

Supporting community action on AIDS in developing countries

Understanding and challenging HIV stigma Toolkit for action

MODULES B & C

- More understanding, less fear
- Sex, morality, shame and blame

About the organisations involved

Academy for Educational Development

Founded in 1961, the Academy for Educational Development (AED) is an independent, non-profit organisation committed to solving critical social problems and building the capacity of individuals, communities, and institutions to become more self-sufficient. AED works in all the major areas of human development, with a focus on improving education, health, and economic opportunities for the least advantaged in the United States and developing countries throughout the world.

www.aed.org

International Center for Research on Women

Since its founding in 1976, International Center for Research on Women (ICRW) has worked with partner organisations and governments throughout the world to promote gender equitable development, reduce poverty, and change the lives of millions of women and girls and their communities – undertaking focused, evidence-based, action-oriented research; providing technical assistance to partner organisations, donors and governments; and advocating for new or improved policies and programmes.

www.icrw.org

International HIV/AIDS Alliance

Established in 1993, the International HIV/AIDS Alliance (the Alliance) is a global partnership of nationally based organisations working to support community action on HIV and AIDS in developing countries. Our shared mission is to reduce the spread of HIV and meet the challenges of AIDS. To date, over \$140 million has been channelled to more than 40 developing countries in support of over 3,000 projects, reaching some of the poorest and most vulnerable communities with HIV prevention, care and support, and improved access to treatment.

Registered charity number 1038860

www.aidsalliance.org

For more information about Alliance publications, please go to www.aidsalliance.org/publications

© Text: Academy for Educational Development, International Center for Research on Women and International HIV/AIDS Alliance, 2007

Developed by Ross Kidd, Sue Clay and Chipso Chiya

© Illustrations: Petra Röhr-Rouendaal, 2006

First edition published September 2003

Revised edition published June 2007

ISBN: 1-905055-28-5



Wood pulp sourced from
a sustainable forest



Elemental Chlorine
Free (ECF)

Information and illustrations contained in this publication may be freely reproduced, published or otherwise used without permission from Academy for Educational Development, International Center for Research on Women and International HIV/AIDS Alliance. However, these organisations request that they be cited as the source of the information.

The first edition of this resource was made possible by the generous support of the American people through the United States Agency for International Development (USAID). This revised edition was made possible by the Swedish International Development Cooperation Agency (Sida). The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or Sida.



USAID
FROM THE AMERICAN PEOPLE



Understanding and challenging HIV stigma: Toolkit for action

About this toolkit

This toolkit was written for and by HIV trainers in Africa. It has been designed to help trainers plan and organise educational sessions with community leaders or organised groups to raise awareness and promote practical action to challenge HIV stigma and discrimination.

The toolkit evolved out of a research project on 'Understanding HIV-related stigma and resulting discrimination' that was conducted in Ethiopia, Tanzania and Zambia from 2001 to 2003. The research was implemented by the International Center for Research on Women (ICRW) in collaboration with research institutions in the three participating countries. The first edition of this toolkit was developed by the CHANGE Project AED (Academy for Educational Development) and ICRW in partnership with the research institutions and non-governmental organisations (NGOs) in these three countries who helped to design the original toolkit. It was developed and written by Ross Kidd and Sue Clay.

This edition was revised by the International HIV/AIDS Alliance country office in Zambia, building on the original toolkit, and includes experience of the Alliance's Regional Stigma Training Project, which has introduced the toolkit to many countries in Africa through a training of trainers (TOT) and networking process. The national TOT workshops and follow-up workshops conducted by members of the growing anti-stigma network have created a base of experience for revising and updating the toolkit. At a regional workshop in Zambia in August 2005, members of this network helped to review the toolkit and make changes and additions.

By the end of 2006, more than 300 anti-stigma trainers from many organisations have been trained by the Alliance using this toolkit. These include the following key partner organisations:

Burkina Faso: Initiative Privée et Communautaire Contre le VIH/SIDA au Burkina Faso (IPC)

Côte d'Ivoire: L'Alliance Nationale Contre le SIDA en Côte d'Ivoire (ANS-CI)

Ethiopia: ActionAid, Hiwot, Save Your Generation Association (SYGA)

Kenya: Regional AIDS Training Network (RATN), Network of people with HIV/AIDS in Kenya (Nephak)

Mozambique: International HIV/AIDS Alliance in Mozambique, Rede Nacional de Associações de Pessoas Vivendo Com HIV/SIDA (Rensida)

Nigeria: Network on Ethics, Human Rights, Law, HIV/AIDS Prevention, Support and Care (NELA)

Senegal: Alliance Nationale Contre le SIDA (ANCS)

Tanzania: Kimara, Muhimbili Medical College of Health Sciences (MUCHS)

Uganda: The AIDS Support Organization (TASO)

Zambia: International HIV/AIDS Alliance in Zambia, Network of Zambian People Living with HIV (NZP+)

This edition, developed and written by

Ross Kidd, Sue Clay and Chipso Chiiya

Acknowledgements

Key collaborators who have helped with its development during the two phases have included:

Botswana: Oratile Kidd-Moseki, Sam Setumo

Ethiopia: Aklilu Kidanu, Awraris Alemayehu, Berhanu Zenbere, Dagmawi Selamssa, Hailom Banteyerga, Ethiopia Tilahun

Mozambique: Amos Simbamba, Carlos Mussua, Emedius Teixeira, Sonia Almeida

Tanzania: Gad Kilonzo, Jessie Mbwambo, Judith Mulundu, Mboni Buyekwa, Naomi Mpemba, Peter Kopoka, Pfiriael Kiwia, Sabas Masawe, Willbroad Manyama

Uganda: Florence Ayo, Jacinta Magero, James Byakiika, Richard Serunkuuma

United Kingdom: At the Alliance secretariat, Liz Mann for her support throughout this project and to the Communications team who co-ordinated the design development and production of this toolkit

USA: Anton Schneider, Gayle Gibbons, Jessica Ogden, Kerry MacQuarrie, Laura Nyblade, Rohini Pande, Sanyukta Mathur

Zambia: Aggrey Chibuye, Clement Mufuzi, Estella Mbewe, Gertrude Mashau, Levy Chilikwela, Martin Chisulu, Mary Mweemba, Mutale Chonta, Sidney Sipia Mwamba, Titus Kafuma, Victoria Chivunga, Virginia Bond.

Design by Jane Shepherd

www.coroflot.com/janeshep

Illustrations by Petra Röhr-Rouendaal

Printed by Dexter Graphics in the UK

www.dextergraphics.com

In memory of Martin Chisulu, Chama Musoka, Hamelmal Bekele (Happy), Andrew Mukelebai and Regina Mulope.

Contents

Module B – More understanding, less fear

Introduction	3
--------------	---

Exercises

B1	Assessing knowledge levels – three exercises	5
B2	Assessing fears about HIV and AIDS	6
B3	Dealing with fears about our own status	7
B4	Fears about non-sexual, casual contact	8
B5	Fears about HIV at home	10
B6	Why people don't believe facts about HIV and AIDS	12

Module C – Sex, morality, shame and blame

Introduction	13
--------------	----

Exercises

C1	We are all in the same boat!	14
C2	Things people say...	16
C3	Who is labelling whom?	19
C4	Stereotyping – 'big brother and big sister'	20
C5	Judging characters	22
C6	Value clarification exercise	24
C7	Breaking the sex ice	26
C8	Promiscuity, prostitution and preaching	30
C9	Where did you get it?	34
C10	Risk-taking and stigma	35
C11	Traditional beliefs and stigma	37
C12	Carrying condoms carries stigma	38

Annex 1

QQR fact sheet	39
----------------	----

Pictures

Character cards	40
-----------------	----

Other booklets in *Understanding and challenging HIV stigma: Toolkit for action* include:

Introduction

Using the toolkit

Module A

Naming the problem

Module D

The family and stigma

Module E

Home-based care and stigma

Module F

Coping with stigma

Module G

Treatment and stigma

Module H

MSM and stigma

Module I

Children and stigma

Module J

Young people and stigma

Moving to action module

Thinking about change

Moving to action

Developing skills for advocacy

Picture booklet

General stigma pictures

Rights pictures

Additional booklets will be published as new modules are developed.

B module

Introduction

HIV stigma is rooted in both fear and ignorance. Research has shown that everyone has some information about HIV and AIDS, but few have enough information to overcome irrational fears associated with HIV and its transmission. Most people know that HIV can be transmitted through sex, but many people still have fears about risk through non-sexual, casual contact. For instance, they may avoid a fellow bus passenger who is coughing and suspected to be HIV positive for fear of ‘breathing in the virus’, or they may be fearful of cleaning the bed sheets of someone who is sick at home. This fear of casual contact will often lead to isolation and segregation, and PLHIV (or suspected to be living with HIV) may be given separate plates and cups, a separate room and so on.

Attitudes and beliefs about transmission are also affected by incorrect and incomplete knowledge. As trainers, facilitators, community workers and educators, it is essential that we give clear, unambiguous messages about how HIV is and is not transmitted.

Lack of knowledge leads to stigma, but **knowing facts is only half the story!** People may know the basic HIV and AIDS messages but often **don’t believe them**. They know them as simple slogans or rules – e.g. you can’t get AIDS from shaking hands – which they are expected to follow blindly without any real understanding. These messages do not stop people fearing infection through casual contact.

The HIV stigma study¹ identified knowledge gaps in the following areas:

- how HIV is and is not transmitted
- the difference between HIV and AIDS
- what it means to live with HIV, e.g. opportunistic infections can be treated
- an HIV positive test result does not mean instant death
- PLHIV can be as productive as any other members of society.

Since the study was published, antiretroviral (ARV) medicines have become widely available in many parts of Africa. Knowing that these bring hope and well-being can also help to combat stigma.

Other influences

The correct information people have received may be contradicted by **other beliefs** – what they have learned from the family, clan, tribe, church, school and media – as well as their own life experiences. Often these popular beliefs (e.g. that HIV is caused by sleeping with a woman who has had a miscarriage) are more persuasive than the facts provided by HIV trainers.

