Handout 3.1 - Pictures for Stigma Discussion (picture 1)

Pictures for Stigma Discussion (picture 2)
Meron is 28 years old. Three years ago she was tested for HIV. She was a member of one of the evangelical churches, which had planned a mass wedding ceremony for its members. All those taking part had to take a test. After her test, Meron was simply told that she would not be taking part. She was given no counseling or support. She only guessed that she was positive.

Meron did not tell anyone for two months. She stopped going to church and felt very alone. Then she asked one of her close friends for advice. Her friend suggested that she go to Zewditu Hospital Voluntary Counseling and Testing Center to check her results. Her friend offered to go with her. Meron took the test again, but this time talked for a long time to a counselor. The test came back positive.

Meron continued to see the counselor, and eventually told her Auntie whom she stays with. Meron joined a skills-training scheme for people living with HIV and learned tailoring skills. Now, two years later, she runs a successful tailoring business. She has married and is expecting her first baby. In her spare time, Meron gives talks to schools and workplaces about HIV and AIDS.

1. How do you think Meron felt when she was told she couldn’t take part in the mass wedding ceremony?

2. How would describe Meron’s behavior before going to the counseling center?

3. In what ways did counseling make a difference to Meron?

4. What concerns might Meron have about the child she is expecting?
Handout 3.3 - Character cards

Description
These cards are used to provide a set of character types which can be used for discussion or making stories. These cards allow us to talk about our assumption about different types of people, e.g. stigmatization towards sex workers and street children.

Use
There are 32 characters in this handout, cut out each character and paste on to idea cards so that they can be displayed on the floor or wall or distributed to different participants.
HIV/AIDS Stigma Reduction
Handout 3.4 - Definition of Stigma and Discrimination

Stigma is an ‘act of identifying, labeling or attributing undesirable qualities targeted towards those who are perceived as being “shamefully different” and deviant from the social ideal.’

Stigma

Stigma is a process of having the character of a person appear negative in the eyes of others. It occurs when somebody or a community labels another person or group and sets them apart as unwanted.

In respect to HIV and AIDS it is caused by silence, rejection and isolation and limits the ability of people living with HIV or AIDS or those seen as having the disease to cope with their condition. It causes added stress and leads to discrimination and all its harmful results.

HIV related stigma is often layered upon pre-existing stigmas concerning socially marginalized and vulnerable groups (injecting drug users, men who have sex with men, commercial sex workers, women, and children). Conversely, people living with AIDS may become implicitly associated with stigmatized behaviors, regardless of how they became infected. So once there is a stigmatizing environment, all sufferers from the AIDS scourge are looked at through tinted lenses and they are subjected to more suffering even from their family and friends.

Stigma generally refers to a negatively perceived defining characteristic, either tangible or intangible. It is an attribute used to set the affected persons or groups apart from the normalized social order, and this separation implies devaluation (Gilmore and Somerville 1994). In regard to HIV/AIDS, the stigma may be associated with the actual infection or on behaviors believed to lead to infection.

As the global pandemic first received international recognition, populations of men who have sex with men (MSM), injection drug users (IDU), and sex workers (SW), these already socially marginalized groups began to face additional stigmatization. In such cases, “… the stigma attached to AIDS as an illness is layered upon preexisting stigma” (Herek and Glunt 1988:887). The association with an incurable disease is then used as medical justification for established patterns of exclusion of groups already deemed morally questionable (McGrath 1992). Conversely, people living with HIV/AIDS (PHA) may become implicitly associated with stigmatized behaviors, regardless of how they actually became infected (Tan and Brown 1994). These pathways of stigma are difficult to disentangle, but mutually reinforce each other (Bunting 1996).

Furthermore, stigma may be applied with varying degrees of force, depending on local moral judgments about means of acquisition (Kegeles et al. 1989). In Southeast Asia, a clear gradient of “guilt” and “innocence” has formed the discourse surrounding HIV/AIDS. Sex workers or IDUs who contract HIV are classified as most guilty, with clients of SW following. At the other end of the spectrum, common wisdom posits monogamous wives infected by their IDU or SW-client husbands as “innocent” and “vulnerable,” while their HIV positive children, infected during pregnancy, birth, or breastfeeding become the ultimate “defenseless victims.” Varying degrees of stigma
are applied to these PHA groups, and often to their family members or immediate communities.

**Discrimination and stigma**

The concepts of stigma and discrimination are closely linked, and they are frequently referred to together. Some authors choose to refer to discrimination as “enacted stigma” (Malcolm et al. 1998). Because discrimination often includes public restrictions and punishing actions, however, it can frequently be more easily identified. In order to tackle manifestations of stigma, deeply rooted social attitudes will also be addressed particularly the stigmatizing social norms.

