Expanded Total Facility Approach

Stigma-reduction Training for Health Workers

In-service Training Guide

EXPANDED TFA

Zambart

Research and Development to Improve Health for All

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Continued overleaf

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Training Guide Glossary (linked to TFA)

Community Facilitators:

Members of partner organisations (which may link to Special Focus Populations) who attend the Training of Trainers Workshop, with health workers, and support the Step-down training.

HIV Care and Treatment Clinics (CTC):

HIV clinics in Tanzania where the some of the stigma-reduction training has been implemented, in order to increase access to people who use drugs.

Gallery Walk Report Back:

Small groups post their flipcharts around the room, and the whole group walks around each group to listen to the report back.

Health Worker Facilitators:

Certified Health Workers who have been trained at a TFA Stigma-reduction Training of Trainers workshop.

Men who have sex with Men (MSM)

In this manual, we use the acronym MSM to refer to gay, bisexual and other men who have sex with men. We use MSM instead of other terms or acronyms because it is commonly understood in most African countries and used by members of this population.

Special Focus Populations:

Specific groups that are disproportionately affected by HIV and/or HIV-related stigma and discrimination.

Step-down Training:

Stigma-reduction workshops held at the health facility, conducted by health worker facilitators.

Stigma Champions:

Health workers who form a committee after attending the step-down training, in order to organise further stigma awareness activities.

S&D

Stigma and discrimination.

Stop-Start Drama:

A planned role-play involving participants. Participants are given a scenario and roles to play. Once they have shown the problem, facilitators pause the play and ask for suggestions from the audience e.g. What should happen next? How can we change the situation? Participants can replace the actors to try out solutions.

Training of Trainers (ToT):

Five-day workshop, facilitated by Master Stigma-reduction Trainers, where health workers are trained in both facilitation skills and stigma-reduction exercises to become health worker facilitators for the TFA.

Young People:

Adolescents and young people. Not age-specific since the stigma faced by this group is on the basis of being seen as young.

Introduction

This Training Guide was developed as part of the Expanded Total Facility Approach (TFA) Project, funded by the Bill & Melinda Gates Foundation. It is implemented in Zambia, Ghana, and Tanzania with the aim of reducing HIV-related stigma and discrimination in health facilities and amongst staff in health facilities.

The Guide is a handbook for health workers and members of partner organisations who have been trained as stigma-reduction facilitators. These health worker facilitators, having been trained in both participatory facilitation and stigma reduction in a trainer of trainers workshop, use the handbook when they roll out the training to the majority of staff in their health facilities — a process referred to as 'Step-down Training.'

The Guide contains core exercises that can be used and adapted across health facilities and for HIV prevention and care services, as well as other services linked to the needs of people living with HIV as well as people accessing HIV services for prevention. This Guide also includes exercises targeted at reducing stigma towards some populations who face additional stigma in accessing HIV services in the three countries, namely; people who use drugs, gender and sexually diverse clients, health workers living with HIV, and people with TB. The training approach has been developed over the last 20 years and has been shown to have a significant impact on reducing stigma and discrimination among health workers. All the stigma-reduction exercises are participatory and depend on skilful use of interactive methodologies.

Before offering the Step-Down training, the stigma reduction facilitators should read and understand this guide and use it to prepare teaching materials. The content is intended to provide guidance. The guide encourages facilitators to also use their own creativity to prepare additional teaching materials.

The Expanded Total Facility Approach

Stigma and discrimination in health facilities continue to challenge access to quality HIV prevention and care services across the world. The Total Facility Approach (TFA) to HIV-related stigma and discrimination is an evidence-based intervention that has been implemented in health facilities in Ghana and Tanzania and has been shown to reduce stigma towards clients and among staff and increase access to services.

In 2023, the TFA was expanded in three countries: Ghana, Zambia, and Tanzania. The training program includes an adapted in-service training for health facility staff, as well as new courses for student nurses and trainee health workers and a refresher course or Continuing Professional Development component for existing facility staff.

What is the Total Facility Approach?

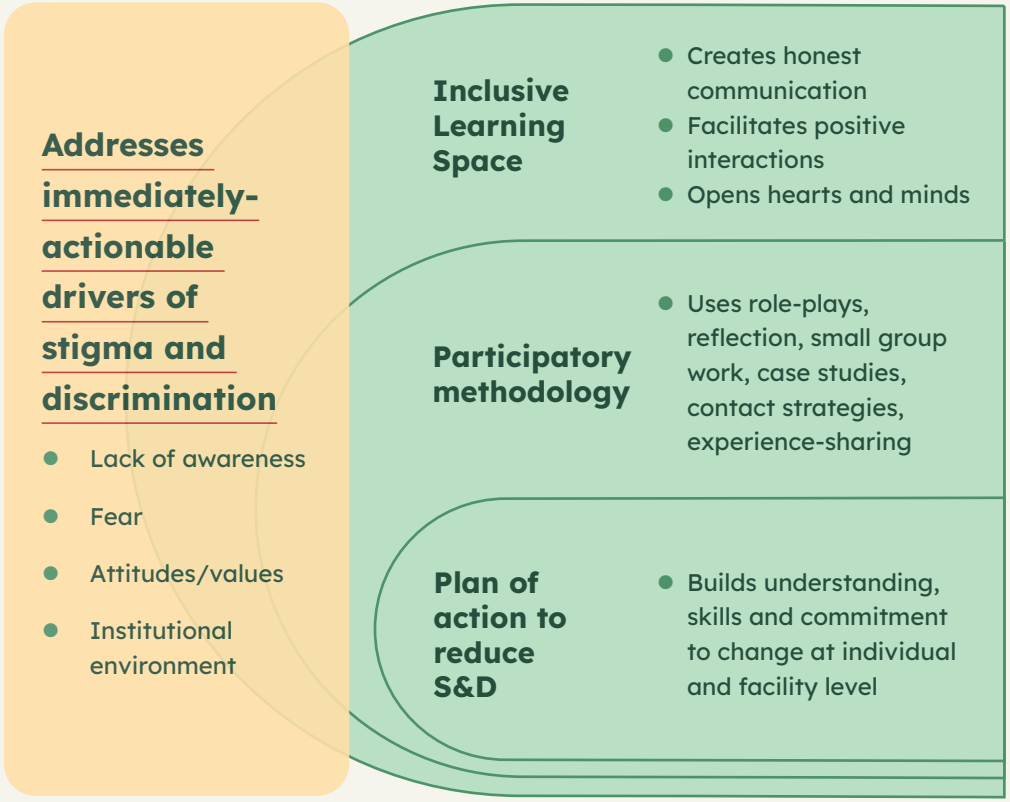
- An innovative, in-service intervention to reduce stigma among staff, in a Health Facility, in order to increase access to health services and improve HIV outcomes.
- A modular, peer to peer stigma reduction training program that is flexible and can be adapted to suit differences in HIV, health systems and social contexts.
- A training program that uses stigma-reduction tools that have been tried and tested in many countries and have been shown to reduce stigma when delivered to all staff (clinical and non-clinical),

The Expanded TFA will provide the first opportunity to extend the TFA approach to include pre-service training for health worker students and refresher training for qualified health workers who have been part of the in-service TFA. If successful, with the support of stakeholders and professional bodies, the TFA will receive formal recognition nationally and globally, and be positioned for scale up.

What Makes Stigma-reduction Training Different?

Participants who attend the stigma-reduction training often describe it as a very 'special' experience that makes it different from other training workshops. The training approach has been developed over the last 20 years by a team of master trainers in Africa and Asia. A sequence of core exercises ensure that the training is successful in taking participants on a sometimes emotional, thought-provoking journey of understanding, challenging and reducing HIV stigma and discrimination.

How the Stigma-reduction training works



Building an inclusive, safer environment:

From the beginning of the workshop is the first step to enabling participants to open up and share experiences, thoughts, opinions, and values in a way that will initiate reflection and enhance the move towards change. To do this, the training is interspersed with songs, mixer games, and icebreakers, which helps to bring energy and fun, and builds a strong sense of belonging in the group , which in turn fosters trust, and breaks down barriers between participants. Trust is particularly important because TFA training usually mixes up different levels of health workers, auxiliary staff, and general workers in the training. Facilitators take great care to value all contributions from participants, to learn names and to ensure that everyone feels 'seen.' By feeling close and safe, participants will be more likely to have open minds and hearts: essential ingredients for changing stigma!

Addressing the drivers of HIV stigma:

Using different themed exercises and techniques, the TFA stigma-reduction training helps participants to address the underlying drivers of stigma. These include:

- **Lack of awareness of stigma and the damage that it causes:** Is addressed using exercises that give participants time to reflect about diverse situations and behaviours. One key reflection focusses on different experiences of being stigmatised, not only related to HIV but to other health conditions and/or social identities. This builds greater awareness of stigma and the damage it does. The reflection begins to build empathy. Other exercises use pictures codes, role-plays, and scenarios to build awareness.
- **Fears about transmission:** In lower-HIV prevalence countries, health staff are often less clear about how HIV is, and is not, transmitted. These tools provide health staff with simple, clear explanations of HIV transmission, which they can share with colleagues and clients.
- **Values and judgments:** Are addressed using exercises that provide an opportunity to reflect upon and discuss values and beliefs, myths, and misconceptions and how they impact service provision. The exercises include value clarification and gender norms exercises as well as an exploration of language and name-calling used against different populations.
- **The institutional/environmental driver:** Is addressed mainly in the wider TFA program through consultations with management and stakeholders. Several exercises in the curriculum focus on factors linked to the environment, like confidentiality, which is often cited as a barrier to using health facilities. Several case studies are included for in-depth discussion about confidentiality, as well as activities which encourage empathy and professionalism. Exercises that build skills to challenge stigma in the health facility environment, and which plan action and policies to reduce stigma are also key to the training. Following the step-down training, health facilities might choose to address this driver by making changes to health facility space and other factors that may lead to HIV stigma and discrimination. For example, if a waiting room for an Anti-retroviral therapy (ART) clinic is too public, the waiting room could be made more private.

The power of contact:

Most participants may not have had a chance to openly meet with, or listen to, members from stigmatized group. This lack of direct contact leads to judgments and assumptions which are made without any understanding of individual and specific group experiences.

One of the most powerful exercises in this TFA Training Guide is the 'Panel Exercise', which involves setting up a panel of members from specific groups that are disproportionately affected by HIV and/or HIV-related stigma and discrimination such as young people, people living with HIV, people from gender and sexually diverse populations, people who use drugs, people with TB, or health workers living with HIV. Members of these groups volunteer to be interviewed using questions from the audience (participants) and share their stories about the role that stigma and discrimination has played in their lives. This exercise is often a turning point in the training, which creates empathy and understanding, and helps participants accept individuals.

> **"We must stop stigmatizing. Who are we to judge? These are our brothers, and we just need to accept them. They are just clients, coming to us for a service — why should we treat them any differently?"**
>
> Young Nurse, Accra (after the MSM panel).

Moving to action:

Is strongly addressed throughout stigma-reduction training by taking time to process exercises and activities with the group. Discussion and listening play a key role in raising awareness and understanding. After a role-play, a brainstorm, or small-group discussions, time is spent on helping participants to identify their key learning points, and ask,

'How can we change this? What actions do we need to plan together?'

Thus, the need for change and action against HIV stigma and discrimination is built into the agenda. The importance of individual and collective action is highlighted throughout.

Participatory Training Techniques Used in this TFA Guide

This guide uses a range of methods and techniques. The boxes below provide tips on how to make the best use of each one.

Warm-up Games. Songs. Energizers. "Group Splitters."

Description/reason: Keep energy and interest level high and help to build group safety.

Tips:

- Facilitators can develop their own styles and games.
- Use "group splitters" (different methods to organize participants into groups) as energizers to get participants to move around and mix up.
- Songs are great for building group spirit.
- Games help to break the ice and get participants talking to each other.

Buzz groups

Description/reason: Two people sitting next to each other quickly discuss their first thoughts on a topic provided by the facilitator.

A quick way to get a discussion or brainstorm started.

Tips:

- Buzz groups are a trainer's way of getting instant participation and creating safety so that participants are not working alone.
- After a few minutes get a point from each pair to start the brainstorm, then allow others to contribute extra points.

Discussion and Processing

Description/reason: Participants reflect upon their own experiences, share with others, analyze issues, and plan for action together.

Discussion and processing are an important step in any exercise, as they give participants an opportunity to process what they are learning.

Can be in pairs, small groups or in plenary.

Tips:

- Start the discussion with Buzz Groups and an open question.
- Observe carefully to ensure everyone can participate and encourage participation of those who not engaging.
- Use rephrasing skills (quick summaries of what participants say) to increase the group's understanding and affirm participants' contributions.
- Ask your co-facilitator to record key points in a large-group discussion.

Small Group Work

Description/reason: Enables greater participation, especially if some participants find it difficult to participate in large group discussions.

Small groups can be used to carry out tasks, dividing up topics to cover more aspects of a subject.

Aim for groups of 3–5 participants. This ensures that all the group members have a chance to participate.

Tips:

- Plan your "group splitters" (ways to organize participants into groups quickly and efficiently).
- Keep changing the members in a group for each exercise.
- Give clear instructions and check that groups have understood the tasks
- Plan the report back process (e.g., use round-robin method, gallery, 2-4-all, or individual group presentations; see more details below).
- Ask your co-facilitator to record key points in a large-group discussion.

Card Storms

Description/reason: Facilitators present the topic with an opening question

Participants work in pairs and write words or short phrases on cards (one per card) which are taped on the wall, creating a brainstorm of ideas.

Once everyone is finished, the cards are clustered into categories and discussed.

Card storms are more flexible than brainstorms, as the cards can be moved around, taken away, or organized to suit topics.

Problem and solution trees use card storms.

Tips:

- Make sure you give out plenty of cards. Do not limit the number of ideas participants can contribute.
- Involve participants in clustering the cards into categories and then reading through or summarizing the categories.
- Use the categories to analyze further (for example with small group work or role-plays).
- Do not forget to "process" your Card Storm. For example, ask the group what stands out, what they learned from the points.
- For participants with mixed literacy skills, work in pairs, or have facilitators write the cards and read through the Card Storm together.

Case Studies

Description/reason: Stories or scenarios based on real-life situations provide a focus for discussion in groups.

Case Studies help focus participants and make abstract ideas real.

Tips:

- Provide a range of case studies to tackle different aspects of a topic.
- Give characters local names to make them more relatable (change names from the original people to ensure confidentiality).
- Give participants questions following the case studies to focus the discussions.
- Ask each group to report back from their case-study discussions.

Role Plays/Drama

Description/reason: Participants act out the situations or themes.

Participants act out analysis of an issue or try out solutions to a problem as a way of reporting what they have discussed.

Role-play can also be used to help with skills practice.

Drama helps make things real.

Tips:

- Give clear instructions or descriptions of what you want to be role-played.
- Give a time limit to ensure role-plays are brief and to the point.
- Always process the role-play. Get participants to debrief the plays. Ask key questions like: What did you see happening? / Does this really happen? / What would help to solve this situation?

Rotational Brainstorms

Description/reason: Another form of brainstorming in small groups.

Questions are posted on flipcharts around the room.

Each group is given a question and begins by recording ideas on a flipchart.

After a few minutes, each group rotates to the next flipchart and adds points to the existing list.

During the exercise, each group contributes ideas to all topics.

Tips:

- Use this technique when there is a range of linked topics or questions.
- Remember to prepare your ‘group splitter’ and to stick up your questions on flipcharts before you start.
- For report back, use the Gallery Walk Report Back approach as the facilitator leads all participants together as a group to each of the flipcharts around the training space.

Picture Tools

Description/reason: This guide includes a set of picture tools which help participants to identify different forms of stigma.

These pictures can also be used to start discussions or as the basis for a story or role-play.

Tips:

- Make sure pictures are selected and prepared ahead of time.
- Ensure that everyone can see the picture (for example, enough copies, large enough sizes).
- Ask probing questions to get as much information as possible.
- Remember, there are no wrong answers as everyone will see slightly different things in the same picture.
- For participants with visual impairment, you can describe the pictures in detail or use them to tell a story.

1-2-4-all

Description/reason: A more creative way to report back after an activity.

1. Participants reflect individually about what they have learned (or a particular question).
2. They pair up with a partner to share ideas.
3. Then pairs join with another to discuss and agree on key feedback points for the large group (all).

Tips:

- Encourage participants to make notes during the reflection time.
- Use bells or drumbeat to signal changeover time.
- During plenary feedback ask groups not to repeat points that have been mentioned already.

Training tips

During the Training-of-Trainers (ToT) workshop in the TFA, various training techniques and methodologies are discussed and tried out to enable health worker facilitators to effectively facilitate the Step-down Reduction exercises contained in this guide.

This section includes some extra tips to help health worker facilitators prepare for training sessions before, during and after the ToT to make sure they are confident and prepared to deliver high-quality, effective stigma reduction training.

Before the training

- The Health Worker Facilitator Training Team consists of a minimum of two facilitators. The team should meet to plan the agenda and divide the tasks so that each one has clear roles and responsibilities. Trainers should agree who will lead which exercise. Those who do not lead are active co-facilitators. See “Work as a Team” below for tips on working with a co-facilitator.
- Discuss the materials and any other resources you may need and agree who is responsible for obtaining them and how, and when they will become available. Once they are obtained, prepare all the materials and resources.
- Prepare a detailed timetable for use by facilitators. See “Manage Time” section and “Less is More” box for tips on planning your timetable.
- Check out the venue, if possible, so that you can plan how you will use the space. Ask for the largest room possible because of the interactive activities. Some facilities will have fixed benches or limited space. Be prepared to be flexible. Explore outside space as a possibility if the allocated room is not suitable.

At the Start of the Training

(see Opening Session below)

- **Arrive** at least one hour before participants are scheduled to arrive to give yourself enough time to get organized.
- **Prepare** the space and materials including writing your initial flipchart headings.
- **Distribute training packs:** Ensure that any materials for the participants (folders, notebooks, timetables, handouts) are ready for distribution. Include name tags where participants write their own names.
- **Double check logistics** such as snacks, lunch, and water to make sure all is in order.
- **Introduce yourselves** as the facilitators and think of a short, simple way for participants to introduce themselves.
- **Use icebreakers, games, or songs** to help participants relax, have some fun, and feel free to speak out in the group.
- **Set ground rules.** Agree on rules to ensure that everyone gets an equal chance to participate. For stigma reduction training, it is important to make sure that ground rules include agreeing to make the training a safe space.

Creating a Safe Space

It is important that the ground rules include making the training a safe space. Facilitators should help participants identify some rules that they agree will help make the space feel safe.

During the Workshop

(see Opening Session below)

Assume that the training group may include people living with HIV or members of groups disproportionately affected by HIV and/or HIV related stigma and discrimination or that participants may have family and friends from these groups.

- Facilitators should never assume that participants living with HIV have disclosed their HIV status to others.
- Facilitators should keep these assumptions in mind throughout the workshop and work with respect and sensitivity. For example, never say 'those people' always use 'we/us' instead of 'they/them'.
- It is possible that a participant may disclose their HIV status and/or a special focus population identity to the group, possibly for the first time. Facilitators should be aware of this possibility and be prepared to handle the disclosure in a supportive and sensitive manner.

Do not feel the need to disclose your HIV status

If facilitators are living with HIV or are from a Special Focus Population, they should not feel the need to disclose this. They should also feel free, if they wish to, and if it feels appropriate at the time.

Manage space

- Change the space and arrangement of chairs and tables to suit each activity and provide variety.
- Start off with a circle or semi-circle so that everyone can see each other.
- Let participants know that this is not a workshop where they sit in the same chair and next to the same people for the whole time. They may want to label their folders or notebooks; in case they get moved around.
- Use outside space or break-out rooms for different activities where possible.

Less is more

A common mistake facilitators make is to pack in too much content. This can lead to participants feeling rushed or missing out on important information.

In stigma reduction trainings, where participants are faced with emotionally challenging content, it is especially important to make sure they have enough time to process the material without feeling rushed.

Manage time

Good time management begins before the training, by making realistic plans for content and timing.

- Allow enough time. Exercises usually take longer than anticipated. When planning your timetable, include more time for each exercise than you think you will need. It is much easier to add things than to take things out.
- Start on time, even if there are only a few participants present. This will show those who come late that you are serious, and that time is precious for the training.
- In a short training program, there is not enough time to go into all the issues in depth. You will need to manage time carefully or your overall objective will be lost.
- Agree how much time you need for each session — and work to these time limits. Do not allow sessions to drag on too long! As a co-facilitator, agree that one of you will watch the timing for each session. Finish on time! Do not drag things on at the end of the day.
- Leave time for wrap-up and reflection at the end of each session.
- During breaks, check with your co-facilitators about how the timing is working out, and adjust the remaining agenda/exercises as needed.

Work as a Team

- Take turns in the lead role.
- Support each other. If one facilitator runs into trouble, the other can help her/him/them out. Avoid criticizing your fellow facilitators in front of participants.
- Meet at the end of each session to debrief how the session went and plan for the next session. Give each other feedback.
- Having a team of facilitators helps to keep energy and interest levels high and offers participants a variety of training styles. Use each other's strengths, for example call your co-facilitator to help explain a point if you get stuck or ask your co-facilitator to plan an energizer, or group splitter, if you need one.
- Clearly define roles and responsibilities of each co-facilitator ahead of time.

Record Discussions on Flipcharts

- Recording notes during plenary discussions on the flipchart provides a permanent visual record, helping participants know what has been discussed and what needs to be added. Note: participants and facilitators should not record any names on the flipcharts to protect confidentiality.
- Writing down points triggers other ideas and provides the basis for a summary of the discussion. Notes also help you as facilitators if you are going to write a report.
- Many participants like to take a photo of the flipcharts, which helps them to report back after the training.
- Always remember to read aloud what is written on the flipchart; this enables participants with visual impairments or low literacy skills to know what has been recorded and to be involved in recapping ideas.
- One facilitator should guide the discussion, while the other can write on the flipchart. Try to avoid facilitating and writing on a flipchart at the same time to allow you to focus on what participants are saying. If you are facilitating alone, ask someone in the group to help you record.
- Write only the main points or key words, not everything that participants say.
- Use participants' own words so that they recognize their own contributions.
- Write largely and clearly so people at the back of the room can see.
- When participants are working in small groups, encourage them to identify a group member to take notes and report to the full group when time allows for plenary discussion.

Work with Feelings

- Stigma-reduction training covers topics such as HIV, sexual diversity and gender non-conformity, drug use, values and beliefs, which may trigger strong emotions and feelings.
- Feelings may be triggered during reflections about memories, thoughts about personal values and beliefs, or when listening to individual experiences and discussions.
- Understanding how stigma feels is part of the process of changing stigma.
- Feelings are a powerful tool. Use them with the group to explore the impact of stigma and the way it affects people. Sometimes you can develop dramas and role-plays, to build on participants' stories and use them to try out different responses, or ways of challenging stigma.
- It is important for facilitators to validate feelings expressed by participants. Facilitators should avoid dismissing, minimizing or discrediting feelings. For example, if someone shares a story that is personal and sad or frightening, the facilitator should acknowledge and validate the contribution, saying something like, "Thank you for sharing. This sounds very sad and frightening." This helps participants to feel heard and reinforce the safety of the training space before asking others to share similar experiences.
- Encourage participants not to shy away from discomfort since some level of discomfort is a natural part of learning about stigma. At the same time, becoming overwhelmed emotionally does not help participants learn and can be unhealthy. It is important for participants to pay attention to how they are feeling and to take care of themselves. They should feel free to take a break if they need to.
- Facilitators should also pay attention to how participants are doing emotionally. They should notice if one or more participants seem to be overwhelmed. If so, consider taking a break and check in with any participants who seem to be having a hard time to make sure that they want to continue.
- If possible, facilitators should have a counselor or other mental health specialist on hand during the training, or available to participants afterwards through referral, in case the training triggers overwhelming emotions or past trauma.
- After an emotional session, you may want to take a break or do a song to help people come out of the strong emotion and pick up their

spirits. Movement is particularly good at helping participants "reset" themselves after an emotional session. You can have participants shake their arms and legs, literally "shaking off" their discomfort. If a song feels appropriate, chose a gentle song, or one about solidarity. For example, the song that works well in Ghana is 'We Shall Overcome'.

Be Prepared to Handle Difficult Questions

- Some participants may find learning about HIV, sexual and gender diversity, drug use and stigma and discrimination extremely difficult, because it challenges some of their most strongly held beliefs and ideas. This means that, as a facilitator, you may experience some hostility and resistance and be faced with some difficult questions. If you are working with one or more co-facilitators, brainstorm together all the difficult questions that you think the participants might ask and discuss how you could handle them.
- Remember that when participants are asking questions it means that they are engaged and are thinking through the things that they are learning during the training course. It also means that you have created a safe space where participants feel comfortable to express their views and explore issues openly.
- Take advantage of opportunities for meaningful, heartfelt exchange. If participants express doubts or challenge the content, this is a chance to help them, and the group, have a deep discussion that allows people to open up their minds and hearts to new ideas.
- Do not silence the questioners! Rather allow them to express themselves so that any prejudices come out, rather than remain repressed. However, do not let discussions get out of hand and gently challenge negative attitudes.
- Remember that you will not be able to change everyone's attitudes immediately. Your main focus is to provide information and opportunities for analysis and discussion.
- Keep participants' focus on everyone's right to equal treatment and access to healthcare.
- Encourage reflection. Facilitators can use gentle questioning to encourage participants to reflect about what they are asking, instead of answering them directly. This can help participants feel more active and in charge of their learning and avoids setting up a confrontation between facilitators and participants.
- Do not be afraid to say you do not know. You can always refer the question back to the group, "What do others think?" Alternatively, you can find out the answer for a later date.

Be Aware of Power Dynamics

Facilitators should always be aware of power dynamics between facilitators and participants and amongst participants themselves.

Training groups in the health facilities often include a mix of genders, ages, and religious and cultural influences. However, stigma reduction trainings have additional unique factors that can affect power relationships. The "Total Facility Approach" means participants will include a mix of ages, levels of education, and professional designations - for example, nurses, doctors, guards, receptionists.

Power dynamics and relationships can show up in different ways. As a facilitator, an easy way to spot these relationships is to notice where participants are sitting and who is participating. Ask yourself:

- Who is sitting at the front of the room?
- Who is sitting at the back?
- Who is speaking up?
- Who is not speaking up?
- Who am I calling on? Who am I paying attention to?

Notice if there are any patterns. Are men speaking up more often than women? Are medical staff speaking up while support staff stay quiet? Do your best to even out an imbalance, making the relationships as equal as possible. Some ways to do this include:

- Ask participants to "take off their hats" as they come in — setting aside their role as "doctor" or "nurse" or "guard" to become training participants. Tell them they can pick their "hats up" as they depart at the end of the training.
- Ask participants to notice these patterns for themselves and come up with ideas as a group for how to "level the playing field."
- Use creative 'Group Splitters' to mix participants into more diverse groups. See "Use Creative Group Splitters" box.
- Regularly change the composition of small groups.
- Play "Musical Chairs": Have half of those in the front of the room switch with someone at the back of the room, or from one side to the other.
- Use redirecting to encourage everyone to speak in a discussion. "We have heard what the doctors think, can we hear from other groups now?"

At the End of Each Training Session or Workshop

- Plan how you are going to bring the session to a close.
- Always include a wrap-up and summary to help participants process and reflect upon what has been learned and experienced in the session/workshop.
- If possible, make the wrap-up participatory, not just the facilitator talking through what has happened, but participants telling the facilitator, and each other, what they think happened, and what they are taking away. This will help facilitators identify whether any key points have been missed or misunderstood that may need to be revisited in later exercises.
- Include one or two key takeaway messages from each exercise in your summary.
- After you have wrapped up the training, you might want to use a song or a game as one of the final activities.
- Carry out the evaluation as planned at the beginning of the training.
- Debrief with your co-facilitators.
- Review each exercise and give each other feedback.
- Collect any flipcharts or cards that you might use for a report or the documentation of the training. If trainers have access to a smart phone, it can be helpful to take pictures of the flipcharts to use for reference during later reporting or planning.

Working in Tricky and Oppressive Environments

In some countries, or even communities, some topics may be difficult to discuss because the environment that promotes hostility and misunderstanding of certain groups and issues. Two of the key groups who are often affected by this kind of oppressive environment are also those who face deeper stigma: people from gender and sexually diverse populations, and people who use drugs.

There are currently 64 countries where homosexuality is criminalized. Although there have been some changes in recent years, and discrimination on the grounds of sexuality is banned, there are still countries where people from Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI) communities face violence, arrest, and even the death penalty. Sometimes people who support these communities (allies) have also been threatened.

For this reason, it is important that health worker facilitators use their role to help promote access to health services for all groups, especially those who are disproportionately affected by HIV. In each country, the TFA focuses on all people living with HIV and/or accessing HIV prevention services, and Special Focus Populations that are linked to in-country HIV epidemic trends and to groups disproportionately affected by HIV and/or by stigma and discrimination.

While the TFA project promotes the meaningful engagement of community partners, (including partners working with gender and sexually diverse populations), all those involved have a responsibility to ensure their safety, as they work alongside health worker facilitators. This means that members from the group have a choice about what they choose to disclose and discuss in a training session. Confidentiality is important: No one should ever be introduced as a member of a Special Focus Population (for example, MSM) but can be identified as someone who works with that community. We should always discuss how we can support all community members who partner with us to be safe and as free from fear as possible. There are more details about this in the ‘Panel Exercise’.

Health Worker Facilitators also face risks if they are seen to promote equality, where the law states that all things are not equal (e.g. same-sex relationships). They may get labelled or be isolated by colleagues. The flipside of this is that being a stigma-reduction facilitator is an opportunity to be a role-model and a champion of quality care for all people. These issues will be explored in the Training of Trainers Workshops, where Health Worker Facilitators have a chance to express their fears and practice handling difficult situations.

The key approach is to focus on the right to access health care, information, treatment and support. The focus is also on professionalism since, as health workers, we pledge to do no harm and to treat our fellow human beings without judgment. As we strive to reduce the HIV epidemic, if we do not target people most disproportionately affected, the epidemic will never end. If stigma is a barrier to accessing prevention and treatment, the virus will thrive.

Use Creative “Group Splitters”

Many of the exercises require participants to work in small groups. As a facilitator, you can use the process of splitting into groups to keep energy high, ensure that participants mix and talk to each other rather than stay with the same people all the time. You can also keep participants interested by using different ways of breaking into groups. There are so many ways to divide into groups- try not to use “1,2,3 all the ones together” too much - challenge yourselves to avoid using these more than twice! Here are some ideas for “Group Splitters”:

- **Actions:** Write or draw different actions on slips of paper (feeding a baby, dancing, walking as if you are in a hurry). Or whisper an action in someone’s ear. Ask each participant to take a paper without showing anyone. When you shout, “1, 2, 3,” ask them to start doing the action and find others who are doing the same action.
- **Songs:** Write the names of common songs that everyone will know on a paper; ‘Happy Birthday’, the national anthem, popular songs of the time and ask each participant to take a slip and start singing until they find others singing the same song. Whisper a song title in participants’ ears if anyone has a visual impairment or low literacy skills.
- **Animal sounds:** Write the names of different animals, or draw them, on slips of paper. Each participant must make the noise of their animal and find others making the same noise.
- **Same clothing:** Before you divide the group, look at the clothes people are wearing and see if you can divide them by colors - “everyone who is wearing stripes come together,” “everyone who is wearing sneakers.” Facilitators should adapt to their community. This technique should not be used if there are sensitivities about clothing colors due to politics, or if there are women in the group wearing mourning attire, or if there is a clear difference among participants’ clothing because of religion or tribe or profession.
- **Things in common:** This is a random way, but you can use it approximately and then mix people if necessary. Adapt it to your community. Say things like - “everyone who lives close to the river,” or “everyone who attended ____ school.”
- **“Fire on the mountain, run, run, run”:** Make this into a chant– everyone runs around in a circle and then you say - “be in threes,” or, “be in pairs” and participants move quickly to those next to them to form a group.
- **Birthday line (If you have enough space):** Ask participants to stand in a line in the order of their birthdays with January at one end, December at the other end. To make it more fun, ask participants to do so without talking. Once they are in a line, you can then count them off into groups.
- **Bus conductors:** In many countries, conductors must tout for customers by shouting their destination and persuading customers onto their bus. Choose a destination for each group that you need and write it on a slip of paper. You might choose interesting places such as Livingstone (Zambia), Kilimanjaro (Tanzania), and Cape Coast (Ghana). Ask for volunteers to be the conductors. Give them a destination and tell them how many customers they need to attract. It is usually chaotic but fun!

How to Use The Manual

This manual is arranged in three sections:

1. Core Curriculum Exercises.
2. Exercises for Special Focus Populations.
3. Appendix of Picture Tools.

A selection of Core Curriculum Exercises should be included in the Stigma-reduction Training in Health Facilities. There are 12 exercises which cover general HIV stigma from different perspectives and in different contexts. Some of the Core Curriculum Exercises include targeted questions for special focus populations, which allows them to be incorporated into the broader program. For example, targeted questions can be adapted for young people, a group in sub-Saharan Africa who face heightened HIV stigma and discrimination and more challenges accessing HIV services. There are sample training agendas for each section, which incorporate the core exercises as well as those for special focus populations.