¹ Nyblade, L. and Pande, R. et al (2003) *Disentangling HIV and AIDS Stigma in Ethiopia, Tanzania and Zambia*, Washington D.C., ICRW

Module B – More understanding, less fear



On the last day of a six-week counselling course that included many sessions on AIDS facts, a man said, *“I don’t believe this HIV business. The real reason people are getting sick is kufunga (sickness attributed to a man sleeping with a woman who has had a miscarriage).”*

The trainer threw up her hands and said, *“How can you say this after all of the things I’ve taught you?”* The man replied, *“Okay, if you want me to say HIV is the cause of the sickness I’ll say it, but I don’t really believe it.”*

Mongu counselling workshop, Zambia

A new approach is needed that provides more than raw facts, and instead helps people to own or internalise the information and overcome their fears. This module intends to:

1. **Create safe opportunities for participants to raise all the fears, concerns and questions they have about HIV and AIDS.**
2. **Assess participants’ knowledge level about HIV and AIDS.** Find out what they know and don’t know, including their beliefs and misconceptions.
3. **Provide information geared directly to people’s fears and misperceptions about getting HIV through casual contact.** Provide information to challenge misperceptions and help participants fully understand HIV transmission and make informed decisions about different risk situations (e.g. accidents).
4. **Provide information on the progression of illness and treatment for PLHIV** in order to counter views that people who are HIV positive will die immediately.
5. **Provide the information in a practical and participatory learning process** that allows people to internalise the information, discuss it with their peers, connect it to their own ideas and experience, and apply it to the situations they regard as risky in their daily lives.
6. **Analyse and challenge incorrect popular beliefs,** e.g. “Every time you have sex with a woman your viral load goes down”, “Sleeping with a virgin cures AIDS”, “AIDS is caused by sleeping with a woman who has had a miscarriage”.
7. **Emphasise common sense around hygiene;** we would not share razors with other people, and we would not drink from a cup or eat from a plate that has blood on it.
8. **Emphasise that sex is the main route for HIV transmission.** Explain that even though we are discussing non-sexual, casual contact, people’s greatest risk of getting HIV is through having unprotected sex. If appropriate, ask participants whether persistent belief in casual transmission somehow makes it easier to justify unsafe sex.

Exercise B1 Assessing knowledge levels – three exercises

Facilitator's notes

The aim of these three exercises is to help the facilitator and the group gain a sense of the knowledge levels of the participants around HIV.

Choose one of these exercises only. Use the QQR fact sheet (see page 39) as a resource for answering questions or clarifying areas of confusion. Do not spend too long on these exercises or people will get bored. Emphasise that the games are not exams.

Objectives

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

Time

1 hour



Step-by-step activities

A. Brainstorming on the move

1. Put up flipchart paper on different walls of the room and write a question at the top of each sheet:
 - *What is HIV?*
 - *What is AIDS?*
 - *How can you get HIV?*
 - *What are the signs/symptoms of AIDS?*
 - *How can you prevent HIV?*
 - *How can you live positively with HIV?*
 - *What do we know about ARVs?*
2. Ask participants to walk around in pairs and write down:
 - what they know about the topic
 - any questions
 - concerns or fears.
3. Then review each sheet and respond to questions, concerns or misinformation.

B. Things we want to know about HIV and AIDS

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

C. One step forward

1. Ask participants to stand with their backs against one wall of the training room.
2. Improvise a microphone (e.g. a banana, a wooden stick). Then say, "All those who know the three routes of HIV transmission take one step forward."
3. Interview a few of those who step forward to find out their answers. Continue this process, adding new statements each time.
4. After a while, stop and get participants to discuss how much they know or don't know.

Sample questions

- What are the three routes of HIV transmission?
- What is the difference between HIV and AIDS?
- Name two bodily fluids that can contain HIV.
- What does the 'window period' mean in HIV testing?
- Why can't you get HIV from shaking hands with a PLHIV?
- Name three things you know about mother-to-child HIV transmission.
- What are three advantages of taking ARVs?
- What is the meaning of a CD4 count?
- How can you stay healthy after becoming HIV positive?

Exercise B2 Assessing fears about HIV and AIDS

Objectives

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

- articulate their fears about HIV and AIDS
- explain how these fears affect how they respond to PLHIV.

Time

30 minutes

Step-by-step activity

Fears about HIV – card storming

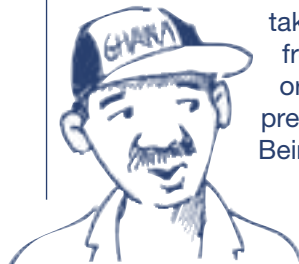
1. Hand out cards and ask participants to think about their three greatest fears about HIV. Ask them to record each fear on a card.
2. Tape the cards on the wall and cluster common points.

Processing

3. Ask the group:
 - *What is the connection between fear and stigma?*
 - *What do we learn from this?*

Examples of fears about HIV and AIDS

Getting infected. Dying slowly and painfully. Blame, shame, isolation by others. Shame – people talking about us. The unknown. Infecting my partner. Divorce or separation. Losing friends. Losing jobs. Neglect. A friend getting sick and dying. Loss of hope. No chance to have children. Helplessness. Having to take responsibility if a parent dies. Getting HIV from nursing someone else. Leaving children as orphans. Burden to my parents if I get sick. Getting pregnant and then discovering I am HIV positive. Being scared for my teenage children.



Summary

Thank participants for being open about their fears and how they affect their attitudes and sometimes create stigma. Explain that these fears are natural and we all have them (they are rooted in basic fears of contagion), but that the fears play a major role in creating stigma.

Exercise B3 Dealing with fears about our own status

Facilitator's notes

This exercise is designed to get participants to look at their own fears about their HIV status. People who don't know their status – many participants will be in this situation – often have fears linked to stigma, that may stop them going for an HIV test.

This exercise should only be done if or when the trainer feels the group is ready and he or she has built up the required level of trust. As a facilitator, you need to decide whether this exercise is appropriate for the group. If many participants have already disclosed that they are living with HIV, it may not be relevant.

Objective

By the end of this session, participants will be able to talk more comfortably about their own possible HIV status.

Time

45 minutes

Step-by-step activity

Individual reflection – five minutes

1. Ask participants to find a place to sit on their own. Then say, *“Think about a time in your life when you may have been at risk of getting HIV. What happened? How does it feel now?”*

Sharing in pairs

2. Then say, *“Pair off with someone you feel comfortable with and share your feelings or fears. You don't need to explain the circumstances. Instead, focus on the feelings or fears triggered by this incident in your life. What stops us from talking to others about our fears?”*

Processing

3. Ask the participants:
 - *How was the exercise?*
 - *What kind of support do we need to be able to talk about our fears?*



Exercise B4 Fears about non-sexual, casual contact

Facilitator's notes

This is a high priority exercise. We encourage all groups to use it.

The first question asks, "What fears do you think people in the community have?" Our aim is to find out indirectly what are participants' own fears.

Objectives

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

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

Time

1 hour

Materials

Copies of the *QQR fact sheet* on page 39.

Step-by-step activity

Card storm

1. Divide into pairs and buzz, "What fears do you think people in the community have about non-sexual, casual HIV transmission?" Ask pairs to write single fears on cards and tape them on the wall.

Examples from Côte d'Ivoire workshop

Swimming in the same pool. Working together. Sharing an office. Shaking hands. Washing a body. Witchcraft. Sharing clothes. Sweat. Visiting a patient. Sharing toilets. Drinking from the same glass. Eating from the same plate. Eating with a PLHIV. Sleeping together. Mosquito bites. Saliva. Kisses. Hair salon. Caring for a patient. Childbirth. At the dentist. Burial. Giving blood. Using a razor blade. Tattoos. Sharp objects. Praying together in a church or mosque. Washing a patient's clothes.

2. Cluster similar fears. Then ask participants to prioritise, "What do you think are the biggest fears?"

Option 1: Role play

3. In small groups, select one of the high priority fears and make a role play to show how people stigmatise because of fear of this form of contact.
4. Ask pairs to present their plays. After each role play ask, "What happened? Why do people think those forms of contact will lead to HIV infection?" Push participants to explore what is really behind the fear; to disentangle the fear.
5. Hand out copies of the *QQR fact sheet* and discuss. In pairs, get people to practise how they can use *QQR* to dispel fears about casual contact.

Examples of role plays from Ethiopia toolkit workshop

Shaking hands: Friend avoids shaking hands by pulling his hand away. Why? "HIV will spread through body contact so I don't want to touch him."

Kissing on cheek: Person avoids kiss on cheek, using as an excuse, "I can't hug you because I have a bad cold". Why? "There may be cuts on the face and I may contract the virus through kissing the cheek."

Injured person: Person avoids contact with injured person who he suspects is HIV positive. Why? "Blood might get on me if I touch him and I would get HIV."

Sharing toilet: PLHIV goes to toilet. Another person avoids using the toilet after him. Fears that HIV can be transmitted through the toilet seat.

Sharing utensils: Plates put into a separate pile and name written on each plate so that they can be kept separately. Fears that he will be infected through germs left on the plate.

Exercise B4 Fears about non-sexual, casual contact



Option 2: Margolis wheel

3. Hand out and discuss the *QQR fact sheet*.
4. Organise a Margolis wheel (or carousel) with an inner circle and outer circle.
5. Ask those who feel confident with QQR to sit in the inner circle and be the experts, and those who are less confident will be the researchers.
6. Give each researcher a question to find the answer to. Each researcher spends a minute with each expert in turn and collects the answers to the question.
7. Come back into the large group. Ask, “*How was the exercise?*” Clarify any outstanding issues.

Sample questions for Margolis wheel

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

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

Case studies to practise QQR

A family member who is HIV positive cuts her finger when she is cooking. The blood falls into the food. What is the risk involved?

