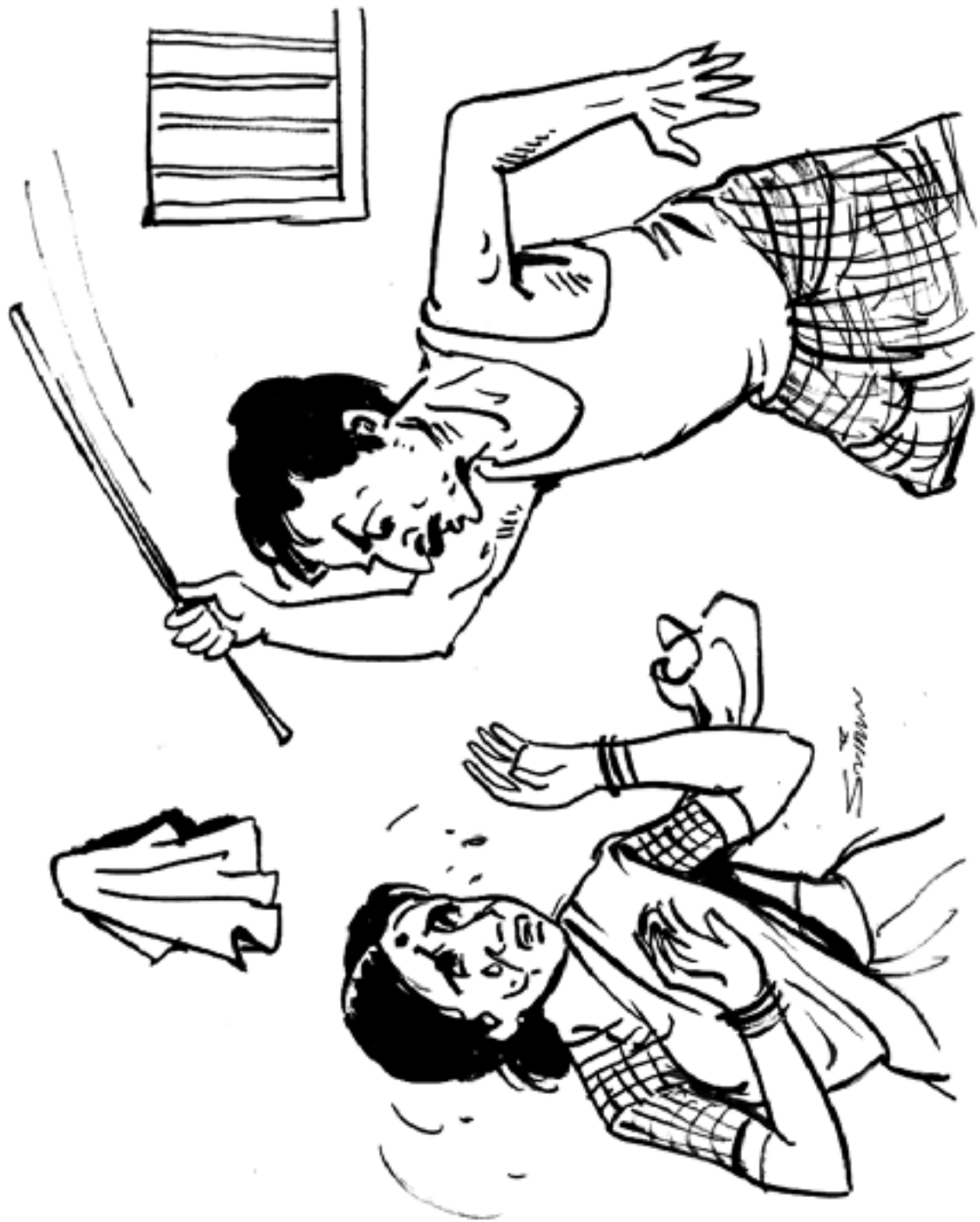




B. Violence Pictures

Description: These pictures show different forms of violence as a starting point for discussion. These pictures can be used as single pictures for a specific module or a full set of pictures for use in the module, “Naming Gender Violence through Pictures” (B1). The pictures include different forms of violence: physical, emotional, economic and sexual.

No.	Title	Description
B1	Physical violence	Man beating his wife with a stick
B2	Physical violence	Drunken man threatening wife with bottle; children crying
B3	Physical violence	Family throwing oil over daughter-in-law (dowry killing)
B4	Physical violence	Landlord beating laborer with a stick
B5	Physical violence	Abortion – killing unborn female child
B6	Emotional violence	Woman belittled by husband in front of her parents
B7	Emotional violence	Woman shamed/stigmatized for not having children
B8	Emotional violence	Eve teasing: youth on motorbike harass young women
B9	Economic violence	Man takes money away from wife by force
B10	Economic violence	Husband wastes family money on card playing
B11	Economic violence	Property grabbing; woman forced to put thumb print
B12	Sexual violence	Incest; father/uncle forcing daughter/niece to have sex
B13	Sexual violence 2	Man raping woman
B14	Sexual violence 3	Marital rape; husband forces his wife to have sex