Discrimination is composed of “... the actions or treatment based on the stigma and directed toward the stigmatized....” (Bunting 1996:67). The stigmatized find themselves ostracized, rejected and shunned (Alonzo et al. 1995) and may experience sanctions, harassment, scapegoating, and even violence based on their infection or association with HIV/AIDS (APN+1999; McGrath 1992). Discrimination may spring from social disapproval of the infection and its implied behaviors or from fears due to lack of knowledge about how HIV/AIDS can or cannot be transmitted. Because the HIV pandemic emerged so suddenly and progressed so quickly, in many countries discrimination could result from people’s belief “... that not enough time remains to weigh carefully the strengths and weaknesses of various alternative solutions to an AIDS-related problem” (Herek and Glunt 1988:888) and the reaction is thus to err on the side of caution, even at the expense of individual rights.

- Discrimination occurs when a distinction is made against a person that results in his/her being treated unjustly on the basis of their belonging or being perceived to belong, to a particular group.
- Because of the stigma associated with HIV and AIDS and the discrimination that may follow the rights of the people living with HIV and AIDS and their families are frequently being violated.

**This violation of human rights increases the negative impact of the epidemic:**

- At the level of the individual it causes undue anxiety and distress.
- At the family and community level, it causes people to feel ashamed, to conceal their link with the epidemic and to withdraw from participation form more positive social responsibilities.
- At the society level such discrimination against people living with HIV reinforces the mistaken belief that such discrimination is acceptable and that those infected should be ostracized and blamed.
Examples of how stigma is expressed through discrimination:

- PLHA being blamed for their infection and told they deserve it;
- People running away from you because of a disease you have, or because of your personal attributes such as the way one talks, color of the skin, religion, tribe, social class;
- Fear of disclosing that one is HIV positive because one would be stigmatized if known to be HIV infected;
- I feel stigmatized in my workplace because people have known that I am HIV positive. As a result they isolate me, my bosses do not want to assign me challenging tasks because they believe that I have no future in the company;
- Feeling ashamed because one has HIV and AIDS, or TB;
- Self-stigma-PLHA reacts to and begins to accept negative judgments of society.
Handout 3.5 - Action Planning to Fight Stigma

HEALTH CENTER

Forms of Stigma: Clinics creates gossip by isolating chronic patients. Limiting physical contact with chronically ill patients because of fear of contracting disease demoralizes patients, makes them feel unwanted and may destroy their will to live. Nurses make assumptions about patient’s sexual history and may judge them for “having had too many partners.” Some health workers give up on their patients, assuming they are going to die quickly, so “why waste their time.”

Strategies to Combat Stigma:

1. Provide spaces for health workers to talk about their own attitudes, feelings, fears and behavior.
2. Help them deal with fears about their status and burnout.
3. Teach skills on how to handle patients sensitively.
4. Develop codes of practice.
5. Update health workers on HIV and stigma issues through in-service training.
6. Get feedback from clients (community walk through clinic to identify stigma points)

COMMUNITY

Forms of Stigma: PLHAs and families face isolation, insults and discrimination. In some cases they are kicked out of rental accommodation or their businesses suffer (e.g. people stop buying from them).

Strategies to Combat Stigma:

1. Involve community leaders and community organizations in promoting anti-stigma work.
2. Use people living with HIV as role models and facilitators.
3. Organize community meetings, peer group meetings and home visits.
4. Organize drama performances.
5. Make links between clinic and community. 6) Inform community members what is involved in caring for PLHAs—physical care, counseling, etc
HOME BASED CARE (HBC) WORKERS
Forms of Stigma: HBC workers face stigma by association—rejected by the community who say they carry AIDS. They also face rejection by patients when they make home visits. Wearing uniforms triggers stigma towards family (by neighbors). Visits are seen as a “death warrant.”

Strategies to Combat Stigma:
1. Stop wearing uniforms during home visits.
2. Raise awareness by providing correct information on HIV, TB, and stigma; and how to take care of PLHAs and TB patients.

FAITH GROUPS

Strategies to Combat Stigma:
1. Use churches/mosques as place to discuss stigma.
2. Get faith groups to recognize that they stigmatize-- that they blame and judge people for getting HIV.
3. Educate religious leaders on stigma and help them play a leading role in anti-stigma action.
4. Encourage them to become counselors in a non-stigmatizing way; and role models for treating PLHAs in non-stigmatizing ways

WORKPLACE
Forms of Stigma: Workers gossip about other workers who are assumed to have HIV. Loss of opportunities once one’s status is known, e.g. loss of job, promotion.

Strategies to Combat Stigma:
1. Win support of the owners/managers
2. Create trustful environment that workers won’t lose jobs if they disclose status.
3. Work with managers to set policies: health benefits, continuity of employment.
4. Incorporate stigma into benefits-offer VCT and ARVs-educate workers on rights.
5. Encourage PLHA support groups within the workplace.
6. Promote a code of conduct.
MEDIA
Forms of Stigma: Incorrect, fear-inducing messages on AIDS and PLHAs. Disseminate message that AIDS = immediate death. Contradictory information so the community is confused.

Strategies to Combat Stigma:
1. Provide up-to-date and correct information.
2. Avoid threatening images.
3. Give a positive and hopeful view of PLHAs: pictures which show PLHAs who are in good health and who are living normal lives and who can actively contribute to their family and the society.
4. Involve PLHAs in educating media workers on these issues.