Reducing Stigma related to Gender, Culture and HIV/AIDS

Facilitator’s Guide
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### Acronyms

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<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retroviral (drugs used to slow down the rate at which the HI virus reproduces in the blood, in order to protect the immune system and prevent an infected person from contracting AIDS-related illnesses.)</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus - The virus that causes AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother to child transmission (of HIV)</td>
</tr>
<tr>
<td>STIs</td>
<td>Sexually transmitted infections</td>
</tr>
</tbody>
</table>

### Key terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement</td>
<td>Completion, accomplishment</td>
</tr>
<tr>
<td>Barrier</td>
<td>Obstacle</td>
</tr>
<tr>
<td>Category</td>
<td>Class or division</td>
</tr>
<tr>
<td>Concept</td>
<td>Idea</td>
</tr>
<tr>
<td>Constraint</td>
<td>Limitation imposed on movement or action</td>
</tr>
<tr>
<td>Culture</td>
<td>The way of life of a group of people, including their language, behaviours, beliefs, values and symbols</td>
</tr>
<tr>
<td>Dimension</td>
<td>Measurement of size, such as length, width or height</td>
</tr>
<tr>
<td>Diversity</td>
<td>Difference</td>
</tr>
<tr>
<td>Epidemic</td>
<td>An outbreak of disease spreading among many people</td>
</tr>
<tr>
<td>Evaluation</td>
<td>An activity or set of activities designed to measure the value of a project or programme</td>
</tr>
<tr>
<td>Marginalisation</td>
<td>The process of pushing or keeping people to the margins, or the edges, of society, so that they are not included in decision-making and access to resources</td>
</tr>
<tr>
<td>Migrate</td>
<td>To move from one place/country to another</td>
</tr>
<tr>
<td>Myth</td>
<td>A story or belief based events or ideas that cannot be proven</td>
</tr>
<tr>
<td>Prejudice</td>
<td>An opinion or attitude formed before having the facts or reasons to back it up</td>
</tr>
<tr>
<td>Religion</td>
<td>A set of personal or institutionalised attitudes and practices based on devotion to a god or supreme being and/or beliefs about the origins and meaning of life</td>
</tr>
<tr>
<td>Resources</td>
<td>Supplies of useful skills, money, goods, information or services that are available or needed</td>
</tr>
<tr>
<td>Sacred</td>
<td>Seen as holy or blessed</td>
</tr>
<tr>
<td>Stigma</td>
<td>A feeling of strong disapproval or shame directed at individuals or groups because of their circumstances, history, identity or other characteristic</td>
</tr>
<tr>
<td>Taboo</td>
<td>A social, religious or cultural custom that forbids people from doing or talking about something</td>
</tr>
<tr>
<td>Victimisation</td>
<td>Negative treatment based on a particular quality or characteristic associated with a certain person or group</td>
</tr>
</tbody>
</table>
Preparation

Purpose of the Guide

This Facilitator Guide is designed to provide facilitators with basic knowledge and skills to equip Community Mentors to promote stigma reduction in relation to gender, culture and HIV/AIDS.

It examines the concepts of gender and sexuality, cultural norms and practices, and looks at how these contribute to stigma around perceptions of behaviour and HIV risk.

The Guide focuses on the factors that contribute to vulnerability and risk of HIV infection in girls and women, lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals, people who engage in sex work and men who have sex with men (MSM).

The Guide aims to challenge the views of both participants and facilitators, through a supportive process of self-reflection, exchange of knowledge and experience, and shared learning. The intended outcome is that facilitators and Community Mentors will be able and motivated to promote a sensitive, rights-based approach to reducing stigma that supports HIV prevention efforts.

How to use the Guide

The Guide is intended for use in a 5-day training workshop. Each day builds understanding of key concepts and uses practical activities to encourage participants to relate the information and examples presented to their daily lives and local contexts.

The Guide models various facilitation methods, including formal classroom training, role plays, case studies, discussions and brainstorming. The Facilitator Guide should be used in conjunction with the Community Mentor Activity Guide, which participants will keep as a resource for their community-based stigma reduction and HIV prevention activities.

Notes to the facilitator

• Read the Facilitator Guide, the Community Mentor Activity Guide, the handouts and the Training Programme well ahead so that you are familiar with the material, the connections between the modules and the time required.

• Try to get advance knowledge about your participants — such as numbers, ages, gender, role in the organisations, and particular concerns in relation to the topics to be covered.

• Make sure all the resources you will need for the sessions are available the day before.

• Check and prepare the training venue in advance to ensure it will meet your needs. Work out how you will adapt the activities if you have limited space or other constraints.

• Use the session guidelines to plan the programme but add individual touches according to the group’s needs. For example, choose ice breakers — or invite participants to propose ice-breakers — that are appropriate to the needs and circumstances of the group and that everyone can participate in.

• Plan your introductions to ensure that everyone feels included and learns something about the group.

• Build on the experience of your participants: they provide a rich pool of knowledge and ideas that can add value to the training.
Introduction

Outcomes
By the end of this session participants will:
- Be familiar with the names of other participants and the organisations they are from.
- Understand the purpose and scope of the course.
- Be aware of terms that are used throughout the manual.
- Define their expectations and realise how they fit into the course outline.
- Be aware of trainers’ expectations of participants during the course.