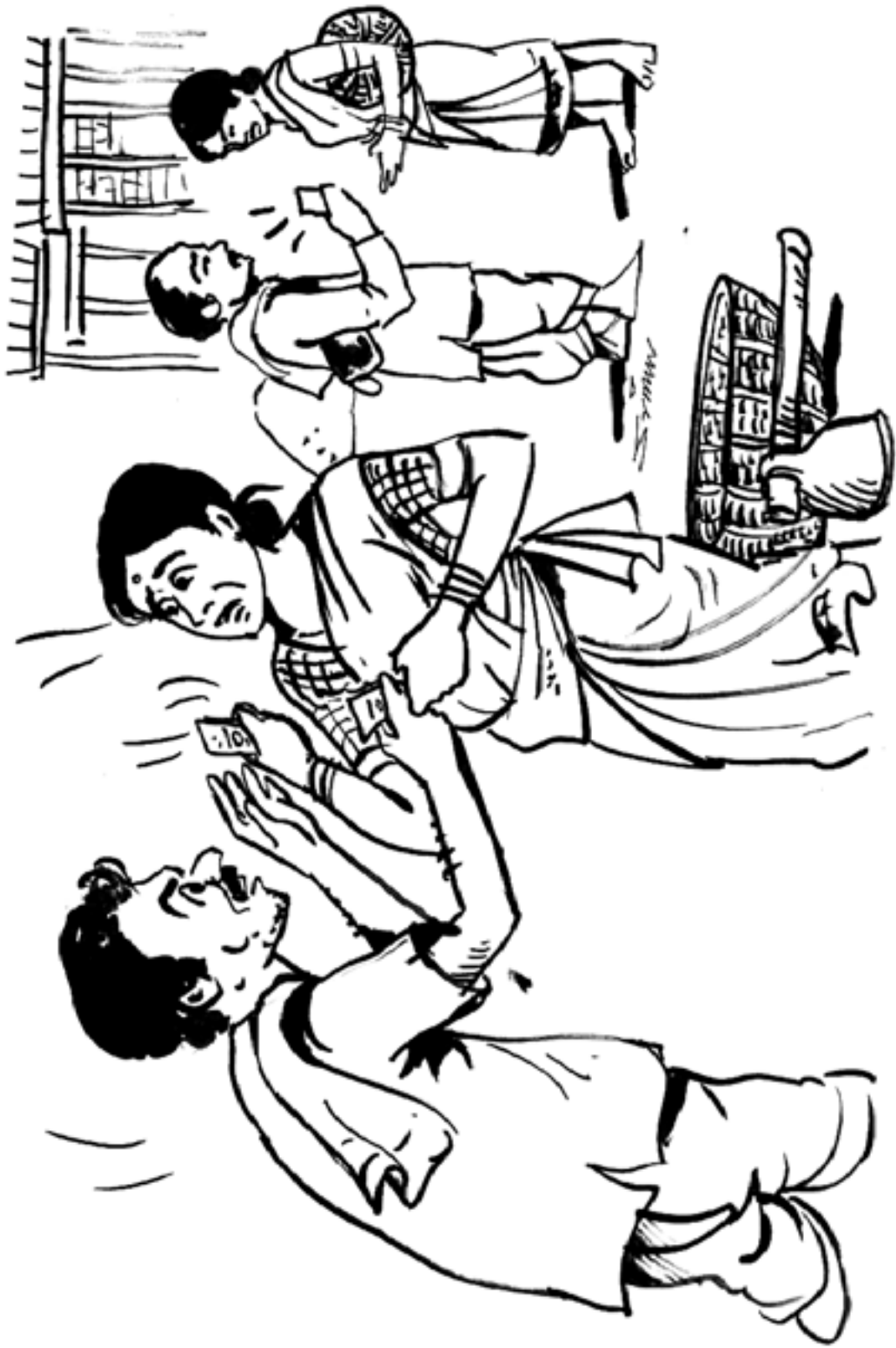


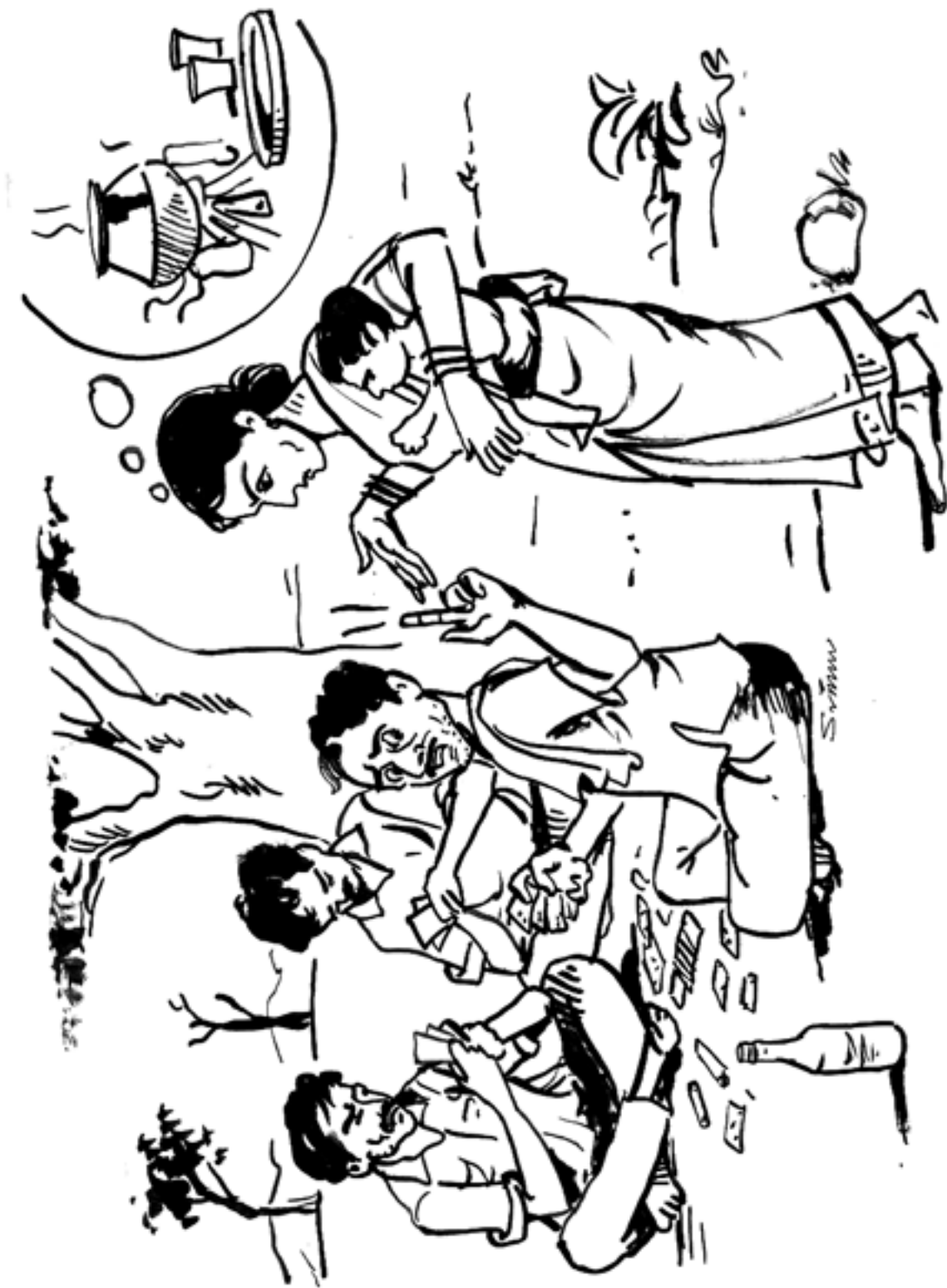




















C. Family Picture Cards

Description: Each card represents one member of a family. The cards can be combined to make families of different sizes (e.g., one grandmother, one father, one mother, two teenage girls, one young boy, one baby). The cards are used in the module, "When HIV Enters the Home" (A12). The pictures make it possible for people to talk anonymously about their own experience of family issues. These cards overlap with the LIFE CYCLE CARDS.

No.	Title
C1	Grandfather
C2	Grandmother
C3	Father
C4	Mother
C5	Teenage Boy
C6	Teenage Girl
C7	Six-year-old Boy
C8	Six-year-old Girl
C9	Baby



C1



C2



C3



C4



C5



C6



C7



C8



C9



D. Life Cycle Cards

Description: These pictures are used to represent stages in a woman's (and man's) life cycle. These cards are used in the "Life Cycle" module (A13) in which participants identify both stigma and violence taking place at different points in the life cycle of men and women. These cards overlap with the FAMILY CARDS.

No.	Title
WOMEN	
D1	Birth/Small Baby
D2	Childhood
D3	Teenage/Adolescence
D4	Marriage
D5	Old Age
MEN	
D6	Birth/Small Baby
D7	Childhood
D8	Teenage/Adolescence
D9	Young Man
D10	Old Age