A woman is cleaning up after a small child (with HIV) who has had diarrhoea. She has cuts on her hand. What is the risk involved?

A few men are sharing a carton of *chibuku* (maize beer) in a bar. One of the men has sores on his lips and blood gets into the *chibuku*. What is the risk involved?



There is a car accident. A person who is injured is rushed to the hospital by a ‘Good Samaritan’ who comes across the accident soon after it happened. At the hospital the nurse on duty can’t find gloves. She says to herself, “*I don’t know the HIV status of this person. If I touch him, I might be infected. What am I going to do?*”

Exercise B5 Fears about HIV at home

Facilitator's notes

One of the things that makes this exercise interesting is the drawing of the house, so be sure to include this step. It involves the use of a mapping technique – in this case applied to the household. Use the *QQR fact sheet* (see page 39) to help explain HIV transmission.

Objective

By the end of this session, participants will be able to identify the places in the home where family members may have fears if someone is living with HIV.

Time

1 hour

Step-by-step activity

Household mapping

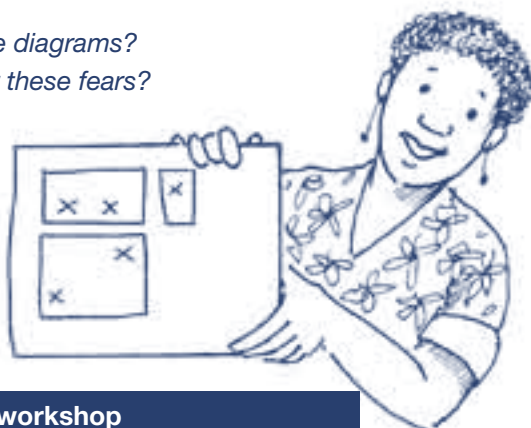
1. Divide into small groups.
2. In groups:
 - Make a drawing of a typical house in your community on a flipchart sheet.
 - Mark on the drawing points in the house where people might be scared of getting HIV through non-sexual contact with someone living with HIV, leading them to stigmatise or isolate.

Report back

3. Ask each group to present their drawing and explain why each area that they have marked makes them scared and results in stigma.
4. After each group presentation, explore in the large group whether there is any risk and how you can explain it to others (use QQR to help).

Processing

5. Ask the whole group:
 - *What do we learn from these diagrams?*
 - *How can we help to counter these fears?*



Example from Tanzania TOT workshop

Bathroom	X	Bedroom	
	X	X	X
	X	X	X
Kitchen			
X	X	X	
Sitting room			
		X	

Exercise B5 Fears about HIV at home



Possible points of fear and stigma in the household

Bathroom

- Fear of getting HIV while helping to wash or clean someone who is sick.
- Fear of sharing facilities.

Bedroom

- Told to stay in the bedroom away from visitors.
- Family prevents their children from playing with PLHIV.
- No sharing of blankets and clothing.
- Given separate plates and utensils and asked to eat here alone.
- Left out of family discussions and decision-making.

Kitchen

- Prevented from cooking for the family.
- Fear of accidents while cutting meat – fear of HIV transmission through blood.
- Family eats together without PLHIV – no sharing of food.

Sitting room

- Minimal contact with visitors – kept in hiding.



Exercise B6 Why people don't believe facts about HIV and AIDS

Facilitator's notes

Different age, gender or religious groups often have different beliefs, so you may want to do this exercise in various age, gender or religious groupings.

Objective

By the end of this session, participants will be able to describe a number of beliefs and myths that affect people's attitudes towards HIV and AIDS.

Time

1 hour

Action ideas

- Ask participants to make up new slogans about HIV and AIDS.
- Divide into pairs. Ask each pair to prepare a discussion session on one aspect of basic facts about HIV and AIDS using a code (picture, drama, story) and discussion.

Step-by-step activity

Introduction – brainstorm

1. Divide into pairs and ask them to brainstorm myths and beliefs about HIV and AIDS.
2. Divide into task groups. Ask each group to select one of the beliefs and try to explain it.
 - *Where does this belief come from?*
 - *What are some of the reasons or thinking behind the belief?*
 - *Whose interests are served by this saying or belief?*
 - *How does this belief lead to HIV stigma?*

Option: Make a drama to show how this belief is accepted and how it influences people's thinking.

Examples of popular beliefs

Condoms transmit HIV. HIV is caused by sleeping with a woman who has had a miscarriage. HIV is caused by witchcraft. The partner who falls sick first is the person who got infected with HIV first – who 'brought HIV into the family'. Sex with a virgin cleanses you of HIV. Every time you have sex with another person your viral load goes down. If one partner is HIV positive, the other must also be HIV positive. Holy water or prayer can cure you of AIDS. God is punishing you so there is no cure. Prayers and fasting are better than ARVs. Free ARVs are not as powerful as those that you pay for.

Factors affecting our beliefs – card storm

3. Hand out cards and ask, "What factors affect what we believe about HIV and AIDS?" Ask participants to write down points on the cards. Ask participants to cluster similar cards and summarise the different categories.

Factors affecting our beliefs

Day-to-day experience and survival learning. Common sense understanding of other illnesses. Teachings of the family, clan, tribe, church. Ideas from our peers. Facts learned at school. Media messages. Popular beliefs and sayings. Level of trust in AIDS educators or health workers.

Processing

4. Ask, "What do we learn from this? How can we help to challenge some of the beliefs and myths that lead to stigma?"

Why people may not trust the facts

- Educators give contradictory, confusing or incomplete information.
- Audience may not believe educator because of own beliefs, life experience and knowledge.
- Different messages come from different NGOs and trainers.

Module

Introduction

HIV is primarily transmitted through sex, so people assume that we contract HIV through sex and ‘immoral behaviour’. Some people think that getting HIV means you have sinned! This is why there is so much shame and blame.

In the HIV stigma study² many people reported that they believe PLHIV contracted it through sexual activity that goes against social norms or religious teachings. The link between sex, religion and stigma is also crucial where there is strong belief that HIV is a punishment from God.

This module aims to tackle the difficult subjects of sex and morality in our daily lives, and explores these issues in relation to HIV-related stigma.

The module is divided into a number of sub-sections. We encourage you when planning workshops to select exercises from each of the sections.

Starters

Exercise C1 We are all in the same boat!

Exercise C2 Things people say...

Judging

Exercise C3 Who is labelling whom?

Exercise C4 Stereotyping – ‘big brother and big sister’

Exercise C5 Judging characters

Exercise C6 Value clarification exercise

Sex and sin

Exercise C7 Breaking the sex ice

Exercise C8 Promiscuity, prostitution and preaching

Exercise C9 Where did you get it?

Beliefs and stigma

Exercise C10 Risk-taking and stigma

Exercise C11 Traditional beliefs and stigma

Exercise C12 Carrying condoms carries stigma

² Nyblade, L. and Pande, R. et al (2003) *Disentangling HIV and AIDS Stigma in Ethiopia, Tanzania and Zambia*, Washington D.C., ICRW

Exercise C1 We are all in the same boat!

Facilitator's notes

This is a warm-up game to introduce the idea that we are all affected by HIV, and yet we stigmatise those who have HIV.

You can use any game that eliminates or excludes participants. These games trigger discussion on how it feels to be eliminated or excluded from the group. At the end of the game ask those who were eliminated, *"How did you feel when you were out of the game and left sitting watching the other players?"*

Objective

By the end of this session, participants will be able to recognise that all people are at risk of getting HIV so there is no point in stigmatising those who already have HIV.

Time

15 minutes

Step-by-step activity

We are all in the same boat! – warm-up game

1. Facilitate the game described below. Use the local language to make it easier for everyone to participate.

In the river, on the bank

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

"You are standing on the bank. When I say 'In the river', you should take one step forward. However, if I say 'On the river', you should not move. When I say, 'On the bank', you should take one step back to your starting position on the bank. If I say 'In the bank', you should not move. If anyone makes a mistake, he or she will be eliminated from the game."

Then start the game. Give the commands quickly. If anyone makes a mistake, ask them to leave the game. Play until only a few people are left in the game, then stop and debrief – while participants are still standing.

Report back

2. Ask participants:
 - *Those who went out of the game – how did you feel?*
 - *Those who are still in the game – how do you feel?*
 - *What happened when someone made a mistake?*
 - *What can we learn from the game about stigma?*

Examples of responses from stigma workshops

Those kicked out of the 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 so they would join me in the loser category.

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

I felt very nervous. I wanted to avoid being singled out so I was very careful. 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. I felt powerful, like a winner.

What happened when someone made a mistake?

People laughed, pointed fingers, mocked, insisted they leave the game, shouted.



Exercise C1 We are all in the same boat!

Zambian sayings

Whatever misfortune befalls me, tomorrow it may be you!
Your friend's misfortune can become your misfortune.

*Chaona muzaka chapita mawa
chili pa iwe.*

Your funeral is my funeral.
When I have a funeral, you
will come to comfort me. We
will take care of each other's
burdens.

Malilo nikulilana.

Examples of responses from stigma workshops (cont.)

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 (stigmatised) feel bad. Laughing at others making mistakes can be interpreted as a form of blaming. Laughing at the behaviour of others happens naturally or unconsciously – it just comes out. Stigma is like this – often we are unaware that we are doing it. We are only acting out the way we have been socialised. It is easy to make a mistake in the game and in real life, e.g. not using a condom or taking risks in our sexual behaviour. You only get HIV once. Those who were still in the game were watching and judging others' behaviour. This is just like the way we stigmatise.

Summary

- This game shows us that 'we are all in the same boat'. There is no separation between **us** and **them**. We are all facing and living with this epidemic together. We are all affected. We have all taken risks at one time in our lives and many of us still do, and we all have family members and friends who have died of AIDS.
- Lots of people like to laugh at and make fun of others, but one day they may also 'fall into the river' and others will laugh at them. Remember, HIV affects everyone.
- Stigmatising others **makes us feel superior to others**. It makes us feel that we are right and they are wrong. Yet we may be in the same boat.
- All of us are at risk of getting HIV, so there is no point in stigmatising or blaming those who are already affected. We could join them any day!



