Introduction to the Toolkit

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

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

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

What is the Toolkit?

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

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

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

How the Toolkit Is Organized

This toolkit is divided into five chapters:

- **Chapter A:** HIV Stigma—Naming & Owning the Problem
- **Chapter B:** Gender Violence—Naming & Owning the Problem
- **Chapter C:** Shame and Blame—Stigma & Emotional Violence
- **Chapter D:** More Understanding and Less Fear
- **Chapter E:** Moving to Action

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

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

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

Why Include Stigma in HIV and AIDS Prevention Efforts?

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

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

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

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

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

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

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

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

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

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

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

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

5 Ibid.
Purpose of the Toolkit

■ Goal

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

■ Specific Objectives

1. Help health workers see that stigma and gender violence exist, that these issues hurt women and people living with HIV and fuel the HIV epidemic, and that by changing their own attitudes and actions they can help reduce stigma and gender violence and make health services more accessible to everyone.

2. Provide space in which health workers can discuss their own feelings and fears, and the values that underlie stigma and gender violence. Help them look critically at their own attitudes and take ownership of a new set of values and norms.

3. Help challenge the view that gender violence is an acceptable norm, and help health workers develop a new code of practice on how they deal with cases of battered women, including the provision of counseling.

4. Help health workers learn skills to provide health care services to people living with HIV and women in a supportive and caring way.

5. Improve health workers’ knowledge about HIV and AIDS to overcome fears and misconceptions about HIV transmission through non-sexual casual contact.

6. Help health workers become “HIV competent” by improving their knowledge about HIV testing and counseling, anti-retroviral therapies, universal precautions, the role of opportunistic infections and other relevant issues. This increased understanding and awareness will allow them to serve as community hubs of information on HIV and AIDS, model more supportive approaches through their own behavior, and advocate effectively for the reduction of HIV stigma and gender violence.

7. Provide opportunities for people to talk about how they can help reduce stigma and develop practical strategies for challenging stigma and discrimination.

■ Target Groups

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

■ Front line health care providers—registered medical practitioners (RMPs), traditional birth attendants (TBAs), pharmacists and lab technicians; and

■ Government health workers—doctors, nurses and community health workers based in government health centers and clinics.
Introduction to the Toolkit

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

Each module is divided into the following parts:

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

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

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

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

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

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

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

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

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

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

1. Create a SENSE OF COMMUNITY and build OPENNESS AND SAFETY to talk about HIV and AIDS, stigma, and gender violence.

2. NAME THE PROBLEM—get participants to describe how stigma and gender violence occur in different contexts.

3. Help participants OWN THE PROBLEMS OF STIGMA AND VIOLENCE—to recognize that “we are all part of these problems.” Help participants reflect on their OWN words, attitudes and actions.

4. Help participants see the EFFECTS of stigma and gender violence on people living with HIV, women, their families and communities—how it hurts people who are stigmatized and abused, and indirectly hurts people who are perpetrating the stigma and violence.

5. Analyze the ROOT CAUSES of stigma and gender violence, such as fears and misunderstanding about HIV transmission, moralizing attitudes, and men’s use of force to control and dominate women.
6. Address FEARS AND MISCONCEPTIONS about getting HIV through non-sexual casual contact, and develop TECHNICAL KNOWLEDGE on HIV and AIDS services (testing, counseling, etc.).

7. Challenge the VALUES that underlie stigma and gender violence and help people get a read into their own attitudes.

8. Build COMMITMENT to changing attitudes and doing something about stigma and gender violence.

9. Help participants learn the attitudes and skills to provide SUPPORT AND CARE for people living with HIV and provide counseling to women who have been abused.

10. Develop STRATEGIES and PLANS for taking action against stigma and gender violence.
Making Your Own Training Program

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

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

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

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

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

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

■ Select the modules that suit your objectives, target groups and context
The toolkit is NOT a standardized package for a single training course or program. You are not expected to work your way through all of the modules. Use it selectively. Pick out those exercises that suit your own target group and needs and devise your own training program.
The modules can be used to design different types of workshops for different groups. For instance, you may want to introduce stigma as one of a number of topics in a course for health workers; or you may want to run a short workshop on stigma and gender violence as their own topics. Feel free to select and adapt the materials to suit your own purposes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**WARM-UP GAMES AND SONGS:** Trainers are encouraged to use their own games and songs to break the ice, build group spirit and create energy for sessions.
Stop-Start Drama—A Special Technique

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

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

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

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

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

Facilitation Techniques

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

In conclusion, Stop-Start Drama is a powerful technique that helps participants understand and solve problems through role playing and discussion.
Tips for Participatory Trainers

BE WELL PREPARED

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

PREPARE THE ROOM

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

MAKE PARTICIPANTS FEEL COMFORTABLE

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

ASK WHAT THE PARTICIPANTS REALLY NEED TO LEARN

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

ASK QUESTIONS AND LEAD DISCUSSION

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

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

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

KEEP PRESENTATIONS SHORT AND SIMPLE!

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

KEEP CHANGING YOUR METHODS

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

CHECK THE ENERGY LEVEL

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

WATCH THE TIMING AND PACING

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

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

TEAM FACILITATION

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

A Special Note on Working with Feelings

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

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

The following tips may help:

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

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

Strategies and Approaches

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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