D1



D2



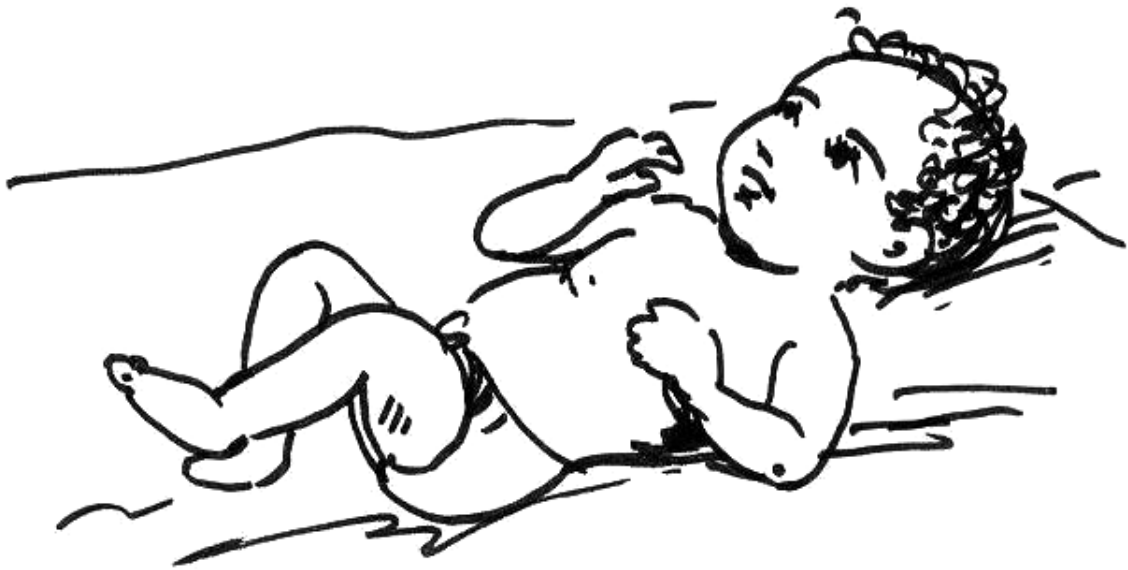
D3



D4



D5



D6



D7



D8



D9



D10

E. Casual Contact Cards

Description: Different activities that people fear might lead to their contracting HIV. Used in the “Casual Contact Game” (module D5) where participants put cards into HIV-risk categories.

No.	Title
E1	Sex with sex worker
E2	Blood transfusion
E3	Barber shop
E4	Breastfeeding
E5	Kissing a child
E6	Using unsterilized needles, scissors or equipment
E7	Sharing clothes
E8	Sleeping in the same room with person living with HIV
E9	Carrying person living with HIV to the hospital
E10	Coughing
E11	Getting HIV from toilet seat
E12	Walking along the same road as person with HIV
E13	Caring for HIV patient
E14	Delivering baby
E15	Checking pregnant mother
E16	Shaking hands
E17	Cooking
E18	Mosquitoes
E19	Serving food