Exercise C2 Things people say...

Objectives

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

- identify labels used by people to stigmatise PLHIV and other stigmatised groups
- understand that these words hurt.

Time

1 hour

Preparation

Set up six flipchart stations – blank sheets of flipchart paper on different walls of the room – with a topic on each sheet, e.g. Things people say about PLHIV, sex workers, teenage girls, men who have sex with men (MSM), orphans and widows. Select the groups that are the most stigmatised in your area.



Facilitator's notes

This is a high priority exercise. It helps participants to verbalise the stigma towards different types of people. The language used can be very strong so it needs to be carefully facilitated.

In this exercise participants can express their own stigmatising labels for other groups under the cover of attributing them to 'the people'. So while some of the words are those commonly used by the community, some are the words actually used by participants themselves.

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

In debriefing this exercise it is important to focus on how participants really feel about these names rather than focusing on the words themselves. This helps to avoid embarrassed laughter. The whole point of this exercise is to help people recognise how these words can hurt.

Extra tips

- The number of flipchart stations/categories depends on the number of participants and the amount of time you have. With a large number of participants you will need many stations/categories so that the groups are not too big.
- The rotational brainstorm is fun, but the real learning comes in the debriefing. Make sure you allow enough time and energy for this.
- You need to explore your own feelings about these issues before trying to facilitate this discussion with others.
- Challenge the laughter. Often participants will laugh out of embarrassment. This is a good opportunity to ask, "How do you feel about the laughter?"

Step-by-step activity

Fruit salad – warm-up game

1. Set up the chairs beforehand in a circle. Allocate roles to each person, going around the circle: PLHIV, sex worker, teenage girl, MSM, orphan, widow. Continue until everyone has been assigned a role. Then explain how the game works:

*"I am the caller and I do not have a chair. When I call out two groups – e.g. PLHIV and sex workers – all the PLHIV and sex workers have to stand up and run to find a new chair. I will also try to grab a chair. The person left without a chair becomes the new caller and the game continues. The caller may also shout 'Revolution!' and when this happens, **everyone** has to stand up and run to find a new chair."*

Start the game by shouting, "PLHIV and sex workers!" and get the PLHIV and sex workers to run to a new chair.

Exercise C2 Things people say...



Things people say... rotational brainstorm

2. Divide into six groups based on the roles used in the game, e.g. all the sex workers, all the orphans, etc. Ask each group to go to their flipchart station. Ask each group to write on the flipchart all the things people say about those in that group. After two minutes, shout "Change!" and ask groups to rotate and add points to the next sheet. Continue until the groups have contributed to all six flipcharts and end up back at their original list.

Examples of 'things people say...' from Zambia workshop

PLHIV

Promiscuous. Sinners. Immoral. People who sleep around. Naughty. Careless. Bewitched. Death sentence. Walking corpses. They didn't listen. Deserve to die. Guilty. It's their own fault. Punished by God. Dangerous – will infect others. *Kaliyenoko* (say goodbye to your mother). *Kanayaka* (the light is on). No sex – not meant to have sex or have children.

Sex workers

Whores. Bitches. Promiscuous. Sinners. Immoral. Irresponsible. *Mahule*. Sex maniacs. Serial killers. Women without shame. Enjoy sex too much. Too lazy to work. Money crazy. Husband grabbers. HIV carriers. Eating without having to work. Sell your bottom to feed your mouth. Make money by lying down. Poor – need money.

Teenage girls

Naughty. Promiscuous. Prostitutes. Spring chickens. Sweet sixteen. Husband stealers. Opportunists. Sex objects. They love old men. Give them money and they are yours. They like nice things. They like three Cs – cash, car and cellphone. HIV carriers.

MSM

Immoral. Sinners. Unnatural. Abnormal. Misfits. Insane. Need therapy. They fear women. HIV carriers. Sex maniacs. Sex organs don't function. Should not get married. Should not be allowed to adopt children. Should be segregated. Like money. *Yakumbuyo*.

Street children

Criminals. Beggars. Violent. *Kapondo*. Dropouts. Rejects from poor families. Useless. *Kawalala*. Burden. Social menace. Lost. Forgotten. Victims. No future. Parents died of AIDS. Parents were immoral. Diseased. Need to be controlled. Separate from other kids. Die fast. Starving for attention. Miserable. Misunderstood. Hopeless. Abused.

Widows

Husband killers. Their fault that their husbands died. Kill husbands to inherit wealth. HIV carriers. Dangerous – source of evil and trouble. Witches. Evil people. Threat to other women – husband stealers.

Exercise C2 Things people say...

! Action ideas

Try these exercises with your own community group or family and friends and discuss the power of language.

“ We are not victims, we are not patients, and we are not sufferers. These names are both derogatory and disempowering. We are people living with HIV. We laugh, we cry, we dance, we sing, we play, we argue, we pay tax, we are parents and children. We belong to families. We are all in communities. Above all these things we are part of human nature. That is the second challenge: destigmatising ourselves and HIV and AIDS. ”

Thanduxolo Doro, speaking at the First National Summit for People Living with HIV/AIDS, Eskom Conference Centre, Midrand, South Africa, October 2002.

(Source: SafAIDS)

Report back

- Bring everyone together into a large circle. Ask one person from each group to take turns standing in the middle of the circle and reading out the names on their flipchart, starting with *“I am a street child (or other group) and this is what you say about me...”*

Processing

- After all lists have been read out, ask the following questions:
 - How do we feel about these names?
 - Why do we use such hurtful language?
 - What are the assumptions behind some of these labels?
 - What does this show us about the link between language and stigma?

How do we feel about these names? From RATN regional workshop

Sad. Angry. Humiliated. Unfairly treated. Rejected. Embarrassed. Ashamed. They are pointing fingers at me – it makes me sad and ashamed. I wish I could die. I feel really bad – rejected and criticised by others. They are pushing me away. It makes me feel unfairly treated. It's no fault of mine I got HIV, but I am blamed. I'm going to hide my illness from others so I won't be stigmatised. I feel hopeless. All my confidence is gone. I don't know how I will survive. I have teenage daughters and it makes me angry to hear these names.

Summary

- We are socialised or conditioned to judge other people. We judge people based on **assumptions about their behaviour**.
- Sex is taboo** – it is regarded as something shameful that we should not talk about. So people who have lots of sex are assumed to be shameful.
- PLHIV, sex workers, teenage women and MSM** are all labelled as sexually immoral and called promiscuous, sinners, irresponsible, AIDS carriers. The judgements in this case are based on sexual morality.
- Layers of stigma** – people affected by HIV stigma, e.g. women, sex workers, MSM, are often already stigmatised/disadvantaged before they get HIV. They have the least power to resist or challenge stigma.
- These labels show that when we stigmatise we stop dealing with people as human beings – **we forget their humanity** (by using mocking or belittling words) and this gives us a feeling of power and superiority over them.
- These labels are based on assumptions for which we have insufficient information. They are **generalisations** that have no validity – we simply assume that ‘other people’ are dirty, lazy, promiscuous, bad luck, etc.
- We attribute characteristics to a group and everyone who belongs to that group**, e.g. all PLHIV are promiscuous.
- Stigmatising words are strong and insulting** – they have tremendous power to hurt, humiliate and destroy people's self-esteem. *“When we are shamed and blamed, it is like being stabbed with a knife – it hurts!”*
- Why do we condemn some groups and accept others?** We are not saying that sex workers are right or wrong. Whether or not you agree with someone, you don't have the right to belittle them. You must look at a person as a human being and empathise as if they are your son or daughter. Put yourself in the shoes of the other person. How would you feel to be called these names? Even if you don't like the person, try to understand them.

Exercise C3 Who is labelling whom?

Objective

By the end of this session, participants will be more aware of differences and the harm involved in labelling other people.

Time

1 hour



Step-by-step activity

Greetings game³

1. Ask the group to sit in a circle and hand out cards and markers. Then lead the following exercise:

Ask one half of the group to, "Draw on your card the face of someone with a **good quality**, e.g. someone who is kind, a good listener, cheerful. You decide what quality you want to draw." Ask the other half to, "Draw the face of someone with a **bad quality**, e.g. a liar, thief, selfish person, murderer, adulterer, wife beater, etc."

Ask each person to show the card and explain the quality of the face drawn. Collect the cards and shuffle them so that they are all mixed up.

Greeting 1: Ask everyone to stand up and move around the room, greeting as many people as they can in a warm and friendly way.

Taping cards on backs: From the pack of cards, tape one card on the back of each person without letting them see which card they have been given. No one should tell the others what picture they have been given. Ask someone to stick the last card on your own back – ideally a card with a bad quality.

Greeting 2: Ask everyone to move around again, greeting each other. They should greet each person according to the label they see on their back. If they are greeting someone who has a 'liar' label, they should show their dislike of liars in their face and body movement. If they can't remember what the picture on someone's back means, they should treat that person with caution.

After everyone has greeted one another and moved into groups of friends, ask them to sit down in a circle, leaving their labels on.

Report back

2. Ask the participants:

- How did you feel during the first greetings? During the second greetings?
- Did others treat you differently? How? How did that make you feel?

Processing

3. Ask everyone to take off their labels, so that they can see how they have been labelled. Then ask, "What did you learn from this exercise? What does this tell us about stigma?"

Summary

This exercise helps you feel the pain and misery that we experience when faced with the prejudice of others. Just because someone has HIV does not mean that they are suddenly a bad person. Yet people's attitudes can change radically once it is known that someone is HIV positive. Is this fair?

³ Adapted from Welbourn, A. (1995) *Stepping stones: A training package in HIV/AIDS communication and relationship skills*, London: ActionAid

Exercise C4 Stereotyping – ‘big brother and big sister’



Objective

By the end of this session, participants will be able to recognise how they stereotype and make assumptions about other people without knowing the full story.