Exercises for Special Focus Populations

The three countries implementing the Expanded Total Facility Approach Study will focus on young people as one of the populations most affected by HIV stigma and discrimination. For this reason, the Core Curriculum Exercises all contain integrated content about young people, or which can easily be adapted to focus on young people. For example, case studies, role-play scenarios, and pictures. The other special focus populations include health workers living with HIV, people who use drugs, people with TB and gender and sexually diverse populations. We have included additional exercises to discuss and break down the stigma faced by these particular special focus populations.

These exercises include:

- Stigma faced by health workers living with HIV.
- Stigma faced by people who use drugs.
- Gender and sexual diversity stigma.
- Stigma faced by people with TB.

Appendix of Picture Tools

Pictures that depict different types of stigma and settings for stigma are important tools for stigma reduction training. This manual contains a wide range of pictures developed over the years. All pictures are based on true stories and experiences. The pictures include:

- Stigma in Health Facilities.
- Stigma towards young people.
- Stigma towards people who use drugs.
- Stigma faced by gender and sexually diverse populations.

About the Exercises in this Manual

Each exercise is laid out in the following format so that they are easy to facilitate:

Facilitation Notes:

Brief background information on the topic and notes to facilitators about the overall aim of the exercise and any extra advice on how to facilitate it.

Objectives:

The aim of the session and what participants will know or be able to do by the end of the session.

Materials and Preparation:

Materials like flipcharts, markers, and masking tape are not always listed, as these should be readily available for all sessions. Preparation includes things to consider before you start the exercise. This includes arrangement of the room, or chairs and materials needed for the exercise, for example, copies of case studies or role-plays. If small groups will be used, there will be a reminder to plan your "group splitter" — how you will divide participants into small groups.

Activity Steps:

Step-by-step activities taken by the person leading the exercise. Note that Step 1 usually tells you how to introduce the exercise, so that participants will be clear about what they are being asked to do. Questions or instructions from the facilitator to the participants are written in italics.

Processing:

Most exercises have a processing step, after the main activity of the exercise, which helps participants reflect upon what new learning from the exercise means to them and how it may change the way they see or do things. This is an important step in a stigma reduction exercise. It leads to the beginning of action and change.

Summary:

Most exercises include some notes for summarising the topic. Facilitators should always refer to the key points that have been raised by participants during the activity or processing. However, you can refer to the summary points to help wrap up the topic.

Handouts:

Where there are handouts for an exercise, we have placed them immediately after the exercise for convenience.

Core Curriculum Exercises

Exercise	Time	Theme	Adaptations for special focus populations	Description
Opening activities	40 minutes	Welcome.		This is the first session of the training and includes introduction games, warm-up exercise, objectives and ground rules.
Naming Stigma through Pictures	45 minutes	Naming the problem.	Use additional Pictures.	Small groups look through pictures. Analyse one in depth (forms/ reasons for stigma). Share examples from own experiences. Report back. Lessons are processed through discussion.
Stigma Reflection	40 minutes	Naming the problem.		Reflection alone about a time when we felt rejected/ isolated. Share in pairs. Process exercise together in circle.
Confidentiality and Stigma	45 minutes	Values.	Choose relevant case studies or role-plays.	This exercise involves a simple game where participants write down private information, they do not want anyone else to know and then hand it to another participant. Group discusses how they feel holding someone's information, and their feelings about their own information being held by someone else. This is followed by small group discussions about case studies on broken confidentiality in health settings.
Quantity, Quality and Route of Entry (QQR)	45 minutes	Knowledge.		This is essential for low-prevalence countries. Most health workers in high-prevalence countries now have information about transmission. The QQR Tool is taught and then participants practice how to explain HIV transmission to colleagues.
Value Clarification	30 minutes	Values.	Revise questionnaire as needed.	Questionnaire completed alone. Discussion to process any feelings/ thoughts/ beliefs/ reflections.
Outside the 'Gender Box'	1 hour	Values.		Small groups draw 'ideal man/ ideal woman;' identify typical roles and norms. Individuals identify ways in which they do not fit into the 'Gender Box.'
Bingo	10 minutes	Values/ Icebreaker.	Develop your own sheet to suit your context.	Individuals race to complete a bingo sheet with signatures from other participants. Followed by discussion about what happened in the game.
Things People Say	40 minutes	Values/ language.	Ensure Special Focus Population groups are included.	Small groups rotate around a series of flipcharts, discussing and writing common names or phrases that are used about particular groups e.g. Things people say about young women; things people say about people living with HIV, followed by a discussion about language and stigma.

Exercise	Time	Theme	Adaptations for special focus populations	Description
Panel Discussion	1 hour	Contact.	Include your Special Focus Population.	A group of people from the Special Focus Population take part in a facilitated round table discussion, answering questions from the health worker participants. Time afterwards to mingle. Followed by reflection and discussion about lessons learned.
Managing Stress to Reduce Stigma	45 minutes	Supporting HWs with workload/ burnout.	Can include a client from special focus population in the stop-start drama.	Reflection about how health workers are affected by stress followed by a stop-start drama to generate ideas for troubleshooting. Small group work to identify structural and individual opportunities for support.
Be the Change	30 minutes	Challenging stigma.	Choose scenarios to fit your context.	Simultaneous paired role-plays based on scenarios where stigma takes place in a facility, to practice different skills and techniques for challenging stigma.
Code of Practice and Action Plan	1 hour	Challenging stigma.		Participants work in small groups to imagine and draw the best stigma-free health facility. Then reflect on things that need to change to work towards the vision. Groups/ departments draw up a simple 'Code of practice' to work in a stigma-free way, along with an action-plan.

Gender and Sexual Diversity (GSD) Stigma-reduction Exercises

Exercise	Time	Description
Identity Soup	15 minutes	Short exercise to explore what identity means, how we describe ourselves and how gender and sexuality fit into the discussion.
Gender and sexual diversity	45 minutes	Mini presentation mixed in with quiz about the key concepts of gender and sexuality.
Terminologies	30 minutes	Quick mingling game to help understand different terminologies around GSD.
Perceptions about Mental health and some Populations more affected by stigma	30 minutes	Role-play and PowerPoint presentation about beliefs around populations more affected by stigma and mental health.

TB Stigma-Reduction Exercise

Exercise	Time	Description
Challenging TB in Health Facilities	45 minutes	A Stop-start role play set in a health facility, followed by a team quiz game about TB, transmission, and treatment.

Health Workers Living with HIV Stigma-reduction exercise

Exercise	Time	Description
Navigating Stigma: Supporting Health workers living with HIV	45 minutes	Starts with a role-play and a trouble-shooting discussion. Followed by small group scenario discussions. Ends with positive messages to/ from colleagues living with HIV

Drug-Use Stigma-reduction Exercises

Exercise	Time	Description
Learning More about Drugs	40 minutes	'Card Storm' of all the drugs participants know leading to a classifying exercise in small groups.
Understanding and overcoming our fears about working with people who use drugs	60 minutes	Rotational brainstorm exploring fears health workers have about people who use drugs. Followed by a 'Card Storm' focussing on fears about providing services to PWUD. Problem-solving to address the fears.
Why do people start using drugs?	45 minutes	Brainstorm about why people use drugs. Small groupwork to discuss case studies.
Understanding drug-use addiction and co-occurring conditions	30 minutes	Buzz and brainstorm about addiction. Followed by presentation showing effect on brain of drug addiction as a disease. Discussion comparing stigma towards PWUD and those with heart disease.
Physical and psychological dependency	45 minutes	1.Guided fantasy about feeling very sick (comparing to withdrawal symptoms) and what support you would need. Explanation about physical dependency. 'Card Storm' on effects of withdrawal. 2. Case study Story about psychological dependency followed by discussion.
Providing treatment and care for people who use drugs, living with HIV	50 minutes	Brainstorm on co-occurring conditions for PWUD, living with HIV. Mini lectures about misdiagnosis, missed diagnosis and drug interactions. Presentation about methadone.
Using our new knowledge	30 minutes	Small-group discussions of scenarios of clients who come for support.

Sample training agendas

Creating Tailor-made Agendas for Health Facility and Special Focus Populations

We have included some sample agendas of core exercises and some mixed with those that have been designed to cover topics relevant to the special focus populations. In relation to delivering the step-down training, there are options based on health facility management preferences. For example, in the past some health facilities chose to have a two-day Step-down Training, but for some it was difficult to free staff up for such a chunk of time, and they preferred to spread the 2- day training across two weeks, or as 4 x half-days, 5 x three-hour sessions across 2 weeks, or break it into eight 2-hour weekly sessions. The modular format of the curriculum is flexible and can be designed to suit each facility.

Assumptions

The Step-down Training is between 12 and 16 hours long (depending on which exercises are used and whether time is allowed for recaps and reflection). We assume each training day would have 4 exercises in the morning and 2 in the afternoon (approximately 6 hours). Most sessions are 45 minutes to 1 hour. Some are shorter.

2-day Stigma Reduction Training (General and Focus on Young People).

Day 1
Opening Activities.
Naming Stigma through Pictures.
Stigma Reflection.
QQR.
Confidentiality and stigma.
Managing stress to reduce stigma.
Outside the ‘Gender Box’.
Day 2
Bingo.
Things People Say.
Value Clarification.
Panel Exercise.
Writing Codes of Practice and Action Plans.
Be the Change.

Two-day agenda with focus on Gender and Sexual Diversity (GSD) Stigma.

Day 1
Opening Activities.
Naming Stigma through Pictures.
Stigma Reflection.
Confidentiality and Stigma.
QQR.
Outside the ‘Gender Box.’
Perceptions about mental health and some Special Focus Populations.
Value Clarification.
Day 2
Breaking the Sex Ice — BINGO!
Identity Soup.
Gender and Sexual Diversity.
Panel Discussion.
Terminologies.
Challenge the Stigma — and Be the Change!
Writing Codes of Practice and Action Plans.

Four Half-Day Training Sessions (GSD focus).

Session 1
Opening Activities.
Naming Stigma through Pictures.
Stigma Reflection.
Confidentiality and Stigma.
QQR.
Session 2
Breaking the Sex Ice — BINGO!
Value Clarification.
Outside the ‘Gender Box.’
Perceptions about mental health and some Special Focus Populations.
Session 3
Identity Soup.
Gender and Sexual Diversity.
Panel Discussion.
Terminologies.
Session 4
Challenge the Stigma — and Be the Change!
Writing Codes of Practice and Action Plans.

Two-day Agenda with Focus on Stigma Faced by Health Workers Living with HIV and People with TB.

Day 1
Opening Activities.
Naming Stigma through Pictures.
Stigma Reflection.
Things People Say.
Confidentiality and stigma.
TB Stigma in health facilities.
Value Clarification.
Outside the ‘Gender Box.’
Day 2
Bingo.
Stigma towards Health Workers living with HIV.
Panel Discussion/
Managing Stress to Reduce Stigma.
Be the Change.
Writing Codes of Practice and Action Plans.

Four half-days Agenda with Focus on Stigma Faced by Health Workers Living with HIV and People with TB.

Session 1
Opening Activities.
Naming Stigma through Pictures.
Stigma Reflection.
Things people say.
Session 2
Confidentiality and stigma.
TB stigma in health facilities.
Value Clarification.
Session 3
Bingo.
Outside the gender box.
Panel Discussion.
Session 4
Stigma towards Health Workers living with HIV.
Managing Stress to reduce stigma.
Be the Change.
Codes of Practice and Action plans.

Two-Day Agenda with Focus Stigma Faced by People who Use Drugs.

Day 1
Opening Activities.
Naming stigma through pictures.
Stigma reflection.
Learning more about drugs.
Understanding and overcoming our fears about working with people who use drugs.
Value Clarification.
Day 2
Bingo.
Understanding drug-use addiction and co-occurring conditions.
Physical and psychological dependency.
Panel Discussion.
Providing treatment and care for people who use drugs, living with HIV.
Using our new knowledge.
Writing Codes of Practice and Action Plans.

Eight 2-hour Sessions with Focus on Stigma Faced by People who Use Drugs.

Session 1
Opening Activities.
Naming Stigma through Pictures.
Session 2
Learning more about drugs.
Understanding and overcoming our fears about working with people who use drugs.
Session 3
Stigma reflection.
Why do people start using drugs.
Stigma and confidentiality.
Session 4
Bingo.
Understanding drug-use addiction and co-occurring conditions.

Session 5
Physical and psychological dependency.
Using our new knowledge.
Session 6
Value Clarification.
Panel Discussion.
Session 7
Managing stress to reduce stigma.
Be the change.
Session 8
Writing Code of Practice and Action Plans.
Evaluation.

Stigma Reduction Training Exercises

40 mins

Opening activities

Facilitators' notes

The opening session of any training is very important, but even more so for the stigma-reduction training because you want participants to engage as soon as possible and feel that they are in a safe space. Take time to plan and prepare. Arrive at the venue at least one hour before participants are scheduled to arrive to set up the chairs and ensure logistics are in place (for example, materials, refreshments). Agree on your opening game or song. These opening activities are designed to break the ice and help participants to relax and feel safe together.

Try to create a warm and friendly atmosphere where everyone can participate. Remember to listen carefully to contributions from the group members; this will encourage others to listen too.

Our objectives

- To 'break the ice' and help to build a safe and friendly atmosphere.
- To introduce the training with the backing of the health facility management.
- To explain the objectives and program and agree on rules for the training program.

Materials

- Nametags (see below)
- Markers
- Flipchart
- Flipchart written with ground rules (include usual rules like timekeeping, confidentiality, cell phones on silent etc)

Preparation

- Prepare Code of conduct flipchart
- Make packs for participants to include notebooks, timetable, pen

1. Arrival

When participants arrive, ask them to register and make a nametag. Ask them to think of a rhyming name (adjectives beginning with same letter as their first name) e.g., 'Nice Nchimunya, 'Kind Kofi,' 'Artistic Amina.' This is a good activity for early participants and using first names will help to break down barriers around status.

2. Opening speech

Health facility manager explains the background and importance of the stigma and discrimination-reduction training.

3. Welcome

Introduce yourselves as the facilitators and welcome participants.

4. Ice breaker and introductions

Use a song or game to break the ice followed by short, paired introductions. Ask participants to pair up with someone they do not know and to tell them their name, which department they work in, and one of their hopes for the future. Then take turns as pairs to introduce each other to the big group e.g., 'This is Efua and she works in the OPD, she dreams of building a big house for her family;' 'this is Patson, and he works in the security office. He dreams of buying a motorbike to start a courier business.'

If you have attended a Training of Trainers Workshop you may remember 'I Cha La Le Ko' ('We Can Do It') which works well to mix pairs up.

Ice Breaker idea

The 'Walk Around' Game is a simple icebreaker to use at the beginning of a workshop. Ask participants to walk freely around the room and tell them that when you shout 'Stop!' they should pair with the nearest person and listen for instruction.

Ideas for instructions include

- Greet the person as if you haven't seen them for 5 years.
- Approach the person as if you owe them money and want to avoid them.
- Compliment your partner about something they are wearing.

After the final instruction has been carried out, ask the group members to stay with their partners for the paired introductions.

5. Objectives

Explain the objectives of the training program and relate them to participants' expectations and fears.

Workshop objectives

By the end of this workshop we will:

- Have greater knowledge, understanding, and skills to enable us to decrease the level of stigma in providing services at healthcare facility level.
- Have explored our values and attitudes and be able to understand the impact that they could have on providing services.
- Have agreed on specific things we can do to provide friendly and welcoming health services for all clients.

6. Timetable

Ask participants to look at their timetable and explain the starting and stopping times. Explain that punctuality is important because there are many topics to be covered in a short time.

7. Ground rules or ground contract

Explain that due to limited time, you have prepared a list of the common rules for workshops. Ask participants if they want to add any other rules that would help to make the training a safe space. Once the list is agreed, ask group members to come and sign their name on the flipchart to show they will stick to the 'contract' (this is light-hearted, but helps to show that the agreement is serious).

Examples to include in the Group Contract

- Cell phones on silent or vibration mode — calls and messaging during breaks only.
- Punctuality — start and end on time.
- Active participation.
- Confidentiality: What is said in the room stays in the room, and there will be no documentation of who said what.
- Respect each other's views — value diversity.
- Commitment that training leads to action!

8. Code of practice/ action plan

In keeping with a focus on action, at this first session introduce participants to the idea of the code of practice and action plan they will be developing. Facilitators should post a flipchart with "Ideas for the Code of Practice/ Action Plan" written on it. They should include a brief pause and reflect after each exercise, to ask participants what they will change, based on this exercise and what can be changed collectively. This demonstrates that participants recognize that challenges related to stigma and discrimination are present in the facilities where they work and are asking themselves, "What can be done to overcome this challenge?".

45 mins

Naming Stigma Through Pictures

Facilitators' notes

This is one of the best exercises to use at the beginning of a training session, because it is simple, everyone can participate, and it opens the discussion about stigma. Participants look at pictures showing stigma, (see Appendix 1: Picture Tools), and describe different forms of stigma in health facilities. Our objective is to get health workers to 'name the problem': to recognize that stigma exists and to identify what it looks like. There is also an opportunity to start discussing why stigma occurs and to identify some of the causes of stigma. In this exercise, if you are focussing on a special focus population, you can include pictures relevant to that group (for example, young people, people who use drugs, people with different gender and sexual identities). You can also add questions, or probe more deeply during report-back, about the particular stigma that that population faces.

Our objectives

By the end of this activity, participants will:

- Be able to identify different forms of stigma in different contexts.
- Have begun to understand why stigma happens.
- Have begun to understand the effects of stigma.
- Be able to discuss examples of stigma from their own health facilities and communities.

Materials

- Copies of pictures (laminated, if possible, for posting on wall)
- Tape for posting pictures
- Flipchart with picture questions
- Markers
- Copies of handout on key stigma definitions.

Preparation

- Select pictures for use during the training (include several that focus on your target group).
- Stick the pictures on the wall. Space them well apart so that groups of participants can see them easily.
- Decide how you will divide participants into small groups (see "Creative Group Splitters").
- Write up picture questions on flipchart (and have a copy ready to give to each group).
- Plan space for the small-group discussions.
- Write up definition of stigma.

1. Introduce the exercise

This exercise helps us to name stigma in our own context. Instead of just giving you a definition, we many pictures that show different kinds of stigma in different places. We have included pictures showing young people and the types of stigma they may face. We want you to use these pictures to share your own knowledge and experiences of stigma.

2. Divide participants into groups of three or four.

Ask groups to move around and look at as many pictures as they can, discussing as they go. After a few minutes, ask each group to select one picture and take it down from the wall.

3. Questions

Ask groups to discuss the following questions:

- What is happening in the picture in relation to stigma?
- Why do you think it is happening?
- Does this happen in your health facility or your community?

Allow 15 minutes for the discussions. Tell groups that they will be reporting back to the large group. Participants can take notes if they wish.

4. Report back

Ask each group to report back by holding up their picture to show it to their fellow participants and answering the questions. The facilitator records key points of forms, causes, and examples of stigma on flipchart as the groups present.

5. Processing

Ask the large group,

- "Does anyone have anything to add about what is happening in these pictures?
- "What are the major forms of stigma that we have seen so far?"
- "Do young people face different types of stigma in health facilities?"

6. Summarise

Refer back to the pictures and points from the groups to make some of the following points:

- We have been socialized to stigmatize others – to judge, blame or isolate.
- Often, we are not aware that we are stigmatizing others.
- Some groups face double stigma (e.g. for being a young woman and being HIV-positive) — an example of double, layered or Intersectional Stigma.
- Stigma in health facilities can be a barrier to different groups when they try to access health services.
- Young people often experience stigma in the form of judgments and scolding from health workers, especially if they need support around sexual health, HIV or pregnancy.

Reminder: Code of Practice/Action Plan

Encourage participants to add issues that they feel are important to address in the "Code of Practice/Action Plan" flipchart. One example may be to have some copies of the pictures that can be used to talk about stigma to colleagues.

7. Definitions

Briefly present the definitions of stigma below and provide handout to participants.

Stigma definition

Stigma as a Social Process

Stigma is a social process that human beings engage in and that we do to each other, sometimes without realizing it. Stigma is not a thing that exists like an elephant or a door! Rather, stigma is a social process that is constructed by us. It is shaped by negative attitudes, prejudice or false beliefs that society or individuals hold about people or groups with specific characteristics, circumstances, health conditions or symptoms. Stigma often unfolds in the context of power with links to social status and to pushing people down or out due to certain characteristics that, in a particular context or setting, are considered undesirable by dominant societal norms in that place. Stigma tends to protect the social identify of certain groups by projecting negative characteristics onto 'other' groups. For example, blaming migrants for TB transmission.

Stigma is a social process that involves:

1. **Pointing out or labelling differences.** For example, a persistent cough.
2. **Attributing those differences we have labelled to assumed negative behaviour.** For example, you have a persistent cough which is linked to both TB and HIV, and you can be judged as being irresponsible or 'promiscuous.'
3. **Separation ('us' and 'them')** in the form of isolating, shunning, rejection of those people or groups we have labelled and attributed negative characteristics to. For example, the person with assumed or diagnosed TB is isolated by friends.
4. **Which leads to loss of status followed by discrimination.** For example, the person with assumed or diagnosed TB is thrown out of their house by the landlord and others think less of them, as well as them feeling degraded.

Discrimination

The process of stigma can result in discrimination. Discrimination is when stigma results in an action (when stigma is enacted or played out) that is demeaning for the person being stigmatised and when the action is directed at the attribute under focus and considered undesirable. For example, the person with either assumed or diagnosed TB is discriminated against when they are thrown out of their house or put down publicly on the basis of their TB.

Examples of many forms of stigma

- name-calling
- finger-pointing, laughing and gossiping
- judgments about dressing
- exclusion
- harsh punishments
- isolation at school
- denying food
- violence
- insults and derogatory language
- rejection from family

Examples of the causes of stigma

Research has been conducted to try to understand why people stigmatize others. The main reasons include:

- Many people do not realize that they are stigmatizing another. Often, they do not see that their words and actions are hurtful. Perhaps they do not have a chance to reflect and understand how they are stigmatizing.
- Fear is often a cause of stigma. It could be fear based on a lack of information — for example people may still not be sure how HIV is transmitted and think they should avoid any kind of contact with anyone who is HIV positive. This can result in stigmatizing avoidance behaviour and isolation of people living with HIV.
- Moral judgments and religious beliefs can also lead to stigma. For example, if a young woman falls pregnant outside of marriage, some people will want to punish her, or chase her from the family, because she has done something against their moral values. Another example is that some people believed that HIV was 'sent' as a punishment to some people because they had 'sinned.'

Examples of the consequences of stigma

Stigma has consequences for individuals, and also for families, communities, organisations.

- It can cause people to feel isolated and lonely, depressed and even suicidal.
- It can lead to people not getting Antiretroviral (ARVs) because of their fear that others may find out that they are living with HIV. For example, if health workers are living with HIV, it is hard for them to openly access ARVs since they worry that they may lose their professional status.
- Stigma can stop people talking about HIV. For example, if you are worried about a friend or family member having HIV, you may be reluctant to suggest they get tested.
- Stigma may stop people from sexually diverse groups (e.g. MSM) from asking for advice from health workers and from being open about their health concerns and risks with health workers.
- Fear of disclosure of HIV status may stop people from sharing their HIV status with others who could provide them with support and help them to access treatment.
- Stigma can result in people who use drugs being afraid to ask for information or support when they need it. They may fear they will be judged or excluded if they even talk about their drug use.
- Young people may be afraid to ask for sexual and reproductive health services and support from health facilities if they fear that they will be judged or scolded due to their age.

Types of stigma

There are different types of stigma.

Perceived Stigma

This is when a person considers that a difference, which can be a health condition or a group or social identity or social behaviour, is a negative difference, and having this difference or disclosing this difference may lead to being treated badly by others.

Anticipated stigma

This involves a person affected by the difference, either directly or through association, expecting and fearing to experience stigma if the health condition, behaviour or identity becomes known to others.

Internalised Stigma

This happens when a person internalises being treated badly by others, and they in turn consider their own health condition, identity or behaviours to be shameful and that they are deserving of criticism and discrimination. The result is that they feel they are less deserving and that their identity is spoilt.

Intersectional Stigma

This is when differences rooted in race, class and gender oppression intersect with each other and with other differences, for example a health condition such as HIV, to result in a deeper experience of stigma and discrimination.

Enacted Stigma

This refers to stigma resulting in actual experiences of being devalued or disadvantaged or excluded because of a difference that is deemed to be negative by some others. When we stigmatize others, we enact stigma.

Experienced Stigma

Means when a person with a difference is stigmatised (treated badly through being devalued and/or disadvantaged and/or excluded) and experiences stigma in different forms.

40 mins

Stigma Reflection

Facilitators' notes

This exercise draws out participants' own experience of being stigmatized. It asks them to think about a time in their lives when they experienced stigma or rejection, and to use this experience to help them understand how it feels to be stigmatized. Reflecting on this painful experience helps participants see how hurtful stigma and discrimination can be. The exercise requires trust and openness within the group, so it should not be used as the first exercise. Wait until participants are beginning to open with each other and are ready to share some of their own experiences.

You should also note that the exercise focuses on stigma in general, and not HIV-related stigma in particular. This is why the instructions are,

"Think of a time in your life when you felt isolated or rejected for being seen as different from other people."

This exercise needs a good introduction to help participants break out of their initial discomfort about reflecting and sharing their own experiences with others. It is important to set ground rules for this exercise. Emphasize that the sharing is voluntary, and people should only share their own story, not that of their partner in the large group. Emphasize the importance of confidentiality, and that what is shared should stay in the room.

As this exercise can trigger painful memories or experiences for some participants. As facilitators, you can discuss how you will provide support and reassurance (see 'Work with Feelings' in the Tips for Training section). Remember that the strength of feelings that can emerge illustrates the impact that stigma has on someone's life.

Our objectives

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

- Describe some of their personal experiences of being stigmatized.
- Describe how it feels to be stigmatized.
- Recognize that their own actions play a part in creating stigma in their health facility, and that their own actions can likewise help make their health facility stigma-free.

Preparation

- Move chairs apart so that everyone is sitting alone.

Activity steps — Stigma Reflection

1. Introduce the exercise

"We're going to do a simple exercise, that can sometimes feel quite difficult to do . The aim is not to upset anyone, but to help us to get in touch with the feelings of stigma."

2. Individual reflection

Ask participants to sit on their own and close their eyes.

"Think about a time in your life when you felt isolated or rejected for being seen to be different from others. What happened? How did it feel? What impact did it have on you?"

Allow a few minutes for participants to really reflect.

3. Sharing in pairs

When you observe that participants are ready say,

"Share your experience with someone with whom you feel comfortable. You will not have to share your experience in the big group unless you want to."

Give the pairs a few minutes to share their stories with each other.

4. Sharing in plenary

Invite participants to sit in a closed circle. Facilitators sit as part of the group. Ask,

"How was the reflection?"

Take a few answers and then ask,

"What were some of the feelings that came up?"

Ask if anyone would like to share their stories in the large group. This is voluntary; no one should be forced to give their story. Ask participants to only share their own story, not that of their partners. People will share if they feel comfortable. Wait a few minutes- it usually takes time before someone volunteers. They can reflect on the process of the exercise and how it made them feel if they don't feel comfortable sharing specific stories. If a participant shares, thank them, and acknowledge their experience. Say things like,

"That must have been difficult."

"That is a very powerful story."

Allow enough time for two or three people to share. Try not to rush through even if the silence or energy feels difficult.

5. Processing

Staying seated in the circle,

"What do we learn about stigma from this exercise?"

6. Summary

- This exercise helps us get an inside understanding of how it feels to be stigmatized, shamed or rejected. It helps us understand how painful it is to be stigmatized.
- The feelings of being stigmatized are very painful and the impact last a long time.
- Stigma destroys people's self-esteem. People begin to doubt themselves. They feel very isolated at a time when they need the support and company of other people. The impact of stigma can have long-term effects.
- Everybody has felt isolated or treated like a minority at different times in their lives. We have all experienced rejection or exclusion by others.

7. Closing

Ask people to stand up and hold hands and use a comforting song or gentle exercise to bring the group back together. For example, in Ghana, 'We Shall Overcome' works well.

45 mins

Confidentiality and Stigma

Facilitators' notes

This exercise looks at how stigma can affect the rights of people living with HIV (and other stigmatized populations) in health facility settings, with a particular focus on the right to privacy and confidentiality.

Confidentiality is an important topic to discuss in the context of stigma in health facilities for several reasons. Many people are afraid to use services because they fear a lack of confidentiality. If they take an HIV test, will their results be confidential? If they seek treatment for a sexually transmitted infection, will they be judged by the health care workers? If a health worker finds out that a young person is sexually active, will they keep confidentiality or tell their parents, teachers or neighbours? If a health worker goes to collect her ARVs will her colleagues break her confidentiality and spread rumours around the facility? If a man talks about his male partner, will the health workers understand about same sex relationships, or will they want to turn a client into a 'case' to discuss with their colleagues?

This exercise starts with a simple game where participants write down private information, they do not want anyone else to know and then hand it to another participant. As a facilitator, it is very important to ask everyone to promise not to read someone else's paper. The discussion or processing after the game is where the issues will really emerge. The game is followed by small group case study discussions to help participants understand how rights can be violated and to explore some possible realistic solutions.

NB: Shared confidentiality is when information is shared within an institution for the benefit of the client. For example, a doctor may need to know you are taking ARVS if they are prescribing medicine for you. Information is not shared with anyone outside of the health facility or with health workers within a health facility who do not need to know that information for your care.

Our objectives

By the end of this activity, participants will have:

- Identified human rights that link to health care and how one may get violated because of stigma if one is from a marginalized group.
- Discussed the right to privacy and confidentiality.
- Acknowledged the potential impact on clients, when a health worker violates confidentiality.

Materials

- Small slips of paper, photocopies of the case studies and handout, flipcharts and markers.

Preparation

- Decide 'Group Splitter.'

Activity steps — Confidentiality and Stigma

1. Introduction

The aim of this exercise is to explore how confidentiality and stigma are connected- how stigma and discrimination often result in the violation of rights, particularly when targeted at clients who may be vulnerable or anxious about accessing health services, because they are from a marginalised group. The exercise will focus on one of the most fundamental rights which pertain to health care- the right to confidentiality and privacy.

2. Group activity: Trust game

Tell the group that we are now going to focus on one of the most important rights related to health care- that of privacy and confidentiality. Hand out a slip of paper to everyone. Ask participants to think of a piece of private information they would not want anyone else to know. Ask them to write the private information on a piece of paper, fold it up, and do not show it to anyone. Now ask each person to pass their paper to the person on the left. Stress that no one should open the papers.

3. Reflection

Ask participants:

- "How does it feel to have your private information in someone else's hands?"
- "How does it feel to have someone else's private information in your hands?"
- "How do you think it feels for clients to have their private information in the hands of health workers?"

Now ask for the papers to be returned and tell participants they can destroy their papers (or do whatever they want with them).

4. Processing

"What does this game tell us about confidentiality?"

"How does confidentiality link to stigma?"

5. Case studies

Divide participants into small groups and give each group a case study. Ask them to read the case study together and discuss the questions.

6. Report back

Ask each group to read their case study and outline their key discussion points.

7. Summarize

Using points raised by the participants and adding from those below if not mentioned:

- People from groups affected by stigma, including people living with HIV, have the same human rights as anyone, but their rights are often abused because of stigma and fear.
- When rights are violated in health facilities, the violation becomes a barrier that may stop some clients at risk, from accessing services. As a result, they are more vulnerable to getting HIV and may be more likely to pass it to others.
- Young people may be particularly worried about their right to confidentiality with respect to health workers sharing their information with their family or other professionals. They may face rejection or violence in their families or workplaces or community if confidential information is shared to them by Health Workers.
- All Health Workers, irrespective of their employment status, are required by their own ethical codes of practice (and often by law) to keep the information that they learn about their patients, confidential.
- Raising awareness amongst Health Workers and other staff about the importance of confidentiality can help to protect clients' rights and ensure that everyone can have access to health care. Developing a Code of Conduct to reduce stigma and make facilities more welcoming is one way of protecting human rights.

Case study A

Emmanuelle is a sex worker who prides herself on her professionalism in her work. She insists on condoms with her clients, even when they offer her more money for unprotected sex; she makes sure she has regular health check-ups; and she is able to take care of her partner and family members with her earnings. One day, when she refused to have unprotected sex, a client raped her. Afraid that she would be arrested by telling the police that she had been raped by a client, she did not report the incident, but rushed to the clinic to get post-exposure prophylaxis (PEP). The first nurse she saw was very cold and refused to give her PEP, stating that a police report was needed. Afraid to tell the nurse her story, she went home and prayed that she had not been infected with HIV.

Discussion

1. **What are the confidentiality issues in Emmanuelle's case?**
2. **What could you do if you were Emmanuelle?**
3. **As a health worker, how could you ensure that Emmanuelle gets a better service at the facility?**

Gender And Sexual Diversity Confidentiality
Case Studies

Case study B

Ebu is 26 years old and works for a local NGO. He is worried that he may have an STI and goes to the clinic for some tests. When the nurse is taking his details, he mentions that he has a boyfriend. The nurse looks shocked and tells him that she will pray for his soul. She picks up her Bible from the desk and calls two colleagues to explain what she is doing. She tells Ebu that he must come to the next Scripture Union meeting at the clinic so that everyone can pray for him. Ebu feels very uncomfortable and decides he will never go back to that health facility.