E1



E2



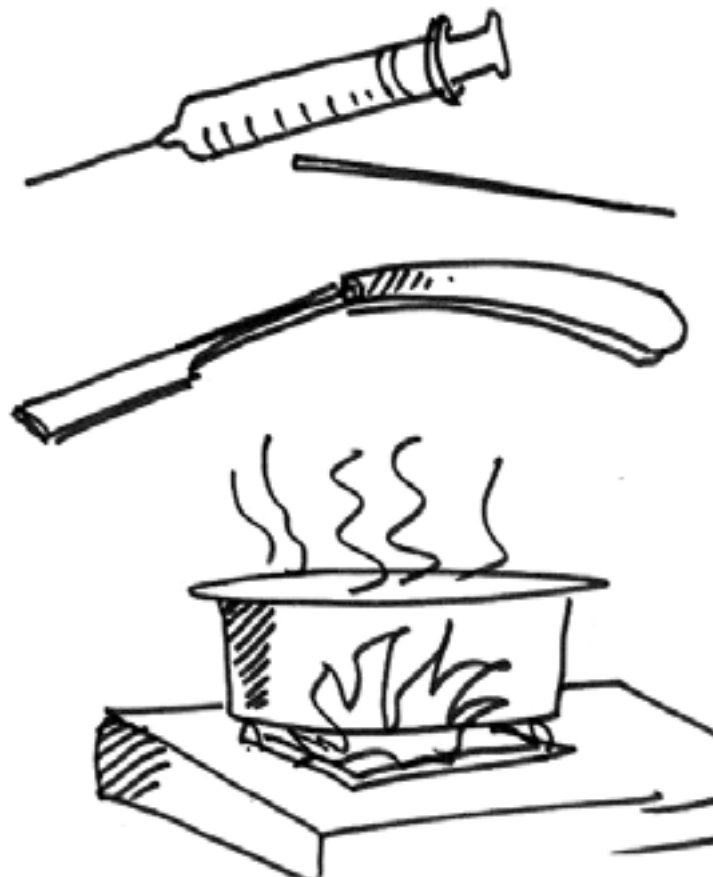
E3



E4



E5



E6



E7



E8



E9



E10



E11



E12



E13



E14



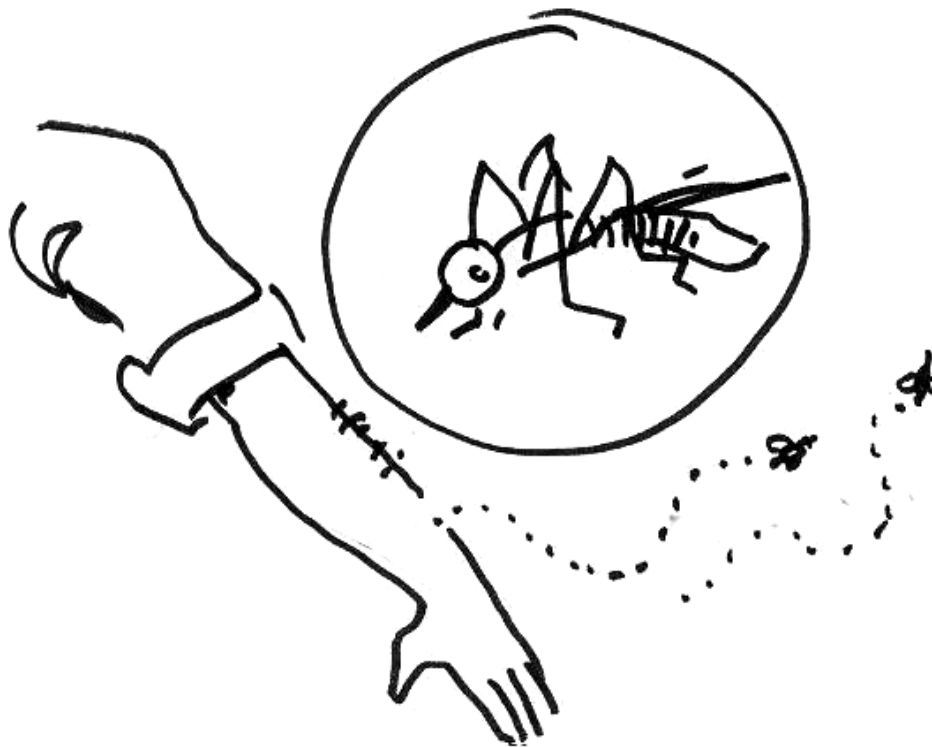
E15



E16



E17



E18



E19

F. Occupation Cards

Description: These cards show different occupations (e.g., farmer, sex worker, doctor, etc.). Used in the “Judging People” module (C4). The cards allow discussion about our assumptions about different types of people (e.g., stigmatization toward sex workers, truck drivers, etc.).

Use: Four characters per page. Cut out each character and paste onto stiff board so that they can be displayed on the floor or wall or distributed to different participants.

No.		No.	
F1	Businessman	F2	Barber
F3	Doctor	F4	Beggar
F5	Farmer	F6	Prisoner
F7	Engineer	F8	Rickshaw puller
F9	Police	F10	Sex worker
F11	Tailor	F12	Sweeper
F13	Teacher	F14	Truck driver
F15	Working Woman	F16	Washerman



F1



F2



F3



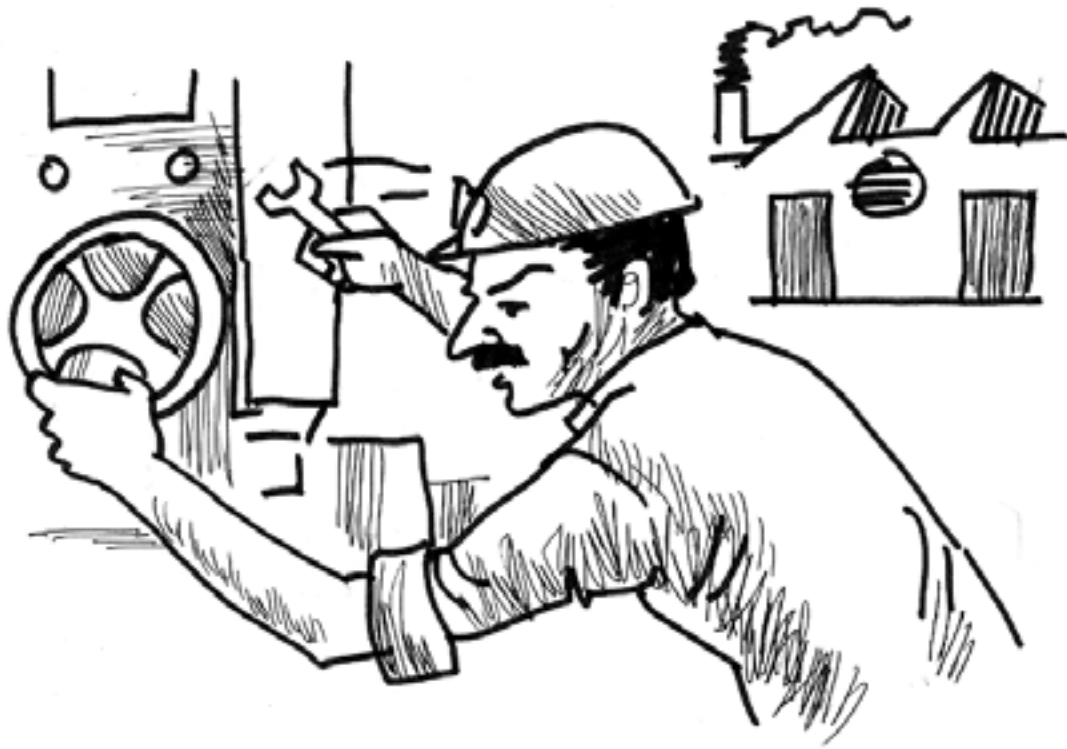
F4



F5



F6



F7



F8



F9



F10



F11



F12



F13



F14



F15



F16

G. Animal and Bird Cards

Description: Pictures of animals and birds for use in the module, "Introduction to Stigma" (A1). Each participant is given two pictures (one from the positive and negative lists) and asked to choose what they like and dislike. This is an easy introduction to the concept of stigma.