Time

2 hours



Materials

Role cards (see below) – copy and cut along dotted lines

Step-by-step activity

Introduction

1. Explain how the game is played. Tell participants that, “Some of you will be judges, others will be contestants. We need six volunteers – three women and three men – to be contestants.” Hand out a contestant role card (below) to each contestant.

Explain that, “The rest of you will be the judges. You will pick someone to be a big brother or big sister role model. There will be three rounds of judging. At each round you will be given new information about the six contestants. While the contestants are reading their briefing notes and getting ready, you should discuss among yourselves what criteria you will use in judging them. Your aim is to select the most worthy contestant.”

Competition

2. Organise the competition one round at a time. For each round, each contestant stands in front of the judges and provides a new piece of information about herself or himself which is written on the card.

Contestant role card	Round 1	Round 2	Round 3
A	Married woman with two children.	Sex worker – selling sex at hotels at the weekend.	This is the only way she can pay school fees for her children.
B	Doctor at government teaching hospital.	He sometimes steals drugs from the pharmacy.	Uses the drugs to treat people at a small clinic that he runs in his spare time in the compound.
C	Teenage girl living with her aunt in a village.	She has dropped out of school and travels regularly to town.	She has to do piecework to support her aunt who is sick, and her three younger brothers.
D	Married man with four children.	He survives by poaching game from the local reserve.	He contributed a huge sum of money to rebuild the local church.
E	Young male musician who sings about peace and love.	He sometimes smokes cannabis (<i>dagga</i>).	He works with street children as a volunteer in his spare time.
F	Female district council member. Good role model.	She allocates plots of land to her relatives and friends.	She is raising money to set up a shelter for women who have faced domestic violence.



Exercise C4 Stereotyping – ‘big brother and big sister’



Allow the judges to decide the ranking of the contestants at the end of each round and announce their decision (which is recorded on the flipchart). You can ask participants to stand according to their ranking.

Making the judgement

3. After the third round, the group should decide who is the big sister or big brother. Then discuss:

- *How did you make your decision? What criteria did you use?*
- *What did we learn from this exercise?*
- *Why do we judge others?*

Examples of why we judge others

- It helps to make me feel better or superior.
- It helps to increase my power and control over others.
- It 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 church teaches me to judge – to point out the sin in others.

Summary

- We often make assumptions about other people without knowing much about them. They are **generalisations** that have no validity – we simply assume that ‘other people’ are dirty, lazy, promiscuous, bring bad luck, etc.
- Stigmatising **makes us feel superior to others** and more moral than other people. It makes us feel that we are right and they are wrong. Yet we may be in the same boat.
- We should aim to accept rather than to judge or condemn others, e.g. we may not agree with the lifestyle of a sex worker, but we should not condemn or reject her. We should promote an attitude of ‘live and let live’.
- Whether or not we agree with other people, we don't have the right to judge them. We should **treat them as human beings** and allow them their humanity. To stigmatise is to wipe out their humanity and treat them as having no value.

Exercise C5 Judging characters

Facilitator's notes

This exercise, if poorly facilitated, could reinforce stereotypes. Help the group focus on trying to understand the characters rather than judge them. The exercise uses a technique called 'hot-seating'. It is important that the characters are given enough time to prepare their roles and really think about who they are and why they find themselves in the situation. Ideally, prepare volunteers before the exercise starts.

Objectives

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

- understand more about the types of people we often judge
- challenge the assumptions behind our judgements about other people.

Time

1-2 hours

Materials

Selection of *character cards* (see pages 40-53)

Step-by-step activity

Judging characters⁴ – role play

1. Ask for four volunteers to be in a role play. Decide on the situation and who will be whom. Use the *character cards* to help develop the roles.

Sample scenario: A young girl is returning to school but her mother has no money for school fees. She meets a friend, from her school, who is well dressed and has a cellphone (she is selling sex). The friend asks why she is looking sad and wearing old clothes, etc. She suggests introducing her to someone who can help. The fourth character is an older man who becomes a sugar daddy to the schoolgirl, helping her with school fees in exchange for sex.

2. Ask the volunteers to perform the role play for long enough to show the entire situation (there may be different scenes to show what happens).

Hot-seating

3. The four characters sit in front of the audience and stay in role. Tell the participants they can ask the characters any questions they like, in order to help them to understand the situation better. Ask them to try to stay neutral – the aim is to understand, not to judge. Ask the characters to stay in role and really think about their answers.
4. Record the answers on a flipchart.
5. Thank the volunteers and ask them to return to the group. Pull out some of the key issues from the flipchart for further discussion.

Examples of questions from theatre workshop, Lusaka

Questions to schoolgirl

How do you feel about your sugar daddy? Was there any other way you could get the money? Have you told your parents what you are doing? Do you want to get married in the future?

Questions to friend with sugar daddy

Where is your family? How did you start selling sex? Do you have a boyfriend? Do you like what you do?

Questions to sugar daddy

How do you feel about this girl? Are you married? What do you get out of the relationship?

Questions to mother of schoolgirl

Is there any way you can earn money for the school fees? Where is the father? Is there anyone else in the family who can help?

Processing

6. Ask the participants:
 - *What did we learn from this exercise?*
 - *Why do we judge some people?*
 - *What kind of questions did we ask?*
 - *What are the assumptions behind these questions?*
 - *How does understanding more affect our judgement?*

⁴Adapted from Kilonzo, Dr G. Joinet, B. and Mugolola, T. (1994) *The fleet of hope*

Exercise C5 Judging characters



Examples of answers to questions

- I like my sugar daddy; he is kind and helps me pay my school fees.
- I know I could try to sell things in the market to make money, but how can I do this and go to school?
 - This girl makes me feel young again. My wife is always busy and has no time for me.
 - I am disabled and cannot work. Her father spends most of the time in the bar.

Judging ourselves – reflection

1. Ask participants to spend ten minutes alone and reflect about:

- *What have you done in your life that is culturally unacceptable?*
- *What judgements could be made against you by others?*
- *How would they make you feel?*

Sharing

2. Ask participants to pair up with someone they feel comfortable with. Discuss how it felt to do the reflection (**not** the unacceptable behaviour, but the feelings). **Option:** Come into a large group for sharing.

Processing

3. Ask the participants:

- *How was the exercise?*
- *How are you feeling?*
- *What do you learn from this?*
- *How can we change the way we judge people?*

Summary

- We make assumptions about other people's behaviour based on their **occupation, appearance, and/or perceived sexual behaviour**. In making these assumptions we often generalise, e.g. saying that all people in a certain occupation are promiscuous. This, of course, is wrong. You may be a female singer, but this does not mean that you are promiscuous.
- **We stigmatise or condemn people without knowing their actual behaviour**. As humans we often believe or assume the worst about other people, e.g. the female singer is assumed to be sexually active because of her occupation, but this assumption may be wrong.
- Stigmatising 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.
- Stop blaming PLHIV and help to normalise HIV and AIDS. Get people to **regard PLHIV as people with an illness, not people with bad behaviour**. "Let he who is without sin cast the first stone."

Exercise C6 Value clarification exercise

Facilitator's notes

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

Objectives

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

- analyse why people are judged differently
- analyse the assumptions behind our judgements about PLHIV.

Time

30 minutes

Materials

Set of statements (see right) written on flipchart sheets and taped on the wall.

Step-by-step activity

Rapid survey

1. Ask participants to go to each flipchart and write down their opinion about each statement – agree, disagree or not sure.
2. Tabulate the results for each question, e.g. 15 agree, 10 disagree, 3 not sure.

Plenary discussion

3. Take one statement at a time. Ask someone to read out the statement and the result. Then ask anyone who agrees to explain why and anyone who disagrees to explain why. Discuss. Then move on to the next statement.

Processing

4. Ask participants, “*What are the assumptions behind these statements?*”

Option: Establish places for different views on separate walls of the room (or on the floor) – strongly agree, strongly disagree and not sure. Then read out each statement and ask participants to walk to the place that represents their opinion. Ask a few participants to explain their views. Do a quick summary (or ask a trainee to do this) and introduce the next issue. Don't let this session drag on – keep trainees moving and thinking!

Summary

- Values play a key role in forming judgements.
- We all have different views but some strongly negative views can fuel stigma.

Set of statements

- A. A PLHIV should eat and sleep separately from the rest of the family.
- B. Family members should be told when a member tests positive for HIV.
- C. People with HIV deserve it because they have been doing bad things.
- D. If one partner gets AIDS, the other partner should look after him or her.
- E. A normal man never rejects a sexual opportunity.
- F. It is unacceptable for women to express their own sexual desires.
- G. Condoms should only be available to unmarried people.
- H. I believe there are innocent and guilty victims of HIV and AIDS.
- I. PLHIV should not be allowed to have children.
- J. HIV and AIDS only happen to married people.
- K. Men face less stigma than women. Boys will be boys – they are just unlucky when they get HIV. Women lure men so they are sinners.

Exercise C6 Value clarification exercise

! Action ideas

Discuss the value statements at home with family or friends.