Discussion

1. **How has the right to confidentiality been broken in the story?**
2. **What is the impact of this breach of confidentiality?**
3. **As a health worker, what do you think should be done to protect Ebu's rights and avoid this situation happening again?**

Case study C

Cephas works as a peer educator to encourage young people to get tested for HIV, particularly those from key populations. Cephas is well known at the clinic and popular with the nurses. One day Cephas takes a new client Kwame to go for a test.

Cephas leaves Kwame with the nurses and agrees to meet him the following week.

On the bus home Cephas receives a call from one of the nurses at the clinic, who says, 'I thought you should know that your client tested positive.'

Discussion

1. **How has the right to confidentiality been broken in the story?**
2. **What is the impact of this breach of confidentiality?**
3. **Is there anything that can be done to avoid this situation happening again?**

Gender And Sexual Diversity Confidentiality
Case Studies

Case study D

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

Discussion

1. **How is Barbara breaking confidentiality?**
2. **What could you do if you were one of the clients?**
3. **As a Health Worker, what do you think should be done to protect these client's rights?**

Gender And Sexual Diversity Confidentiality Case Studies

Case study E

Yaw has been referred to the clinic by one of the peer educators, because he suspects he may have an STI. Unfortunately, the nurse who usually sees the MSM clients has been called away and Yaw is seen by a newly transferred clinical officer. After examining him, the clinical officer takes Yaw's history and is shocked to hear that he has sex with men. He calls a psychiatric nurse to come and talk to Yaw so that he can receive treatment for his 'mental condition.' Yaw feels confused and decides he will never go back to that clinic.

Discussion

1. **How has confidentiality been broken?**
2. **What could you do if you were Yaw?**
3. **As a Health Worker, what do you think should be done to protect these Yaw's rights?**

General Confidentiality Case Studies

Case study F

Sister Joyce works in a busy district hospital and takes her health seriously. She worries about HIV because her husband often travels for work, and she thinks he is not always faithful. Sister Joyce takes an HIV test at the ARV clinic every 6 months. One day her result comes back positive. She decides to knock off early from work as she is a bit in shock and needs time to come to terms with what has happened. Before she reaches her house, she receives a call from a colleague who works in a different department, who has heard what happened and is checking that she is okay.

Discussion

1. **How has confidentiality been broken?**
2. **What would you do if you were Sister Joyce?**
3. **As health workers, how can we protect Sister Joyce's rights?**

Case study G

Chinyama is 45 years old and has recently been diagnosed with TB. He has already started his treatment and has to go back to the clinic for some tests. Unfortunately, he missed his appointment yesterday because his bicycle got a puncture, so he goes the next day. He reports to reception and tries to explain what happened to the receptionist. However, the receptionist is tired and grumpy and says very loudly, 'Look-the chest clinic was yesterday. You people are tiring us, always coming on the wrong day.' Other patients are looking at him. Chinyama looks down and wonders whether to just go home.

Discussion

1. **How has confidentiality been broken?**
2. **What would you do if you were Chinyama?**
3. **As health workers, how can we protect Chinyama's rights?**

General Confidentiality
Case Studies

Case study H

Malama is a student nurse who is doing her second-year practical at the teaching hospital in the capital city. Malama was born with HIV and has been taking ARVs for as long as she can remember. However, she realises that she is running out of her meds and will not have time to get back to her home clinic. She goes to see if she can collect some from the hospital pharmacy. The next day she is with her fellow students, following the senior nurse on the ward round and there is a patient who has HIV. The nurse calls Malama and says, 'I think you can explain to this one, after all you know all about this disease.' Malama looks surprised as she has not talked about her status to anyone.

Discussion

1. **How has confidentiality been broken?**
2. **What could you do if you were Malama?**
3. **As Health Workers, how can we protect Malama's rights?**

Case study I

Kim recently tested positive for HIV and is due to have a viral load test tomorrow. She has gone to visit a friend and leaves her phone with her older sister charging at her house. While she is gone, the phone rings and her sister answers. An outreach worker is calling and assumes it is Kim who has answered. He reminds her about the coming appointment. Kim's sister is shocked, and starts to ask questions, when the outreach worker realises it is not her.

Discussion

1. **What do you think will happen?**
2. **What can Kim do in this situation?**
3. **As Health Workers, how could Kim's right to confidentiality be protected?**

General Confidentiality
Case Studies

Case study J

Mwaango is 17 years old and lives in Chawama. She is in Grade 9 at school, and has an older boyfriend, whom she has been dating for 6 months. They sometimes have sex together. For the last few days Mwaango has been worrying that she may have an STI because her vagina is itchy, and she has a vaginal discharge. She asks her best friend Jade what she should do. Jade warns her that if she goes to the clinic, she might become the 'talk of the day.' Jade had had a bad experience there when a health worker told her Aunty after she went for an HIV test. The girls decide to go to the pharmacy instead, but they feel embarrassed to explain the problem. Mwaango buys some cream, but the problem seems to get worse in the next few days.

Discussion

1. **What was the impact of Jade's experience at the clinic? How did it effect Mwaango?**
2. **Why does Mwaango go to the Pharmacy?**
3. **What do you think Mwaango should do next?**

Case study K

Salim is a young man who is on a methadone prescription at the hospital and has just learned he is living with HIV. He decides that he would prefer to get his ART treatment at a Care and Treatment Clinic (CTC) near where he lives. Salim arrives at the CTC to enrol in treatment and one of the nurses recognises him from the Methadone program and says loudly in front of others, "Why have you come here? You should go to the methadone clinic for your HIV care, that is where you people should get your ARVs." Salim notices some of the other clients are looking at him and whispering. He quickly leaves the CTC.

Discussion

1. **How has confidentiality been broken?**
2. **What can Salim do in this situation?**
3. **As health workers, how can Salim's right to confidentiality be protected?**

Drug Use
Case Studies

Case study L

Hasina is a young woman who recently found out that she is pregnant. Hasina has been using drugs but is determined to stop and she has enrolled on the methadone program. She goes to the Ante-Natal Clinic for the first time to attend an information session. As she is registering her details, a nurse calls out to her colleagues giving the talk 'Don't forget to talk about the dangers of using drugs when you are pregnant!' The other mothers in the session all look at Hasina, who now wants to run away.

Discussion

1. **How has confidentiality been broken?**
2. **What can Hasina do in this situation?**
3. **As Health Workers, how can Hasina's right to confidentiality be protected?**

Case study M

Baraka is a young man who uses drugs and one day is hanging out with some friends by one of the kiosks in town. As he is chatting to a friend about some possible work, he sees one of the nurses from the CTC walking towards him, with a friend, carrying shopping. The nurse and her friend are chatting closely and seem to be pointing at him. As she approaches, she asks Baraka, 'Why haven't you come to get your prescription?' Baraka feels embarrassed and does not answer. His friends are all watching.

Discussion

1. **How has confidentiality been broken?**
2. **What can Baraka do in this situation?**
3. **As Health Workers, how can Baraka's right to confidentiality be protected?**

Drug Use
Case Studies

Case study N

Mboni is 30 years old and has been living with HIV for 5 years. He goes to the clinic to collect his methadone and meets an old friend on his way. The friend says he will escort him to the Clinic. When Mboni arrives, he meets the security guard near the doorway. The guard says loudly, 'Hey you, everyone is looking for you, you have not been picking up your ARVs!' Mboni's friend asks him what the guard is talking about.

Discussion

1. **How has confidentiality been broken?**
2. **What can Mboni do in this situation?**
3. **As Health Workers, how can Mboni's right to confidentiality be protected?**

Confidentiality

What is confidentiality?

- Confidentiality is an agreement or set of rules that limits access or places restrictions on certain types of information. In a health setting, confidentiality relates to information about clients, including their health, sexual orientation, gender identity, drug use and HIV status.
- Each person may choose to disclose information to those whom s/he trusts and who will treat this information with respect. However, because of stigma, many people living with HIV and with other co-morbidities (for example, TB) choose not to disclose. If they belong to a group that is considered to have negative characteristics by some others, this can make disclosure of HIV even harder.
- Every person has the right to confidentiality. Every person has the right to decide what aspects of his or her life are private and what can be released into the public domain (e.g. on social media, in the community etc). This includes the right to confidentiality regarding a person's HIV status or sexuality.
- Confidentiality is a human right - an essential part of the right to privacy. This right is protected by the constitution of many countries. It protects the individual's home, life and reputation, plus personal information such as medical records.
- A Health Worker may discover things about a client, such as HIV status, sexual health, sexual orientation or drug use, that are considered private. The health worker should keep this information confidential and has an ethical responsibility to do so.
- The Health Worker should protect the information provided by a client and not disclose an illness or any other private information to any third party outside of the health facility staff. The information should not normally be shared without the specific permission or consent of the owner. Information shared between health care workers about a client must always be done for the purpose of enhancing the health of the client. This is called shared confidentiality.

Why is confidentiality important?

- If a Health Worker breaks confidentiality, they put the client at risk of being rejected by the family and facing other forms of stigma and discrimination.
- The Health Worker builds a relationship of trust with the client by agreeing to keep information confidential.
- If a person feels their information about their HIV status, sexual orientation, or gender identity will remain confidential, they will be more likely to seek counselling, testing, treatment, and support.

What Happens if Confidentiality is Broken?

Failure to respect the right to confidentiality will drive the HIV epidemic underground:

- The client may lose trust in the Health Worker and become afraid to share other important information about their health for example, a cough or a symptom of a sexually transmitted infection. As a result, they do not get the best treatment for their condition.
- The client may be subjected to stigma and discrimination by family or by an employer. Where sexual practices are criminalized, clients even face harassment, blackmail, or arrest.
- Once stigmatized, the client may avoid health services, which have exposed him/her to stigma, and as a result may not access treatment, care, and support.
- The client may lose confidence and become more secretive about their HIV status, for example not telling sexual partners. As a result, transmission of HIV may be more likely.

Young People and Confidentiality

When a young person first visits a clinic alone, it is important that they are assured of confidentiality by the Health Worker. This will help to build their trust and confidence and enable them to access the services they need.

Some Health Workers may find it difficult to keep confidential information about a young person they know, or whose family they know. It is crucial that health workers follow their ethical and professional commitment to confidentiality and put the health needs of the young person first, (if there is concern about the safety of the young person, health workers must follow their safeguarding policy in terms of who to notify).

Confidentiality and Stigma

- Gossiping and finger-pointing are often a result of broken confidentiality. Some people forget about a person's right to privacy; their value judgments about how someone might have become infected with HIV override their professional obligation of confidentiality. The need to discuss and speculate about a patient, with colleagues, takes priority.
- Sometimes there is tension between confidentiality and stigma. For example, if Health Workers put so much emphasis on confidentiality, it can sometimes feel stigmatising. There can be a sense of, 'What is this thing that no one must know about?'
- Some activists chose to go public about living with HIV, saying that they feel free from the burden of hiding their status and the worry of others finding out. However, the important fact about this is that they have chosen to disclose, rather than having others break their confidentiality.

45 mins

Fears about Nonsexual Transmission: Quantity, Quality, and Route of Entry (QQR)

Facilitators' notes

In this exercise, Health Workers identify specific forms of contact with people living with HIV that they fear might result in their acquiring HIV. Then they explain the reasons behind their fear. The trainer presents the QQR tool, and the group can then explore whether the fear is real or not.

Fear of HIV transmission is one of the main drivers of stigma, and it is important to allow health workers, especially those with little training on HIV issues (e.g., clerical workers, guards), even nurses in low-prevalence countries) time to explore how HIV is, and is not, transmitted. Being able to give clear information about HIV transmission is an important tool in eradicating stigma.

Our objectives

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

- Name their fears about HIV transmission in relation to specific forms of contact with people living with HIV.
- Explain why HIV cannot be transmitted through nonsexual casual contact using the QQR tool.

Materials

- Flipchart
- Copies of QQR handout.
- Question sheets for Margolis wheel.
- Index cards with research statistics written on them (see overleaf)
- Tape

Preparation

- Write "QQR" on a flipchart.
- Make copies of QQR handout.
- Arrange chairs in two circles, one inside the other, chairs facing each other (make sure they are distanced).
- Make copies of question sheets for Margolis wheel (half the group will need Question sheet 1, the other half Question Sheet 2).
- Write up some of the findings

Examples of Research Statistics For Index Cards

Examples of Research statistics written on index cards. These findings come from a baseline survey conducted in Ghana in June-August 2017 in 20 health facilities in five regions, including this facility. Trainers collected through the random selection of staff from all departments and across all levels of medical and non-medical staff.

- 35% of health facility respondents said they routinely use double gloves when caring for clients living with HIV.
- 16% say they avoid physical contact with clients living with HIV.
- 53% say they use gloves for all aspects of care with clients living with HIV (even types of care that do not require gloves).
- 63% say they use extra precautions with clients living with HIV that they don't use with other clients.
- 35% say they are worried about getting HIV from touching the clothing or bedding of a person living with HIV.

Activity steps – Fears About Non-sexual Transmission

1. Introduce the exercise

'The aim of this exercise is to ensure that we are all clear about how HIV is transmitted and is NOT transmitted- and gives us a chance to practice explaining transmission to colleagues and clients.'

Hand out the index cards: With the research statistics randomly to different participants. Tell the group that you want to share some findings from the baseline study on stigma in health facilities in Ghana (from 2017). Ask those with cards to read them out. Then ask the group if they have any thoughts or comments about the findings. Do the practices sound familiar? Has anything changed since 2017?

2. Buzz

Ask participants to buzz with a partner: What lies behind these fears? How do we think that we can get HIV from routine caring like feeding or bathing a patient? Take one point from each pair. Record their points on a flipchart.

3. QQR

Present and explain the QQR tool – give participants a few minutes to reflect on the tool and ask any questions. Give out the QQR handouts.

4. Margolis Wheel

- See diagram overleaf of the Margolis Wheel arrangement.
- Ask participants who feel confident to use QQR to explain transmission, to sit in the inner circle and be the 'experts' and those who are less confident will be the 'researchers' who are sitting in the outer circle.
- Give each researcher a copy of Question Sheet 1 and explain that they need to ask the experts to help find the answers. Each researcher spends a few minutes with the expert in front of them and asks the first question. When facilitators give a sign, each researcher moves one chair to the left and asks the next question to the next 'expert.'
- After 3 changes and questions, ask participants to change chairs so that the researchers sit in the inner circle. Give the new researchers Question Sheet 2 and continue as before.

Activity steps – Fears About Non-sexual Transmission

The Margolis Wheel consists of two circles of chairs – an inner circle (for the experts) facing outwards, and an outer circle (for the researchers) facing inwards. This way, all participants will be in a pair facing each other, with one "expert" and one "researcher".

5. Debrief

Come back into the large group. Ask: How was the exercise? How do you feel about QQR? Are there any further questions about HIV transmission? Clarify any outstanding issues.

Reminder: Code of Practice/Action Plan

Take a few minutes to ask the group what can we change as individuals based on what we've learned and what do we need to work together on collectively with management?

Write these points on the Code of Practice flipchart.

Question sheet 1

1. Can you tell me why it is impossible to get HIV from shaking hands with someone?
2. Can you explain why there is no risk of getting HIV while feeding a patient?
3. Can you tell me why there is no risk of getting HIV from bathing a patient?

Question sheet 2

1. Can you tell me why you cannot get HIV from touching the bedding of a patient?
2. Can you tell me why there is no risk of getting HIV from taking a patient's temperature?
3. Can you tell me why there is no risk of getting HIV from helping to lift a patient?

QQR

There are three conditions, all of which need to be present, for HIV to be transmitted.

1. There must be enough QUANTITY of the virus in body fluids.

HIV is found in large quantities in blood, semen, vaginal fluids, and breastmilk, so in these fluids there is a risk of transmission. HIV is found in small quantities in saliva, vomit, feces, and urine, but not at all in sweat or tears, so in these cases there is no risk.

2. There must be enough QUALITY: the virus must be STRONG ENOUGH.

We now know that people living with HIV who have undetectable viral loads (defined as equal to or less than 50 copies/ml (WHO 2024)) are not able to transmit the virus through sexual contact (see box). The risk of a person living with HIV whose viral load is undetectable passing the virus through other exposures is negligible. There has never been a documented case of HIV transmission from a child who is living with HIV to another person. HIV does not live on the surface of the skin; it lives inside the body. HIV cannot survive outside the human body. It starts to die as soon as it is exposed to air.

3. HIV must have a ROUTE OF ENTRY

Enabling the virus to pass through the skin into the bloodstream of the person who is HIV negative:

- Through a vein (e.g., a needle injection, which puts infected blood directly into the blood of the HIV negative person)
- Through the lining of the anus or vagina (during sex), or through sores on the penis
- Our body is a closed system: healthy skin is an excellent barrier against HIV. HIV cannot pass through unbroken skin. Even if skin is broken, HIV cannot pass through it easily.

U=U (undetectable equals untransmittable)

Undetectable viral load: ART can reduce a person's viral load to the point where it is so low (usually between 20 to 50 copies/ml depending on the test) that it cannot be detected by measurement. This is called "having an undetectable viral load." This is why U=U is an important message to tell people

Viral load suppression: ART helps to suppress a person's viral load.

Excellent adherence (taking ART as prescribed) is important to suppressing viral load and achieving an undetectable viral load.

Having an undetectable viral load:

- Prevents the sexual transmission of HIV; studies show that when a person has an undetectable viral load, they cannot transmit HIV to sexual partners.
- Improves the health of a person living with HIV.
- Does not fully clear the virus from the body or cure someone of HIV.

Post-exposure prophylaxis (PEP)

Post-exposure prophylaxis (PEP) refers to the use of antiretrovirals (ARVs) after potential exposure to HIV to prevent transmission of the virus. PEP must be started within 72 hours after possible exposure to HIV, but the sooner you start PEP, the better. PEP has little or no effect in preventing HIV infection if it is started later than 72 hours after HIV exposure.

Pre-exposure prophylaxis (PrEP)

Pre-exposure prophylaxis (PrEP) refers to the use of ARVs to prevent HIV acquisition if one is likely to be exposed to the virus. In some countries vulnerable groups such as young women, sex workers and MSM can access PrEP. It is also available to sero-discordant couples. PrEP usually involves taking a pill every day, or injections. PrEP should be used along with other prevention methods, such as condoms, and HIV treatment as prevention (TasP). PrEP does not prevent pregnancy or other sexually transmitted infections.

20 mins

Value Clarification Exercise

Facilitators' notes

This is an exercise that helps participants to think through their values and how their values may lead them to judge others and impact on the health services they provide. It is important to remind participants that the exercise is not about changing their values or beliefs but about showing the link between morals and judgments and how they can unconsciously influence service provision. It is important to reassure participants that their value sheet is private and will not be shared with anyone. It is a tool for reflection. As a facilitator you should make sure that the discussions are not personalized during processing.

Our objectives

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

- Explore values and beliefs around HIV, sexuality and relationships.
- Discuss how values can influence our work as health workers.
- Explore the impact of values and beliefs on access to quality service provision.

Materials

- A copy of the Values Sheet for each participant.

Preparation

- Make your own Values Sheet. Note: Make your own value sheet for your special focus population (See examples below of statements about each group. Include at least 20 statements, using some from each category).
- Arrange chairs in such a way that participants cannot see each other's answers when filling in the value questionnaire.

Activity steps — Value Clarification Exercise

1. Introduce the exercise

"This is a simple exercise to help us to reflect on our values and beliefs and to then think about how these values may influence our behaviours, especially in a work situation. The aim of the exercise is not to change your values, but simply to reflect on them. We are going to use a question sheet which we will ask you to fill in alone. You will not be asked to share your answers with anyone."

2. Values Sheets

Hand out the Values Sheets, ask participants to sit and reflect on the questions and statements and then fill it in.

3. Discussion

After everyone has finished, come together in the large group and discuss the following:

- Any thoughts or comments about the value questionnaire?
- How do our own values and beliefs influence our behavior and attitudes towards other people?
- How do values and judgments link to stigma?

4. Summarise

Summarize discussion, using the following summary notes, where necessary

- We are often socialized to judge other people based on assumptions about their behavior. People living with HIV, MSM, transgender people, people who sell sex, people who use drugs, can regarded as breaking social norms and some people think they deserve to be condemned and punished.
- We need to be aware that our values and opinions can have an effect on clients, especially if they sense that they are not welcome in the clinic, or, worse still, are treated with hostility.
- As Health Workers, we have a professional obligation to remain objective and non-judgmental with clients and avoid letting our personal beliefs and attitudes become barriers to providing compassionate and high-quality care to clients.

Reminder: Code of Practice/Action Plan

Take a few minutes to ask the group what we can change as individuals based on what we have learned and what do we need to work on collectively with management?

Write these points on the Code of Practice flipchart.

Values sheet

Statements with General Focus and Young People	Agree	Disagree	Not sure
I believe that young people should not have sex before marriage.			
I believe that young men are naturally promiscuous.			
I think that women should not tolerate violence or threats from their husbands.			
I think that using condoms spoils sex.			
I want my partner to be faithful to me.			
I think that young men sometimes suffer from depression and other mental health issues but do not talk about it.			
If my partner was HIV positive, I would keep it a secret.			
If I found out that my brother had been with sex workers, I would be shocked.			
I think it is better to talk openly about sex to			
young people so that they can ask questions and be responsible.			

Statements with General Focus and Young People	Agree	Disagree	Not sure
I can freely mix with different groups in the community, including those from poor homes and those from the upper class.			
I think that attitudes are changing in Africa towards gay men.			
I believe that everyone, no matter their sexual preferences, has a right to access information about HIV and contraception.			
I think it is better to stay married even if you are not happy, than to get divorced.			
I think social media is causing harm to young people's relationships.			
I think young men should be taught how to respect girls properly.			
I think that both young men and women should be taught how to cook and keep a house clean and smart.			
I think some health workers stigmatize young people.			

Statements with General Focus and Young People	Agree	Disagree	Not sure
Some people think that if you have TB, you are being punished for bad behavior in the past.			
I think that as a health worker I should ensure that all patients are treated equally.			
I believe that young people are losing their African culture and traditions.			
I think that young women who get pregnant often get blamed while young men do not take responsibility.			
I know my HIV status and am open about it.			
I believe it is OK if a young woman wants more than one boyfriend.			
If I found my teenage daughter with condoms in her handbag, I would be worried.			
I think it is natural for a young man to experiment with a lot of partners before he settles down.			
If a young person is HIV positive, he or she should tell their girlfriend or boyfriend.			

Handout – Values Sheet

Statements with General Focus and Young People	Agree	Disagree	Not sure
I think that watching pornography can be harmful to relationships.			
I think all young people should have access to contraception in order to prevent early pregnancies.			
I would like more training about young people and their health needs.			
If my daughter got pregnant before she was married, I would still support her and her child.			
Most people sell sex because of poverty or because they can't get other work.			
I think that young men should learn how to be strong and hide their true feelings.			
If I see a young woman shouting in the street, I think she has not been taught well.			
If I saw a young man crying, I would probably think he was a weak person.			

Statements with Focus on Gender and Sexual Diversity	Agree	Disagree	Not sure
I believe that people should not have sex before marriage.			
I believe that men are naturally promiscuous.			
I think that women should not tolerate violence from their husbands.			
I think that using condoms spoils sex.			
I want my partner to be faithful to me.			
I think that men who have sex with men (MSM) should see a psychiatrist so that they can change their behaviour.			
If my partner was HIV positive, I would keep it a secret.			
If I found out that my son or a male relative had sex with other men, I would be shocked.			
Men who have sex with men have the same rights as heterosexuals			
I think it is better to talk openly about sex to young people so that they can ask questions.			
I can freely mix with different groups in the community, including MSM.			
I think that attitudes are changing in Ghana towards MSM.			

Statements with Focus on Gender and Sexual Diversity	Agree	Disagree	Not sure
MSM have a right to access information about HIV.			
I think it is better to stay married even if you are not happy, than to get divorced.			
I don't understand MSM relationships.			
I think young men should be taught how to respect girls properly.			
If a religious leader is HIV positive, he or she should tell the congregation.			
I think some health workers stigmatise MSM.			
Some people think that you must be possessed by bad spirits if you are MSM.			
I think that as a health worker I should ensure that all patients are treated equally.			
I believe that being MSM is going against African culture.			
I think that there should be special health services for groups like MSM with trained health workers so that they feel safe.			
I know my HIV status and am open about it.			

Handout – Values Sheet

Statements with Focus on Gender and Sexual Diversity	Agree	Disagree	Not sure
I believe it is OK when women look for sex outside of marriage if they are not happy with their husbands.			
If I found my teenage daughter with condoms in her handbag, I would be worried.			
An MSM cannot be a religious person.			
If a young person is HIV positive, he or she should tell their girlfriend or boyfriend.			
If someone does not want to say if they are male or female, that is their right.			
TV and the Internet has a big influence on people's moral values.			
I would like more training about MSM and their health needs.			
If my son or another male relative told me, they were MSM I would accept them and offer support if they needed it.			
Most people sell sex because of poverty or because they can't get other work.			

Statements with Focus on Drug Use	Agree	Disagree	Not sure
I believe that people who use drugs are being irresponsible with their lives.			
I think that drug use needs to be discussed more openly with young people.			
I think that all health workers should learn about addiction and how it affects people.			
I know that many people use substances like tea, coffee and alcohol but do not consider them to be drugs.			
If I found out that a member of my family was using illegal drugs, I would not want anyone at work to know.			
I think that there should be more drug treatment programs in my country.			
I think that some drugs are fun if you just use them occasionally.			
I think it is natural for young people to try out drugs, especially things like cannabis.			
Drugs scare me!			
I would like more information about different drugs and how to help those who use them.			

60 mins

Outside the Gender Box

Facilitators' notes

This exercise helps participants to explore the impact that gender expectations can have on all of our lives, and how they can influence the way we think about people who step outside the 'Gender Boxes.' Before you start the exercise, check that participants understand the definition of gender.

Gender refers to the socially constructed roles and responsibilities assigned to men and women by society. These roles are learned; they vary between cultures, and they change over time.

Our objectives

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

- Explore gender norms in our society and how they influence our upbringing, attitudes and beliefs.
- Examine the negative impact that gender norms can have on our lives and those who do not conform to gender norms.
- Reflect on how we have stepped outside of gender norms in our own lives and to see how necessary sometimes it might be to step outside the gender norms.

Materials

- Flipcharts, markers.
- Pre-written cards (see table below- write one point per card).
- Masking tape/sticky stuff.

Preparation

- Create different piles for men and women (colors/shapes).

1. Introduce the Exercise

"We are going to explore the link between gender norms and stigma in this exercise. This exercise is not about changing your view of gender, but we want to reflect together on how rigid views of gender norms can impact on all of us. In particular, strict views on gender can help to fuel stigma towards those who do not conform to gender norms and can lead to gender-based violence."

2. Definition

Check that participants understand the definition of gender (given in facilitator notes).

3. Getting into groups

Divide participants into two groups and give each group a flipchart sheet and some markers. One group will focus on women, one group will focus on men. The first task is to think about and discuss in your groups, ideas about stereotypes of the 'ideal' man and 'ideal' woman (in your communities). Ask the groups to draw a picture of the typical man or woman (think about how they look, even the clothes they wear) and then write some of the words around the figure, words that are often associated with 'ideal' men and women.

Examples from Ghana ToT for Health Workers

An Ideal Woman

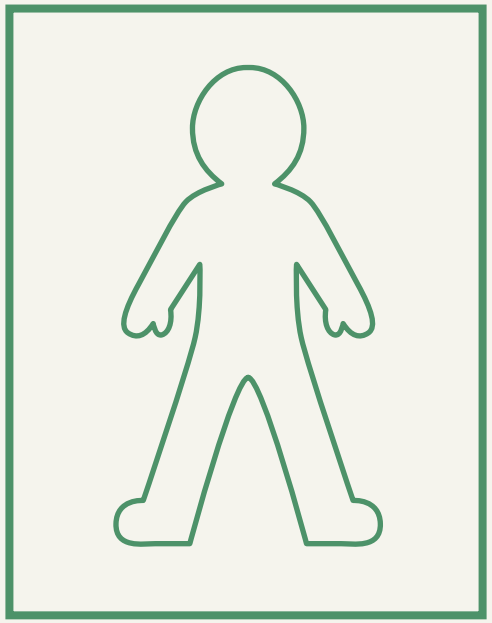
Lower education/ occupational ambitions; Well-endowed; Feminine; Soft; Dresses decently; Must be a nurse or teacher if they do work; Childbearing; Must not be promiscuous; Wears waist beads; Submissive; Wears earrings; Homemaker; Non-leaders; Married before 30.

An Ideal Man

A womanizer; Hard working; Drinks liquor; Owns cars/ houses; Produces many kids; Potent; Deep voice; Walks majestically; Muscular; Has a six pack; Big dick; Aggressive; Strong; Bread winner; Rugged, Tough; Don't cook; Don't cry; Wear men's clothes; Good in bed; Rich; Wise.

4. The Gender Box

Stick up the flipchart sheets and have a look at them as a group. Now ask the groups to draw a box around their figure (including all the words). This is the 'Gender Box.'



5. Gender Cards

There are 2 sets of pre-written cards (one for men, one for women — they could be color-coded, or just labelled). Staying in their groups, ask participants to stick the cards — either inside the gender box if they think it fits the stereotype, or outside the box if it is does not.

6. Reflection

Once all the cards are stuck up, look at the flipcharts together. Ask the group for any thoughts or reflections.

7. Outside the Gender Box

Now give everyone a blank card and ask them to think about something about themselves or something that they have done in their lives, that would put them outside 'their gender box'. It might be a decision they made, a job that they have done, a hobby or interest, or something linked to their family or relationships.

Ask them to write their cards and stick them on the wall (wherever they like). Invite the participants to look at the wall together and see if anyone needs clarifications or wants to comment.

8. Discussion

Ask:

- "How does it feel when you are outside the Gender Box?"
- "What are the advantages and disadvantages of staying inside a Gender Box?"
- "What is the link between rigid gender norms and stigma?"

Summary Notes

Gender is a social construct and is often seen in terms of either being male or female which is a binary-based concept. However, gender is fluid, flexible and subject to change - it is a purely social construction. Some young people are now talking of identifying as 'gender non-binary.'

Stepping outside the gender box can lead to stigma and even violence. Violence against people who do not fit into typical gender norms (for example, some MSM or transgender people) is often about 'policing' masculinity and upholding traditional male norms.

Keeping an open mind about gender and gender norms helps us to provide better healthcare for people who do not fit into the gender boxes and may eventually help to lead to more acceptance of diversity in society.

Reminder: Code of Practice/Action Plan

Take a few minutes to ask the group what we can change as individuals based on what we've learned and what we need to work on collectively with management.

Write these points on the Code of Practice flipchart.

> **'Gender Box' was so fun – participants (in the Step-down Training) really enjoyed doing it, many realized that there were a lot of roles that we take up, but they did not realize that it placed them outside societal expectations of a gender.**
>
> Health Worker Facilitator, Ghana

> **It was fun realizing that we have a little male in us and males have a little female in them.**
>
> Participant from Accra Step-down Training

You don't like playing football at school and would rather read your book.

Men

You like to keep your hair long.

Men

You have no time to spend with your young children.

Men

You love playing games with your baby daughter.

Men

You are in love with a man.

Men

You cry at sad movies.

Men

You cried when your mum passed away.

Men

You often go out drinking with your friends.

Men

You agree to stay home for a year to look after the children so that your wife can take a management job that involves travelling.

Men

You have never learnt to drive.

Men

You never talk about your feelings.

Men

Gender Box Cards

You love cooking and often cook the evening meal at home.

Men

You earn more than your wife.

Men

You like driving big cars

Men

You hate wearing dresses.

Women

You loved playing football at school.

Women

You never want to get married - you like being single.

Women

You are a bad cook and often just buy take-away foods.

Women

You drive a big car and give your partner a lift to work.

Women

You are the main breadwinner in the house.

Women

You like children but do not plan to have any of your own.

Women

Gender Box Cards

You think that you should be the one responsible for creating a happy home.

Women

You are building your own house and enjoy helping with the building.

Women

You are in love with a woman.

Women

You keep your hair short and natural.

Women

You love baking cakes.