No.	Positive	No.	Negative
G1	Hen	G2	Crow
G3	Parrot	G4	Eagle
G5	Peacock	G6	Owl
G7	Sparrow	G8	Vulture
G9	Camel	G10	Bear
G11	Cow	G12	Cat
G13	Deer	G14	Crocodile
G15	Dog	G16	Donkey
G17	Giraffe	G18	Fox
G19	Goat	G20	Monkey
G21	Rabbit	G22	Pig
G23	Squirrel	G24	Tiger



G2



G4



G1



G3



G6



G8



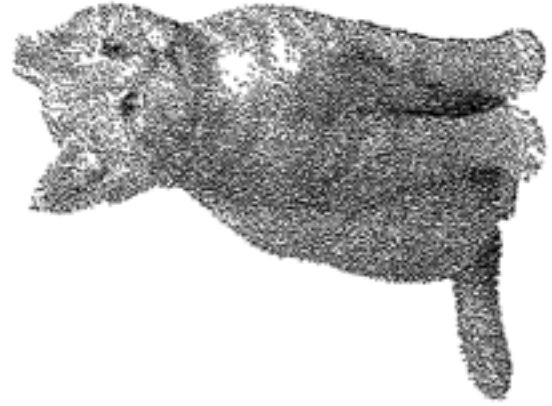
G5



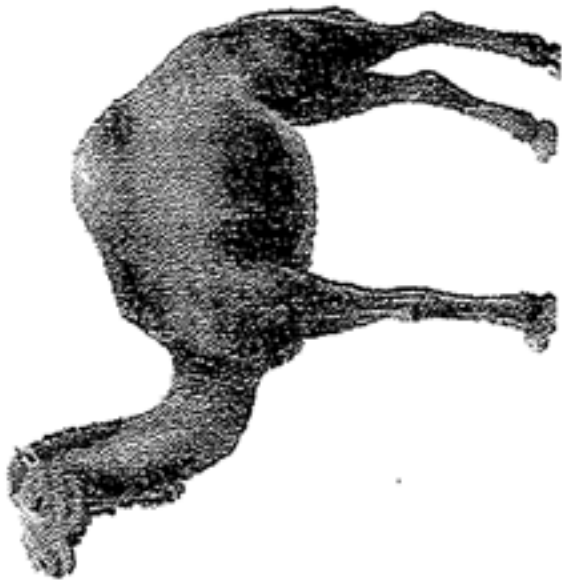
G7



G10



G12