Method
- Introduce ourselves
- Brainstorm expectations
- Review programme and confirm which expectations can be met in this workshop
- Complete pre-course questionnaire

Suggested introductory activity
Each participant and facilitator introduces him/herself and mentions an aspect of their identity that is important to her/him (e.g., profession, language, cultural group, gender, traditional dress, position, skill or interest).

Purpose and programme
Take participants through the proposed programme. A suggested programme is provided on the next page. It allows for a practical programme on Day 4. You may need to adapt it according to participant needs and the schedule for any guest speakers and visits.

Participants’ expectations
Invite the participants to brainstorm and discuss their expectations of this training workshop.
Record each workshop expectation on a flipchart.
If some of the participants’ expectations cannot be met because they are outside the scope of the course, explain this and if possible identify resources they can use to fulfill those expectations.

Facilitators’ expectations
Participants are free to use the language they are most comfortable with.
Participants will be tolerant, participate fully and share their experiences and views for the benefit of all.
Participants will raise concerns or problems with the facilitator directly as they arise (i.e., not wait until the last day of the workshop).
Participants will not criticise or judge what someone else has said or done; rather ask ourselves ‘What can I learn from this?’ and offer alternative views or approaches.
<table>
<thead>
<tr>
<th>Day</th>
<th>Module/Theme</th>
<th>Timeslot/Duration</th>
<th>Topic/Activity</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
<td>Arrival &amp; registration</td>
<td>Facilitator guides, Participant workbooks</td>
</tr>
<tr>
<td>2</td>
<td>Module 1. Exploring diversity</td>
<td>Morning</td>
<td>Introductions, collection of pre-assessment sheets (questionnaires)</td>
<td>Handout 1: Pre-assessment sheets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Afternoon</td>
<td>Expectations</td>
<td>Flipchart &amp; koks</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Discussion of key concepts</td>
<td>(enough for 4 groups to have 2 colours)</td>
</tr>
<tr>
<td>3</td>
<td>Module 2. Gender &amp; sexuality</td>
<td>Morning</td>
<td>From stereotypes to stigma</td>
<td>Handout 2: Diversity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Afternoon</td>
<td>Understanding sex and gender</td>
<td>Flipchart &amp; koks</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Gender inequality and sexuality</td>
<td>Preslk.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Exploring cultural beliefs, norms and practices</td>
<td>Copies of Handout 3: Generalisations and Handout 4: Reflection</td>
</tr>
<tr>
<td>4</td>
<td>Module 3. Culture &amp; stigma reduction</td>
<td>Morning</td>
<td>Shifting cultural norms to end stigma</td>
<td>Flipchart &amp; koks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Afternoon</td>
<td>Discussion with invited speakers</td>
<td>Guest speaker/s</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Field visit/community dialogue</td>
<td>Group photo</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Depart for field visit</td>
<td>Depart for field visit</td>
</tr>
<tr>
<td>5</td>
<td>Module 4. Practicing tolerance and inclusion</td>
<td>Morning</td>
<td>Reducing discrimination, preventing HIV and promotion health</td>
<td>Handout 5: Genderbread</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Afternoon</td>
<td>Distribution and collection of post-assessment sheets (questionnaires)</td>
<td>Person</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Photos, certificates</td>
<td>Resources</td>
</tr>
<tr>
<td>6</td>
<td>Module 5. HIV prevention and health promotion</td>
<td>Afternoon</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>7 (Sat)</td>
<td>n/a</td>
<td>Afternoon</td>
<td>Departure</td>
<td>n/a</td>
</tr>
</tbody>
</table>
Pre-course Assessment

Distribute HANDOUT 1: PRE-TRAINING QUESTIONNAIRE. Explain the purpose of this: it is to assess participants’ previous experience of the topics covered in the course and their views of stigma and discrimination in their communities. Go through the questionnaire with the group to ensure everyone is clear about what is required. Most of the questions require ticks and it should only take 6-10 minutes to complete.

Handout 1: Pre-Training Questionnaire

1. NAME

2. ORGANISATION

3. POSITION

4. GENDER
   - FEMALE
   - MALE

5. AGE
   - 18-24
   - 25-40
   - 41-55
   - 56-65

6. Have you attended any training on issues related to stigma and HIV/AIDS before? Tick yes or no below

   a) HIV PREVENTION
   b) HIV/AIDS TREATMENT LITERACY
   c) GENDER INEQUALITY
   d) CULTURAL PRACTICES AND HIV
   e) MANAGING DIVERSITY
   f) LGBTI RIGHTS
   g) STIGMA REDUCTION
   h) SEX WORK/TRANSACTIONAL SEX
   i) GENDER-BASED VIOLENCE

   YES
   NO

7. What are the main issues you deal with in your work on HIV/AIDS? (Tick all topics that apply)

   a) ABORTION
   b) CULTURAL PRACTICES AND HIV
   c) GENDER INEQUALITY
   d) GENDER-BASED VIOLENCE
   e) HIV COUNSELLING AND TESTING (HCT)
   f) HIV PREVENTION
   g) HIV/AIDS TREATMENT ACCESS, CARE AND SUPPORT
   h) HIV/AIDS TREATMENT LITERACY
   i) LGBTI RIGHTS
   j) MANAGING DIVERSITY
   k) PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV (PMTCT)
   l) SEX WORK/TRANSACTIONAL SEX
   m) STIGMA REDUCTION
   n) TEENAGE PREGNANCY
   o) TRADITIONAL CIRCUMCISION AND INITIATION
   p) VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC)
   q) OTHER (PLEASE DESCRIBE)

Names are required in order to compare responses to this questionnaire and one that will be conducted at the end of the course. No names will be used in reporting on this and the questionnaires will be returned to participants.