Women

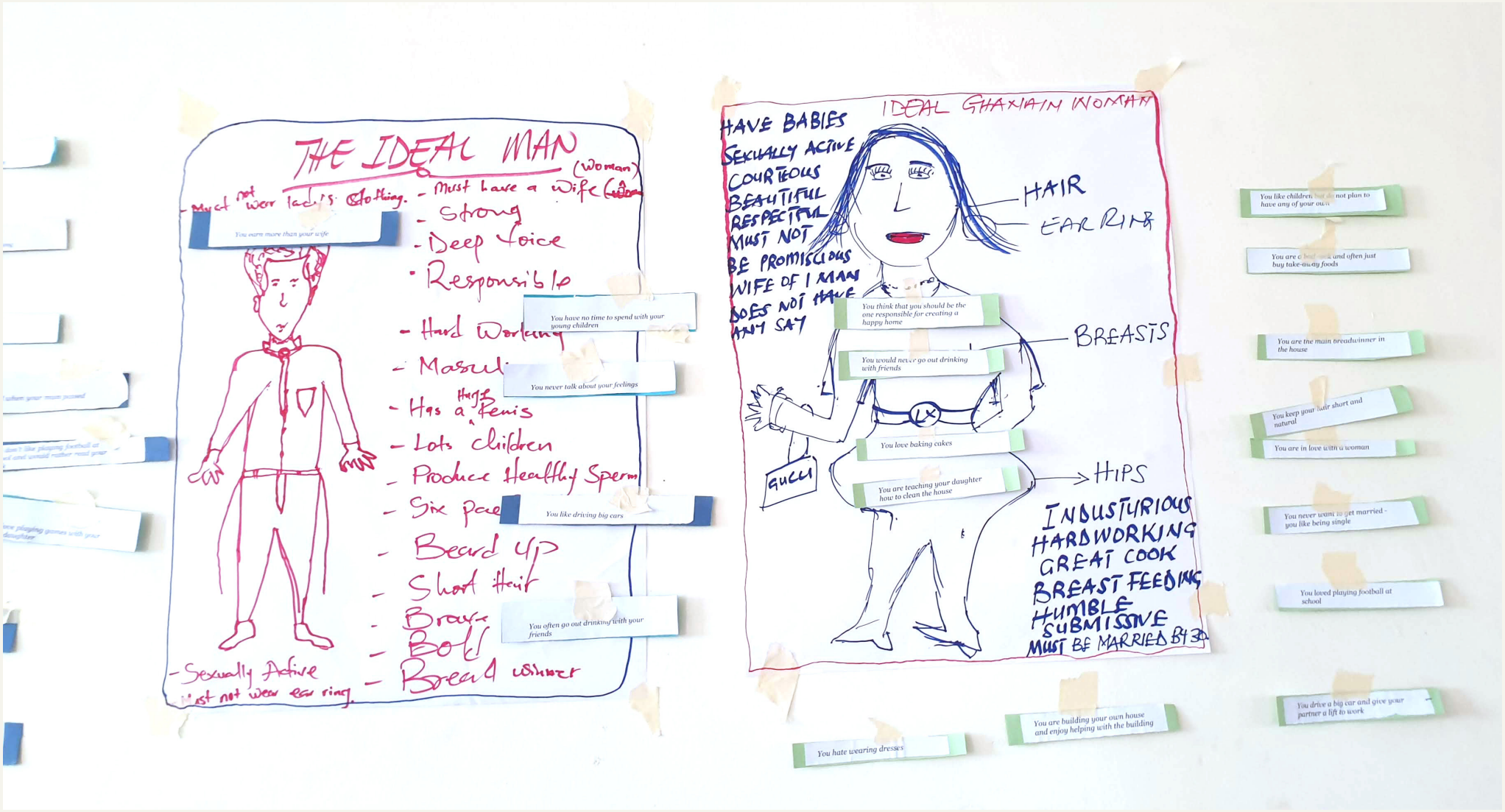
You would never go out drinking with friends.

Women

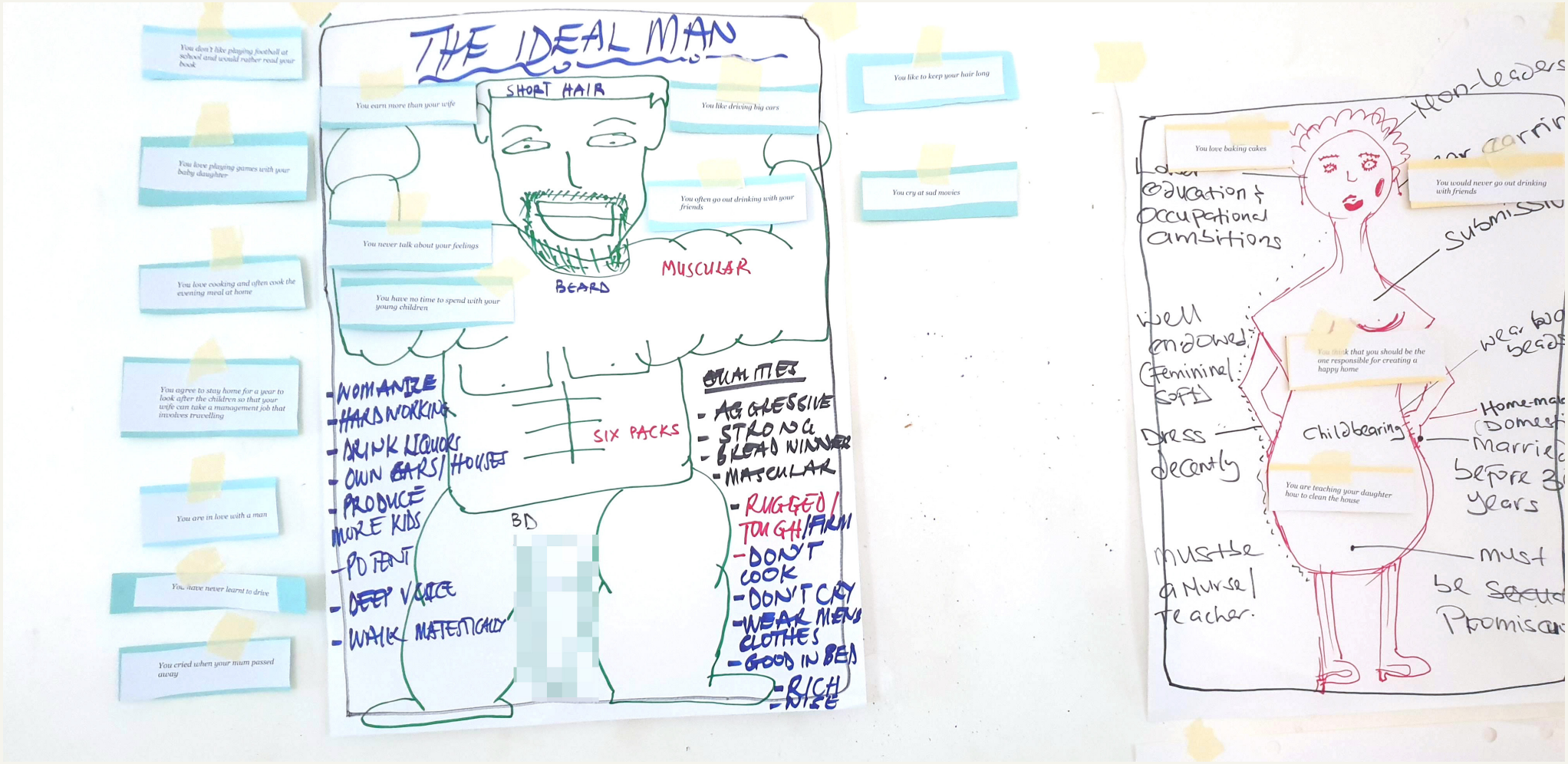
You are teaching your daughter how to clean the house.

Women

Examples from workshops



Examples from workshops



15 mins

Breaking the Sex Ice — Bingo!

Facilitators' notes

In our role as health workers, we often find it difficult to talk to our clients about sex. Talking about sex is sometimes considered "taboo" or "abnormal" and may feel uncomfortable. Our attitudes and beliefs about sex can lead to stigma against those seeking support around HIV, sexual and reproductive health, or other health services. We need to try to talk more openly about sex, especially if we are working in services linked to sexual health and HIV so that our clients can ask questions freely and receive the right information to enable them to lead healthy lives. Young people may find it difficult to get information about sex, especially with increased access to images on social media and pornography and health workers can play an important role.

This exercise is an energizer that raises the topic of sex and talking about sex. Processing the 'game' is the important part - where participants have a chance to reflect on the 'easy' and more 'tricky' boxes and how they feel approaching the topics with fellow participants. If you can give a small prize (even a bowl of sweets, or someone to serve the winner tea) it adds to the excitement.

Our objectives

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

- Explore their own feelings about talking about sex; to talk more openly with clients to ensure they receive the information they need to live healthy lives.
- Recognize that the taboo associated with talking about sex often links to stigma.
- Be more aware of the assumptions we make about other people.

Materials

- Copies of BINGO sheet for each participant
- Small prize if possible (You can make a funny prize e.g. the winner will be served tea first for the next 2 days).

Preparation

- Write up BINGO Rules on a flipchart (See overleaf)
- Make your own bingo sheet: We have included a sample sheet, but it works better if you design the Bingo sheet to fit your local context (especially re. travel and food boxes). Always include some about sex, condoms, sexuality) then add your own categories.

Bingo Rules

Write up rules on a flipchart:

- The aim of the game is to get a different signature in each box, by asking people if they fit the category.
- You can only sign someone's paper once.
- You cannot sign your own paper.
- You do not have to sign anything you do not feel happy about.
- You are racing against each other!
- When you have filled every box — shout BINGO!

1. Rules of the game

Read through the rules for BINGO and make sure everyone understands.

2. Play the game

Ask participants to have a pen ready and tell them you will hand out the Bingo sheets, but no one should look until you say START! Ask participants to stand up and get ready to mingle. Say GO! when everyone has their paper.

3. Processing

When someone has shouted BINGO, check the paper for all the signatures and present the prize. Then gather the group together for a debrief.

Ask:

- "What happened during the game?"
- "Were any questions more difficult than others?"
- "What did we learn about our perceptions of each other?"
- "What does this tell us about our attitudes to sex?"

Reminder: Code of Practice/Action Plan

Take a few minutes to ask the group what we can change as individuals based on what we've learned and what we need to work on collectively with management.

Write these points on the Code of Practice flipchart.

Sample Sheet

Someone who has been to Nigeria.	Someone who has been a member of a choir.	Someone who loves sex.
Someone who uses condoms.	Someone who knows someone who is gay.	Someone who loves to talk about politics.
Someone who is keeping a big secret.	Someone who had sex when they were a teenager.	Someone who loves to sing and drink beer.
Someone who has more than three children.	Someone who speaks more than one language.	Someone who loves to eat chips.

Make your own Bingo sheet

Someone who uses condoms.	Someone who knows someone who is gay.	Someone who loves sex.
Someone who is keeping a big secret.		

40 mins

Things People Say...

Facilitators' notes

In this exercise participants identify words used to stigmatize people from groups that face more stigma. The language can be very strong, so people need to understand WHY they are being asked to make lists of stigmatizing words. This exercise is called 'Things people say' because this allows participants to express stigmatizing words while attributing them to 'people,' rather than admitting that they may have used the words at times. While some words are those commonly used by the community, other words will have been used by participants. For this reason, it is important to follow the structured way in which the report- back on the flipcharts, and processing, is done. Reporters should use the phrase ' I am a …… and this is what YOU say about ME.'

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

Extra Tips for Facilitators:

- When processing this exercise, focus on how participants feel about these names, rather than the words themselves. This helps to avoid embarrassed laughter that can often occur. The whole point of this exercise is to help participants recognize how these words can hurt.
- Challenge the laughter. Often participants will laugh out of embarrassment. This is a good opportunity to ask the group 'How do you feel about the laughter?'
- The rotational brainstorm is fun, but the real learning comes in the debriefing, so make sure you allow enough time and energy for this.
- Remember that some of the participants may belong to one or more of the groups under discussion or be close to family and friends who do. The exercise can be very powerful and may trigger sad emotions. Take time and acknowledge how group members are reacting.
- Explore your own feelings about these issues before trying to facilitate this discussion with others.

Our objectives

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

- Identify words used to stigmatize people living with HIV, young people and those from key populations.
- Recognize that these words hurt and impact on self-esteem and mental well-being.
- Understand the link between language and stigma.

Materials

- Flipcharts and marker pens

Preparation

- Write out 4-5 flipcharts (include the groups that your TFA is focusing on e.g. young people; MSM, people living with HIV, people who use drugs). Start each one with "Things people say about…" (See overleaf for prompts)
- Stick the flipcharts around the room at different stations. Place a marker pen by each flipchart. Arrange the chairs in a circle. For the group splitter: write a list of the groups (singular) e.g. young woman, person living with HIV, person who uses drugs.

Flipchart prompts

Write each of these prompts at the top of an individual flipchart:

- Things people say about people living with HIV.
- Things people say about MSM.
- Things people say about people who sell sex.
- Things people say about young women.
- Things people say about people who use drugs

1. Introduce the Activity

Arrange chairs in a closed circle and introduce the exercise:

"The aim of this exercise is to help us explore the link between language and stigma. It is not an easy exercise and can bring up strong feelings. We are going to ask you to think about all the different names and words that are used against certain groups in our communities. But before we start, let's play a quick game to get you into groups."

2. Warm Up Game Group Splitter

Walk around the group and ask each participant to read out the category you point to (e.g. young woman, person living with HIV...) Start at the top, second one to second participant and keep going up and down the list. This will be the group they belong to.

Ask them to read it out, as this helps them remember.

The facilitator then stands in the middle of the circle and says: When I call out two groups, for example, 'people living with HIV and young women,' all the people living with HIV and young women have to stand up and run to find a new chair. I'm also looking for a chair. The person left without a chair becomes the new caller. The caller may also shout 'revolution' — when this happens, everyone has to stand up and find a new chair.

Then, shout out two of the groups– people with those roles run to a new chair. This starts the game. Continue for a few rounds as energy levels allow.

3. Rotational Brainstorm

Point out the flipcharts posted around the room, so that participants can see where their group starts. E.g. those from the 'young women' group, go to the flipchart marked 'Things people say about young women'. Explain that each group spends a few minutes at the flipchart, discussing, and then writing down, all the things' people say about that group (in any language, including slang or street language). When the signal is sounded (a drumbeat, song, clap) groups move round to the next flipchart and continue until all groups have been to every flipchart. When groups get back to their original flipchart, ask them to bring it to the circle for report back.

4. Report back

Bring everyone together into a large circle. Explain that we will listen to the report back from all the groups before commenting or discussion. Ask one person from each group to read through the list of words, starting by saying I am a... (young woman/person living with HIV) and this is what YOU say about ME:' then read the list.

Avoid taking any comments until all the flipcharts have been read out.

5. Processing

After all the lists have been read out, allow time for participants to digest all the words. Then you can ask the following questions, allowing enough time for people to respond. There may be some sadness or heaviness in the group.

- How do you feel about these names?
- Why do we use such hurtful language?
- What does this show us about the link between language and stigma?
- How does language like this affect the services we offer in our health facility?

6. Summarize

(Using words from the participants as much as possible)

- The words used in this exercise show that when we stigmatize, we stop dealing with people as human beings. Using shaming words gives us a feeling of superiority over others. They also serve to separate us from 'them.'
- Stigmatizing words are very strong and insulting. They have tremendous power to hurt, humiliate, and destroy people's self-esteem.
- People more affected by HIV stigma can be linked to belonging to a group that is disproportionately affected by group identity stigma, e.g, women, young people, and men who have sex with men. Pushed down and out by society, they can lack the power to challenge stigma.
- The hurtful words used to describe people who use drugs act only to keep them isolated and separate from the rest of society and show no understanding of the complexity of drug use.
- There is a strong link between stigma and gender. We have seen the stigma faced by girls and women if they do not fit into the usual expectations placed on them by society.

Reminder: Code of Practice/Action Plan

Take a few minutes to ask the group what can we change as individuals based on what we've learned and what do we need to work on collectively with management?

Write these points on the Code of Practice flipchart.

60 mins

Panel Discussion

Facilitators' notes

This exercise provides an opportunity to help participants understand more deeply some of the issues facing people from stigmatised groups. It gives participants an opportunity to ask questions to increase their understanding of the needs of the stigmatised groups in the communities especially in relation to accessing health facilities. It also gives those from the groups, a chance to 'tell their story' and be listened to. It is important to have members of any special focus populations and persons living with HIV at the table, and to ensure that they are briefed about the exercise and aware of what is being asked of them.

The panel facilitator should be able to act like a friendly TV chat show host and should ensure that the session is handled with sensitivity and that the questions are not too intrusive or inappropriate. This exercise has worked well with groups of healthcare workers, and if facilitated effectively, can result in a change of attitudes and greater understanding.

Briefing the Panel and Providing a Safe Space

Being a visible and vocal member of a stigmatized group in some countries may be risky (e.g. those from LGBTQI communities) and it is crucial to ensure that the risks are minimized by briefing the panel well so that they understand the format of the panel exercise and what is expected of them.

Meet with the panellists before the exercise so that you can spend time with them and run through what is expected of their participation. Discuss the exercise with them in depth. If possible, conduct a training session with them so that they can practice sharing their experiences and opinions, and how to handle tricky situations.

See 'Things to explain to the panel' overleaf.

Our objectives

By the end of this session participants will have:

- Listened to first-hand experiences from members of stigmatized populations and people living with HIV (the panellists).
- A greater understanding of the challenges encountered by groups who face stigma.
- Explored and discussed experiences of stigma in health facilities and ideas for making services more friendly and accessible.

Preparation

- Questions from participants (share with panellists in advance).
- Set up a round table/panel-style seating arrangement at one end of the room, and rows of chairs for the audience. (It is not a general discussion session — the audience just listens).

Things to explain to the panel:

About the workshop and its' general aim to try to reduce stigma towards groups that face more stigma in health facilities

The audience (participants) will be staff from health facilities

The exercise will be quite informal and run like a 'TV chat show,' facilitated by one of the facilitators, who will try to put the panellists at ease

That the panel will be asked questions that have come from the audience, and will be able to tell their stories, share their experiences of using health facilities (both positive and negative) and offer positive suggestions if they like, on how to reduce stigma

Tell panellists that if there are any questions that they prefer not to answer they can just say 'pass'

Tell the panellists that there are some simple questions that are always asked, so that they can think about what they might want to say:

- Tell us about yourself (Background, work, social life etc.)
- Tell us about a positive experience you have encountered at the health facility
- What do you feel most proud of in life?
- What are your dreams for the future?
- If you were given powers to change anything in the health facilities, what would you change?

Ask the panellists to think through issues of disclosure — for example if they are living with HIV, will they want to discuss this? What are the pros and cons?

Check if any of the panellists have any concerns or fears about taking part in the exercise, after the briefing

Discuss whether there are any fears about being known by the audience or being identified as coming from a certain group. Some panellists may prefer not to take part in the workshops that are close to where they stay

Check the panellists have thought through any implications that may arise from speaking openly about living with HIV, accessing sexual and reproductive health services (or being MSM or gender non-conforming).

Preparation for the exercise:

1. Ask the participants to submit their questions in advance

e.g. the day / morning before the exercise; so that the questions can be collected and edited by the facilitators. The questions should also be shown to the panellists in advance. Explain to the health workers that they can ask anything they would like to know to help them understand more about those from the marginalised groups who you have on the panel. But also remind them to be sensitive and not to ask any questions that they themselves would not be comfortable to answer.

Preparation for the exercise:

2. Preparing the questions

Read through the questions and combine any similar ones. Edit out any that are offensive, e.g. judgmental, related to personal sexual behavior, etc. Arrange questions in a way that will help panellists to warm up and discuss openly. For example, don't start with the most intense or difficult questions; start with some more gentle questions to ease into the discussion. Aim for 10–12 questions.

Ensure that the following questions are included:

- Please tell us a bit about yourself (background, work, social life).
- Tell us about a positive experience you may have encountered at the health facility.
- What do you feel most proud of in your life?
- What are your dreams for the future?
- If you were given powers to change anything in the health facilities, what would you change?

3. Arrange the room

with a table at the front for the panel and chairs around it. Ensure that there is water for panellists and some paper and pen for notetaking.

1. Introduce the exercise

Introduce the exercise in the style of a TV or radio chat show (shows in which a host invites a few people to talk about a particular topic, from their own life experiences). Introduce the panel (or let them introduce themselves) and explain that the aim is to really listen to the voices of the panel as they answer the questions that came from the audience.

2. The Panel

Try to have about 10 questions. Allow the panel to discuss for up to an hour. Try to ensure that each panellist gets a chance to answer the questions but alternate who answers first each time. Take a short break if you sense that the panellists or audience need one.

3. Mingle

Allow some time for mingling (e.g., a tea break) so that the audience can mix informally with the panellists.

4. Debrief

Make time to reflect together after the discussion to assess what participants have learned from the exercise.

Examples of reflection questions:

- What did you learn from the panel discussion? What really stood out for you?
- What key messages and information will you be taking away from this discussion?

Reminder: Code of Practice/Action Plan

Take a few minutes to ask the group what we can change as individuals based on what we've learned and what do we need to work on collectively with management?

Write these points on the Code of Practice flipchart.

45 mins

Managing Stress to Reduce Stigma

Facilitators' notes

It is important to acknowledge the stress that affects health workers. This stress can be due to work overload and conditions of service or due to personal reasons or health conditions. Stress can affect how we deliver services and impact on the quality of our service delivery and be a cause of stigma. For example, if a nurse is feeling overwhelmed by the number of clients in the waiting room, and has personal problems, she may fail to adequately attend to a client, and then the client may feel stigmatised.

This exercise provides an opportunity for health workers to share their experiences of stress and discuss together strategies for managing it and ways of supporting each other. The facilitators should be aware that they may not be able to find solutions to eliminate all the stress that health workers face, but the idea is to create a space where participants feel listened to, and problems can be tackled together.

Our objectives

At the end of this session participants will have:

- Discussed the feelings and impact of stress on health workers.
- Identified some of the causes and consequences of stress at work, and how it may lead to stigma.
- Explored steps and changes that would help to reduce stress and provide greater support to each other.

Materials

- Flipcharts
- Markers
- Copies of drama roles.
- Cards or coloured paper for each participant or the emojis.

Preparation

- Arrange a few chairs in front and anything else to use in the drama.

1. Introduce the Exercise

"The aim of this exercise is to explore the effect of stress on health workers and how it can sometimes lead to stigma in how we deliver health services."

2. Reflection

(15 minutes) Arrange chairs so that participants are sitting separately, facing different directions. Tell them we are going to do a reflection- ask them to close their eyes, breathe, take time to relax.

Read each question slowly, leaving a minute or so between, repeat them to take more time. Give time for participants to reflect.

- How often do you feel tired at work?
- Have you ever felt burnt-out at work? How does it feel?
- Do you ever feel frustrated working with clients? What happens?

After a few minutes, hand a paper and marker to everyone and ask participants to draw an emoji showing how they feel when they are stressed. Then ask them to pair up with someone and share their emoji, and how it felt to do the reflection.

Example of emoji from Zambia workshop

3. Process in group

Bring the group back into a semi-circle. Ask the group How was the reflection? Does anyone want to share? Ask everyone to lay their emojis in front of them and have a look at each other's.

4. Stop-start Drama

Explain that you are going to try out a Stop-start Drama. Ask for 6 volunteers to take part in a drama that has the following 6 characters:

a) Sister in charge. She has problems at home (her son is drinking too much; her husband seems disengaged); she is short-staffed at work; there is a waiting room full of patients; and no power due to load-shedding.

b) 2 junior nurses (male or female) who are working with her; they have a lot of questions and need advice.

c) Her son (calling on the phone to ask for money, sounding drunk).

d) A doctor who is waiting to be briefed.

e) 2 or 3 patients who are getting angry because they are waiting so long.

Explain how it works; the volunteers will play out the first scene to show the stress that the sister is under. At some point, you the facilitator, will shout 'STOP!' and everyone pauses while you take reflections and suggestions from the rest of the participants. You can ask someone to come and take over one of the roles to try out the next step. The key question is,

"What will help to reduce the stress here?"

5. Processing Questions

When you have tried out a few suggestions in the drama, ask the group:

- What did we see happening?
- What were some of the things that lead to the stress?
- How does stress lead to stigma?
- What can we do to support each other and ourselves when we are stressed?

6. Ideas for taking care of ourselves and each other

Split participants into small groups, according to departments and give each group a flipchart and marker. Ask them to discuss and answer the following questions:

"What are some of the structural or organisational changes that would help to reduce stress?"

"What individual actions can we make to take care of ourselves and each other when we are stressed?"

7. Summary

Many health facilities across the world are poorly resourced and under-staffed creating an environment which can be hectic and stressful, and difficult for health workers, especially when there are many clients waiting for health care.

As health workers, sometimes we are prone to stress and do not realise that it may influence the way we attend to our patients. In the worst situations, our stress can turn into anger and blame, and we may direct this towards clients. This can be experienced as stigma by some clients.

It is important to learn and develop techniques to manage the stress. Sharing our experiences about our stressful moments may bring some level of relief, and together we can agree different ways to support each other and at the same time ensure a more welcoming service for clients

30 mins

Challenge the Stigma, Be the Change!

Facilitators' notes

This exercise aims to explore how we can challenge everyday stigma, especially in our place of work. Participants learn how to be assertive and then practice this skill in a series of simultaneous paired role-plays. The practice helps participants to see that acting against stigma whenever and wherever it happens is one of the steps we can all take to begin to act and bring about change.

Our objectives

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

- Have practiced using assertiveness skills to challenge stigma.
- Understood the importance of speaking out.

Materials

- Flipchart for recording responses.
- Markers.
- Tape.

Preparation

- Write definition of 'assertiveness' on a flipchart.

1. Introduction

Explain that the session is aimed at practicing how to challenge stigma when it occurs in everyday settings.

2. Buzz and Brainstorm

Ask participants, who are in pairs, what they understand by the term assertiveness. Record points on a flipchart. After you have enough responses share the assertiveness definition and some of the points if they haven't been mentioned.

Definition of Assertiveness

Saying what you think, feel, and want in a clear, honest, and confident way that is good for you and good for others. It does not involve showing anger or being aggressive and can come from a place of compassion.

Tips about being assertive:

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

Example: If a colleague comes to you to gossip about another colleague who she thinks has tested HIV positive, you might say,

'I don't think we should be gossiping. Let's work out how we can support her — next time it could be you or me.'

3. Paired role-playing (round 1)

Explain that we will practice how to challenge stigma and discrimination in different common work situations, using assertiveness. Ask participants to stand in two lines facing each other and to pair up with the person opposite them. Read out the scenario and tell everyone to make a quick role play all at the same time.

Scenario 1

You are both Health Workers. One complains to the other (the challenger) about a client, saying that the young female client has come for an HIV test, and she looks much too young to be having sex. The colleague says she must be very promiscuous and immoral. However, the other health worker challenges the stigma by responding to the colleague using assertiveness skills. Play!

Activity steps — Challenge the Stigma, Be the Change!

4. Debrief

Stand in a big circle and ask one of the pairs to show their role-play. Then watch another pair. After each role-play ask, “How did the challenger do? What approach did the challenger use? Did it work? What other approaches might be used?”

After each performance, ask other participants if they have a better or different way of challenging the ‘stigmatizer’ and let their pair show their play. After each new attempt ask, “What made a difference?” (Answers might include, e.g., good arguments, strong voice level, body language, confidence, etc.)

5. Paired role-playing (different scenarios)

Ask participants to stay with the same partners and do another role-play using the additional scenarios below. For each new scenario, partners should take turns playing the ‘stigmatizer’ and ‘challenger’ roles.

Note: Facilitators can decide how many rounds to play based on the time available (leaving 15 minutes for debriefing, processing, and summarizing). They can also make up their own scenarios.

After each scenario, come together in a circle and debrief, as in step 4.

6. Processing

Ask, “What have we learned about the best ways to challenge stigma?”

7. Summarize

- We can all challenge stigma on an individual level using an assertive approach.
- Professional policies and codes of conduct in health facilities should be implemented alongside individual action against stigma and discrimination to protect clients. Senior managers should oversee this process.
- The most powerful responses to people who are stigmatizing are those that make the stigmatizer stop and think rather than feeling defensive. Many of us are not aware that the things we say or do can be stigmatizing.

Additional Scenarios

Scenario 2

Health Worker A (stigmatizer) is talking down to young woman client who has come to the ART clinic for the first time. The young woman is shabbily dressed and obviously from a poor background. She has asked about possible side-effects. Health Worker A starts shouting saying ‘You don’t need to know about that — you wouldn’t understand anyway! Just take the medicine once a day.’

Health Worker B (challenger) decides to talk to him/ her.

Scenario 3

Two young people who arrived at the clinic a long time ago, are still sitting in the same place, waiting to be seen by the nurse. When asked about them, Health Worker A (stigmatizer) says ‘I just told them to wait. They are young and have all the time in the world. Where are they rushing to? They shouldn’t even be doing what they’re doing at their age’

Health Worker B (challenger) decides to challenge her.

Scenario 4

Health worker A (stigmatizer) is talking to the receptionist about a young man who is waiting in the line. She says ‘He looks so dirty; I think he is using drugs. I do NOT want people like him in this clinic.

Health Worker B (challenger) overhears and decides to challenge her.

60 mins

Writing a Code of Practice and Action Plan

Facilitators' notes

This is the final exercise of the training and facilitates participants to develop a code of practice that brings together all the learning and reflections that have been developed on a gradual basis over the training. The Code of Practice should include individual changes participants can make, as well as those that need to happen at the facility level. This exercise starts by asking participants to write down all the forms of stigma and discrimination that might happen in a health facility, based on discussions from the training. Participants are then asked to imagine what the most welcoming health facility that is open to all clients and provides friendly excellent services for all people, would look like. They then reflect on whether any of these things are already happening in their own facility and what might need to change. Once they have identified what is happening, this will help them develop the actual Code of Practice and Action Plan.

Remember to refer to the flipchart 'Code of Practice and Action Plan' that may have points written up from the previous exercises. Facilitators should ensure that the code of practice and action plan make specific mention of providing stigma-free services to clients from your special focus population who may be seeking HIV and other health services.

Our objectives

By the end of this session participants will have:

- Described what a stigma-free health facility would look like in general for all clients, and for those from the special focus populations (Code of Practice).
- Identified actions that can be taken by Health Workers and managers to create a stigma-free facility (action plan).

Materials

- Flipchart from earlier sessions with ideas for the Code of Practice and Action Plan.
- Cards for participants.
- Flipchart for each group.
- Tape.
- Markers/ crayons/ glue/ glitter/ stickers (any creative materials that can be used to make the picture of the stigma-free facility).

Activity steps — Writing a Code of Practice and Action Plan

1. Introduce the first part of the exercise

"This exercise helps us to think about the things that are working well and the things that need to change to tackle stigma in our health facility."

2. Card storm

Existing forms of stigma and discrimination in health facilities: Divide into pairs and give each pair a marker and several cards. Ask them to write one point per card.

"What are some of the key forms of stigma that we have identified during the training that happen in our health facilities?"

" Include the stigma we have identified specifically towards our Special Focus Populations (name them) young people, MSM, people who use drugs, Health Workers living with HIV)."

Stick the cards on the wall so that everyone can see them.

3. Work in groups

Ask each pair to join another pair so they are in groups of 4 (or work in department groups). In their groups, ask participants to first discuss,

"What would the most friendly and welcoming health facility in the world look like?"

Give each group a flipchart — ask them to create an image of the facility with pictures and words to capture their ideas. Encourage them to be creative, have fun, and exaggerate ideas.

4. Are we doing any of that?

Stick up the pictures and ask the groups to reflect on what they have identified as key features of a friendly and stigma-free facility.

"Are there things that we, as health workers, or that the health facility as an organization are currently doing to reduce stigma in our health facility?"

Take several contributions. Ask groups to include these in the Code of Practice that they develop in the next step.

5. Review the Action Plan flipchart

The facilitator shares what participants have put up on the "Code of Practice/ Action Plan" flipchart that has been up since the beginning of the training.

6. Group work

Code of practice for a stigma-free health facility. Divide into groups (from the same department or from similar jobs). Give each group a flipchart and ask the groups to write on their flipcharts:

"A Stigma-free health facility is one in which …," and ask groups to make a list of practices to create a stigma-free health facility and to write down anything that needs to be changed to make the facility stigma-free.

7. Report back

Ask the groups to report on an alternating basis — one point per group. As groups report discuss points and agree on any changes or additions.

Sample responses

"A stigma-free health facility is one in which…"

- Clients are treated equally and with respect and dignity, regardless of who they are.
- All clients receive the same high-quality medical care without discrimination, regardless of their HIV status, age, gender, or other characteristics.
- Medical information of clients is treated confidentially.
- Health services are provided free of judgmental attitudes.
- Health workers speak to clients in a respectful and dignified manner.
- Health workers listen to clients with care and empathy, and without judgment.
- Clients can give their informed consent to the services available to them.
- The client's circumstances (e.g. their criminalized existence) are not a barrier to their accessing health care and treatment.
- Clients' complaints about stigma and discrimination are dealt with effectively
- Standard precautions are used with all clients.

8. Action plan (groups)

Ask the same groups to do the following:

- Make a list of three changes you will make to create a stigma-free health facility after the training.
- Make a list of three things you would like managers to do to create a stigma-free health facility.

9. Take Away

Participants take the Action Plans back to their department and facility to discuss with their staff teams.

10. Stigma Champions

Explain to the participants about the Stigma Champion Group which will be formed in the facility as part of the Total Facility Approach. Ask any staff who are interested to carry on stigma-reduction activities to talk to the facilitators after the training.

Modules for Special Focus Populations

Gender and Sexual Diversity (GSD) Stigma

20 mins

Identity Soup

Facilitators' notes

This short exercise serves as an introduction to the gender and sexual diversity (GSD) concepts. It helps participants to think about what constitutes identity and to think about their own identity and the words they use to describe themselves to new people. This helps to show that the gender and sexual diversity concepts apply to us all, not just people who identify with groups that face more stigma. It also helps us to think about all the different things that make up our identity; we are more than just our gender or sexual orientation.

Our objectives

- To introduce participants to the idea that there are many aspect that make up our multiple identities

Preparation

- Draw a big pot of 'identity soup' (see diagram overleaf) full of words that make up identity (nationality, gender, age, status, job, hobbies, tribe, religion, culture, family, education, residence).