G9



G11



G13



G14



G15



G16



G18



G20



G17



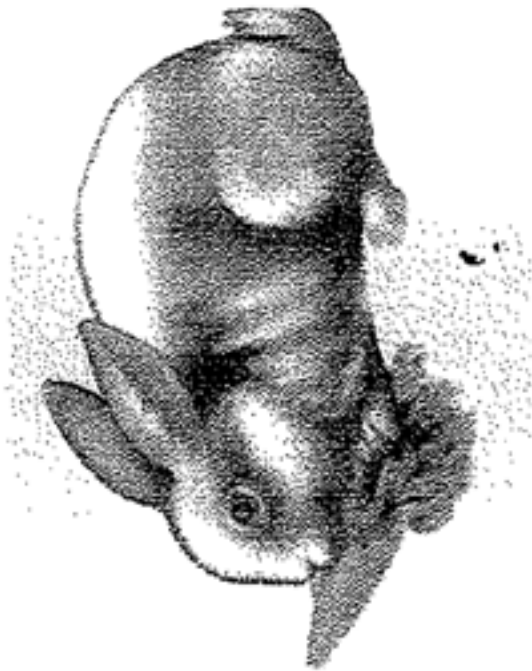
G19



G22



G24



G21



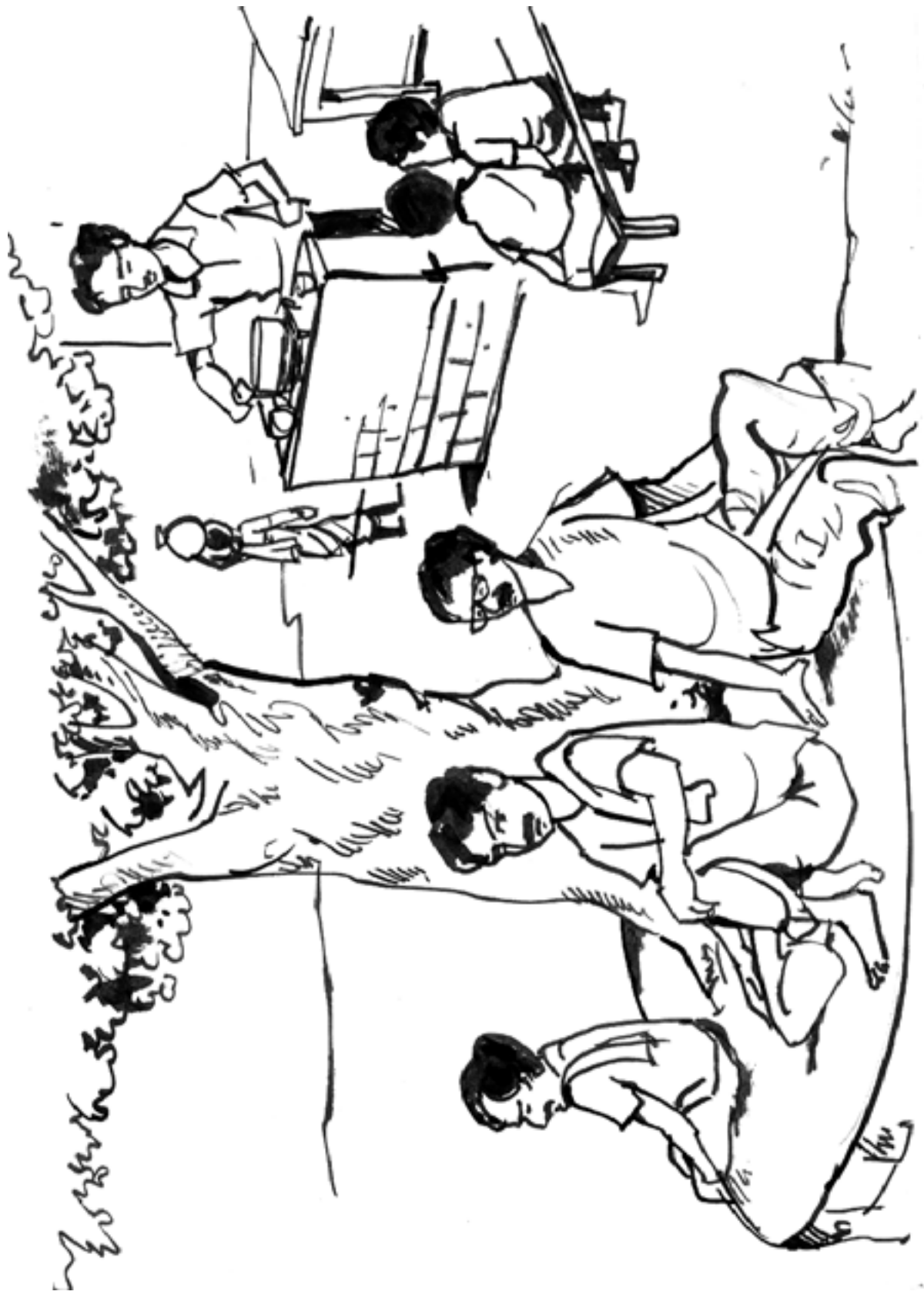
G23

H. Context Cards

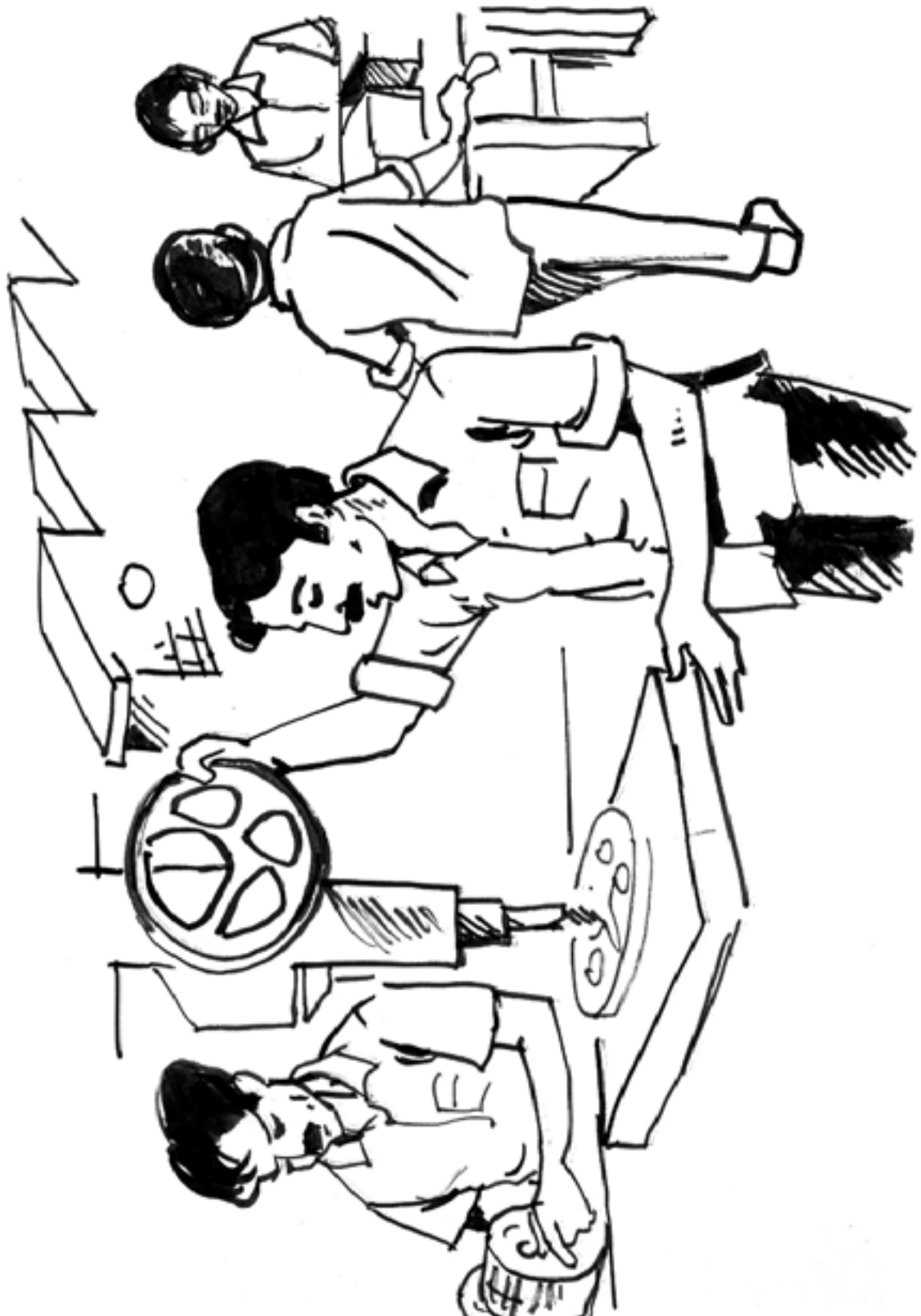
Description: These cards show different contexts in which stigma or violence takes place. The cards are used in the module, “Stigma and Violence in Different Contexts” (A5)