This applies to any training, through their organisations, AFSA, other organisations or training institutions.

This applies to the work of the participant, not the organisation.
8. Which groups of people do you work with in the community?  
(Tick all that apply)  
a) BOYS (UNDER 18 YEARS)  
b) COMMUNITY LEADERS  
c) COMMUNITY ORGANISATIONS/NGOs  
d) GIRLS (UNDER 18 YEARS)  
e) HEALTH CARE PROVIDERS  
f) LGBTI PEOPLE  
g) MEN WHO HAVE SEX WITH MEN  
h) OLDER MEN  
i) OLDER WOMEN  
j) POLICE  
k) REFUGEES AND/OR MIGRANTS  
l) SCHOOLS  
m) SEX WORKERS  
n) SOCIAL SERVICES  
o) SURVIVORS OF VIOLENCE  
p) YOUNG MEN  
q) YOUNG WOMEN  

9. To the best of your knowledge, are any of the following groups of people viewed or treated negatively in your community? (Tick all that apply)  

<table>
<thead>
<tr>
<th>Group</th>
<th>YES</th>
<th>NO</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) BOYS/MEN WHO DO NOT UNDERGO CIRCUMCISION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) BOYS/MEN WHO MAKE SCHOOLGIRLS PREGNANT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) BOYS/MEN WHO UNDERGO TRADITIONAL CIRCUMCISION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) GIRLS WHO HAVE SUGAR DADDIES OR BLESSERS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) LGBTI PEOPLE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) MEN WHO ARE SUGAR DADDIES OR BLESSERS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) MEN WHO HAVE SEX WITH MEN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) REFUGEES AND/OR MIGRANTS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) SCHOOLGIRLS WHO ARE PREGNANT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) SEX WORKERS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k) SURVIVORS OF VIOLENCE/RAPE SURVIVORS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Participants can tick yes if they have personal experience of this, or have heard it reported in their work or community, or in the local media.
10. Why do you think this is?
   a) IT IS DUE TO IGNORANCE
   b) IT IS BECAUSE PEOPLE LIKE TO BLAME OTHERS
   c) IT IS BECAUSE CULTURE TEACHES PEOPLE TO REJECT THESE INDIVIDUALS
   d) IT IS BECAUSE RELIGION TEACHES PEOPLE TO REJECT THESE INDIVIDUALS
   e) IT IS BECAUSE THE BEHAVIOUR OF THE GROUPS I NOTED/TICKED IS MORALLY WRONG
   f) IT IS BECAUSE THE BEHAVIOUR OF THE GROUPS I NOTED/TICKED SPREADS HIV
   g) IT IS BECAUSE THE BEHAVIOUR OF THE GROUPS I NOTED/TICKED CAUSES HARM TO OTHERS
   h) OTHER (PLEASE EXPLAIN)...........................................................................
   i) I DON’T KNOW

11. How do you feel about this? Tick the answer that is closest to how you feel.
   a) I THINK IT IS CORRECT TO DISCRIMINATE AGAINST PEOPLE WHO DON’T FOLLOW CUSTOMS AND RELIGIOUS RULES IN THE COMMUNITY – THEY BRING IT ON THEMSELVES
   b) I THINK IT IS NORMAL TO DISCRIMINATE AGAINST PEOPLE WHO DON’T FOLLOW CUSTOMS AND RELIGIOUS RULES IN THE COMMUNITY
   c) I THINK IT IS NORMAL TO BLAME PEOPLE WHO ARE DIFFERENT
   d) I DON’T AGREE WITH DISCRIMINATING AGAINST PEOPLE
   e) I FEEL STRONGLY THAT DISCRIMINATING AGAINST OTHERS IS WRONG
   f) DISCRIMINATION NEEDS TO BE STOPPED IF WE ARE TO OVERCOME HIV/AIDS
   g) DISCRIMINATION NEEDS TO BE STOPPED IF WE ARE TO OVERCOME HIV/AIDS AND GENDER-BASED VIOLENCE

12. Do you feel able to inform and educate people in your community about discrimination?
    Tick the answer/s closest to how you feel.
    a) NO. I DON’T HAVE ENOUGH INFORMATION MYSELF
    b) NO. I DON’T HAVE THE SKILLS TO EDUCATE PEOPLE
    c) NO. I LACK THE CONFIDENCE TO SPEAK OUT ON THIS ISSUE
    d) NO. I DON’T THINK PEOPLE WOULD LISTEN
    e) NO. I DON’T THINK IT IS NECESSARY
    f) YES BUT I NEED MORE INFORMATION
    g) YES BUT I NEED MORE TRAINING
    h) YES BUT I NEED MORE CONFIDENCE
    i) YES, I AM ALREADY DOING THIS EFFECTIVELY

13. What do you hope to get out of this training?
    .............................................................................................................................
    .............................................................................................................................
    .............................................................................................................................
    .............................................................................................................................
    .............................................................................................................................
MODULE 1: EXPLORING DIVERSITY

LEARNING OUTCOMES

By the end of this module participants will:

- Be able to define key concepts that are used throughout the course.
- Understand the process by which perceptions of different groups and individuals lead to discrimination and violence.
- Identify and analyse stereotypes in their communities and barriers to embracing diversity.
- Think critically about their own attitudes towards diversity.