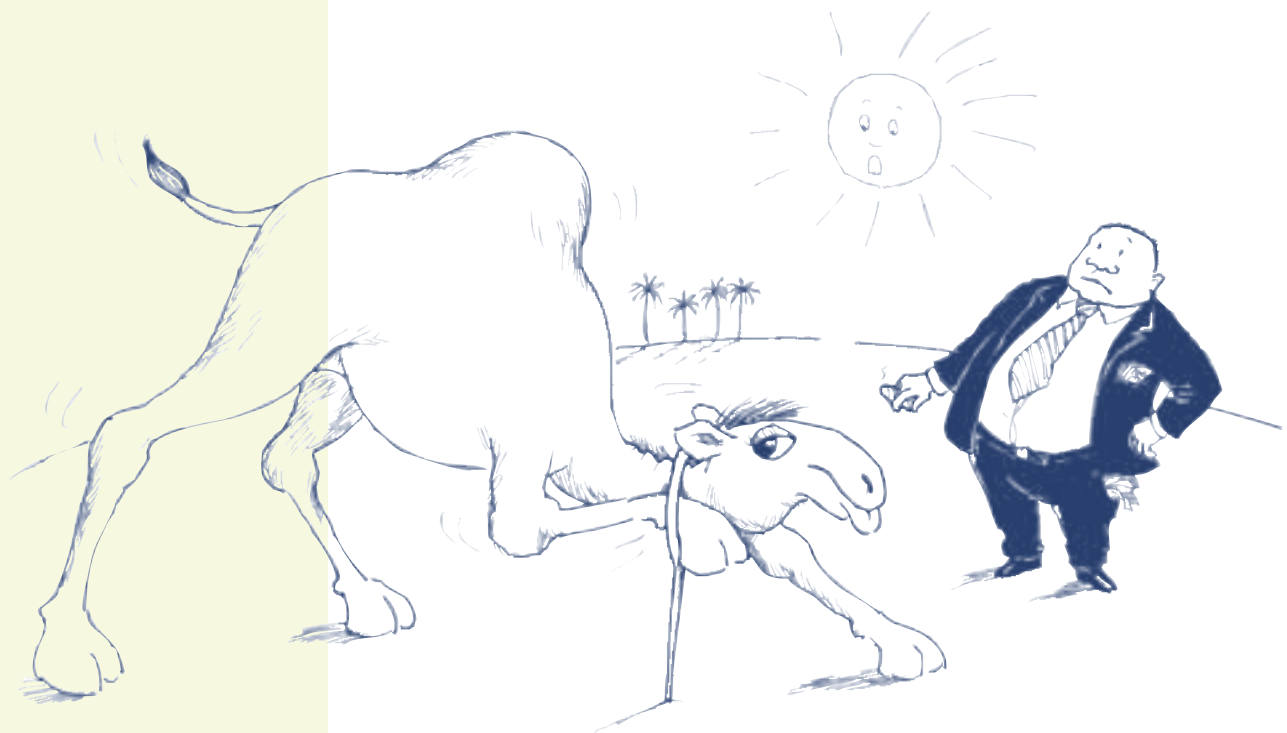
Behind the statements

Statements A, B and I are based on fear and lack of knowledge about HIV and AIDS – they assume that other people can get infected through casual contact with PLHIV.

Statements C, F, G and J involve social stigmatising – PLHIV or other stigmatised groups are blamed and shamed for certain behaviours.

Statements E and F are about male power and domination and women's subjugation.

“ It is easier for a camel to pass through the eye of a needle than it is for a rich man to enter the Kingdom of Heaven. ”



Exercise C7 Breaking the sex ice

Facilitator's notes

These exercises are designed to help people overcome their fears, talk more openly about sex and create a debate about attitudes and judgements around sex and sexuality. The exercises are meant to be optional – select those that suit your audience and context.

Objectives

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

- talk more openly about sex and their feelings about sex and sin
- recognise that the view that sex equals sin is one of the roots of stigma.

Time

30 minutes

Materials

Different coloured paper and pens but the same colours for exercise D.

Preparation

Prepare a *bingo sheet* for each participant. Copy the one on page 27 or adapt it for your target group or setting.

Step-by-step activities

A. Bingo – mixer game

1. Hand out a *bingo sheet* to every participant.
2. Write up the rules for the game on a flipchart.

Rules

- The aim is to complete all the boxes on the page.
- To complete a box you must have it signed by someone who is willing to sign for that category.
- Each player can only sign another player's card once.
- Don't feel pressured to give out personal information if you don't want to.
- The game ends when someone shouts "Bingo!" or "10 minutes is up".

Processing

3. Ask participants, "How was the game? What did you learn?"

Responses from West African TOT workshop – Côte d'Ivoire

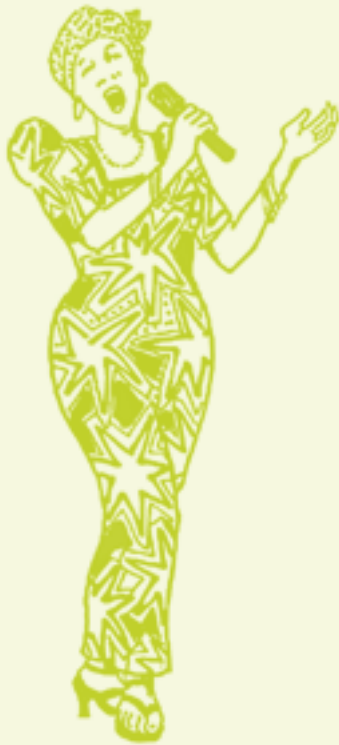
- Felt stigmatised – others made assumptions about me and what I did (e.g. drinking beer, loving sex).
- Helped me become more comfortable with other participants (e.g. willing to say "I like sex").
- Had to be quite firm in refusing to sign one of the boxes asked of me.
- The exercise helped me get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



Summary

The game (and stigmatisation) is about judging and making assumptions about other people's behaviour – looking at people and guessing their behaviour.

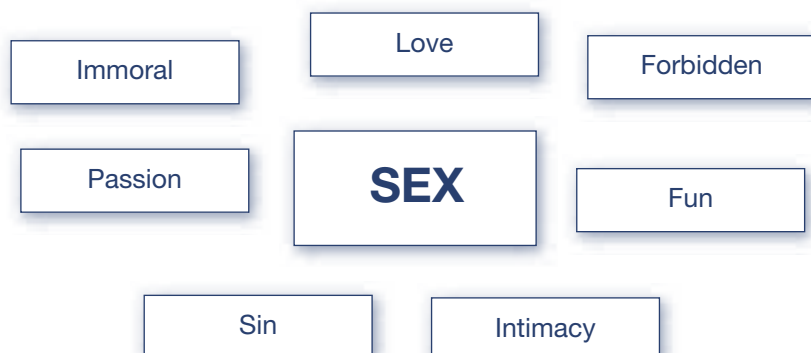
Exercise C7 Breaking the sex ice



Sample bingo sheet		
Someone who speaks more than one language	Someone who loves to sing and drink beer	Someone who has more than three children
Someone who loves loud music	Someone who loves to talk about politics	Someone who uses condoms
Someone who goes to church every week	Someone who loves sex	Someone who has been a member of a choir
Someone who likes eating <i>kandolo</i>	Someone who did not like going to school	Someone who has never been to this town before

B. Our images of sex – card storming

- Put up the word 'Sex' on a card in the centre of the wall.
- Hand out cards and markers to participants and ask them to write the first things they think of when they hear the word 'Sex', and tape them on the wall around the central card (see sample below).



Report back

- Ask, "What does this tell us about how people think about sex?"

Exercise C7 Breaking the sex ice



Facilitator's notes

This activity gets people thinking about how they reveal information about their own experiences of sexual activity, and is a good way to get a discussion going.

To ensure confidentiality, explain that participants should:

- sit apart from each other so no one can see what anyone else is writing
- use the same colour pen
- write something for each answer.

C. Why do women or men have sex? – brainstorming

1. Divide into same-sex groups. Ask the men to brainstorm why men have sex and the women to brainstorm why women have sex. Ask each group to record points on the flipchart.
2. Pin up the flipcharts alongside each other and compare the views of women and men.

Why do women have sex?

To satisfy sexual desires (biological need). To feel good/sweet/nice. To have children. Expression of love/intimacy with a man. Respond to a man's needs. Make peace with husband/boyfriend. Get a husband. Prove you are a woman. Get money/favours from a man. Forced/raped. Searching for the right size/skill in a man. Cleansing.

Why do men have sex?

Biological need. Natural activity. Feeling/urge. Lust. Relief. Reduce stress. Relax. Prove manhood. Pleasure/enjoyment/feel good. Enjoy life. Satisfy wife/girlfriend. Love/intimacy. Show men's superiority. Have children. Make peace with wife/girlfriend. Experiment. Cultural cleansing.

3. Discuss:

- *What are the differences and similarities between the two lists?*
- *What does this tell us about our attitudes to sex?*

D. Anonymous participatory sex survey

1. You need at least two people to run this exercise otherwise it can become too slow. One person can ask the questions, the other collects the answer slips after each question and records the answers on a flipchart. Make sure you don't muddle up the answer slips!
2. Explain why we are doing this survey. Assure them that no one will know their answer.
3. Hand out ten small slips of paper to each participant (ideally, use one colour for men and a different colour for women).
4. Ask the first question (see sample questions on page 29) and tell participants to put a tick, cross or a number depending on the question. Ask them to fold their papers.
5. Collect the papers in a basket, count the results and record them on a flipchart. Do not present them at this stage.
6. Ask the second question and continue in the same way.

Processing

7. Ask participants:

- *How was the exercise?*
- *How did you feel answering the questions?*
- *What did you learn from the process and from the survey?*

Collate all the answers on flipcharts and present each answer one at a time to enable some discussion. Ask questions like, "What do you think about this answer? Any surprises?"

Exercise C7 Breaking the sex ice

Embarrassment is an opportunistic infection

I am embarrassed to talk about sex
So I avoid talking to my children
I giggle and laugh nervously
Whenever the word sex is mentioned
I am too embarrassed to look up
In the age of HIV and AIDS
My embarrassment continues
About sex, AIDS and condoms
I am even afraid to read about the disease
I am so embarrassed
Now I am at a loss
My daughter, my son
My husband and I have AIDS
We have never talked about sex and AIDS
Even when we knew better
We were too embarrassed
Too embarrassed to protect ourselves
Too embarrassed to keep death at bay
Now I am too embarrassed
To let anyone know about us
My family and AIDS
Then one day
My mother opened my eyes
She said "Your family is not dying of AIDS
It is dying of embarrassment,
A deadly opportunistic infection"
Today we are no longer sick with embarrassment
We know better
That no one ever died of embarrassment
But daily a loved one dies of AIDS

By Mwaganu wa Kaggia



Sample questions

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

Responses from Côte d'Ivoire workshop

- Sex is a taboo subject. It is difficult to talk about sex.
- People were relaxed and laughing – it helped loosen things up and dilute the taboo subject.
- It forced us to reveal what we don't want to talk about in public.
- We were able to talk about our own sexuality without fear.
- Question 2 showed that it is more difficult for women to say openly that they like sex.
- It reinforced the fact that the taboo around sex still exists.