1. Introduction

Introduction to 'Identity Soup.' Think of a popular local dish (e.g. in Ghana, goat light soup or palaver sauce; in Zambia perhaps 'village chicken') and ask the participants to tell you some of the ingredients necessary to make this special dish. Some people will have different suggestions, or special ingredients- this is fine. Link the soup metaphor to the topic of identity:

"We are all made up of many different qualities or ingredients. Like this dish that has many variations, but is still somehow the same dish, we are all made up of different parts that make us human, that make up our identity. Some qualities we value more than others. Yet each contributes to who we are, how we think of ourselves, and how we portray and describe ourselves to the world."

Use the diagram of the soup pot to help explain.

2. Buzz

Ask participants to think about the words that are important to them to describe their own identity; For example, if you are introducing yourself to a new group, what would you say about yourself? Ask them to share their thoughts with the person sitting next to them. For example, you might think about your sex, gender, profession, where you come from, your religion, family status, tribe, and so on. You might say 'I am a Ghanaian woman, a mother, a senior health worker and a Christian.' Someone else might say 'I am a Ghanaian man, a brother, a student and an Arsenal supporter.' There are no wrong answers!

3. Discussion

Ask:

How was it to think about your identity?

Does anyone want to share their words/ description with the group?

4. Summary

- Everyone has many characteristics that make up who they are.
- Some may be visible to others; some may be hidden. Some feel more important than others.
- But think about what it would be like for someone to define you by only one or two of those ingredients.
- The next session focuses on just two areas of identity: gender and sexuality. But people are made up of much more. Please remember this as we discuss the gender and sexual diversity (GSD) concepts.

45 mins

Gender and Sexual Diversity

Facilitators' notes

This session follows 'Identity Soup.' The aim of this exercise is to update participants with current information and thinking, about gender and sexual diversity. Some participants may find some of the information challenging, especially if they are hearing it for the very first time. Be sure to allow enough time for questions and discussion but try to avoid arguments!

The session might feel a bit didactic in style because of the need to share information. However, each concept is followed by some simple quiz questions, with the aim of building understanding and keeping participants engaged.

Allow participants to work in pairs to answer the questions so that it does not feel like a test. And if you can arrange a small prize for the quiz winners, it may provide more motivation.

Take time to read through the section in the facilitation tips about handling difficult questions.

Much of this material originated from: Killermann, Sam, "The Genderbread Person" (2016). ESED 5234 - Master List. 52. itspronouncedmetrosexual.com

Our objectives

By the end of this session participants will:

- Be familiar with the current information on gender and sexual diversity.
- Have discussed terminologies which are globally accepted.

Materials

- Flipcharts
- Index cards with definitions
- Handout: Concepts
- Small prize for quiz winners

Preparation

- Draw the outline of the gender person (see below) on a flip chart.
- Write up each terminology and definition on a flipchart.
- Read through the notes and use them during the presentation so that you include all the points to explain the concepts.
- Arrange chairs so that participants are sitting next to a partner they can talk to

1. Introduce the gender person

It illustrates four dimensions in humans, about gender and sexuality: biological sex, gender expression, gender identity, and sexual orientation. Emphasise that this session is about all of us not just MSM or those in minority groups.

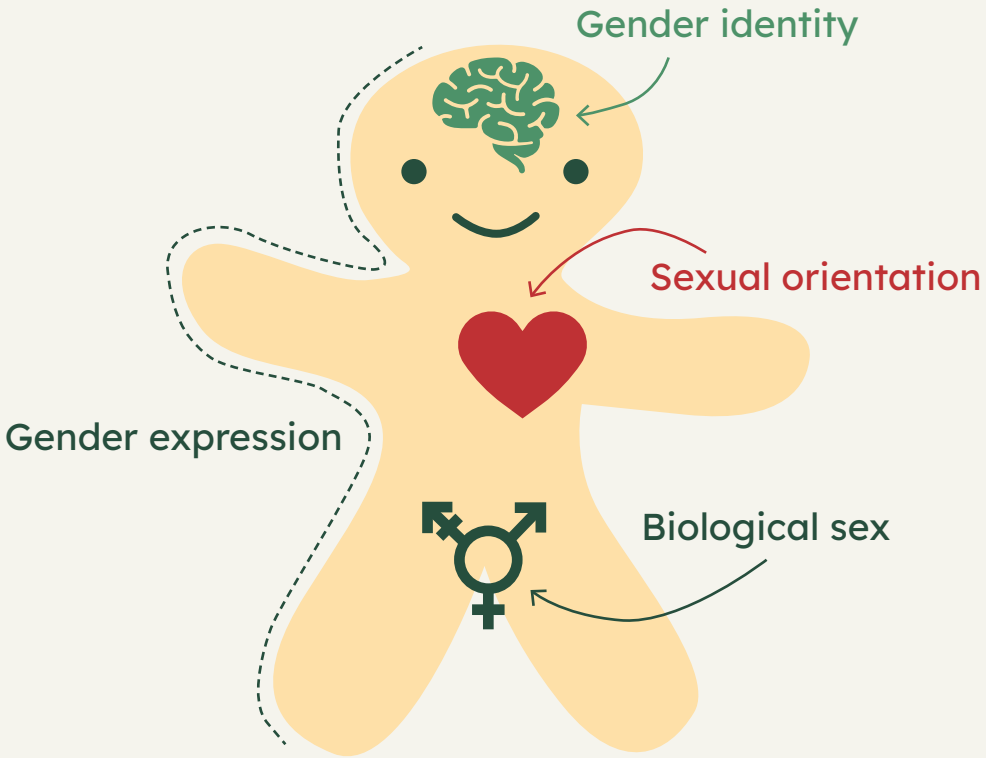
2. Explanation

Explain that you are going to discuss each concept so that everyone understands. After each explanation there will be 3 or 4 quiz questions. Participants can confer with their buzz partner to answer the questions. There may be a small prize for the pairs who get the most correct answers.

3. Concepts

Now present each concept, reading the notes and allowing time for a few questions about each one.

Follow each concept with the quiz questions



Biological Sex

Definition

A medical term used to refer to the chromosomal, hormonal, and anatomical characteristics that are used to classify an individual as female, male or intersex.

- Typically, when a mother delivers a baby, the baby is assigned a sex based solely on the baby's visible genitalia (e.g., a midwife will say 'It's a girl/boy!')
- However, biological sex is much more complicated than just someone's genitalia. Biological sex includes a person's chromosomal, hormonal, and anatomical characteristics.
- Many of us know that typical male sex characteristics include testes, a penis, more testosterone than estrogen, and XY chromosomes ; female characteristics include a vulva, vagina, ovaries, a uterus, more estrogen than testosterone, and XX chromosomes.
- Variations in these characteristics are quite common. Rarely are two females or two males biologically the same. For example, someone may have most but not all of these characteristics. In puberty, it may become apparent that a boy may have larger than usual breasts or a girl may have narrow hips.

Intersex

Definition

A person with more significant variations in their biological sex is typically called 'intersex." Intersex is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male.

- For instance, in approximately one in 2,000 births, the genitalia are not clearly male or female. Other times, there may not be any visual indication that someone is intersex.
- In fact, for many people, the indications that they might be intersex don't appear until they get older (often after going through puberty).
- This is more common than you may think. In approximately 1 in 100 births, there is some deviation in any of the many sex characteristics that were mentioned.

It is easiest to understand biological sex as a continuum, with male and female on either end. [The four concepts are presented as continuums to represent the diversity that exists]

Takeaway messages

- Everyone has a biological sex and biological sex exists along a continuum.
- Biological human diversity is more complicated than most people think!

Quiz Questions

- What 3 characteristics are used to clarify our biological sex?
- What is the first thing a midwife might say when a baby is born?
- What is the term used if we have significant variations in our biological sex
- Approximately how many babies are born with genitalia that are not clearly male or female?

Gender Expression

Definition

The external display of one's gender, through a combination of appearance, disposition, social behavior, and other factors, generally measured on a scale of masculinity and femininity.

- Gender expression is about how you present and express yourself to the world; it often is the most immediate way that someone learns about your gender.
- Clothing, mannerisms, gait (how we stand/ walk), pitch of voice, language choices, pronunciation of language, posture, grooming, social interactions, and much more make up what we consider to be a person's gender expression.
- Gender expression is strongly influenced by gender norms.

Gender Norms

Definition

Gender norms are ideas about how women and men should be and act.

They are culturally defined roles (economic, social, and political), and responsibilities, associated with being female and male, and link to the power relations between and among women and men, boys and girls.

- Gender norms change from culture to culture. For example, an occupation that is commonly seen as 'normal' for women in one country may, in a different country, be commonly seen as inappropriate for women.
- Sometimes shifts in gender norms change over large periods of time. Other times, shifts occur over just a few years or months (e.g. fashion trends).
- **Gender non-conforming** is a term given to people who don't conform to the gender norms that are expected of them. It may refer to behavior, dress or roles
- A person's gender expressions can shift, whether it is because of changing gender norms or just personal discovery or safety.

Takeaway messages

- Everyone has one or more gender expressions, and, for most people, they are influenced by gender norms.
- Gender expression exists along a continuum and, for many people, changes over time—even within a day—and in different settings.
- It is (also) easiest to understand gender expression as a continuum, this time with feminine and masculine on either end. Gender norms often shape gender expressions. Gender norms pressure people of all genders to behave in certain ways.

Quiz Questions

- What are some of the ways in which we express our gender?
- How are our own gender expressions shaped by society?
- Give an example of a gender norm in your society for a man, and for a woman
- What does gender non-conforming mean?
- Give two explanations for why we may change our gender expression at different times.

Concepts

Gender Identity

Definition

A person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth.

- Gender identity is how a person understands their own gender. Deeply felt, it can remain private. Formation of identity is influenced by hormones, environment, biological sex, culture, class, and other personal circumstances.
- Our scientific understanding of gender identity suggests that children can form a gender identity by the age of three.
- Being born biologically one way, but then identifying another way is called transgender

Transgender

Definition

An umbrella term referring to an individual whose gender identity is different from their sex assigned at birth (e.g., someone who is biologically male but who identifies as a woman).

Being transgender may mean that you face a lot of stigma or even violence in places with rigid gender norms or hostility towards gender non-conformity.

Takeaway messages

- Gender identity is one's internal or inside experience of gender; how one wishes to define their own gender. Sometimes it is the same as that person's biological sex, sometimes not.
- Like the other dimensions we've looked at, gender identity exists along a continuum with woman at one end and man at the other.

Quiz Questions

- What are some of the things that help to form our gender identity?
- What is one of the key differences between our gender expression and our gender identity? (External/ internal)
- What term do we use when someone's biological sex differs from their gender identity?
- Why might a transgender person face stigma or violence?

Sexual Orientation

Definition

An enduring emotional, romantic, or sexual attraction primarily or exclusively to people of a particular gender.

- **Heterosexuality:** An enduring emotional, romantic, or sexual attraction primarily or exclusively to people of a different gender. People who are heterosexual often identify as ‘straight.’
- **Homosexuality:** An enduring emotional, romantic, or sexual attraction primarily or exclusively to people of the same gender. People who are homosexual often identify as ‘gay’ or ‘lesbian.’
- **Bisexual:** An enduring emotional, romantic, or sexual attraction to people of all genders.
- **Asexual:** An enduring absence of sexual attraction.

Quiz Questions

- What term do we use if we are attracted to someone of a different gender?
- What term is used if we do not feel any sexual attraction?
- Which terms lie at each end of the sexual orientation continuum?

Gender and Sexuality Concepts (1)

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Definition

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Gender and Sexuality Concepts (2)

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Gender and Sexuality Concepts (3)

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Gender and Sexuality Concepts (4)

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- **Asexual:** An enduring absence of sexual attraction.

30 mins

Gender and Sexual Diversity Terminologies

Facilitators' notes

This session follows the GSD concepts exercise. The focus is on terminology related to gender and sexual diversity, including homophobia and misogyny, which can provide health workers with greater understanding of some of the issues facing gender and sexual minorities, as well as tools to discuss different situations.

It is important to treat the exercise as a chance to learn together, rather than a test of who knows the most!

A note about misogyny: The reason we have included misogyny in the terminologies is because it can help us to understand the roots of homophobia. Misogyny is about a system or society that is based on not valuing women, or believing that men are superior and anything female-related is inferior. For this reason, men who are seen to be feminine, are mocked and discriminated against and this is part of homophobia.

Misogyny is not about individual men not 'liking' women and it is not linked to men being MSM.

Our objectives

- To discuss terminologies linked to gender and sexual diversity which are globally accepted.
- To discuss which terminologies are most important and useful for health workers.

Materials

- Index cards

Preparation

- Prepare index cards with definitions and index cards with terminologies.

Activity steps — Gender and Sexual Diversity Terminologies

1. Introduce the Exercise

"This exercise focusses on terminologies that are linked to gender and sexuality. We can help each other to become more familiar with some of the terms, in order to understand different client groups and some of the issues they face."

2. Two teams

Ask participants to stand in two rows opposite each other

3. Give out cards

Give each of the participants on one side of the line a **terminology** card and each person on the other side a **definition** card.

4. Mingle

Ask everyone to mingle and try to match the terminologies with the definitions. Once they have found their partner they should stand on the same side of the room (If there are extra cards you could decide to give extra cards to participants or match them during the large group discussion)

5. Report back

Use the list below to discuss each terminology in order; ask who has the first card (i.e.) and then ask them to read out the definition that they chose.

6. Discuss terminology

Discuss each terminology briefly, checking that participants are clear about the relevance of the term. Ask: Why it is important be aware of this term as health workers?

7. Final questions

Ask if there are any final questions before you wrap up.

Reminder: Code of Practice/Action Plan

Take a few minutes to ask the group what we can change as individuals based on what we have learned and what we need to work on collectively with management.

Write these points on the Code of Practice flipchart.

Terminologies

Heterosexual

Definition

Being attracted to people of a different gender. Sometimes described as ‘straight.’

MSM

Definition

Men who have sex with men. This term is useful because it includes both men who only sleep with other men, and men who identify as heterosexual and sleep with women, but also have sex with men.

LGBT

Definition

Lesbian, gay, bisexual, transgender. This acronym is commonly used to refer to gender and sexual minority communities. Variations exist that add, omit or reorder letters (e.g., LGBTQ, LGBTQI). The I stand for intersex and the Q stands for Queer.

Homophobia/ Transphobia

Definition

The fear, rejection, or aversion, often in the form of stigmatizing attitudes or discriminatory behavior, towards gay, bisexual and other men who have sex with men, or transgender people.

Heteronormativity

Definition

The presumption that everyone is heterosexual or the belief that heterosexual people are naturally superior to gender and sexual minorities.

Closeted

Definition

The state of secrecy or cautious privacy regarding one’s sexual orientation or gender identity (also referred to as being “in the closet”).

Outing

Definition

Telling people (e.g., through gossip) that someone else is LGBT or a gender or sexual minority without that person’s permission, no matter the intention.

Ally

Definition

A person who openly supports the equal treatment, including in health facilities, of gender and sexual diverse populations

Coming out

Definition

The personal process of accepting and disclosing to others that one is lesbian, gay, bisexual, or transgender.

Misogyny

Definition

The hatred of women, girls, and femininity in society. This manifests in many ways, including violence against women and violence against feminine men.

30 mins

Perceptions about the Mental Health of Some Populations that Face More Stigma

Facilitators' notes

This session provides an opportunity to challenge some of the myths around sexuality and mental disorders. Until quite recently it was believed that people who did not conform to gender or sexual norms must have a mental health problem. Those who were trained a long time ago, may have been taught that same-sex relationships are a result of psychiatric problems and that clients may need referral into mental health or counselling services, to change their sexual orientation. Some may think that psychiatrists would need to be called if anyone admitted to being gay or lesbian or bisexual. However not being heterosexual is not a mental disorder or disability. It occurs across every country in the world, and international medical, psychological and health bodies removed 'homosexuality' from the International Classification of Diseases (ICD) diagnostic tool more than 30 year ago.

The exercise starts with a role-play to introduce the topic. Followed by a short PowerPoint presentation (which was assembled by Ghanaian trainers) followed by a discussion.

Our objectives

- To learn about research and beliefs around sexuality and mental illness.
- To discuss some of the myths we may have learnt or been taught as health workers about sexuality and mental disorders.

Preparation

- Brief 2 or 3 participants to play the role play along with the facilitators — ensure they understand the message of the role-play.
- Read through the Fact Sheet handout before the session.
- Check that the projector is ready to start (or write slides onto flipcharts).

1. Introduce the Exercise

"The aim of this exercise is to make us think about some of the beliefs we may have heard of about sexuality and mental health. Research has changed beliefs over time, and it is important that we understand the latest thinking on this subject."

2. Role-play

Set up a role-play involving 5 participants: a doctor, nurse, a client, 2 people in the waiting room.

- The client has come to the clinic to get treated for an STI.
- The doctor has already examined him and asks him several questions about his wife and any other relationships he has. When the client discloses that he is not married and has a boyfriend, the doctor is shocked and feels s/he must refer him for psychological help.
- Doctor tells the client that he can get help with his problem and that things will be fine in the end.
- Doctor calls the nurse to make the referral. The nurse agrees to refer the client to the counselling service where he can see a psychiatrist.
- The client quickly leaves the clinic, with people in the waiting area watching as he flees.

3. Processing

Ask the group

- What happened in the role-play?
- Why do you think the doctor acted like that?
- How do you think the client felt?
- Do you think anything like this could happen in real life?

4. PowerPoint Presentation

Present the slides and keep the presentation interactive- ask questions as you show the slides or check if the group has any questions.

5. Discussion Questions

- What have we learnt about sexuality and mental health?
- What is the link between stigma and mental illness?

6. Summary Points

- Someone who has same-sex relationships does not have a mental disorder. The WHO removed homosexuality as a 'classified disease' over 30 years ago.
- Same sex relationships occur in every culture, across every country and continent
- Any mental health issues that we might find among the LGBT community are not due to their sexual orientation. If there are mental health issues, they could be partly the impact of stigma and discrimination, isolation, or violence that they have faced in their family or community.
- Research has shown that when people (all of us) experience love and acceptance from family, friends and society, their mental well-being is much stronger.

Reminder: Code of Practice/Action Plan

Take a few minutes to ask the group what we can change as individuals based on what we have learned and what we need to work on collectively with management.

Write these points on the Code of Practice flipchart

Key populations and Mental Health

Ghana
2021

7/18/24 1

What is mental health?

- Mental health is “a state of well-being in which an individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully and is able to make contributions to his or her community (WHO, 2004)

2

Mental health influences the wellbeing of an individual

Physical | **Social** | **Emotional**

3

What is mental illness?

- It is a health condition that involves changes in emotions, thinking and behavior.
- It is associated with distress and/or problems functioning in social, work of family activities

4

Why was being an MSM classified as a mental disorder?

- Homosexuality: **sexual interest in and attraction to members of one's own sex**
- Being an MSM *used* to be seen as a sign of a mental disorder
- In 1973, the American Psychology Association (APA) removed homosexuality from their list of mental disorders.
- The diagnosis of homosexuality as a disorder was removed in 1990 by the WHO, with the ICD-10 stating that "sexual orientation by itself is not to be considered a disorder." (Ghana follows the ICD-10)

5

The way forward !!

- According to WHO, being an MSM implies no impairment in judgement, reliability or general and social and vocational capabilities
- Health professionals can take a lead in reducing stigma associated with sexual orientation and gender non-conformity, in order to ensure equal access to health services for all clients

6

Key Reference

World Health Organization. (2004). *Promoting mental health: concepts, emerging evidence, practice (Summary Report)* Geneva.

Thank you

7

Key Populations and Mental Health

Key Populations and Mental Health

“Mental health: A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”

(WHO, 2007)

The World Health Organization does not classify same-sex attraction as a mental disorder

- The International Classification of Diseases (ICD) is a diagnostic tool published by the World Health Organization used to identify and classify diseases. It is the most widely used classification system, determines how disease incidence is calculated and informs major healthcare decision making globally.
- The ICD is updated approximately once a decade or when there are significant changes in scientific/ clinical consensus around diagnosing disease. The diagnosis of homosexuality was removed in 1990 in the ICD-10 stating that “sexual orientation by itself is not to be considered a disorder.”
- Furthermore, in 2017 WHO gathered a group of experts to assess the appropriateness of the entire category of psychological and behavioural disorders associated with sexual development and orientation. They found that the entire category “neither contribute to health service delivery or treatment selection nor provide essential information for public health surveillance” and plan for it to be removed altogether in the upcoming update to the ICD

The mental health issues that we might find among sexual minorities are mostly linked to stigma and discrimination

- Though we do find higher rates of suicide, depression and other mental health issues among sexual minorities, this is understood to be due in large part to stigmatization, discrimination, rejection by parents, bullying, harassment, etc. and is not due to their orientation.
- Studies have found, for example, significant reductions in suicide attempts among lesbian, gay and bisexual youth in countries where same-sex marriage is legalised.
- Experiencing same-sex attraction or being gender non-conforming are not the direct cause of mental and emotional distress, it is the way in which such identities and behaviours are treated by the society.

Handout – Key Populations and Mental Health

There is agreement among psychiatric professionals that same-sex attractions are part of the normal range of variations in human sexuality and are not an indication of mental illness.

There is a substantial amount of clinical literature demonstrating that same-sex attractions, feelings, and behaviours are normal variations of human sexuality, which is in line with the third category of theories. There is a large body of scientific evidence that indicates that being gay, lesbian, or bisexual is compatible with normal mental health and social adjustment.

Some of the highlights of such scientific evidence include the following:

1. Same-sex attraction is not a result of abnormal psychology.

- Psychologist Evelyn Hooker's (1951) research put the idea of homosexuality as mental disorder to a scientific test and showed that it is not associated with psychopathology. She led sample of homosexual men who were not seeking clinical care for their sexuality and compared them with a matched sample of heterosexual men through a series of psychoanalytic tests and had other psychologists interpret their results without knowing whose . The results between the two groups were similar, showing that homosexuality was not associated with abnormal psychology.
- Psychologist John Gonsiorek in 1982 published a meta-analysis of studies that compared homosexual and heterosexual populations' scores on psychological tests. This study found that most people in both had 'normal' results and that homosexuality is "unrelated to psychological disturbance."

2. Homosexual behaviour is more common than we might think.

- A series of studies by Alfred Kinsey found that 10% of the males in his sample and 2-6% of the females had been more or less exclusively homosexual in their behaviour for at least three years between the ages of 16 and 55. While this is not the same thing as identifying with same-sex attraction for one's entire lifetime, it does demonstrate that same-sex attraction is significantly more common than was previously assumed.

Modules for Special Focus Populations

TB Stigma

45 mins

Challenging TB Stigma in Health Facilities

Facilitators' notes

This exercise focuses on the stigma faced by people with TB, particularly in health facilities. Although there is research on and knowledge about TB and effective treatment in most cases, there is still fear amongst health workers about the risks of contracting TB if they work closely with people with TB, and this can result in stigma and discrimination. TB is also closely associated with HIV in sub-Saharan Africa and thus HIV-related stigma and discrimination can be projected onto people with TB.

TB is also associated with poverty in many communities and the stigma and discrimination faced by people living in poverty is reflected in stigma towards people with TB. Other causes of TB stigma include physical frailty and associations between TB and smoking and lifestyle choices, and sexual behaviour.

This exercise helps to explore some of the causes of TB stigma and uses a quiz to refresh health workers knowledge about TB.

Our objectives

By the end of the session, participants will have:

- Shared experiences and analyzed how TB stigma takes place in a health setting
- Discussed how TB stigma affects the quality of care provided
- Revisited facts about prevention, transmission and treatment of TB, to help to dispel the fears which can lead to stigma

Preparation

- Scenario for Stop-Start Drama
- Choose Group Splitter for quiz
- Copy of quiz questions; read through and select the questions you want to use

1. Introduce the Session

'We want to explore the stigma faced by people with TB, particularly the stigma they may face in a health facility"

2. Stop-start drama

Organize the drama. Ask for 3 volunteers: doctor, nurse and patient. Explain the Stop-Start technique: we ask the actors to show us what is happening in the scenario and then the facilitator will shout STOP! And all the actors freezes. Then we get some ideas about how to change the situation from the audience. We might ask someone to come into the drama or take the place of one of the actors to try out a solution. Then we will play again and see what happens.

Stop-start scenario

There is a very sick patient on the ward who is alone, and from a poor family. The doctor is doing his/her rounds but does not want to go into the ward. S/he glances through the door and writes a prescription without seeing the patient. The nurse is worried because the patient is not recovering, and she expresses her concerns to the doctor...

3. Processing

Ask the group

- What did you see happening in the play?
- How can we help to reduce fears around transmission of TB in our health facility?
- How do we ensure that patients continue to access quality service provision when they are very sick?

Facilitate a discussion with the questions and record answers and ideas on a flipchart.

4. Quiz

Divide the group into two or three teams using a creative group splitter. Arrange chairs so that the members of the teams sit together. One suggestion could be to make a U-shape with the chairs and place a team along each side)

Tell the group that you will be taking turns to ask a question to each team (see questions below). The questions have TRUE or FALSE answers, but you must explain why you choose your answer. If they are not sure of the answer they can pass it to another team. There are 2 points for correct answers, and extra points for passed answers. You can make the quiz light and fun and encourage co-operation rather than competition. Stress that it is not a test, just a chance to revisit some key facts together. You do not have to use all the questions- select up to eight. If you have a health worker who specializes in TB, you could ask them to be the 'judge' of the answers and/or provide more detailed knowledge.

If you have anything that could serve as a prize for the winning team, or just a special handclap/praise song, use it to end the quiz.

5. Summary Points

- Although there is effective treatment for TB in most cases, it is still viewed as a disease that carries stigma, often because of the link between HIV and TB, and/or between TB and poverty, and associations with smoking and lifestyle choices, physical frailty and sexual behaviour.
- This stigma towards people with TB is reflected in health facilities and can lead to health workers avoiding working closely with clients who have TB, or spending less time with them during consultations and hospital stays because of the fear of contracting TB. Although this fear is understandable, providing more detailed knowledge about TB as well as discussing infection control measures that are sensitive to client experience can alleviate fears and reduce stigma.
- We can all work together to ensure that all patients receive quality service provision and have access to treatment and care. The more knowledge we have about TB transmission and risks, the more easily we can protect ourselves and community members, and at the same time prevent situations where we might stigmatise or be perceived to be stigmatising.

Quiz questions: True or false?

TB is an infectious, airborne disease that mostly affects the lungs.

True

TB is a disease caused by a germ called mycobacterium tuberculosis. TB can affect the lungs or other parts of the body. When the disease affects the lung, it is called pulmonary TB and when it affects other parts of the body it is called extra-pulmonary TB. This form of TB may cause serious illness, but the disease is not infectious unless the lungs are also involved. Pulmonary TB is more common than extra-pulmonary TB.

TB can attack any part of the body, e.g. lungs, glands, brain, spine, hip, intestines.

True

The most common part of the body to be affected by TB disease is the lungs, but TB can also attack other parts of the body.

Everyone who gets TB infection will become sick with TB disease.

False

Not everybody who breathes in TB germs will get TB disease. If people are healthy and strong, they can fight the TB germs. The germ can become inactive, remaining alive in the body without causing any disease but can become active later. TB infection does not cause a person to feel sick, and there are no symptoms. TB disease develops when the immune system cannot keep the TB germ under control and the germs begin to multiply rapidly.

You can get TB the first time someone who is infectious with TB coughs in your face.

False

TB is not usually spread by brief contact. There needs to be prolonged contact for there to be any transmission.

Quiz questions: True or false?

You can still transmit TB to other people when you are on TB treatment.

False

There is a possibility of transmission of TB when one is on treatment, but the risk is reduced two to three weeks after starting treatment or when the treatment is likely to have significantly reduced the risk of a person with TB transmitting TB to others.

There are two types of TB — old TB and new (HIV-linked) TB.

False

There is no old or new TB. It is true that people living with HIV are at increased risk of TB because of a weakened immune system. Some people living with HIV find out they have HIV when they are diagnosed with TB; this means they have two infections that weaken their immune system. However, when people living with HIV are on ARVs, their risk of getting TB is significantly reduced once their immune system strengthens and is functioning well. People living with HIV can also take TB preventive therapy to reduce their risk of contracting TB.

Ventilation and sunlight are important methods for preventing TB.

True

Ventilation reduces the risk of getting TB by 90%. Windows

on both sides of a room (air comes in one side and out the other) allows for the TB droplets to be blown out of the space and into the air, where sunlight destroys them. TB germs do not easily survive in sunlight. If someone coughs droplets and these droplets are exposed to sunlight, within minutes the germ will die.

If a room is dark and unventilated, TB germs can stay trapped for up to three days.

It is important to get tested if you have a prolonged cough or cough up blood.

True

Taking a test helps you know if you have TB so you can start treatment promptly.

Quiz questions: True or false?

It is safe to take TB treatment during pregnancy.

True

A pregnant woman can be on TB treatment.

TB is the most common opportunistic infection

True

TB is the most common opportunistic infection. Statistics show that TB is the major cause of death in people living with HIV. This is partly because when people are diagnosed with TB, this is sometimes when they find out they also are living with HIV. They therefore are having to fight two infections at the same time and adjust to two treatment regimens. However, most people living with TB and HIV recover once on treatments.

A person living with HIV cannot be cured of TB.

False

TB can be cured, even in people living with HIV. The main thing is to continue the treatment on a regular and consistent basis.

"In one of the facilities in Ghana, we did an exercise to identify where in the facility stigma happens and the TB ward was identified. They talked about how only junior staff were ever assigned to the TB ward, or that being assigned to the TB ward was considered a 'punishment.' After the stigma-reduction intervention, as part of their action plan, they changed that and all staff, including senior doctors, had to do a turn in the TB ward.

Stigma Researcher, TFA Ghana

Factsheet about TB

What is TB?

TB is a disease caused by a germ called mycobacterium tuberculosis. TB can affect the lungs or other parts of the body. When the disease affects the lungs, it is called pulmonary TB and when it affects other parts of the body it is called extra-pulmonary TB.

Pulmonary TB (TB in the lungs) is more common than extra-pulmonary TB. When TB is extra-pulmonary, it may cause serious illness, but this type of TB is not infectious. In many people, TB lies dormant for many years in the body. In a small number of people, the dormant TB reactivates (“Active TB”) and, when this active TB then affects the lungs, the person becomes infectious to others. It is useful to distinguish between ‘active’ and ‘dormant’ TB. ‘Active’ TB can be sputum-positive or sputum-negative and confined to the lungs or be elsewhere in the body (for example, the bones, the spinal fluid).

How is TB transmitted?

TB germs are spread through the air. People who have active TB carry the TB germs in their lungs or their throat and can spread the TB germs to other people. TB spreads through droplets produced when the infected person coughs or sneezes in the air. If another person inhales these droplets containing the TB germs, they can become infected with TB.

Without treatment, a person who has active TB will infect an average of 10 to 15 people every year. It is easy to pass germs to family members when many people are living closely together. Anyone can get TB. However, not everyone who is infected with TB will become sick. If you are healthy and strong, you can fight the germs and the disease can lie dormant for many years. TB is not easy to catch. Remember: Only one in three people who stay in a home and very close to a person with sputum positive TB will develop TB. Most people have very minimal contact with active TB.

The TB germ dies quickly with sunlight and ventilation — open the windows and let the sun in! If a room is dark and unventilated, TB germs can stay in the room for up to three days thus increasing the risk of infection. After two weeks of TB treatment, most patients diagnosed with active TB are not infectious.

In the first two weeks of treatment, it is recommended to stay home, refrain from work and wear masks inside. The most important thing is to make sure all your family members are screened for active TB, and, if they have no symptoms, understand that a change in health status (for example, developing a cough) means that close relatives should seek screening.

Children under the age of five are at high risk of developing active TB. Many studies have shown that TB preventive therapy in children under 5 greatly reduces the risk of developing active TB and should be offered to all children under 5 in a household where a person has developed active TB. People living with HIV are much more at risk of developing active TB and should be on TB-preventive therapy.

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Myths about TB

TB cannot be transmitted by a woman who has aborted or miscarried.

A woman who has aborted or miscarried needs prompt medical attention and good care (conditions accompanied by bleeding), but she is not able to transmit TB. Whilst some infections are associated with miscarriages, TB is not one of them.

TB cannot be transmitted through sexual intercourse.

Once a person has been on TB treatment for two weeks, he/she/they are most likely to be non-infectious and can continue normal relations, as long as he/she/they feel up to it.

TB cannot be transmitted through sharing utensils with a TB patient

TB is not passed from one person to another through saliva. Saliva that might get onto eating utensils does not contain TB bacteria – saliva is a substance that is made in the mouth, as opposed to sputum that comes from the lungs.

How do you know if you have Pulmonary TB?

Signs and symptoms, which could be suggestive of Pulmonary TB, are:

- A prolonged cough, usually longer than two weeks duration with or without sputum and sometimes blood. New WHO recommendations would be any cough in a high incidence setting warrants screening for TB, but two weeks is the most common cut-off.
- Excessive night sweats and fever
- Loss of appetite and weight
- Loss of energy or easy tiredness and weakness
- Chest pain.