METHOD

- Facilitator discusses with the group the terms that will be used in the training.
- Facilitator takes group through the links between generalisations, discrimination and violence
- Small group exercise – groups discuss prejudice towards different groups based on stereotypes about appearance, HIV-status, sexual orientation, gender, ethnicity and other characteristics.
- Facilitator takes feedback from the groups and summarises discussion.
- Participants undertake a self-assessment of their own attitudes towards different groups.

RESOURCES NEEDED:

Flipchart paper and enough koki pens for small groups to have 2 each.
Handout 1 – Pre-training Questionnaire
Handout 2 - Diversity
Handout 3 – Generalisations
Copy of Handout 3 written up on flipchart paper
Handout 4 – Personal reflection
SESSION 1

KEY CONCEPTS RELATED TO DIVERSITY AND STIGMA

Before we look at stigma, we’ll review some of the key concepts used in this programme and how they are related to each other.

DIVERSITY

GROUP ACTIVITY

The object of Part 1 of this activity is to find out whether and to what extent participants think it is possible to recognise characteristics that may be stigmatising, simply by looking at someone. If participants are already convinced that it is not possible to label people based on appearance, this activity provides a tool for them to explore diversity and labelling with other people. If there is a tendency to label, Part 2 is designed to explore difference and help participants to reflect on visible and invisible differences, and the status and meaning attached to these.

Part 1: Who is…?

Give each group at least one photo taken in South Africa and showing many different people. Some images are supplied (Handout 2: Diversity) but you can also use your own photos or pictures from the media.

Ask each group to look carefully at their picture and answer the following questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Probably</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there anyone in this photo who is NOT a South African?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Is there anyone in this photo who is HIV-positive?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Is there anyone in this photo who is Disabled?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Is there anyone in this photo who is Gay?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Is there anyone in this photo who is Poor?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ask for feedback from Group 1. Make a note on the flipchart of their answers. Put one response per question unless the group did not agree, in which case, note dissenting answers. Ask if the other groups agree and note dissenting answers.

Now ask what are the reasons for the answers given.

If there is unanimous or strong agreement that the answer to any question is Yes or No, move to Part 2 of the activity and then repeat Part 1 using only the photos about which the groups agreed on Yes or No answers.

If there is unanimous or strong agreement that the answer to all the questions is Probably or Don’t Know, continue to Part 2 and then move to the next activity.
Reducing Stigma related to Gender, Culture and HIV/AIDS

PARTNER ACTIVITY

Ask participants in pairs to discuss and note down the types of differences that they observe between people in South Africa. Ask each pair to call out what they have written and get someone to record all the differences on newsprint. Keep the list visible.

Use the checklist below to add relevant differences that may have been overlooked.

Definitions:
A range or variety of differences.
Inclusion of people or things or ideas representing a range of differences.

Read the definitions and check whether participants are clear about the literal meaning of the word – in English and their home languages.

Ask the group in what ways they think South Africa is diverse. For example is it possible to describe the climate or the geography or the animals in a way that includes all the provinces? What about the people?

PART 2: WHAT IS DIVERSITY?

Checklist for diversity

<table>
<thead>
<tr>
<th>Ability</th>
<th>Disability</th>
<th>Illness</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accent</td>
<td>Displacement</td>
<td>Intellect (IQ)</td>
<td>Religion</td>
</tr>
<tr>
<td>Age</td>
<td>Dress</td>
<td>Language</td>
<td>Sexual orientation</td>
</tr>
<tr>
<td>Allergies</td>
<td>Economic status</td>
<td>Lifestyle</td>
<td>Sexual activity</td>
</tr>
<tr>
<td>Appearance</td>
<td>Education level</td>
<td>Marital status</td>
<td>Skills</td>
</tr>
<tr>
<td>Attitudes</td>
<td>Employment status</td>
<td>Mental health</td>
<td>Skin tone/colour</td>
</tr>
<tr>
<td>Bereavement</td>
<td>Ethnicity/cultural background</td>
<td>Nationality</td>
<td>Sources of income</td>
</tr>
<tr>
<td>Birth</td>
<td>Family</td>
<td>Neighbourhood</td>
<td>Sports affiliation</td>
</tr>
<tr>
<td>Citizenship</td>
<td>Gender</td>
<td>Occupation</td>
<td>Values</td>
</tr>
<tr>
<td>Country of birth</td>
<td>Hair</td>
<td>Parenthood</td>
<td>Wealth</td>
</tr>
<tr>
<td>Criminal record</td>
<td>Height</td>
<td>Political affiliation</td>
<td>Weight</td>
</tr>
<tr>
<td>Culture</td>
<td>HIV status</td>
<td>Possessions</td>
<td></td>
</tr>
<tr>
<td>Diet</td>
<td>Gender identity</td>
<td>Pregnancy</td>
<td></td>
</tr>
</tbody>
</table>
Now ask the whole group to state which differences can be seen and which cannot be seen. Distinguish them on the newsprint by underlining or making asterisks in two colours.