Summary

When PLHIV get sick, some people say that "they cannot hide any more" – they are exposed. In Zambia a common word for PLHIV is *kanayaka*, which has many meanings, such as 'the light is on', 'you can be seen', 'the warning light shows you are finishing', etc. These attitudes often link to the way we feel about sex; i.e. that it should be hidden, secret, not discussed. So the shame of HIV and AIDS is that your past sexual behaviour can now be seen.

Exercise C8 Promiscuity, prostitution and preaching

Facilitator's notes

This exercise may need to be changed for different contexts. In Tanzania, for example, participants produced a long list of words for men who are promiscuous (even though the exercise assumes that there will be more words for women and that women are more strongly stigmatised for being promiscuous than men).

Objectives

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

- analyse why there is so much concern about promiscuity
- recognise how they sometimes judge others.

Time

1-2 hours

Materials

Copies of *Rose's story* (see page 32).

Step-by-step activities

A. Definition

1. Do a quick word storm and ask, "What do you think of when you hear the word 'promiscuous'?" Record points on a flipchart.

Irresponsible. Adulterous. Unfaithful. Moving around. Disloyal. Sinner. Chasing money. Sex is a game for them. Dangerous. Chasing AIDS. Prostitutes. No morals. Enjoys sex too much. Sex mad. Someone else – not me!

Summary

- One definition of promiscuity could be, "Promiscuous just means that you have slept with one more person than me."
- Everyone's idea of promiscuous will be different according to their background and beliefs.
- PLHIV are often labelled promiscuous, although you only have to sleep with one person once to become infected.
- Who judges who is promiscuous? How many past partners make you into a promiscuous person? Yet this word is heard a lot in terms of HIV, with many assumptions made about its meaning.

B. Gender difference

1. In gender groups, brainstorm:
 - What do you call a man who has more than two partners?
 - What do you call a woman who has more than two partners?

Gender difference from Zambia workshop

Promiscuous men – men with more than two partners

Umuchende (bull)
Nkutombe ndeya (hit and run)
Fipungwa (careless)
Vigabenga (thugs)

Promiscuous women – women with more than two partners

Solola (prostitute)
Akalivule (young prostitutes)
Chosole-osole (sex object)
Ntomba ndeya (have sex and go)
Mayowaluse (available for sex)
Katoba mayanda (marriage-wrecker)
Chilalele (sleeping around)
Intalangani (jumpy)



Exercise C8 Promiscuity, prostitution and preaching



Action ideas

Next time you hear someone using the word 'promiscuous', ask them how they would define it.

Gender difference from Zambia workshop (cont.)

There were more words to describe promiscuous women. The words about women were much stronger and more insulting, whereas the words about men were more praiseworthy or less judgemental. The way in which sexually active women are judged leads to the blame and stigma that they face around HIV.

Processing

2. Ask the group to discuss:

- Are the judgements on women harsher than on men?
- Do women get blamed more than men if they are HIV positive?
- Are the words used against women more insulting?

C. Prostitution is survival, not promiscuity

1. If there are any organisations in your area working with sex workers, invite a speaker to come and tell her story. Or ask participants to read Rose's story (see page 32) and discuss in small groups.
2. Then ask participants to bring any thoughts or feelings back to the big group.

Processing

3. Ask the group to discuss the following, *"Prostitution is a socioeconomic problem, not a sin. The low status of women means that many women have less education and lower-paying jobs, and therefore are poorer. With few ways to earn money women are pushed into selling sex for goods, favours, or money. Men are always available to pay for sex. What does this mean for us about our own attitudes to promiscuity and sexuality?"*

Summary

- Promiscuous is a label used to stigmatise or judge others.
- One person defined promiscuous as "Someone who has had one more partner than me". In other words, it is simply making judgements about the morals of other people in order to make oneself feel superior.
- People who carry condoms are often viewed as promiscuous, yet in terms of HIV they are being responsible citizens.

D. Preaching

1. Divide into buzz groups. Ask, *"What forms of stigma do you find in the church? How does this make people feel?"*

Examples of stigma in the church

- Preaching against PLHIV – saying HIV is a punishment from God.
- Accusing PLHIV of being sinners – saying they are sex workers.
- PLHIV are asked to move to the front to be prayed for.
- Being told not to shake hands, sit next to or visit people with AIDS.
- PLHIV excluded, e.g. not involved in Bible study.
- Seeing themselves as righteous – everyone else is evil.
- Excluding HIV positive church members.

Exercise C8 Promiscuity, prostitution and preaching

Examples of how stigma in the church makes people feel:

Afraid.
Hurt.
Sinful.

Not encouraged. Not embracing of PLHIV.
Fearful – threatening messages (e.g. warnings of ‘new diseases’).
Isolated.
Blamed.
Hopeless.
Condemned.
Pointed at.
Judged.



Action ideas

If you belong to a church, discuss this sermon with your church leaders or church group.

Rose's story

Rose was brought up in Ndola, Zambia. Her parents died when she was nine years old and she went to stay with her mother's younger brother. Her uncle began sexually abusing her and told her that she must never tell anyone or she would lose her home. Rose knew that what he was doing was wrong, but she was scared that if she told her auntie she would be chased from the home.

The abuse carried on until she was 13 years old, when she befriended an older woman, Mama Banda, a neighbour whom she decided to tell. Mama Banda told her she could come and stay with her, and for a while everything was okay, although Rose saw that her new friend stayed out at night sometimes.

One day Mama Banda asked Rose if she would help her to earn some money. This turned out to mean bringing home a man to spend the night with Rose. He paid the older woman and brought Rose some perfume. The next time he came he brought two friends with him. This is how Rose began selling sex.

She moved from Mama Banda's house when she was 16 to share with another girl who was working on the streets in Lusaka. They earned some good money, although Rose was never very happy. She began drinking a lot of beer to try and forget about what she was doing. She was also beaten and raped several times by different men whom she went with.

It was when her friend was killed by a gang of men that she decided she had to stop otherwise she might die too. She was helped by some outreach workers at Tasinta, an NGO that helps commercial sex workers.

Rose is now married with a young baby and works for Tasinta.

E. The sermon

1. Present the sermon on the next page (translated into the local language) and ask participants to listen and take notes of any stigma in the speech.
2. Ask participants to discuss:
 - *What are the main messages of this sermon?*
 - *Are there stories in the Bible about love, tolerance and acceptance such as 'Let he who is without sin cast the first stone' or 'Love thy neighbour'?*

Summary

Some religious leaders use their religious beliefs, texts and images to perpetuate stigma and discrimination against PLHIV. However, many faith-based organisations are involved in caring for and supporting PLHIV in home-based care and encouraging non-stigmatising behaviour.

Exercise C8 Promiscuity, prostitution and preaching



Sermon



It is an honour for me to share with you words from the Holy Bible in answer to Christ's great commission to the church, as recorded in Matthew 28 vs. 19.

"Go ye to the entire world and make disciples of all men. Baptise them in the name of the Father, the Son and the Holy Spirit and teach them to obey everything I have commanded you."

Our sharing for the day is entitled 'results of an action's consequences'. The Bible says in Galatians 6 vs. 7, "And I say to you, make sure your sin will find you out for God is not mocked. You will reap what you sow".

I am sure we are all aware that an action will always result in a reaction and when we do certain things in life, we should always be ready to face the consequences.

It is because of this realisation that people need to be extremely careful about how they live their lives. One day you will wake up face to face with the results of your sins from yesterday and you will have no one to blame but yourself. Remember, the Bible says, "Your sin will find you out". And so many people today are reaping what they sowed yesterday, last week, last year or many years ago. If someone meets an accident due to speeding or careless driving, are they not reaping from their foolish labour? If someone contracts these 'new' diseases, are they not reaping the fruits of a sinful life?

As the Lord says in Colossians 3 vs. 5, "You must put to death then, the earthly desires at work in you such as sexual immorality, indecency, lust, evil passions and greed... because of such things God's anger will come upon those who do not obey him".

Some of you even visit prostitutes. You know who you are! Let me remind you of the Lord's word from Revelations 2: 22, "I will cast her on a bed of suffering and I will make those who commit adultery with her, suffer intensely, unless they repent of their ways".

Let us always remember that there is a result to every deed and people must be prepared to face the consequences.

Exercise C9 Where did you get it?

Facilitator's notes

This game was developed in Zambia by a group of outreach workers who are all living with HIV. It shows how it feels to be asked, "Where did you get it?" when you go public about having HIV.

Objectives

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

- see that asking PLHIV, "Where did you get it?" can be judging or stigmatising
- analyse why people always ask this question when they meet PLHIV
- explain how this question makes us feel
- formulate arguments to counter this type of question when it occurs.

Time

1 hour

Preparation

Make up a simple song or chant with the words "Where did you get it?" in English or a local language. Ask participants to help you.

Step-by-step activity

Introduction – game and song

1. Explain that this session will look at why the first thing people always ask PLHIV is, "Where did you get it?"
2. Introduce the song or chant and get everyone singing or chanting it, walking around in a circle. Then ask people to stop and explain the game to them.
3. Pass an object (e.g. masking tape) around the circle. When the leader claps, the person holding the object at that time has to step into the centre of the circle. The whole group points their fingers at him or her and chants three times, "Where did you get it?" Continue until everyone has been in the middle (no one has to answer).

Report back

4. In buzz groups ask participants:
 - How did you feel when asked this question with everyone pointing fingers?
 - Do some answers make a difference to how we respond to that person?
 - Why do you think people ask this question?