Extra-pulmonary TB

TB may occur anywhere in the body outside of the lungs, for example, in the lymph nodes, bones, kidneys and the central nervous system.

Disseminated (miliary) TB is caused by the spread of bacteria through the bloodstream.

Many people with extra-pulmonary TB also have pulmonary TB. Diagnosis of extra-pulmonary TB is difficult, but the treatment is the same as the treatment of pulmonary TB, and prolonged in TB meningitis.

If you suspect that you have TB, you should go to your nearest clinic for testing.

TB Treatment

TB is treatable and curable. The treatment for TB involves taking tablets every day for six months, although some patients with more complicated disease in the bones, the brain or the heart may need longer courses of treatment. After the first two weeks from beginning of the treatment, you are most likely to be no longer infectious. It is very important that you remember to take your treatment every day, otherwise the TB germs can get stronger, and medicine becomes less effective.

Do TB patients need to be isolated?

No! Two weeks after you have started taking your treatment you are no longer infectious. This means you can eat, sleep and work with others as normal. You do not need special utensils or separate bedding. Just remember to keep taking the treatment regularly.

How to prevent TB from spreading:

- Seek health care early if you suspect you have TB
- Take regular treatment to cure TB
- Cover your mouth and nose when coughing or sneezing
- Open windows and doors to allow fresh air through the home.

TB And HIV

If you are infected with TB, it does not mean you have HIV or AIDS. However, together HIV and TB are a deadly combination, each disease making the other progress faster. HIV makes the immune system weak, so that someone who is HIV positive and infected with TB becomes much more likely to get sick with TB than someone infected with TB who is HIV negative.

TB is the leading cause of death among people who have HIV because most people are diagnosed with both conditions at the same time. This means that people newly diagnosed with HIV will have a very weak immune system and therefore their body will have less strength to fight off TB. However, anti-retroviral therapy (ART) is a powerful drug combination that very quickly helps the immune system recover. This is why it is so important for people with TB to know their HIV status, and why people living with HIV need to look out for symptoms of TB. People who live with HIV can also receive TPT, which treats dormant TB that is already present in the body. This prevents them from developing active TB disease. HIV is the single major reason why there has been such a large increase in cases of TB over the past decade.

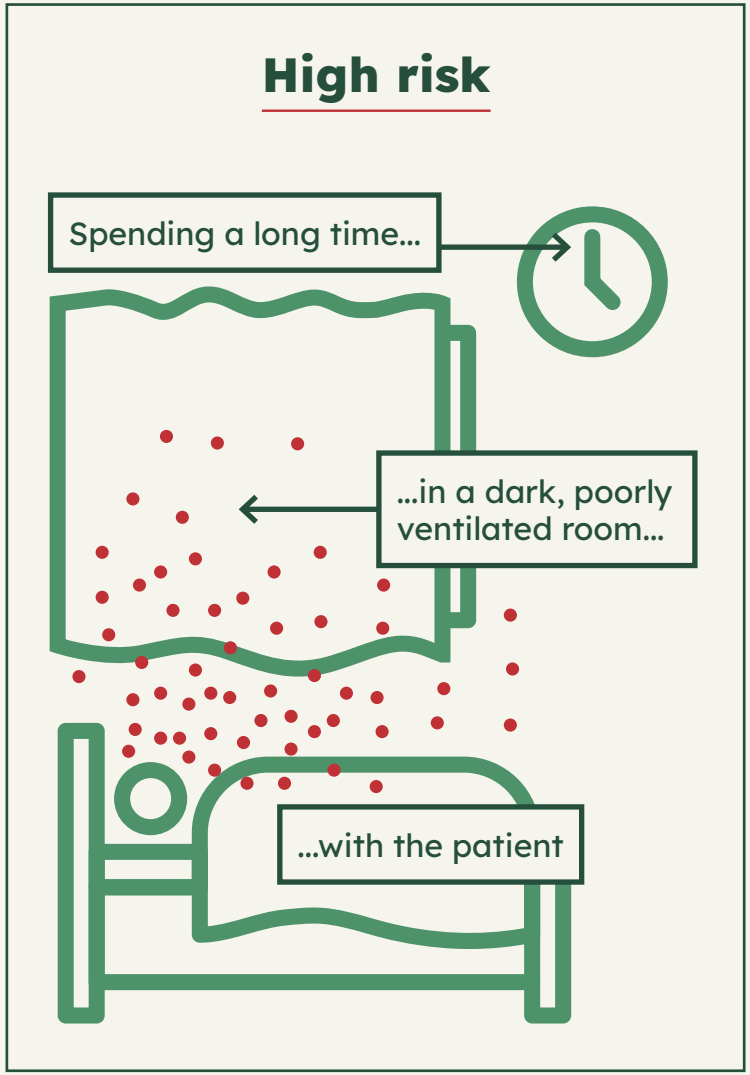
This is a simple tool that you can use to help explain TB transmission

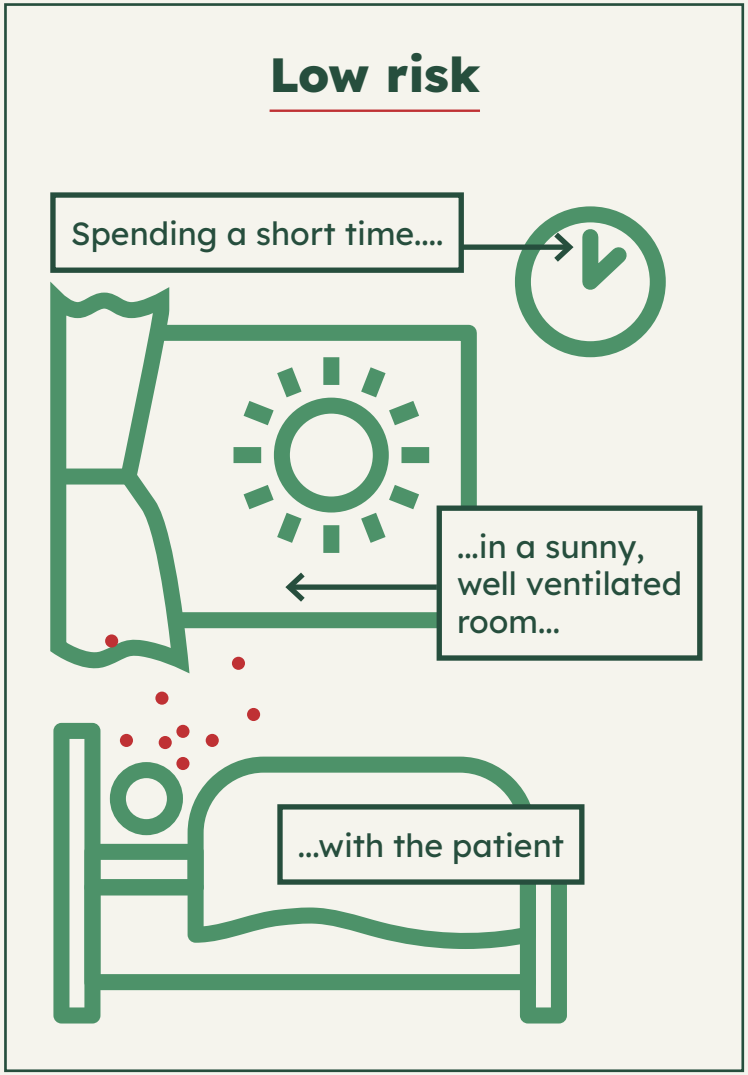
Sketch the diagram to the right on a flipchart to help explain the following points:

TB bacteria are produced through coughing and sneezing. Droplets are then released into the air.

These droplets only survive where there is no ventilation and no sunshine. TB droplets thrive in dark, poorly ventilated places which are not exposed to the sunlight.

Transmission takes place through breathing in the droplets, not through a single, one time contact.





Modules for Special Focus Populations

Stigma towards health workers living with HIV

45 mins

Navigating Stigma: Supporting Health Workers Living with HIV

Facilitators' notes

In countries where HIV has had a high prevalence, the number of health workers in a facility who are living with HIV is likely to be high. Although these staff members work on the front line of health services, many of them do not access HIV testing and treatment services at their own facilities for fear of stigma. Accessing services further away is more complicated and costly and can undermine their management of living with HIV.

The stigma faced by health workers living with HIV is sometimes called 'professional stigma.' This reflects that health workers are judged on the basis of their work, knowledge and the information that they have access to. Hence a common judgment is 'Nurse- even you!,' or 'She should know better.'

The fact that some Health Workers even die before they find out that they are HIV positive, or before they work out how to access ARVs without colleagues finding out, or even because they self-medicate in secret, sometimes without doing any of the required regular blood tests, is both ironic and concerning.

This exercise covers some of the challenges facing health workers living with HIV and explores how they may successfully 'navigate' their way through health services in order to avoid stigma. It also aims to start a conversation about how health workers can support each other in the face of stigma.

Our objectives

By the end of the session, participants will have:

- Identified some of the challenges facing health workers living with HIV that act as barriers to accessing services.
- Have explored possible routes to access services, in order to avoid stigma
- Have discussed ways that colleagues can give each other support and encouragement and avoid stigmatising each other.

Materials

- Flipcharts and markers
- Blank cards
- Copies of scenarios.

Preparation

- Decide on a 'Group Splitter.'
- Write messages of support on cards (overleaf)

Examples of messages to write on cards:

- I've got your back.
- I'm here for you if you need me.
- Hold my hand- we're in this together.
- You are one of us.
- You are not alone.
- We are a family.
- Let me know if you need any support.
- I'm here for you no matter what.
- You are surrounded by love and support.
- I will challenge stigma towards Health Workers when I see or hear it happening.

1. Introduce the Exercise

"This exercise focuses on Health Workers living with HIV and some of the challenges they face in accessing health services."

2. Organise a roleplay

Ask for four volunteers to be in a short role-play. One facilitator can brief them, while the other keeps the rest of the group busy with an energiser or gives instructions about observing the role-play and giving feedback.

Role-play brief

Senior Nurse (living with HIV) travels every month to a rural clinic far away to collect her ARVs. She tells her team she is knocking off early and then walks and walks/ catches transport until she reaches the far clinic.

Two health workers at the clinic who start gossiping once the senior nurse knocks off.

One health worker at the faraway clinic receives the senior nurse and asks her some probing questions as she collects ARVs.

3. Processing

After watching the role-play, ask the group:

- What did you see?
- What are the challenges facing health workers living with HIV?
- How do these challenges link to stigma?

Write answers on flipchart.

4. Navigating stigma Scenarios

Divide participants into four groups and give each group a scenario to discuss, and a flipchart and marker. Ask the groups to draw a map, or a picture showing the journey that the health worker might take in order to navigate any stigma s/he might face. Encourage them to be creative and to work together.

5. Report back

Ask groups to stick up their maps around the room and do a gallery report back. Move around the room together. Each group reads out their scenario and describes the journey on their map.

Ask: What kind of strategies have we seen that we might use to avoid stigma?

How do we support ourselves and colleagues living with HIV to navigate the stigma?

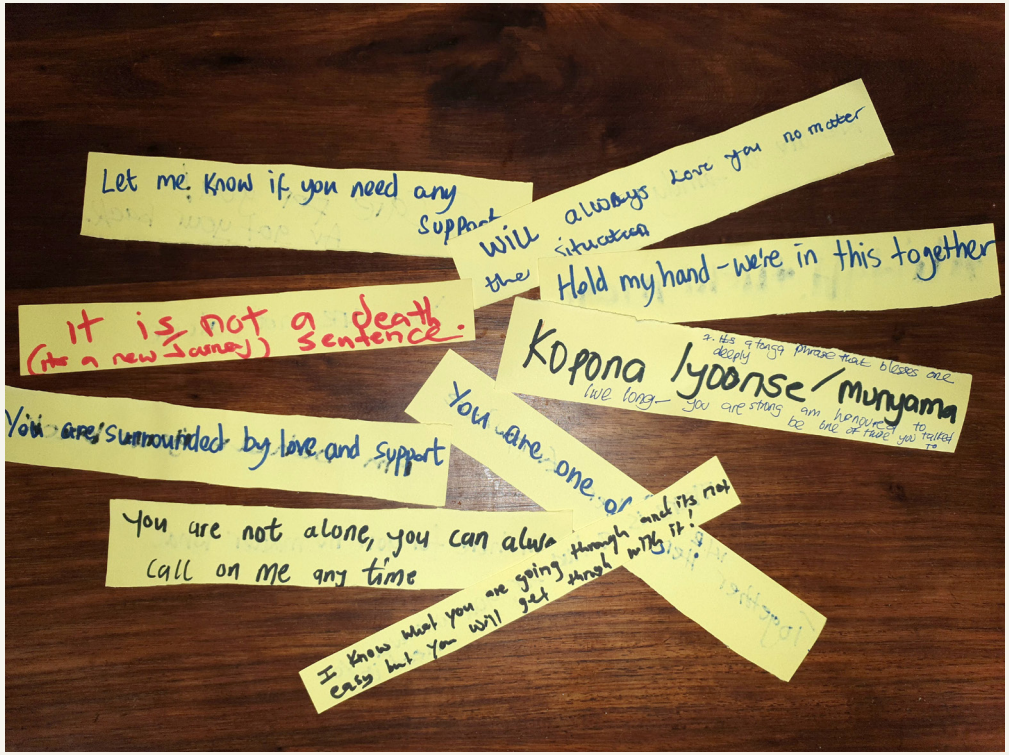
6. Messages of support

Ask everyone to stand and pass around the bag of cards. Participants each take one. Some cards have messages, others are blank. Give markers out and ask the group to write a simple message of support for any colleagues living with HIV. You can ask those with pre-written messages to read out a few as examples. If they want, they can write their own message on the other side of the card.

When everyone is ready, sit or stand in a circle and take turns to read out the messages. You can stick them up or place them on the floor so that everyone can see them.

7. Summary points

- As frontline workers we need to ensure that we all have access to health services and if we have to navigate around stigma, we can support each other to ensure that confidentiality is maintained and that our colleagues receive the care and treatment that they deserve
- If we are living with HIV, we can choose whether we disclose our status to colleagues and who can support us to access health services. Often there are informal structures in place. For example, it could be counsellor who helps nurses to come for services out of hours, or a sister-in-charge who provides practical and emotional support to more junior nurses. These kinds of structures underpin our ability to navigate stigma
- We can all work together with management at the facility to lobby for better working conditions and greater support during times of need. Some organisations employ staff welfare officers who have a responsibility to provide guidance and advice to staff and ensure that their well-being is prioritised.



Messages from Choma Tool Development Workshops

Scenarios

1. You are a student nurse and are doing your practicals at the local clinic. You want to get tested for HIV, because you recently had a broken condom during sex.

What steps might you take?

Who would you talk to?

Where would you go to avoid any stigma?

2. You are a health worker and have recently been transferred to a new facility. You are living with HIV and need to decide how to get your ARVs.

What steps might you take?

Who would you talk to?

Where would you go to avoid any stigma?

3. You are a counsellor at the ARV clinic and have noticed that one of your colleagues has been off sick a lot and you are worried about her. You want to talk to her about HIV.

What steps might you take?

Who would you talk to?

Where would you go to avoid any stigma?

4. You are the Sister-in-Charge and have been taking ARVs for a number of years. You feel ready to be more open at work, about living with HIV, especially because it may help some of the younger nurses who have confided in you.

What steps might you take?

Who would you talk to?

Where would you go to avoid any stigma?

Modules for Special Focus Populations

Stigma and drug use

40 mins

Learning more about Drugs

Source

New Exercise that draws on lecture notes from the Training Manual for Comprehensive Management of Substance Use Disorders, Ministry of Health, Tanzania June 2017.

Facilitators' notes

This exercise is designed for health workers who work in HIV services, who may have clients who use drugs and who may not have much information or knowledge about drug use. It helps participants begin to learn more about the drugs which are available in their communities and the different names given to those drugs (particularly street names for drugs, which may be used by their clients).

This exercise also helps participants understand the different attitudes that people in the community have about drugs and participants will learn that there are drugs that carry negative judgments compared to other drugs that are socially accepted and not usually thought of as drugs. The second part of the exercise focusses on the way in which drugs are classified according to the effect that they have when taken. If the facilitators do not have experience or knowledge of working with people who use drugs, it is recommended that you work with a local agency or NGO who have specialist staff who will be able to answer questions from the participants.

Our objectives

By the end of the session, participants will have:

- Discussed and identified some of the drugs that are available in their city/community.
- Learnt about the different names (street/ slang names) that people who use drugs may use.
- Understood the ways that drugs are classified according to their effect on those who take them.
- Understand that some drugs are socially acceptable while others are not.

Materials

- Flip chart
- Cards
- Masking tape
- Markers
- 3 flipcharts written with one of the titles Depressants/ Stimulants/Hallucinogens.

Preparation

- Arrange chairs in semi-circle facing a wall.
- Decide on your 'Group Splitter

Activity steps – Learning more about Drugs

1. Card storm

Ask participants to work with the person next to them. Hand out cards and a marker to each pair.

Tell participants to think of all the names of drugs they know or have heard about and write the name per card.

2. Clustering

Stick up the cards on the wall and then ask for two volunteers to cluster the cards that are similar. Check if anyone wants to clarify anything. Sometimes you might want to ask: Why is the drug called this? (Perhaps it is linked to the effect the drug has or how it is used.)

3. Other drugs

Add any drugs that have not been mentioned, especially those that are not typically thought of as drugs (coca cola, coffee, cigarettes, alcohol).

4. Classifying drugs

Divide participants into 3 groups and give each group one of the flipcharts. Ask them to identify which drugs fit into their category, they should remove the cards from the wall and stick them on their flipchart.

5. Checking

Stick up the three flipcharts and ask the group to check that all the drugs are in the right category. Facilitators can help if participants are not sure.

Depressants	Stimulants	Hallucinogens
Alcohol	**Amphetamines**	LSD, DMT
Benzodiazepines	**Methamphetamine**	Mescaline
Opioids	**Cocaine**	PCP
Solvents	**Nicotine**	**Ketamine**
Barbiturates	**Khat**	**Cannabis** (high doses)
Cannabis (low doses)	**Caffeine**	Magic mushrooms
	MDMA	MDMA

Adapted from the Training Manual for Comprehensive Management of Substance Use Disorders, Ministry of Health, Tanzania. June 2017.

6. Facts about drugs

A facilitator should present the flipchart classification of drugs and explain the different categories.

Depressants

Depressant substances reduce arousal and stimulation. They affect the central nervous system, slowing down the messages between the brain and body. They can affect concentration and coordination and slow down a person's ability to respond to unexpected situations

Stimulants

Stimulants are a class of drugs that speed up messages travelling between brain and body. They can make a person feel more awake, alert, confident or energetic

Hallucinogens

Cause distortion of a person's thoughts feelings and perceptions. Hallucinogens can cause a person to experience intense emotions and sensations. Hallucinogenic drugs can also cause a person to see or hear things that do not exist.

Distribute the fact sheet about drugs and ask participants to read through it in their own time and note any questions they may have.

7. Summary

- Street names of drugs vary depending on the location, and type of people taking the drugs.
- Medicinal drugs are made to cure or prevent diseases (e.g. Aspirin, ARVs, Valium) but do get used/ abused by people who use drugs.
- Some illegal drugs such as marijuana can reduce pain, change our mood and clear our minds.
- Drugs are classified according to their effects. This can help us to understand how they affect people and which treatments can be used to help people if they want to stop using the drug.
- There are socially acceptable and unacceptable drugs.
- Both socially acceptable and unacceptable drugs can be addictive e.g. someone can feel as dependent on coffee or caffeine (e.g. in coffee, tea) or nicotine (tobacco) as another person feels about khat.
- In recent years there has been a rise in the illicit use of synthetic opioids (painkillers).

Basic facts about drugs

What are drugs?

Drugs can be:

- illegal substances such as heroin, cocaine and cannabis
- misused household products, like gases, glues and aerosols
- medicinal drugs
- alcohol and tobacco
- performance enhancing

Drug misuse can be dangerous for three main reasons:

- you could become addicted to the drug
- the drug could cause you physical and psychological harm
- drug abuse can have a negative effect on your quality of life and relationships

Not all drug use leads to dependence. And not everyone who uses drugs or alcohol wants (or needs) help.

Depressants	Stimulants	Hallucinogens
Slow down the nervous system	Speed up the nervous system	Alter a person's perception of reality
Alcohol	Amphetamines	LSD, DMT
Benzodiazepines	Methamphetamine	Mescaline
Opioids	Cocaine	PCP
Solvents	Nicotine	Ketamine
Barbiturates	Khat	Cannabis (high doses)
Cannabis (low doses)	Caffeine	Magic mushrooms
	MDMA	MDMA

Adapted from the Training Manual for Comprehensive Management of Substance Use Disorders, Ministry of Health, Tanzania. June 2017.

Some common drugs

Marijuana

Other names

Cannabis, Chamba, Weed, Hash, Skunk

How is it used?

Smoked, eaten or vaporised

Short term effects

Feelings of relaxation and euphoria, Spontaneous laughter and excitement, Increased sociability, Increased appetite Memory impairment, Slower reflexes, Bloodshot eyes, Increased heart rate, Anxiety and paranoia

Long term effects

Cannabis use may worsen the course of bipolar disorder, and those who are predisposed to experiencing psychosis (a common symptom of schizophrenia), may be at an increased risk of cannabis-induced psychosis.

Psychosis symptoms include delusions, hallucinations and seeing or hearing things that do not exist or are distorted.

Heroin

Other names

Brown, Powder, White, Ngada, Teli

How is it used?

Smoking, sniffing, injecting (When injecting drugs, there is an increased risk of tetanus, infection, vein damage. If sharing needles, there is an increased risk of: hepatitis B, hepatitis C, HIV)

Short term effects

Feelings of detachment, Slurred and slow speech, Slow breathing and heartbeat, Dry mouth, Reduced appetite and vomiting, Decreased sex drive

Long term effects

No sex drive, erectile dysfunction and infertility in men, Constipation, Dental issues, Damaged heart, lungs, liver and brain, Vein damage and skin, heart and lung infections from injecting, Needing to use more to get the same effect, Dependence on heroin, Financial, work or social problems

Cocaine

Other names

Coke, Crack, Snow

How is it used?

Snorted, injected, rubbed into gums

Short term effects

Happiness and confidence, Talking more, Feeling energetic and alert, Anxiety, Paranoia, Irritability and agitation, Headaches, Dizziness, Higher blood pressure and faster heartbeat and breathing, Higher body temperature, Increased sex drive, Insomnia, Unpredictable, violent or aggressive behavior, Indifference to pain

Long term effects

Dependence, Lung conditions such as bronchitis, Anxiety, paranoia and psychosis, Sexual dysfunction, Kidney failure, Stroke, Seizures, Hypertension and irregular heartbeat, Heart disease and death

Khat

A stimulant, traditionally used for medicinal purposes, or at cultural events

Other names

Miringi, Kat, Miraa, Qat

How is it used?

The buds and leaves of the khat plant (Catha edulis) are chewed

Short term effects

Increased talkativeness , Feeling energetic and social, Alertness and improved concentration, Faster heartbeat and breathing, Slightly higher temperature and blood pressure, Reduced appetite

Long term effects

Worsening of existing mental health problems, Sleep-related issues, Liver disease, Fertility problems, such as impotence and lower sperm count, Digestive problems such as constipation, Sore, inflamed mouth, Psychological dependence, Mouth cancer.

30 mins

Understanding Fears about Working with People who use Drugs

Facilitators' notes

This exercise helps participants explore what they think and feel about working with people who use drugs, their fears about them, and how they respond to them. This helps to name the problem and the root causes of stigma and discrimination directed to and faced by people who use drugs.

We use the wording "What do health workers think about people who use drugs?" Not "What do you think?" The aim at this point is not to personalize, but rather to get participants to start talking about the views in general. Of course, in many cases, they are indirectly talking about their own feelings. You can emphasize even if health workers are apprehensive or have some fears about working with people who use drugs, the important thing is that those feelings do not become a barrier to clients which stops them from accessing services. As long as health workers maintain their professionalism, they will be able to provide HIV services to people who use drugs.

Our objectives

By the end of the session, participants will:

- Be able to name their thoughts and feelings about people who use drugs.
- Understand more about attitudes and behaviours towards people who use drugs.

Materials

- Flip chart and marker pens

Preparation

- Plan the 'Group Splitter.'
- Write one of the following questions on five separate flipcharts and post them around the room

1. What do some health workers think or say about people who use drugs?
2. What fears do health workers have, about working with people who use drugs?
3. What is the difference between you, and someone who uses drugs?
4. What are the similarities between you and someone who uses drugs?
5. What kind of help do people who use drugs need, from health workers?

1. Rotational Brainstorm

Divide participants into five groups

Tell the participants that there are 5 flipcharts around the room. Each group will start at a different flipchart and write their ideas down. After a few minutes there will be a signal (a song or drumbeat) and then each group moves to the flipchart on their right.

Carry out the rotational exercise until each group has contributed to each flipchart.

Ask one person in each group to bring their last flipchart back to the circle.

Sit in a closed circle and ask each person to read out the answers on the flipcharts one after the other. Avoid discussing the answers until they have all been read. Lay the flipcharts in the middle of the circle.

2. Processing

Ask the group: What do you think about these answers? How do you feel about them?

Give the group time to reflect and respond.

3. Summary

- When PWUD come to the health facility for care, they are often stigmatized based on their appearance
- Name calling can be hurtful and leave a big impact. Stigma can be a barrier to people accessing care and treatment
- It is important to be aware of how we feel about people who use drugs, but to ensure that those feelings or fears do not affect our ability to stay professional and continue to offer a service to everyone who comes to our facility

45 mins

Why do people start using drugs?

Facilitators' notes

This exercise aims to help participants understand some of the reasons why people start using drugs. We often want to blame people who use drugs without thinking about why they started using. This exercise will help us understand why we should help people who use drugs and to have empathy instead of judging and blaming them.

Our objectives

By the end of the session, participants will:

- Understand some of the reasons why people starting using drugs.
- Begin to build empathy for people who use drugs.

Materials

- Flip chart and a marker pen.
- Copies of case studies.

Preparation

- Plan your 'Group Splitter.'

Activity steps — Why do people start using drugs?

1. Buzz and Brainstorm

Ask group members to pair with the person next to them and discuss: What are some of the reasons people might start using drugs?

Take one answer from each pair and record on a flipchart

2. Group Work

Divide into 5 groups and give each group a case study

Ask the groups to read through the studies together and discuss the questions. Allow 10 – 15 minutes

3. Report back and processing

Ask each group to read through their case study and share a few points from their discussions about what they learned that was different or new from what they believed or knew before reading the case study.

Record points on flipchart.

4. Processing

Ask: Could similar things happen in your family? To your children? Your colleagues at work? Neighbors? Members of your community?

Would you treat people close to you who use drugs, the way we treat people who used drugs in the community?

5. Summary

- People start using drugs for many different reasons — we should aim to understand, rather than judge
- Sometimes people use drugs on special occasions or events. (e.g. social ceremonies (when a child is born), religious ceremonies, cultural youths' initiation ceremonies.)
- Sometimes people use drugs for medical reasons such as medication to relieve pain.
- Any one of us could had found ourselves in similar situations, or have a family member in a similar situation where drug use becomes problematic or an addiction.

Case studies

Adam

Adam is 26 years old and lives in Dar with his brother. He used to go to university but two years ago he borrowed some money from a fast loan company and got into trouble when he could not pay it back. Adam ended up borrowing more and more money from different people and finally dropped out of university. One of the men who lent him money asked Adam to work for him as a way of paying back the loan. The man was involved in trafficking of heroin and used Adam to do heroin deliveries to different places around town. Adam met a lot of young people his age who were using heroin and started using it himself — at first just occasionally but he soon found that he could not get through the day without a use of heroin. Adam often stays away from home when he is looking for money and trying to find heroin.

- What do you think about Adam's situation?
- What new things have you learned about people who use drugs, from this case study?
- Could similar things happen in your family? To your children? Your colleagues at work? Neighbors? Members of your community?

Juliana

Juliana is 19 years old and sometimes stays with her grandmother, or with friends. She had a difficult childhood — her mother died when she was 6 years old, and she went to live with her uncle and aunty. At their house, she did not feel welcome as there were 4 other children, and little money, Juliana had to do a lot of chores in the house. She attended school until she was 14 but the family said there was not enough money to continue. When she was 12 years old, Juliana's uncle started to sexually abuse her. He knew that she had nowhere to go and threatened Juliana if she ever told anyone. Juliana ran away from home when she was 16 and started using heroin when she was living on the street. The heroin helped her forget about her past, and she now survives by doing some casual work and sleeping during the daytime & engaging in sex work and taking drugs every night.

- What do you think about Juliana's situation?
- What new things have you learned about people who use drugs, from this case study?
- Could similar things happen in your family? To your children? Your colleagues at work? Neighbors? Members of your community?

Mohammed

Mohammed is twenty-one years old and lives under the bridge by the bus station, with three friends whom he has met since he became homeless last year. Mohammed was living with his grandfather and younger sister, but his grandfather passed away. One of his aunties came to take his sister, but she told Mohammed he would have to look after himself. At first Mohammed was working on a construction site and managed to pay rent for 3 months, but then he lost his job and has been homeless since. Mohammed met John who showed him where he could sleep and how to survive on the streets, as well as offering him some drugs to help him forget his problems. Mohammed is trying to get himself sorted out and his aunty has said she will help, but he has so many things to sort out he doesn't know where to start.

- What do you think about Mohammed's situation?
- What new things have you learned about people who use drugs, from this case?
- Could similar things happen in your family? To your children? Your colleagues at work? Neighbors? Members of your community?

Kurwa and Hassani

Kurwa and Hassani are 19 years old and went to boarding school together until last year. At school they had been part of a group who smoked a lot of marijuana in secret, and they were used to being high every day. When school finished Hassani traveled to Uganda to stay with his cousin and managed to get into university. Kurwa stayed in Tanzania and ended up selling marijuana for a friend. He has been arrested several times and went to prison for 6 months last year, where he started using heroin. Kurwa has recently been in touch with his brother, who has offered to help him to stop using heroin. Kurwa hopes he will not let his brother down.

- What do you think about Kurwa?
- What new things have you learned about people who use drugs, from this case study?
- Could similar things happen in your family? To your children? Your colleagues at work? Neighbors? Members of your community?

Stella

Stella is 22 years old and stays with her boyfriend Jacob in a rented room in a house. Stella had been living with relatives since her father remarried and left home as soon as she could to work in one of the big hotels in the city. After 6 months the hotel closed, and Stella lost her job; she ended up sharing a room with two friends. When Stella had no more money, one of the friends suggested she come and work with her, selling sex to tourists by the beach. Stella does not enjoy selling sex and sometimes finds herself in dangerous situations. A few months ago, she started smoking heroin, which helped her get through the night and forget about what she is doing. Jacob her boyfriend also uses heroin and when they have no money, he tells and escorts Stella to go out and earn some money from selling sex.

- What do think about Stella's situation?
- What new things have you learned about people who use drugs, from this case study?
- Could similar things happen in your family? To your children? Your colleagues at work? Neighbors? Members of your community?

45 mins

Concerns about providing HIV services to People who use drugs

Facilitators' notes

The aim of this exercise is to enable health workers from HIV Care and Treatment Clinics (CTCs)* to share their fears and concerns about working with people who use drugs, and to understand how these fears can lead to stigma.

*HIV Care and Treatment Clinics (CTCs) in Tanzania, offer the following services: HIV preventive services, initiation of antiretroviral therapy (ART), and other HIV related issues like cervical cancer screening, human papilloma virus (HPV) vaccination, circumcision, sexual and reproductive health services, screening and testing for non-communicable diseases. In Tanzania, the drug -use stigma exercises were developed to enable CTC health workers to provide services to people who use drugs

Our objectives

By the end of the session, participants will have:

- Discussed their fears and concerns about providing services at the Care and Treatment Clinics (CTCs), to people who use drugs
- Explored how to address some of the fears and identified actions that would help to ensure that people who use drugs will feel welcomed at the CTCs

Materials

- Cards
- Marker pens
- Masking tape
- Flipchart

Preparation

- Flipchart written with: **What are some of the concerns that health facility staff might have about providing services at the HIV care and treatment clinic (CTC) to people who use drugs?**
- Prepare a sample flipchart with a table with the four columns: **Main fear/concern, Where does that fear/concern come from, How do our fears currently affect service provision? What can we do in the future to deal with the fear/concern?**

1. Introduce the exercise

"This exercise provides an opportunity to explore some of the concerns we might have about working with people who use drugs. As health workers in the CTC, one of our client groups includes people who use drugs, and we need to address our concerns so that we can provide a welcoming and effective service."

2. Small group work

Divide participants into groups of three and give each group a set of blank cards and a marker. Ask the groups to discuss the What are some of the concerns that health facility staff might have about providing services to people who use drugs, at the HIV care and treatment clinic (CTC)? Ask them to write one point per card.

Stick the cards on the wall as the groups write them.

Ask 2 or 3 participants to help sort the cards into clusters- putting similar cards together.

3. Report back

Ask one or two volunteers to read through the cluster of cards. Check if anyone needs to clarify any points if they are not clear.

4. Priorities

Ask the group to identify their 5 most common, frequent or biggest fears and to put them in order of priority- they can discuss as a group until they agree (If there are more they can identify more).