Next, ask for examples of people who look the same but may be very different in ways that cannot be seen. Then ask for examples of people who might look very different but have significant similarities that cannot be seen.

Participants can use their activity guides to write out a complete list of visible and invisible differences to assist discussions in their communities.

**ACTIVITY: SOMETHING IN COMMON**

This exercise creates opportunities for participants to find ‘Something in Common’ beyond what they already know about each other.

In plenary, ask what similarities the group would expect to find among them based on being based in the same province and attending the same workshop. Ask them to reflect privately on whether the similarities mentioned apply to them personally.

Next, read out the following four tasks:

1. Find someone in the room who has the same passion as you
2. Find someone in the room who is the same religious values as you
3. Find someone in the room who has the same fear as you
4. Find someone in the room who has the same talent as you.

Explain that every participant must attempt to complete every task but can do them in any order. Invite participants to move around looking for their ‘partner’.

Give the group 25 minutes to complete the activity then take a few minutes to discuss their experiences by asking questions in plenary such as these:

How did you feel doing this exercise?

Did you all find a match for each question?

Did you change any assumptions you might have had when you first came into the workshop about the people you partnered with?

This exercise creates an opening for participants to develop closer relationships and become comfortable discussing difference and later stigma.
ACTIVITY: INVISIBLE DIFFERENCES

Split the participants into pairs. Each pair will have 10 minutes to find 3 ways in which they are different. They should take turns to interview each other for 1 minute to find differences in:

1. Background (e.g., place of birth, family, upbringing)
2. Personality (e.g., shy, outgoing, trusting, controlling).
3. Beliefs (e.g., support for gender equality, land expropriation, immigration control, abortion, death penalty, or other contested issues). Emphasize that the objective here is to identify differences, not to argue about them or try to change their partner’s mind!

At the end of the activity, ask the same three questions as before:

How did you feel doing this exercise?
Did you all find a match for each question?
Did you change any assumptions you might have had when you first came into the workshop about the people you partnered with?

Do we accept diversity?
This activity looks at the extent to which diversity is accepted in South Africa.

GROUP ACTIVITY
Ask participants to work in their groups to discuss different kinds of diversity.
You may assign one of the following topics to each group or ask all groups to look at every topic.
- Sexual orientation
- Religion
- Ability
- Language

The group should spend 15 minutes discussing the following questions:

1. What differences are there among people in relation to this issue?
2. What is considered ‘normal’?
3. What is the attitude of the majority towards minorities?
4. What myths or false ideas do people have about individuals of a different sexual orientation, religion, ability or language group?
5. The South African Constitution says everyone is equal regardless of their differences. How far do you think people in your community fully accept people who are different in some way?

Take feedback from one group and then ask the other groups if they wish to add or contradict what has been said. Summarize the feedback.
What are the benefits and challenges of living in a diverse society?

Every country in the world is diverse in many ways. This is true even countries that do not have high levels of inequality or disease, which have not experienced high levels of migration and where everyone speaks the same language. Such countries still have diversity of abilities, ages, relationships, sexual orientation (even if homosexuality is outlawed), professions, ideas and interests.

In plenary, ask the group to identify benefits and challenges of living in a diverse society.

Write up all the suggestions on the board or flipchart, as below.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Challenge/problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ask the group to vote by show of hands on the following 2 questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are the benefits of living in a diverse society are greater than the challenges?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Is it important for South Africa to overcome the challenges of being a diverse society?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

We will look at ways of overcoming challenges later in the programme. For now we will look at the obstacles to dealing with the challenges and the consequences of ignoring them.

GROUP ACTIVITY

Select the activity according to the response to question 2 above.

OPTION 1 - Discussion: barriers to overcoming the challenges of diversity

Ask the groups to use flipchart paper to identify barriers to dealing with one or more of the challenges of diversity they identified. These might be personal, community or government level barriers. Use the examples in the chart below to prompt or add if necessary.
Reducing Stigma related to Gender, Culture and HIV/AIDS

GROUP ACTIVITY

OPTION 2 - Debate statement 2: ‘South Africa can safely ignore the challenges of diversity.’

OPTION 3 - Debate statement 3: ‘It is important for South Africa to overcome the challenges of being a diverse society.’

Divide the participants into 2 groups - those who agree with the statement and those who disagree. Each group chooses a spokesperson to present their case.

Allow 15 minutes for the groups to discuss why they say the statement is true or false.

Invite the group that supports the statement to present its arguments in 5 minutes.

Then invite the group that disagrees with the statement to present its arguments in 5 minutes.

At the end, ask participants to vote Yes or No on the statement, and ask if anyone changed their minds.