No.	Title
H1	Home/Family
H2	Community
H3	Clinic/Hospital
H4	Workplace
H5	Market
H6	School

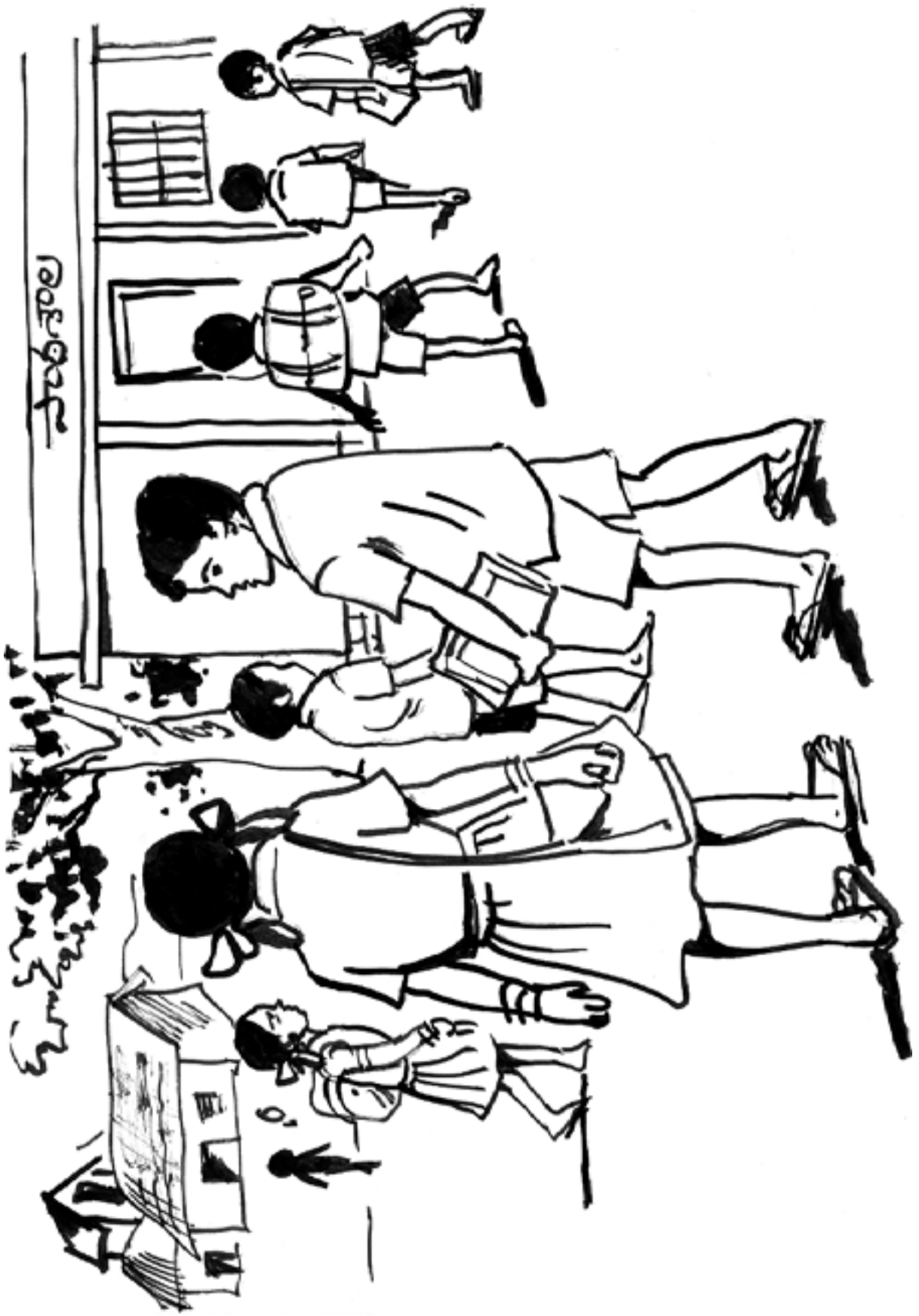














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