Sample Responses from Tanzania

(These are not to be used in the exercise, but are provided to give the facilitator an idea of the kinds of answers the participants may raise)

Major concerns

What are the Health Workers' major concerns about working at the CTC with people who use drugs?

- I may get attacked by patient who uses drugs because of a misunderstanding.
- I may get HIV through an accidental needle prick when taking blood.
- Theft - some patients steal personal things from our offices
- Policy of confidentiality. If we enforce this policy, our patients won't get the support they need from their wives to take the ARVs effectively.
- We also face stigma from the public as people who work with people who use drugs. Our families try to stop us working here, thinking this is dangerous and stigmatizing work.
- Drug using patients not practicing safe use of needles and passing HIV to others
- Drugs-using patients being careless and not following the ARV treatment properly.

5 Main Priorities

- Health risks — getting HIV through needle prick.
- Being attacked by a patient who is a using drugs.
- Theft of personal belongings.
- Fear of stigma from other health facility workers or community as a health care worker working with people who use drugs.
- Adherence issues — Patients who use drugs not adhering to medication, not practicing safe use of needle.

5. How to deal with fear/concerns

Small group work: Divide participants into five groups and give each group one of the five priority fears. Ask the groups to draw the table with four columns as shown on your flipchart.

6. Discussion

Ask groups to discuss each column starting with Where they think the fear comes from/ What lies behind the fear? Then discuss ideas for How they currently address or deal with the fear/ concern.

Now ask the groups to discuss What should be done in the future to deal with the fear?

7. Report back and Processing

Stick the flipcharts around the room and do gallery feedback. (the group moves around the training space together)
Ask each group to report back and take comments from the other groups.

8. Summary

- It is important to understand that fear of caring for people who use drugs can be a major source of stigma. Stigma can undermine the provision of appropriate services to people who use drugs and who are living with HIV and those who wish to know their HIV status.
- As health care providers it can help to explore how we can address our fears. One key issue may include remembering our basic motivation to provide treatment, care and support to human-beings.
- We can come-up with strategies/ skills to increase our confidence in providing services to people who use drugs and are living with HIV, without fear of extra risks.
- Remind participants that they should put any questions they have for the addiction expert who will be joining the training, into the box, as well as any questions they have for the panel of people who use drugs which will take place later in the training.

30 mins

Understanding Drug Use, Addiction and Co-occurring Conditions

Facilitators' notes

This session gives basic information on drug addiction, co-occurring conditions and treatment of addiction. In this session, we build on what participants already know and correct any misperceptions. This session must be delivered by a specialist in drug use treatment and addiction, to answer questions and to ensure accuracy of information. Meet him/her/them beforehand to explain the participatory approach used in the training, and to share what participants already know. Note that there are three sections to this exercise: Addiction, Physical and Psychological Dependency.

Introduce the specialist who will deliver the 'expert' session and mention that they have reviewed the participant's questions and will be integrating answers into the exercises. They will also answer any additional question related to addiction after each exercise. The group should feel free to ask all their questions.

The reason we are showing the images of the healthy and diseased brain and heart side by side is to de-mystify drug use as a medical condition and to show that addiction is a disease like others, e.g. heart disease. Drug use leads to changes in the physical structure of the brain and hence the function of the body organ, in this case the brain. Just as cardiovascular conditions (heart disease) lead to physical changes in the heart, another body organ.

Our objectives

- To introduce the meaning of addiction to participants and build understanding of addiction as a brain disease

Materials

- Flip chart and marker
- Laminated Picture 1 image of the brain and heart scans

Preparation

- Familiarize yourself with all the technical material that is covered in this session

1. Buzz and brainstorm

Ask participants to talk to the person next to them (If the group is large, 24 persons or more, ask participants to form groups of 3-4) and discuss the following question. What do you understand by the word “addiction”? Tell them that they will need to report back to the larger group on what they have discussed.

2. Report back in plenary

- Start with a group and ask them to explain what they understand by the word addiction.
- Ask co-facilitator to write the responses from the groups on a flip chart.
- Go around the room, taking one point from each group until there are no new points to add.

3. Facilitator-led processing

Listen to the responses and then provide the following information and clarifications to help participants understand the changes that happen in the brain with addiction.

Explain that prolonged use of drugs cause changes in the biological (neuronal structures) and physiological (neurotransmission) mechanisms of the brain function. This leads to persistent changes of the brain’s structure and its function.

Share copies of the laminated picture on the next page for the participants to look at. Then ask the following questions and listen to the responses

What do you notice about this set of pictures?

What are the differences between the pictures on the left, and the pictures on the right?

Explain: The picture on the top left shows a healthy brain. The picture below it on the bottom left shows a healthy heart. Now look at the pictures on the right. The picture on the top right shows a diseased brain, caused by prolonged drug use. The picture on the bottom right shows a picture of a diseased heart.

Emphasize the following points:

- This radiological image proves/ confirms that a person who uses drugs has a brain disease which can be diagnosed in tests just like in a person with a heart disease.
- This image proves that addiction is a disease like other diseases such as heart disease, which needs treatment without discrimination, stigma or abuse at treatment sites/ facilities.

Explain that addiction is a chronic brain disease characterized by:

- **Tolerance:** Which is a state in which a person no longer responds to a drug as they did before, and a higher dose is required to achieve the same effect
- **Compulsion:** A behaviour which forces a person to continue using drugs despite the negative consequences
- **Withdrawal symptoms:** These are conditions which appear when a person who uses drugs reduces or quits drug use suddenly. They are painful and debilitating
- **Relapse:** This kind of brain disease is chronic and has a nature of relapsing
- **Need for long term treatment:** Addiction has many problems/ challenges so people with addiction need long term treatment

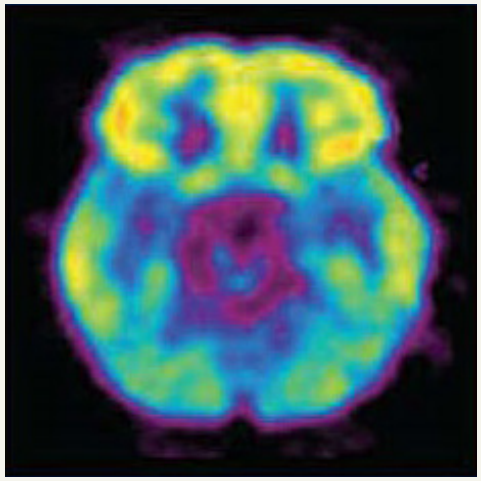
4. Buzz and Brainstorm

Ask participants to form groups of 3-4. Hand out cards and a marker to each group and ask them to discuss the following question:

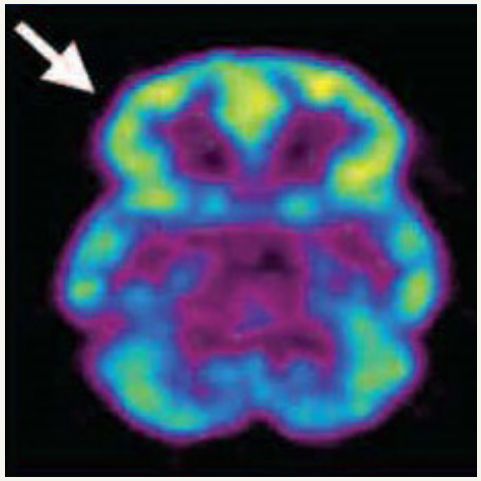
- Why do we stigmatize people with the brain disease of addiction but not people with heart disease?
- Ask groups to write their responses, one point/reason on a card until they have written all their points.
- Ask them to put all their cards on the wall or floor.
- Ask for volunteers to sort the cards into similar clusters.
- The facilitator then summarizes the key points from each clustered bunch of cards.

Activity image

Decreased brain metabolism in person who uses drugs

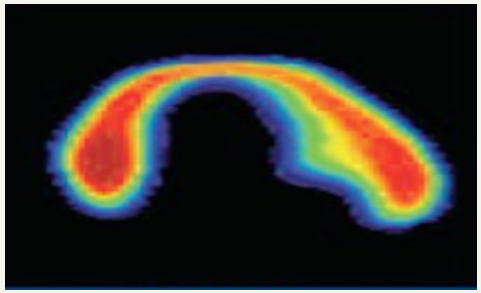


Healthy brain

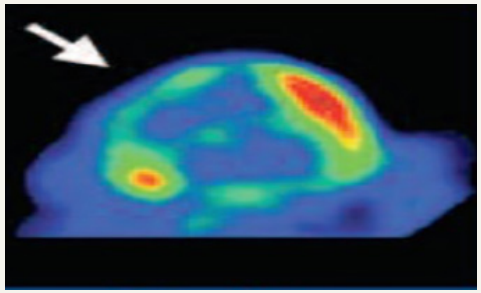


Diseased brain (person who uses cocaine)

Decreased heart metabolism in heart disease patient



Healthy heart



Diseased heart

Adapted from Training Manual for Comprehensive Management of Substance Use Disorders, Ministry of Health, June 2017.

Activity steps

5. Summarize

End this exercise by reinforcing the following points.

- Prolonged use of drugs leads to physical changes in the brain.
- Prolonged use of drugs for those at risk can cause addiction.
- Addiction is a chronic brain disease that needs medical treatment like any other disease.
- Addiction is a chronic disease which can relapse, so it needs long term treatment.
- Addiction is a disease not a moral failing.
- When a person who uses drugs experiences withdrawal, the symptoms make him/her to lose control or be unable to settle in one place for a long time. We will talk more about withdrawal in the next exercise.

1. Buzz and brainstorm

Ask participants to talk to the person next to them (If the group is large, 24 persons or more, ask participants to form groups of 3-4) and discuss the following question. What do you understand by the word “addiction”? Tell them that they will need to report back to the larger group on what they have discussed.

2. Report back in plenary

- Start with a group and ask them to explain what they understand by the word addiction.
- Ask co-facilitator to write the responses from the groups on a flip chart.
- Go around the room, taking one point from each group until there are no new points to add.

3. Facilitator-led processing

Listen to the responses and then provide the following information and clarifications to help participants understand the changes that happen in the brain with addiction.

Explain that prolonged use of drugs cause changes in the biological (neuronal structures) and physiological (neurotransmission) mechanisms of the brain function. This leads to persistent changes of the brain’s structure and its function.

Share copies of the laminated picture on the next page for the participants to look at. Then ask the following questions and listen to the responses

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Emphasize the following points:

- This radiological image proves/ confirms that a person who uses drugs has a brain disease which can be diagnosed in tests just like in a person with a heart disease.
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Explain that addiction is a chronic brain disease characterized by:

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- **Compulsion:** A behaviour which forces a person to continue using drugs despite the negative consequences
- **Withdrawal symptoms:** These are conditions which appear when a person who uses drugs reduces or quits drug use suddenly. They are painful and debilitating
- **Relapse:** This kind of brain disease is chronic and has a nature of relapsing
- **Need for long term treatment:** Addiction has many problems/ challenges so people with addiction need long term treatment

4. Buzz and Brainstorm

Ask participants to form groups of 3-4. Hand out cards and a marker to each group and ask them to discuss the following question:

- Why do we stigmatize people with the brain disease of addiction but not people with heart disease?
- Ask groups to write their responses, one point/reason on a card until they have written all their points.
- Ask them to put all their cards on the wall or floor.
- Ask for volunteers to sort the cards into similar clusters.
- The facilitator then summarizes the key points from each clustered bunch of cards.

60 mins

Physical and Psychological Dependency, Part A: Physical Dependency

Facilitators' notes

This exercise has two parts. The first part (Part A) focuses on the physical dependency that occurs with addiction to help participants understand the physical changes that occur in a person's body and the physical symptoms of dependency in a person who uses drugs and has addiction experiences. The second part focuses on the psychological dependency that occurs alongside the physical changes that occur with addiction. By helping participants understand both the physical and psychological dependency that goes along with the physical changes in the brain explained in Exercise 1 of this session, participants will deepen their understanding of drug use as a medical condition.

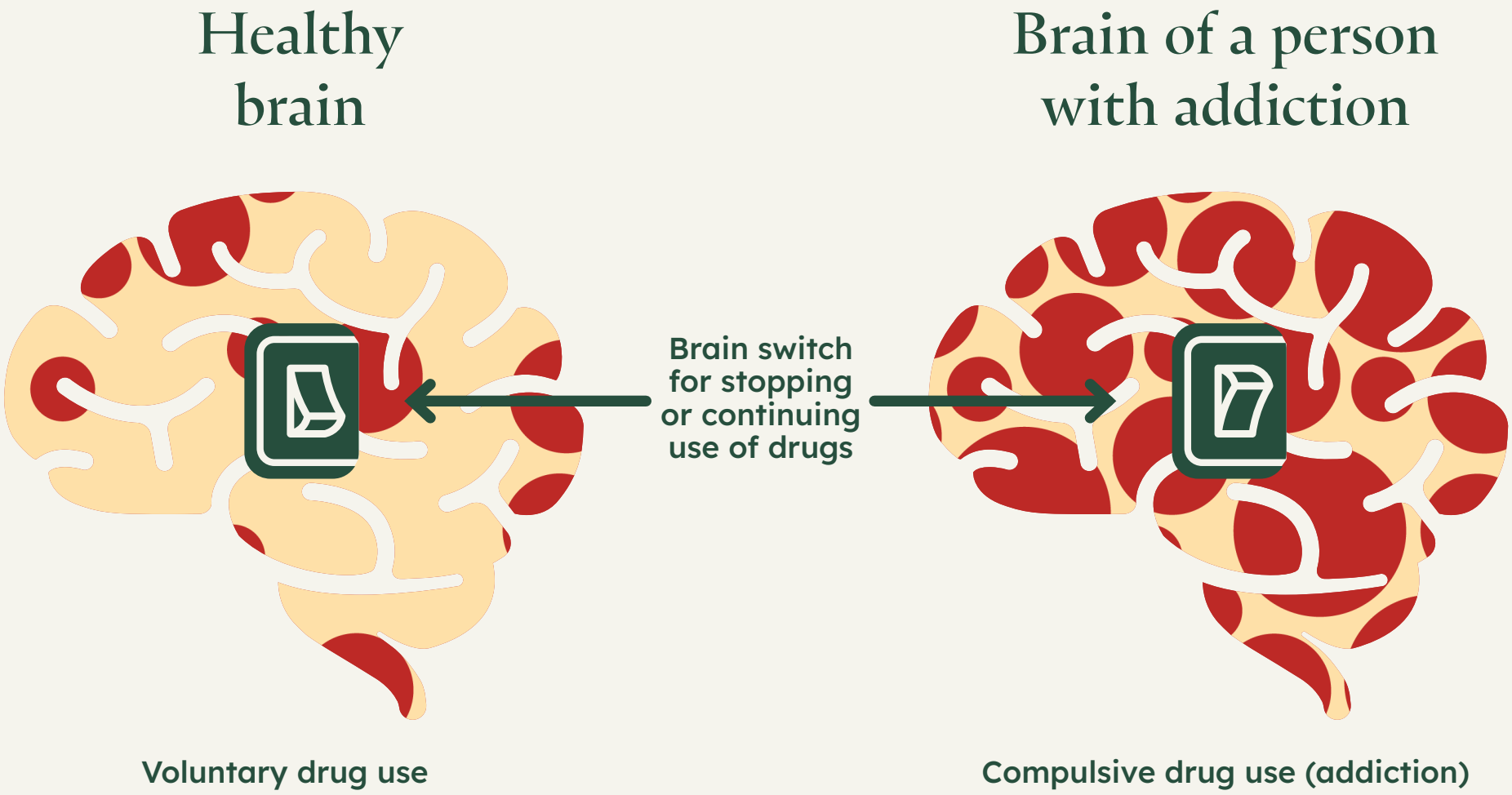
Our objectives

By the end of this exercise, participants will have

- Learnt more about the physical dependency of addiction.
- Explored how they would want to be treated if they were feeling sick or out of control.

Materials

- Flip chart and a marker pen
- Copies of Picture 1: Laminated Picture comparing healthy and addicted brain.
- Copies of Picture 2: Behavioural Manifestations during Progression to Addiction.


Healthy brain
Brain of a person with addiction
Brain switch for stopping or continuing use of drugs
Voluntary drug use
Compulsive drug use (addiction)

Activity image 2

Progression of addiction

1. Guided fantasy

Ask participants to relax and close their eyes. Tell them you are going to describe a scenario that you want them to imagine. Once they have closed their eyes and are settled, read the scenario on the right to them.

2. Ask the group

How was the exercise? Wait for responses.

- What were some of your thoughts? Wait for responses.
- How would you wish to be treated by others when you ae feeling this sick? Wait for responses.

3. Pictures

Explain the following to participants

Drugs lead to physical dependency.

People start using drugs for leisure, at this point, they can control/manage their use without any problem. When the use continues, a brain may fail to control the use, and a person starts taking higher and higher doses of drugs which goes beyond control until he/she becomes dependent on that particular drug.

Guided Fantasy Scenario

Imagine that you wake up one morning with a terrible flu- your throat is sore, your nose is running, you have a fever and a headache and your whole body is aching. You can hardly get out of bed… but you know you need to drink some fluids. You call out to your children (or parents, or flat mates) hoping they will help you. You know you need to get to the clinic, but you are not sure how…… just imagine lying in your bed, feeling helpless and sick.

Now think about how you will want to be treated.

What type of response do you want from the people in your house?

What help would you want from the staff at the clinic?

Take a few minutes to imagine this and when you are ready open your eyes.

Hand out picture 1: Comparing a healthy and addicted brain. Explain that the picture shows how a healthy brain changes over time to become an addicted brain. When a healthy brain starts being exposed to drugs and exposure increases over time, the brain mechanism that can stop the use of drugs fails (the brain 'switch' that allows a person to stop using drugs fails or turns off), resulting in addiction.

Hand out picture 2: Behavioral Manifestations during Progression to Addiction. This series of pictures shows how behaviors alter over time with increasing drug use. This series of three pictures shows how when they first begin using drugs, they are in control of their thoughts and can take drugs and continue with maintaining their regular daily activities. As drug use continues, they become increasingly focused on drug use and less focused on the regular daily activities in their lives as the need for drugs begins pushing out everything else.

4. Explain

Drug use can lead people who use drugs to become physically dependent. As they become physically dependent on the drugs, they will experience symptoms of withdrawal which resemble symptoms of any other disease.

Symptoms of withdrawal are specific features associated with addiction to drugs. They occur when a person stops taking or reduces drug use suddenly.

5. Card storm

Ask participants to work in pairs (If the group is large, 24 or more persons, ask them to form groups of 3-4).

Give each pair/group some cards and a marker. Ask pairs/groups to discuss all the physical symptoms of heroin withdrawal that they know of. It is okay if they do not know for sure, they should just write what they think.

Ask them to write one symptom per card.

Everyone sticks their cards on a wall (or floor) as they are written.

Ask for two volunteers to help sort the cards into clusters of the same/similar symptoms.

Read through the cards together and ask if anyone has clarifications or additions.

Add any symptoms of withdrawal that were not generated from the card storm that are missing from this list of common symptoms: nausea, vomiting, abdominal pain (cramping), diarrhoea, restlessness, sweating, dilated pupils, watery eyes, fast heart rate, tremor, goose pimples.

6. Summary

Emphasize the following points as you wrap up the part A of the exercise

- Drug use creates physical dependency.
- When a person starts using drugs, they are still in control of their drug use, and it is voluntary, the person is in control of their actions and can continue with their regular daily activities. With continued drug use, the brain starts to change slowly and will reach to a point where a 'switch' in the brain is triggered, at this point drug use exceeds and controls the person who uses them. The person is no longer in control, and drug use takes over their life making continuing with regular daily activities challenging.
- Sudden reduction or stopping of heroin causes withdrawal symptoms. These withdrawal symptoms include nausea, abdominal pain, diarrhoea, increase in nasal secretions, tearing, sweating, shaking, muscle spasms and pain and goose pimples.
- Ask one of the group members to read the list of symptoms from the card storm as a way to reinforce these symptoms.
- Symptoms of withdrawal sometimes resemble symptoms of other diseases. We will talk more about this shortly.
- It is important for health service providers to understand that heroin withdrawal symptoms can resemble symptoms of other diseases and may be confused.

60 mins

Physical and Psychological Dependency, Part B: Psychological Dependency

Facilitators' notes

This exercise has two parts. The first part (Part A) focuses on the physical dependency that occurs with addiction to help participants understand the physical changes that occur in a person's body and the physical symptoms of dependency in a person who uses drugs and has addiction experiences. The second part focuses on the psychological dependency that occurs alongside the physical changes that occur with addiction. By helping participants understand both the physical and psychological dependency that goes along with the physical changes in the brain explained in Exercise 1 of this session, participants will deepen their understanding of drug use as a medical condition.

Our objectives

By the end of this exercise, participants will have

- Explored and understood the psychological impact of addiction.

Materials

- Copy of the story.
- Flip chart and a marker pen .

Activity steps — Physical and Psychological Dependency, Part B: Psychological Dependency

1. Story

Read out the story to the group.

Story

Ali is 30 years old and lives with his wife and young baby by the harbor. Ali works in the docks as a casual laborer, while his wife sells tomatoes at the market. Ali had been using heroin for the last 6 years, but he has been on a methadone program for two years. He suddenly stopped using methadone six months ago. He says he wants to be free of any drug use — heroin or methadone. He loves his family and is putting all his hopes in the future of his young son, Jamal. Ali feels very bad. He is uncomfortable and he cannot concentrate on anything. He has stayed home and is lying on his bed feeling an uncontrollable urge to take heroin. All that Ali can think about is that he wants to get high and stop feeling like this. He is holding a small photo of Jamal and keeps looking at it, to remind himself why he wants to remain without his heroin. Ali prays that his wife will be home soon because he knows he might not be able to stay strong. He really wants to get some heroin.

2. Group Discussion

In a plenary format, ask the group:

- Why do you think Ali feels like this?
- Do you think Ali will manage to get through this period?
- Have you ever been in a situation where you felt an uncontrollable urge for something you shouldn't have?

3. Summary

Explain

- When a person who uses drugs feels an urge to use, it becomes extreme to the extent of being a psychological feeling of craving for something.
- The extreme urge is a craving for drugs – and the effects of drugs. Most of the time extreme urges or cravings happen when you stop using drugs for a period of time and it is the main reason for relapsing or going back to drug use.

45 mins

Providing Treatment and Care for People Living with HIV, who use Drugs

Facilitators' notes

This is a series of short exercises designed to provide participants with some basic knowledge on key considerations for providing care for people who use drugs who may come into the clinic. The key components of the exercise are:

- The commonly co-occurring conditions that PWUD may have: HIV, Tuberculosis (TB), some forms of mental disorders and Hepatitis B&C
- The risk of either a missed diagnosis or a misdiagnosis of a co-occurring condition and why this is the case, so that health workers can be aware of this risk to limit the chance of this happening.
- Awareness of potential for drug interactions of co-occurring conditions.

Note that for non-clinical staff this session may be a bit challenging, but there is still information they can take away from it, for example they might have family members who are using drugs, and this session can help them understand that there are a) options for treatment b) how to make sure they are getting the medical care they need for potential co-occurring conditions.

Participants will also want to know more about Methadone treatment than it is possible to provide in this one session. There are therefore handouts to provide more information, as well as a list of where Methadone is being provided in Tanzania and the process for referring a client, if they are interested. Note, not all people who use drugs will be interested in Methadone treatment and should never be forced into a referral.

Our objectives

- To enable health workers to understand some clinical considerations when treating people who use drugs.
- To help health workers to understand some of the treatment challenges facing people who use drugs.
- To provide health workers with knowledge they need to appropriately provide services for people who use drugs.

Materials

- Handouts Methadone.
- Copies of scenarios together with their respective discussion questions.

Preparation

- Write up definitions on flipcharts (Misdiagnosis, missed diagnosis, drug interaction.)

Part A: Co-occurring Health Conditions

1. Buzz and Brainstorm:

Ask participants to work in pairs or small groups (if it is a large group) to discuss: What are some of the common co-occurring conditions that people who use drugs, who are living with HIV, may face?

2. Flipchart

Take one point from each pair and write on flipchart.

Read through the flipchart and add any conditions that are missing (HIV, TB, mental disorders, Hepatitis B&C) and correct any that are incorrect.

3. Information

Share the following information:

- In 2014 (no updated statistics since then, but it is generally believed that this will have increased by many) it was estimated that there are 300,000 people who use heroin and 30,000 people among them are injecting drugs in Tanzania. There are no other statistics or estimates for other types of drug use in the country.
- The most common co-occurring conditions for people who use drugs, particularly people who inject drugs are HIV, TB, Hepatitis B&C and mental disorders.
- (NACP 2014 data) HIV prevalence among people who use heroin is about 18 to 25 percent but for those who inject drugs it rises to 35%. The general population has an HIV prevalence of 5.1%. This means heroin users are 6 times as likely to be living with HIV compared to the general population.
- Explain that understanding co-occurring conditions is critical to providing quality and stigma-free services to people who use drugs. In particular, it is critical to understand three key issues:

  1) PWUD are often at higher risk for HIV, TB, Hepatitis B&C and mental disorders.

  2) There are risks of misdiagnosis or missed diagnoses with PWUD - we will discuss what these are.

  3) There are potential drug interactions between treatment for drug use (methadone) or opioids (usually heroin) and the common co-occurring conditions PWUD face.
- Co-occurring conditions, especially mental disorders, and drug interactions may be underneath/behind/causing some of the behaviors PWUD might exhibit in CTCs in how they present, and also in their capacity to adhere to their medications.

Part B (10 Minutes): Misdiagnosis and Missed Diagnosis

1. Question

Ask the group What is a misdiagnosis?

2. Definition

Provide the following definition:

Misdiagnosis is when we diagnose someone with a medical condition that they do not have. In other words, we diagnose them with a health condition they do not have, instead of the one they actually have.

3. Question

Ask the group What is a missed diagnosis?

4. Definition

Provide the following definition:

A missed diagnosis is when we do not diagnose a client with a health condition that they have—that is, we completely miss a diagnosis of a health condition that is present.

5. Buzz and Brainstorm

Split the group into two halves. Then ask participants within each half to pair with the person next to them and discuss (1 Minute):

- Group 1 pairs discuss: Why might there be a misdiagnosis?
- Group 2 pairs discuss: Why might there be a missed diagnosis?

After a few minutes ask the pairs to come together and share their answers and pick at least three answers to report back to the large group

6. Report back:

Ask representatives from the two groups to present their answers. Capture responses on a flip chart.

7. Summary

Explain the following (if it was not covered in the report-back)

The risks for misdiagnosis or missed diagnosis can occur because symptoms of withdrawal mimic or can mask symptoms of the following health conditions: HIV, both Hepatitis B and Hepatitis C (wasting, fever, diarrhoea, vomiting, lack of appetite), Tuberculosis (TB) (wasting) or mental disorders (poor appetite, poor sleep, irritability, acting out).

Part C: Where there is risk of drug interaction due to treatment of co-occurring medical conditions

1. Define a drug interaction

A drug interaction happens when two or more drugs that a client is taking interact with each other and change the way either drug is working in the body. For example, when a drug interaction occurs, it can change how one or more of the drugs is absorbed, distributed, or removed (cleared or eliminated) by the body, that is how the body responds to the medication and how the medication behaves in the body. When two or more drugs interact, it may result in the increase or the decrease of the drug concentration in the body, thereby causing the drugs to behave differently than expected.

2. Plenary Brainstorm

Ask participants: Do you know of any potential drug interactions for the common co-occurring conditions that people who use drugs, who are living with HIV, may face?

Record answers on a flip chart.

3. Mini lecture

Use visuals -slides or flipcharts. Share the following information and as you are doing so, cross out any drug interactions provided that are not correct, and add to the flip chart any that are missing:

a. HIV Medication:

- Today, in Tanzania, the first line of HIV treatment is the 3-drug combination known as TLD, which contains the drugs tenofovir, disoproxil, lamivudine and dolutegravir.
- Now that Tanzania is using TLD as first-line, no interactions are expected/seen between HIV treatment (TLD) and Methadone, a prescription for opioid drug use.
- However, it is important to note that in the past, when treatment for HIV was different (TLE) and included, an Efavirenz based ART medication, or Nevirapine, these HIV treatments when used, had the effect of reducing methadone

or opioids in the body and could lead to withdrawal for clients who were on methadone. Therefore, it is important to know that some people living with HIV who use opioids or are on methadone may have memory of this and be anxious or afraid this will happen, so you need reassure them this is not the case with TLD.

b. TB drugs

- It is critical to note that Rifampicin, one of the drugs used to treat TB, causes severe withdrawals for people who use opioids or are on Methadone. Therefore, it is important that you know before putting a client on TB treatment if they are on Methadone or using opioids.
- If they are Methadone, you need to make sure that the Methadone dose is adjusted (increased) to ensure the client does not experience withdrawal.
- Explain to the client that they need to tell the staff at the Methadone clinic that they are starting TB treatment and that they may need their Methadone dose adjusted accordingly. If they are taking opioids, it is important to understand and explain to the client that they will need to increase their consumption of opioids to counteract the effect of Rifampicin. Failure to pay attention to this interaction risks the patient will stop taking the medication, which will lead to relapse in TB and possibly Multi Drug Resistant TB.

c. Hepatitis C drugs

- The treatment for Hepatitis C, the drug Sofosbuvir, can increase concentration of Tenofovir, which is one of the three drugs that is in the ART combination treatment, TLD. There is also caution of use of Sofosbuvir with the TB drug, Rifampicin.

d. Hepatitis B drugs

- The most common drug provided in Tanzania for Hepatitis B is Tenofovir. This causes no interactions with any of the other medications for common co-occurring conditions for people who use drugs.

e. Mental health drugs

- In Tanzania, for clients with a diagnosis of depression, Tricyclic antidepressants may be prescribed. It is important to note that Methadone increases the strength and toxicity of the antidepressants which affects the heart. Because Methadone and non-prescription opioids are depressants, use of any depressant medications may result in central nervous system depression.

Part D: Methadone Treatment (Available medical treatment for drug use) (Short lecture)

1. Question

Ask the participants: What treatments have you heard about to help people who use drugs?

Debrief by explaining which are not treatments and then providing the following short lecture on Methadone. Give out handout.

2. Short lecture Methadone Treatment

Methadone is a medication approved by the Tanzanian Medical and Drug Administration (TMDA) to treat Opioid Use Disorder (OUD). If methadone is used as intended, it is safe and effective in helping patients to get well and return to their lives in their communities. It benefits a lot of people who are addicted to opioids.

Providing Treatment and Care for People Living with HIV, who use Drugs

Methadone is one component of a comprehensive treatment plan, which includes counselling and other behavioural health therapies to provide patients with a whole-person approach. Methadone, a long-acting opioid agonist, reduces opioid craving and withdrawal and blunts or blocks the effects of opioids. In Tanzania, Methadone is taken daily in liquid form and can only be accessed at facilities that have approval to dispense it. It is not available in pharmacies as it is a Schedule II controlled medication.

The length of time a person receives methadone treatment varies; the length of methadone treatment should be a minimum of 12 months. Some patients may require long-term maintenance. Patients must work with the health providers who are treating them with Methadone, to gradually reduce their methadone dosage to prevent withdrawal. In Tanzania preferred tapering of methadone doses is based on at least two years' worth of reassessments of their improvements on the medication. Tapering is the process of gradually reducing the methadone dose with the aim of stopping (graduating) from methadone use. In addition, three-person support groups for tapering are offered to clients who would like to participate as a way to support the tapering process. Tapering is not mandatory.

Methadone medication is specifically tailored for the individual patient (and doses are often adjusted and readjusted) and is never to be shared with or given to others. Patients should share their complete health history with their Methadone health providers to ensure the safe use of the medication.

Other medications may interact with methadone and cause withdrawals or heart conditions. Even after the effects of methadone wear off, the medication's active ingredients remain in the body for much longer.

Women who are pregnant or breastfeeding can safely take Methadone. Comprehensive methadone maintenance treatment should include prenatal care to reduce the risks of complications during pregnancy and at birth. Undergoing methadone treatment while pregnant does not cause birth defects. Methadone's ability to prevent withdrawal symptoms helps pregnant women better manage their opioid use disorder while avoiding health risks to both mother and baby. A pregnant woman who experiences withdrawal may be at risk of miscarriage or premature birth, as withdrawal can cause the uterus to contract.

There is a potential for severe side effects with the use of Methadone, as there are with many other medications.

The use of methadone should be taken seriously if clients experience the following symptoms:

- Difficulty breathing or shallow breathing.
- Feel lightheaded or faint.
- Experience hives or a rash; swelling of the face, lips, tongue, or throat.
- Feel chest pain.
- Experience a fast or pounding heartbeat.
- Experience hallucinations or confusion.