Examples for analysing barriers to dealing with challenges of diversity

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Individual (personal) barriers</th>
<th>Inter-personal (community) barriers</th>
<th>National (government, leadership) barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion of people with disabilities</td>
<td>Ignorance about disabilities</td>
<td>Cultural beliefs about disability</td>
<td>Lack of/ineffective initiatives promoting inclusive education.</td>
</tr>
<tr>
<td>Hostility towards immigrants</td>
<td>Fear of the unknown</td>
<td>Lack of previous contact with people from different backgrounds.</td>
<td>Government calling for tolerance without addressing competition for resources.</td>
</tr>
<tr>
<td>Rejection of gay people</td>
<td>Stereotypes about sexual orientation</td>
<td>Religious teaching against homosexuality</td>
<td>Leaders not speaking out against homophobia</td>
</tr>
</tbody>
</table>

We are nearly at the end of this session. In the next session, we are going to look at how we generalise about human beings in all their diversity.

It is natural for people to see ourselves in relation to each other. Our sense of identity is based on our recognition of our own uniqueness, the things we have in common with others, and the differences between us. Our sense of self-worth is strongly linked to the value attached to uniqueness, commonality and diversity.

From a very young age, we make generalisations based on recognising these commonalities and differences. These are important to our safety and comfort. They are largely what we call ‘common sense’.

For example, most of us learn, from experience or from being taught, things like:

- My mother loves me
- I should not accept sweets or a ride from a stranger
- Vegetables are good for me
- It’s important to get enough sleep
- It’s dangerous to get in the path of a hippo
- People who dress in a certain way belong to the same church as me.
However, as we grow older we discover there are exceptions to the rules. The generalisations don’t always work. But we tend to hang onto them. Differences and similarities don’t always mean what they think they do. But we find it hard to challenge our own views.

In the next session, we will look at how generalisations can be used to emphasise similarities and also to draw attention to differences. We will discuss how this can lead to stigma, discrimination and violence.

LUNCH BREAK
SESSION 2

DANGERS OF GENERALISING

FACILITATED DISCUSSION

Take the group through the terms and explanations in the flow chart Dangers of Generalising, below. Make sure everyone understands the terms and can make an accurate translation into their home language, through cross-checking in the group.

Dangers of generalising

GENERALISATION

A belief or statement about an entire group of people, animals, things, events or ideas, based on limited experience or information about individual members of that group.

STEREOTYPE

This is a belief about an individual or a group, based on a generalisation.

Stereotypes develop when people hold fixed beliefs about others. Stereotypes spread when people accept - and repeat - information that confirms their beliefs and reject information that contradicts them.

PREJUDICE

Prejudice means pre-judging; that is, making an assumption or judgment about things or people, before or without getting to know them, based on a stereotype about their characteristics. There are many types of prejudice. Some of the most prevalent are described below.

RACISM

Racism is prejudice that often leads to discrimination – usually against black people – on the basis of the belief that human beings can be divided into different ‘races’ according to skin colour and other physical characteristics, and notions of superiority and inferiority attached to these characteristics.

SEXISM

Sexism prejudice that often leads to discrimination – usually against girls and women – on the basis of stereotypes about sex or gender.

CHAUVINISM

Chauvinism is extreme patriotism and belief in national superiority, leading prejudice towards other countries or people and characteristics associated with them.
ELITISM
Elitism is the belief that certain persons or members of certain groups deserve more respect or better treatment than others because their intelligence, education, social standing, or wealth is greater than that of others.

ABLEISM
Ableism is a form of prejudice based on the belief that people who have developmental, emotional, physical or psychiatric disabilities are of lesser value or deserving of less consideration than people who do have or have not been diagnosed with disabilities.

HOMOPHOBIA
Homophobia is prejudice, including fear and hatred, directed at people who identify or are perceived as being lesbian, gay, bisexual, transgender or intersex, or who do not fit gender stereotypes.

HETEROSEXISM
Heterosexism is prejudice against homosexuals on the assumption that heterosexuality is the only ‘normal’ and hence acceptable sexual orientation.

ETHNOCENTRISM
This is the perception that the values and behaviours of one’s culture constitute the only good, reasonable and natural way of life. Ethnocentrism sees one’s own group as the standard for all judgments about values and behaviour. It leads to a tendency to view differences negatively.

STIGMA
Social stigma means extreme disapproval of a person or group based on appearance, behaviour, health status, or other characteristics that distinguish certain individuals from the rest of a community or society. Causes of stigma include ignorance, fear and resentment.

DISCRIMINATION
Discrimination is behaviour based on prejudice and stigma.
For example, if you believe that overweight people are lazy or that women are weak, that is a prejudice. However, if you behave in a disrespectful or hurtful or unfair way towards someone because s/he is overweight or because she is a woman, that is discrimination. If you believe it is unacceptable to be gay or that people with disabilities are cursed, that is stigmatising. However, if you exclude them from school or church, that is discrimination.
VIOLENCE

Violence is the intentional use of physical force against oneself, another person, or against a group or community that can result in injury, death, psychological harm, or deprivation. Discrimination can lead to violence. Once you believe that an individual or a group deserves to be treated differently because of certain characteristics you associate with them, you do not respect their rights. This can lead to using or tolerating violence against such individuals or groups. For example, if someone assaults or abuses someone because s/he is a child, or a partner, or a homosexual, or a foreigner, they are engaging in violence based on discrimination. At its most extreme, discrimination leads to hate crimes and genocide.
### INDIVIDUAL EXERCISE

The next activity is an individual exercise to encourage participants to reflect on their general attitudes to people with different backgrounds, identities and in different situations.