Processing and stop-start drama

5. Ask participants to discuss, "How can we counter this stigmatising behaviour when it occurs in a social situation?"
6. Ask for volunteers to go to the centre of the ring and play out some suggestions. Discuss after each drama and invite others to take over the roles and try out different ways of challenging this behaviour.

Summary

Help participants to see that:

- this question is judging – we want to know if people have 'sinned'
- the question makes PLHIV feel bad or condemned
- it may reassure us if we find out that the person got it by doing something that we have not done!



Action ideas

Try out these new ways of challenging stigma in your community whenever you hear or see someone stigmatising.

Exercise C10 Risk-taking and stigma



Facilitator's notes

Don't use this game on the first day. Wait until the second or third day when participants are feeling more comfortable.



Objectives

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

- identify the risks we take in our normal lives
- assess how we differentiate types of risk
- see how some risks are seen as acceptable and others as unacceptable, and how these labels lead to stigma
- see that we are nearly all at risk of getting HIV at some time in our lives.



Time

2 hours



Preparation

Prepare a *bingo sheet* for each participant. Copy the one on the right or adapt to fit your target group or setting.

Step-by-step activity

Risk bingo – warm-up

1. Give each participant a *bingo sheet*. Explain that when you say “Start!” they must find out who has taken the risk in the box and ask that person to sign in the box. The first person to fill in the card, (i.e. get nine names, one for each risk) shouts “Bingo!” and is the winner.

Sample bingo sheet		
Someone who has walked home late at night in the dark Sign	Someone who has had a baby Sign	Someone who has travelled by bus on a long journey Sign
Someone who has drunk too much alcohol at one time Sign	Someone who has taken some medicine without seeing a doctor Sign	Someone who has had sex without using a condom Sign
Someone who has eaten food that might have been a bit rotten Sign	Someone who has taken a lift from a person whom they don't know Sign	Someone who has been swimming knowing there were crocodiles in the river Sign

Identifying risks – card storm

2. Write the word ‘Risks’ on a card and tape it onto the centre of the wall.
3. Hand out cards and markers to participants and ask them to write down risks we take in our daily lives on single cards, and tape them on the wall.

Examples of risks in daily life
One-night stand. Having unprotected sex with a new partner. Sleeping with your husband after he has been away for a month. Sleeping with a teenager. Running across the road. Smoking. Travelling by minibus. Getting a tattoo. Getting drunk. Cooking on the fire. Going to a traditional doctor. Playing football on the road. Riding a bicycle in traffic.

4. Ask participants to reorganise these risks into two categories – small or big risk.
5. Ask participants to discuss:
 - Which of these risks are regarded as acceptable? Why?
 - Which of these risks are regarded as unacceptable? Why?

Exercise C10 Risk-taking and stigma

“ I go to a doctor. I tell him I stayed out all night and got a bad cold. He says, ‘That was a dumb move,’ but there is no expression of stigma, i.e. ‘You are a bad person’. My behaviour was stupid, it was ill-advised but this does not make me a bad person.

So if a person gets HIV, we can tell him this was unsafe and ill-advised behaviour, but we are not saying that he is a bad person.”

Anton Schneider,
Change Project AED, USA

Summary

- We all take many risks in our daily lives. All of us are human. Nearly all of us have put ourselves at risk of getting HIV at one time in our lives, even if we have never admitted this to anyone.
- We normally keep these experiences private, we don't share them. Yet these experiences may be what binds us – that we have put ourselves at risk, even if we don't talk about it with others.
- We regard some risks as acceptable and others as dangerous.
- Some risks we know are harmful (e.g. smoking) but we still take them.
- So when we take risks, we have no right to condemn others who take risks.
- Help people see the difference between saying that a person's **behaviour** is risky and saying a **person** is bad.



Exercise C11 Traditional beliefs and stigma



Objectives

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

- discuss and reflect on traditional beliefs
- explore how some traditional beliefs can be turned against people and reinforce stigma
- reflect on their own experiences of stigmatising and being stigmatised.



Time

1 hour



Action ideas

Talk to your parents or elders about traditional beliefs. Discuss whether these are used to stigmatise PLHIV.

Step-by-step activity

Traditional beliefs – brainstorming

1. Divide into four groups. Ask groups to brainstorm traditional beliefs that could lead to stigmatising people with HIV. Each group is assigned to work on beliefs that affect different groups of people: men, women, girls, boys.

Report back

2. Ask groups to report and record the beliefs on the flipchart. Then discuss each of the beliefs and how they can be used to stigmatise PLHIV.

Examples of traditional beliefs

A girl should be a virgin before she gets married.

Mpengele (Tonga) – a ‘hard nut to crack’ or someone who did not fit in.

Muchende (used for Tonga men) – being a bull (having a lot of partners).

A small girl is sent to spy on a woman who is about to get married – the assumption is that she is sleeping around and needs to be watched.

Grandparents talk to the son-in-law before the marriage is concluded to see if he is man enough and will bring the family many children.

Mwana wa musako nindiyo – Your daughter’s friend is ‘relish’ meaning you can have sex with her. Young girls need to be protected and one way is to be looked after by friends and uncles of the father. The father’s friends and uncles would have sexual access to the girl and teach her about sex as a way of protecting her from other males.

These beliefs are not stigmatising, but they can be used in a stigmatising way. For example, ‘A girl should be a virgin before marriage’ is not stigmatising, but when she gets sick with HIV, it will be turned against her as people will say she should have remained a virgin. If a man gets sick, people will say, ‘He was too much of a bull’.

Judging people

3. Ask pairs to buzz the following questions:

- *How have you been affected by these beliefs as an individual?*
- *Have you used any of these beliefs to judge other people?*
- *What changes would you want in the way you treat others or the way you are treated?*

Summary

Some traditional beliefs are used as a vehicle for blame and stigma.

Exercise C12 Carrying condoms carries stigma



Objectives

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

- understand how carrying condoms carries stigma
- think about different ways to challenge this form of stigma when talking about HIV.



Time

1 hour



Materials

Packet of condoms
General stigma pictures 25 and 26 in the Picture booklet

Hagos's story

“ My son was going out with a girl whom we had all met. When he was packing to go to university, he accidentally dropped a packet of condoms out of his bag in front of me. He seemed embarrassed, but I just picked them up and handed them back to him. I told him I was glad he was practising safe sex. Because of my job, I have taught him about gender issues and sex education and condoms. I felt proud of him. ”

Ethiopia tool development workshop

Step-by-step activity

Why are condoms stigmatised – card storming

1. Ask the group if anyone has a condom with them. Tell them you need one for the next exercise. See if people feel free to ask each other, are embarrassed, etc.
2. Tape a condom pack on the wall. Ask participants to pair up and discuss, “*Why do condoms carry stigma?*” Ask pairs to write their points on cards and tape them on the wall around the packet of condoms.
3. Come back as a group and discuss.

Assessing condom use – role play and stop-start drama

4. Divide into small groups and hand out the role play scenarios (see below). You can also use copies of *general stigma pictures 25 and 26* as starting points for a role play.
5. Ask participants to prepare a role play to show the whole group.
6. When groups present their plays, use stop-start drama to explore the issues at a deeper level.

Role play A	Dropping condoms (1) A mother asks her son to borrow some money. As he pulls out his wallet, a packet of condoms falls out.
Role play B	Dropping condoms (2) A father asks his daughter to borrow some money. As she pulls out her purse, she drops a packet of condoms.
Role play C	A girlfriend and boyfriend are talking about having sex for the first time. The girl brings out a packet of condoms.
Role play D	A choir member accidentally drops a condom in church.
Role play E	A group of girlfriends are chatting together at home. One is very religious. Another brings out a packet of condoms.
Role play F	Husband and wife have recently tested HIV positive. They discuss their future. The husband gets out a packet of condoms.

7. Ask participants to discuss:
 - *How can we challenge the stigma around condoms?*
 - *How can we support the idea that they show someone is being responsible?*

Summary

Condoms carry stigma because they are linked to sex and therefore assumptions about people's behaviour. We need to change this so that condoms are linked to being responsible.

QQR – Quality, quantity, route of transmission

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

Quality

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

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

Quantity

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

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

Route of transmission

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

- Our body is a closed system.
- HIV cannot pass through skin.
- Even if you have cuts and sores there is no risk for the following reasons:
 - If you have just cut yourself, the blood flows outwards, away from the bloodstream and it is impossible for anything to swim into your body against that flow; cuts do not suck things in.
 - If you touch someone else's cut, their blood will not swim into your bloodstream (and yours will not swim into theirs).

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

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

Using QQR you can see why there is no risk of transmission by:

Kissing. Hugging. Mosquitoes. Sharing cups and plates. Shaking hands. Giving blood. Sharing toilets. Using the same washing water. Going to school together.

The character cards show different types of people, e.g. businessman, farmer, tailor, schoolgirl, housewife. The cards can be used to explore who is more or less stigmatised and why, or used as a basis for creating stories about how different people are affected by HIV. Photocopy the pages and cut along the dotted line to make the character cards.

Character card 1



Character card 2



Character card 3



Character card 4



Character card 5



Character card 6



Character card 7



Character card 8



Character card 9



Character card 10



Character card 11



Character card 12



Character card 13



Character card 14



Character card 15



Character card 16



Character card 17



Character card 18



Character card 19



Character card 20



Character card 21



Character card 22



Character card 23



Character card 24



Character card 25



Character card 26



Character card 27





Booklets in *Understanding and challenging HIV stigma: Toolkit for action* include:

Introduction
Using the toolkit
Module A
Naming the problem

Module B
More understanding, less fear
Module C
Sex, morality, shame and blame

Module D
The family and stigma
Module E
Home-based care and stigma

Module F
Coping with stigma
Module G
Treatment and stigma

Module H
MSM and stigma

Module I
Children and stigma

Module J
Young people and stigma

Moving to action module
Thinking about change
Moving to action
Developing skills for advocacy

Picture booklet
General stigma pictures
Rights pictures

Additional booklets will be published as new modules are developed.