Cited: https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/methadone

Methadone

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About Methadone

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Drug Interactions with Methadone

SN	Generic Name	Notes
1	Buprenorphine, Pentazocine	Causes acute withdrawal syndrome.
2	Naloxone	Severe causes acute withdrawal syndrome.
3	Tramadol	Causes acute withdrawal syndrome.
4	Benzodiazepines (alprazolam, Diazepam, midazolam)	Causes CNS depression.
5	Opioids (Morphine, meperidine)	Addictive.
6	Barbiturates (phenobarbitone)	Decrease of methadone.
7	Carbamazepine	May cause withdrawal.
8	Ethanol	May cause withdrawal.
ARVS		
9	Didanosine tablet	Decrease in ddl concentration.
10	Stavudine tab	Decrease in d4T concentration.
11	Zidovudine tab	Increase in AZT concentration.
12	Abacavir tab	Decrease in methadone effects.
13	Efavirenz	Decrease in methadone effects.
14	Lopinavir+Ritonavir (Alluvia)	Decrease in methadone effects.
15	Nevirapine	Decrease in methadone effects.
Other common medications		
16	Promethazine	Increase Methadone effects.
17	Dextromethorphan	Increase Dextromethorphan effects.
18	Rifampicin	Causes acute withdrawal syndrome from Methadone.
19	Nifedipine	Increase Nifedipine effects.
20	TCAs (amitriptyline, desipramine, imipramine, nortriptyline, protriptyline)	Increase TCAs toxicity.
21	Ascorbic acid (Vitamin C)	Increase Methadone excretion.
22	Cimetidine	Increase Methadone effects.
23	Ciprofloxacin	Increase Methadone effects.
24	Macrolide antibiotics (erythromycin, clarithromycin)	Increase Methadone effects.
25	ALU (antimalaria treatment)	Decrease in Methadone effects.

Methadone clinics in Tanzania

Main clinics in Dar es Salaam, Tanzania are at Muhimbili National Hospital, Mwananyamala Regional Referral Hospital, Temeke Regional Referral Hospital

Satellite clinics in Dar es Salaam Tanzania are Vijibweni, Round Table, Segerea, and Tegeta.

Main clinics are in other regions name below:

Arusha: 1

Tunduma: 1

Mwanza: 1

Zanzibar: 1

Tanga: 1

Dodoma: 1

Kihonda: 1

Part E: Putting it All together and Consolidating New Knowledge

1. Buzz and Brainstorm

Ask participants to pair with the person next to them (If group is larger, 24 or more persons, ask participants to form groups of 3-4) Ask them to discuss

“What are some of the key issues we need to keep in mind when caring for PWUD who are living with HIV?”

Take one point from each pair and write on flipchart. Keep going around the room until there are no new points.

2. Small group work with Scenarios

Divide participants into five groups.

Give each group a scenario to discuss. Ask groups to write down their answers. Allow 10 minutes for the discussions.

3. Plenary Report back

Ask each group to first read out their scenario, and then share points from their discussion.

The facilitator records key points on the flip chart and checks if any other participants want to add extra points.

Continue to the next group and repeat the process until all groups have reported back.

4. Summary

Facilitator summarizes key points from the session that are illustrated through the scenarios, emphasizing the following:

There are several symptoms for common co-occurring health conditions that are similar to withdrawal. Specifically, HIV, TB, Hepatitis B&C and mental disorders. These symptoms can lead to either a misdiagnosis or a missed diagnosis.

There are several potential drug interactions between some medications to treat health conditions that can co-occur, particularly in people who use drugs. Specifically, interactions between methadone and medication for other illnesses, like TB, Hepatitis B and C and depression.

Because of the issues associated with withdrawal, misdiagnosis, missed diagnosis and drug interactions, healthcare workers need to be very vigilant in ensuring that they do a thorough clinical investigation. Our tendency when treating clients who use drugs is to either:

1) Give them priority, treat them as fast as possible and get them out without proper clinical investigation and instructions

2) Make them wait till the end and treat the ‘easier’ clients first.

Both of these responses are experienced as stigma by the client and may lead to them not coming back.

It is essential to take the time to understand what a client who uses drugs is suffering from and their specific needs, to ensure proper referral for continued care and that they can adhere to their HIV and any other medications they may need.

Scenarios and expected responses for facilitators

Scenario 1

A young man who has told you he is on methadone treatment. He has just tested positive for TB.

Group discussion question

Describe some of the considerations you need to consider as you treat him.

Expected Responses from Participants (correct answers)

As this is a TB diagnosis in a methadone using client and the first line of treatment for TB includes Rifampicin, there is a risk of withdrawal unless Methadone treatment is adjusted.

Scenario 2

A young woman who is living with HIV, has come for help because she has been losing a lot of weight and does not feel like eating. She has been feeling so unwell she tells you she has recently stopped using heroin.

Group discussion question

Describe some of the considerations you need to consider as you treat her.

Expected Responses from Participants (correct answers)

She is presenting with some symptoms of withdrawals; need to assess possibility of other co-occurring conditions (pregnant? Depression? Hepatitis?) as well as if needs to be referred for treatment of her drug use.

Scenario 3

A 30-year-old man recently diagnosed with HIV has been assessed for depression at the methadone clinic and he is prescribed Amitriptyline and methadone.

Group discussion question

Describe some of the considerations you need to consider as you treat him.

Expected Responses from Participants (correct answers)

Depressed patient on Amitriptyline while on Methadone—assess risk of methadone intensifying the effect of Amitriptyline and risk of cardiac arrest.

Scenario 4

An injecting heroin user has been attending the CTC and methadone clinics and has presented with the following symptoms: Fever, Fatigue, Stomach pain, nausea and vomiting, joints pain.

Group discussion question

When you see a client with these symptoms, what do you need to consider as you treat them?

Expected Responses from Participants (correct answers)

This is a patient who either has withdrawal or hepatitis. Needs to be thoroughly investigated to understand what it is. Methadone adjustments may need to be made. Investigate that they are not on Efavirenz-based ART or presence of hepatitis.

Scenario 1

A young man who has told you he is on methadone treatment. He has just tested positive for TB.

Scenario 2

A young woman who is living with HIV, has come for help because she has been losing a lot of weight and does not feel like eating. She has been feeling so unwell she tells you she has recently stopped using heroin.

Scenario 3

A 30-year-old man recently diagnosed with HIV has been assessed for depression at the methadone clinic and he is prescribed Amitriptyline and methadone.

Scenario 4

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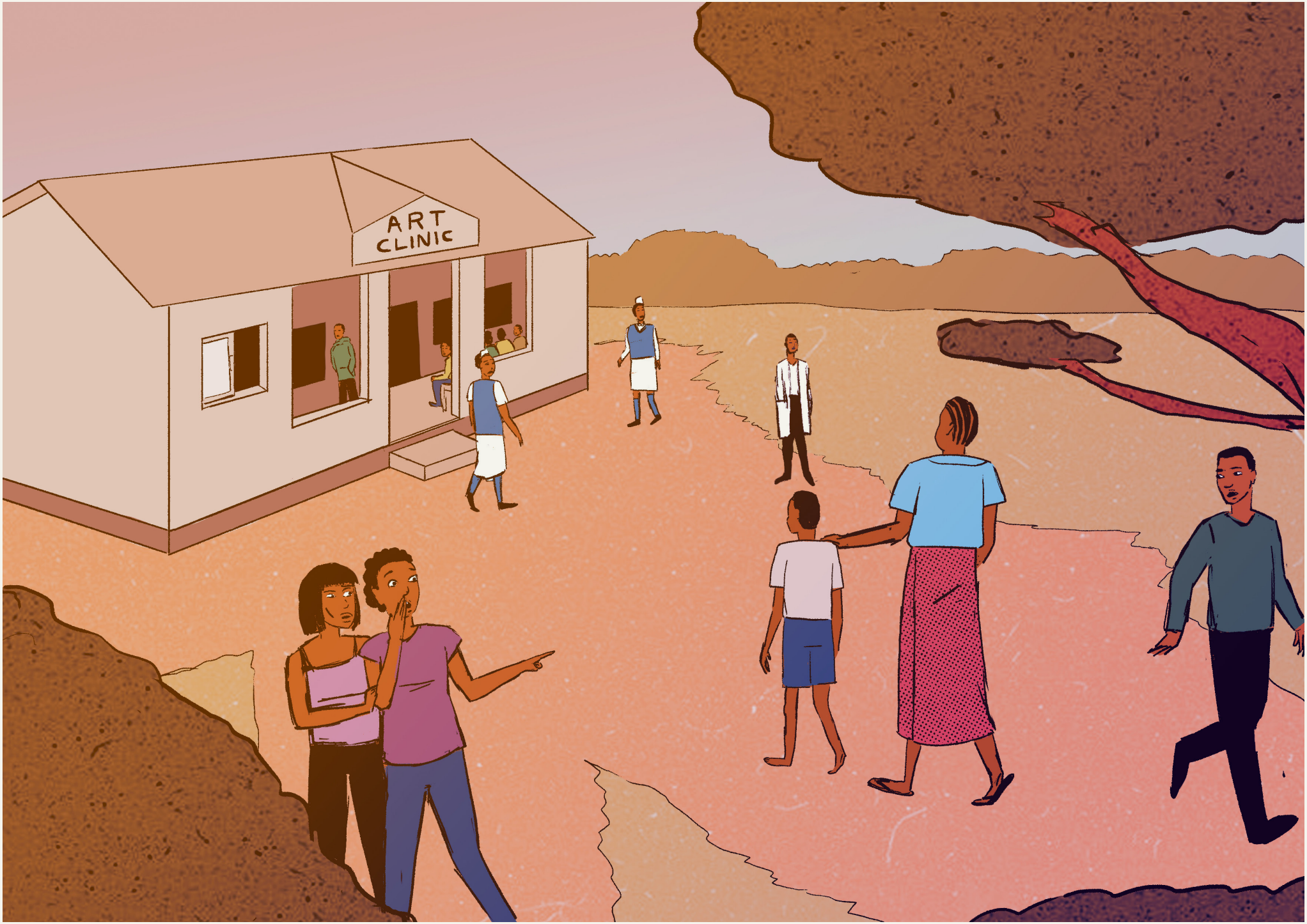
Appendix of Picture Tools

Stigma in Health Facilities


FREE
Condoms


ASK FOR PrEP
21 - 9


FREE
CONDOMS

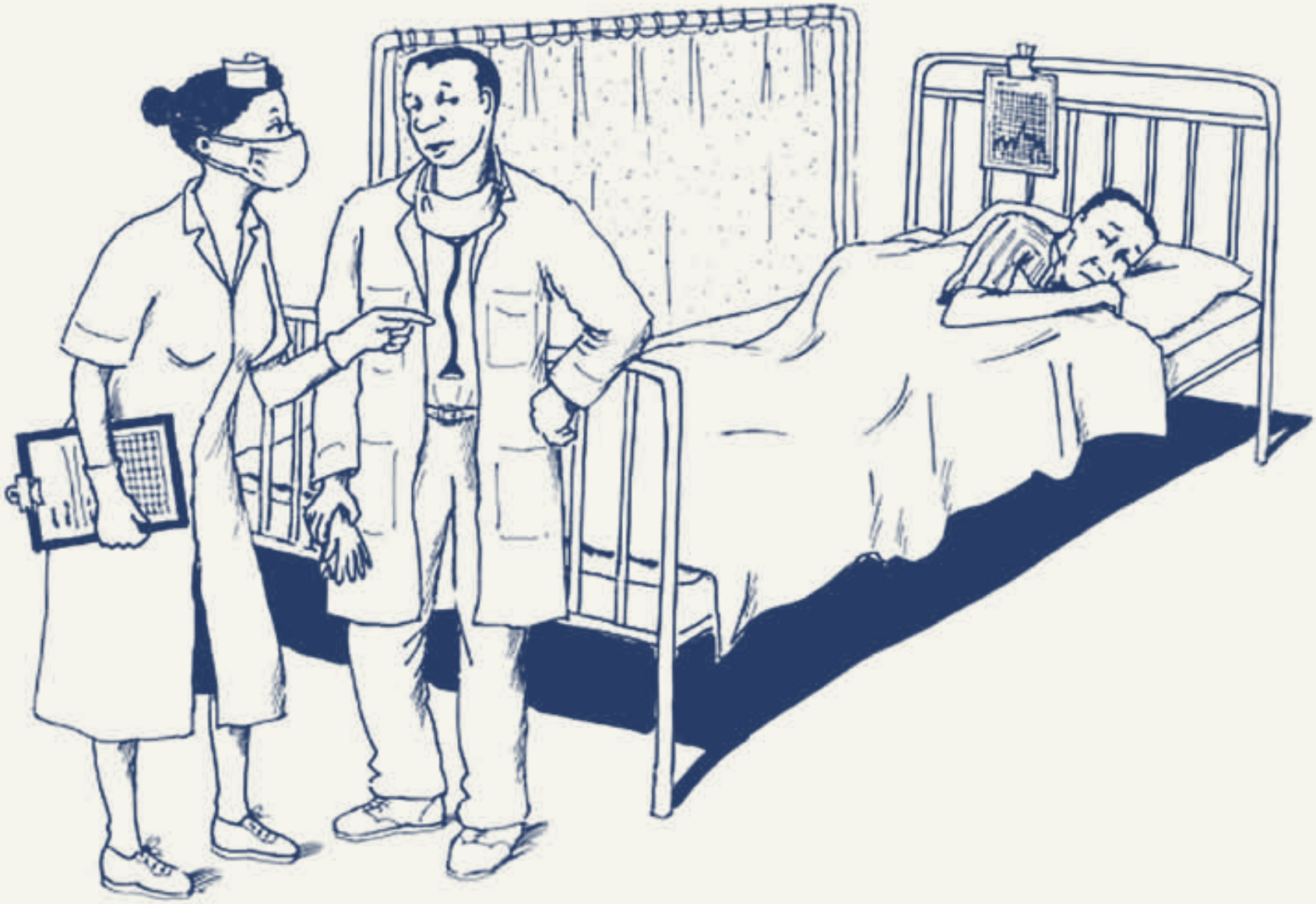

ART
CLINIC


Health Care is a
Right
not a privilege


You can not tell by looking....
CHILD HEALTH WEEK
DOCTOR
AFRIGAY


CLINIC


CHILD HEALTH WEEK
You don't get HIV from hugging someone
Doctor
Use Condoms every time you have sex!




Push!

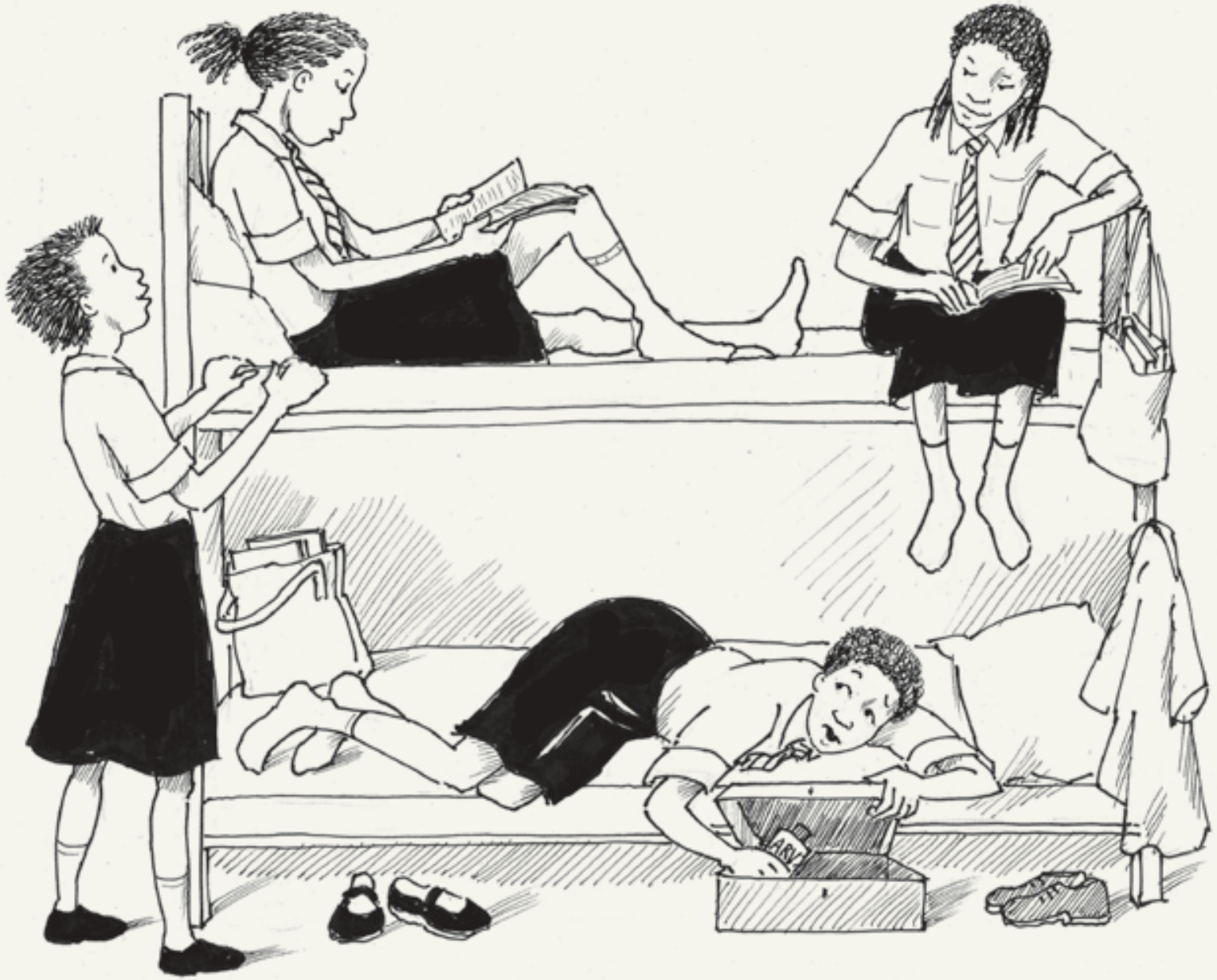

CHART
RIFAMPICINE

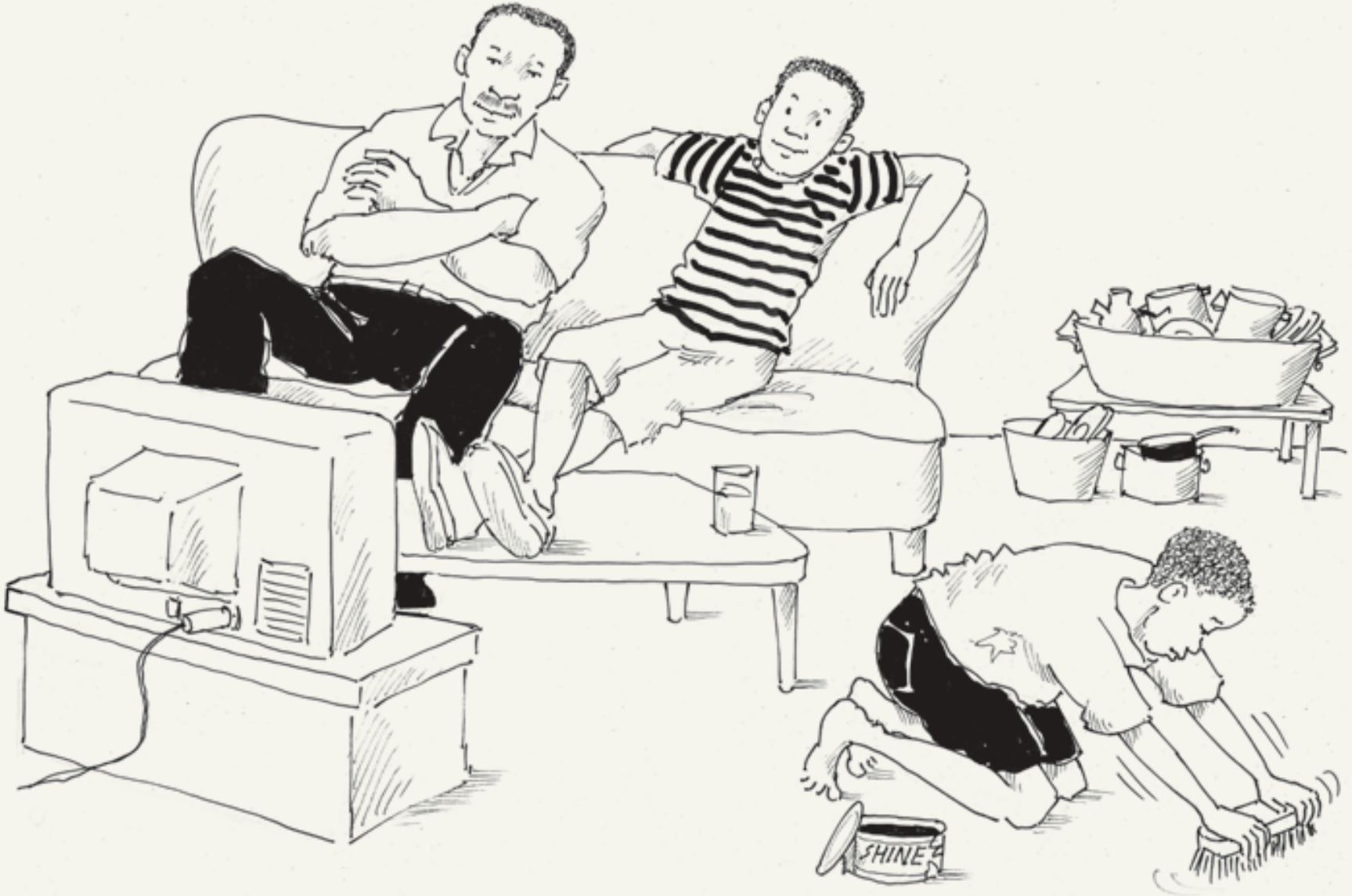

TB CLINIC
TB
is curable

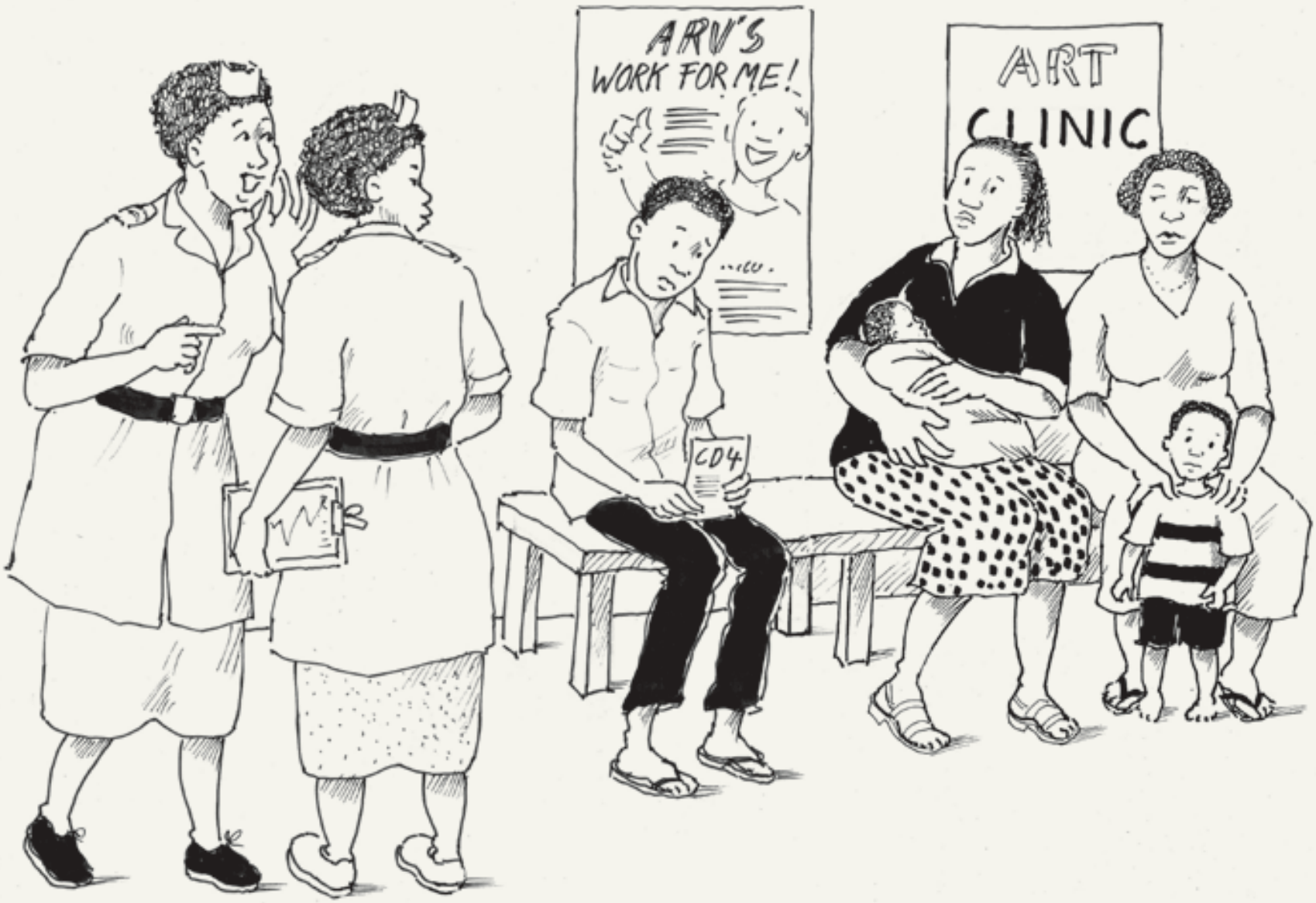

WARD 1

Appendix of Picture Tools

Stigma towards young people




SHINE


ARV'S
WORK FOR ME!
CD4
ART
CLINIC


KNOW
YOUR
STATUS

Appendix of Picture Tools

Stigma towards people who use drugs


HOSPITAL


CTC RECEPTION


DOCTOR


CTOR


EXIT


CLINIC

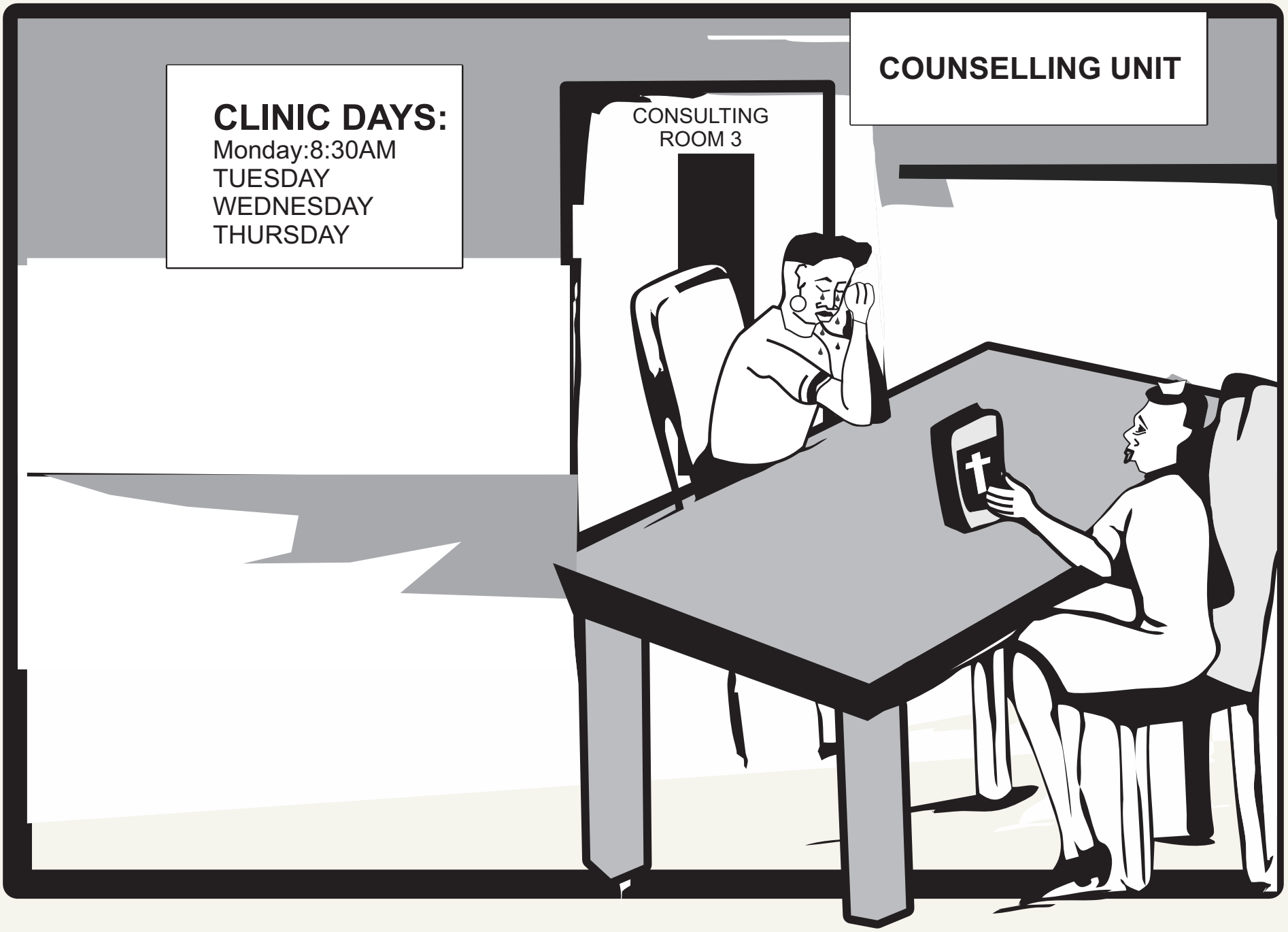
Appendix of Picture Tools

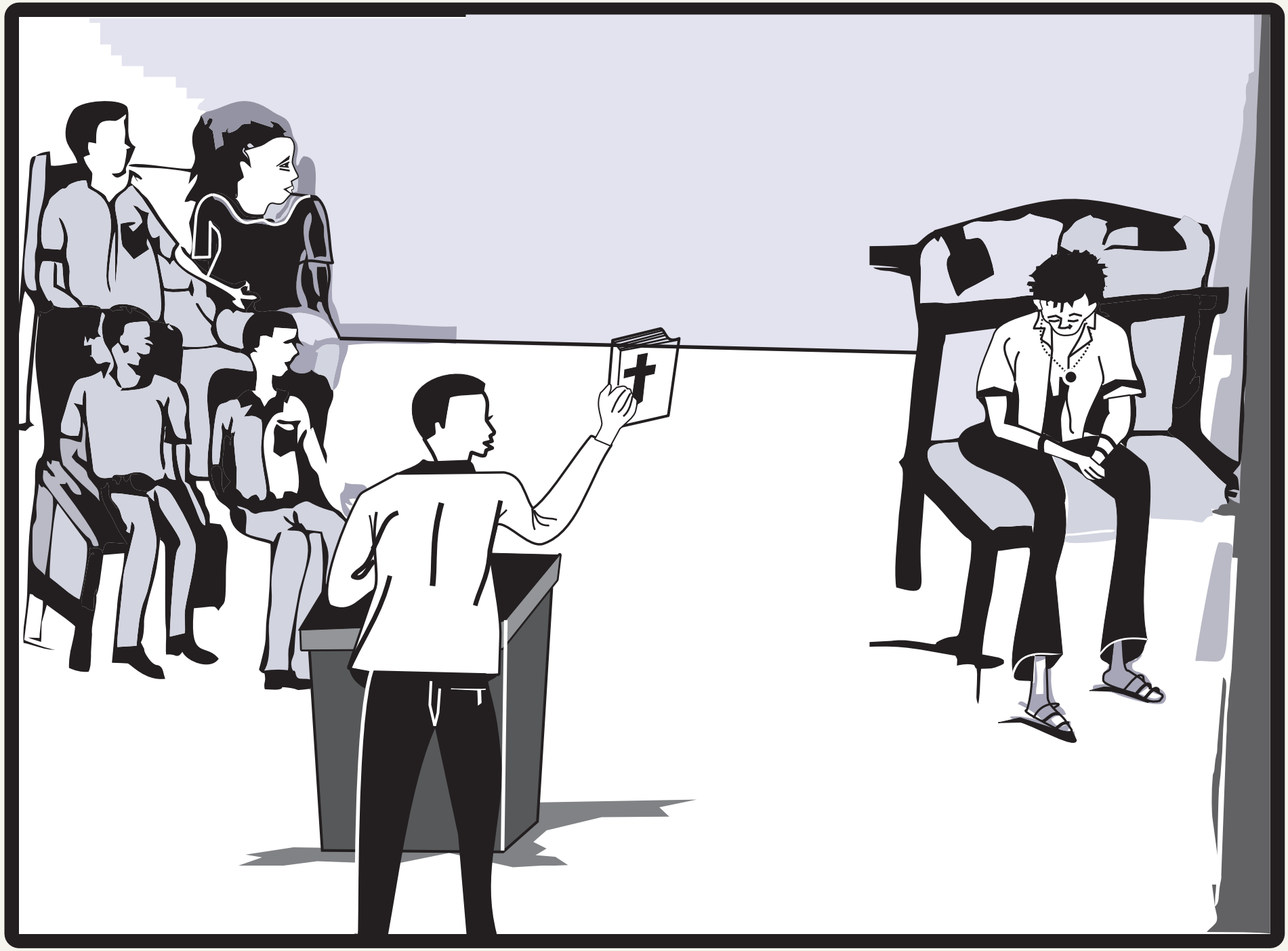
Stigma faced by gender and sexually diverse populations


Star
Night
Club
star
Night
club


RECEPTION


O.P.D
NURSES
ROSTER
CLINIC
DAYS


CLINIC DAYS:
Monday:8:30AM
TUESDAY
WEDNESDAY
THURSDAY
CONSULTING
ROOM 3
COUNSELLING UNIT



Appendix of Picture Tools

General stigma


Sinners!


HIV TEST