**Distribute Handout 3: Generalisations**

Ask the participants to read the list of generalisations and put a mark in the relevant column to show if they think the statement is always true, never true, or sometimes true.

Allow 5 minutes for the handout to be completed.

Display the flipchart paper with a copy of the handout written up where everyone can see.

Read out the first statement and ask participants to indicate by show of hands whether they answered ‘Always true’, ‘Never true’ or ‘Sometimes true’. Mark a tick in the box for each answer given. Go through the rest of the questions in the same way.

<table>
<thead>
<tr>
<th>Generalisation</th>
<th>Always true</th>
<th>Never true</th>
<th>Sometimes true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All birds have wings</td>
<td>✔</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>2. Diabetes is caused by unhealthy eating habits</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Europe is colder than Africa</td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>4. Friends are people who never let you down</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. Gay men are feminine</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6. Having TB is a sign that someone is HIV-positive</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>7. HIV-positive women should not have children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. If you believe you can, you are right; if you believe you can’t, you are right</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. It is acceptable for men to have sex before marriage</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>10. It is acceptable for women to have sex before marriage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. It is important to respect cultural practices</td>
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<td></td>
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<tr>
<td>12. It is difficult to discuss sex and sexuality with a person of the opposite sex</td>
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<tr>
<td>13. Men don’t enjoy window shopping</td>
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<td></td>
<td></td>
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<tr>
<td>14. No one can complete a marathon without training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. People contract HIV by engaging in immoral behaviour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Politicians are corrupt</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>17. Polygamy puts women at higher risk of HIV infection than monogamy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Rich people are corrupt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Religion is important to HIV prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Snakes are dangerous</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

If one or more participants answered ‘Always true’ for any question, put a tick in the relevant box. Do the same if one or more participants answered ‘Never true’ or ‘Sometimes true’. It is not important to know the numbers, just to show whether there are differences of opinion. Examples are given above to show how this might look for statements 1 and 2.
Select a few of the statements and ask participants to explain why they answered as they did.

If there was disagreement, ask someone who disagreed to explain why.

If the answers or explanations are based on factual errors, point these out in discussion. For example, the statement ‘All birds have wings’ is factually always true. There are birds that cannot fly (such as ostriches) but the only known bird that had no wings, the Moa (New Zealand) is extinct.

From stereotypes to stigma

Many of the statements are judgements about behaviours and characteristics that might be considered positive or negative, depending on a person’s values. Ask the group whether believing or repeating any of these generalisations could have a harmful effect. Lead a discussion on this. Use the example below if you need to prompt the participants.

‘People contract HIV by engaging in immoral behaviour’

This might sometimes be true, depending on how people understand the word ‘immoral’.

Let’s take the case of a married man who has multiple partners without telling his wife. He always insists on sex without a condom, contracts HIV and passes it on to his wife. Neither the man nor his wife has been for an HIV test since getting married and promising to remain faithful, so they are not aware of their status.

One of the man’s ‘girlfriends’ is a 15-year-old neighbour whom he makes pregnant. When the girl goes to a clinic, she is scolded by the health workers for having had sex. When she discovers she is HIV-positive, she is pointed out and shamed by the clinic staff and other clients. The man offers to make monthly payments to the girl’s family on condition that they do not tell anyone he made her pregnant. The man continues his outwardly happy married life and people at the clinic and in the community gossip about how the girl got pregnant. Classmates, teachers, neighbours and relatives of the girl say that she has brought shame on her family.

The married man, his wife and the 15-year-old girl are all HIV-positive. Only the girl’s HIV status is known. In this scenario, has everyone contracted HIV by engaging in immoral behaviour? Many people think that cheating on your partner is immoral. In South Africa, if a man has sex with a girl under the age of 16, it is statutory rape. It is generally agreed that rape is immoral as well as being a crime. Some people believe that having sex before you are married is immoral. Could it have a harmful effect on anyone in this scenario to believe and repeat the generalisation ‘People contract HIV by engaging in immoral behaviour’?
GROUP ACTIVITY

Gender stereotypes - what men think about women and what women think about men

Organise the participants into same-sex groups (ideally 5 or 6 people per group) and ask them to select a scribe/rapporteur.

Ask each group to draw up a list of what they think about males if they are females, and females if they are male. The list is drawn up without discussion and no one’s point should be excluded from the list. This activity should also be conducted with very little pre-discussion, to avoid influencing the individuals to think in a particular way.

Allow ten minutes for the groups to compile their lists. Be strict about time and remind participants that this is a list-making exercise, not a discussion session!

Invite one female group and one male group to report back. Display their lists and then invite the other participants to add anything from their lists that is not covered.

Facilitate a brief discussion on what people think about each list, using the following questions.

1. Are the statements negative, positive or neutral?
2. How many women agree or disagree that the statements apply to them?
3. How many men agree or disagree that the statements apply to them?
4. Does everyone know someone who does not conform to the generalisations about men and women?
5. How does it matter if we make generalisations about each other based on sex or gender?

We will come back to this question of sex and gender stereotyping in Module 2.
Men murder 22-year-old woman in suspected lesbian hate crime

More than 10 men broke into the home of LGBTQI activist Noluvo Swelindawo, near Khayelitsha, abducted her, assaulted her and then killed her in what is suspected to be a lesbian hate crime, in December 2016.

Noluvo’s brother Lwazi Swelindawo recalled the time his sister told her cousins that she wanted to join her brother when he went to the mountain to be initiated.

“For the longest time, we just knew udaliwe [she was created the way she was].”

“She was always uncomfortable getting undressed in front of people, so it wasn’t a surprise when she finally came out,” he told the media.

The 22-year-old was dragged from her home in Driftsands in the early hours of Sunday morning before being shot and killed. Her brutal murder is a suspected hate crime.”

“This is a chilling realisation of the dangers women face in their own communities – even more so for women from the LGBTQI community,” Dan Plato, Western Cape Minister of Community Safety, was quoted as saying.

The FreeGender Khayelitsha organisation has been working with the Khayelitsha Police Station to teach staff greater sensitivity in dealing with LGBTI people.

The organisation’s founder, Funeka Soldaat, told reporters that people were still hesitant to report hate crimes to the police “because so often in the past … they were subjected to humiliation at police stations”.

One man was later arrested for the murder.

Outrage about Noluvo’s murder was reflected on social media. Among the comments on Twitter:

“To be lesbian in South Africa is a death sentence it seems.”

“Even when women want nothing from or to do with men, men still feel entitled to their bodies! Homophobia in SA.”

“It’s time people accepted that they won’t lose anything if they accept other people’s sexuality.”

Noluvo, known as ‘Vovo’, is one of many people in South Africa brutally attacked and killed because of their sexual orientation or gender identity, including Eudy Simelane, Gift Disebo Makau, Patricia “Pat” Mashigo, Phumeza Nkolonzi, Michael Titus, Girly Nkosi, Carl Mischke, Noxolo Nogwaza and Dawid Olyne.

PARTNER ACTIVITY

Ask participants to discuss the case study with the person next to them and answer the following questions:

1. Why was the woman in this case study murdered?
2. What links do you see between stereotypes, prejudice, discrimination and violence in this story?
3. What do you think might have influenced the attitudes and behaviour of the man or men who killed her?
4. What is the best way to behave if you have strong feelings of anger, hatred or outrage towards another person?

Invite feedback from the partners and note the range of responses.

Ask the group if anyone can think of an example from another context or country where a person or people were killed because someone considered their beliefs or opinions were worth more than another person’s life.

We will come back to the issue of the right to hold an opinion and the right to life throughout the programme.

CONSIDER A COMFORT BREAK

FACILITATED DISCUSSION

We have looked at how generalisations and lead to stereotypes and prejudice but why does this happen – and how does it lead to discrimination and violence, even murder?

Introduce a discussion on where stereotypes and prejudice come from, drawing on the text below, and inviting experiences or observations from the participants.

Sources of stereotypes and prejudice

Childhood socialisation

One source of stereotyping and prejudice is childhood socialisation. Children learn attitudes and beliefs and behaviours from the way that family and friends speak to and treat others. They may copy, question or reject stereotypical views of different racial, ethnic, religious and other groups, based on their own experiences.

Community reinforcement

Teachers, religious and cultural leaders and other authority figures can influence beliefs and practices, reinforcing or challenging stereotypes and prejudice. This often happens in an effort to make young people conform to community norms and be accepted.

Personal experiences

South Africa, like other countries, is home to people from many different cultures and backgrounds. Colonialism and apartheid legislated racial prejudice and discrimination. It indoctrinated people to believe that there were different races and that those classified white were superior to everyone else. Where people are brought up to believe that they and their culture and customs are more or less valuable than those of other groups, intolerance, conflict and suffering can result.
Reducing Stigma related to Gender, Culture and HIV/AIDS

Media
The media both reflect and shape attitudes. Depending on how and how often they report on different issues, and how they represent different groups, the media can promote tolerance and inclusion, or feed harmful stereotypes.

Law and policy
Laws and government policies and programmes can help reduce or increase prejudice. For example, the South African government has put in place many laws and policies to promote equality, especially racial and gender equality. There is still extreme economic inequality between most black and white people but the government has taken a strong stand against racist and sexist speech and behaviour.

The final activity of the session is a personal reflection. This asks participants questions about their identity, attitudes and experiences. The purpose is to think critically about prejudice towards us and prejudice we might feel towards others.

Read out the text below and then ask the participants to answer the questions. Emphasise that there will be an opportunity to share their answers but that everyone is also free to keep them private.

PERSONAL REFLECTION
Think about what makes you who you are. Answer the questions below honestly. You can write in the space below or use the Handout.

1. What do you consider to be the most important aspects of your identity?

2. What are the main influences on the way that you think and feel, make decisions and behave?

3. Have you experienced prejudice from others based on things about your identity you cannot change (such as your skin colour, height, weight, language, a disability)?

4. Have you experienced prejudice based on things that are important to you but were not valued by others (e.g. religion or culture, a relationship, political affiliation)?

5. Do you feel or show prejudice towards other people? Is there a group of people about whom you tend to have a negative attitude, based on your upbringing or experience, or things you have heard in the media?
MODULE 2: GENDER AND SEXUALITY

LEARNING OUTCOMES
By the end of this module you will be able to:

• Explain the differences between sex, gender and sexuality
• Understand how gender norms are established and maintained
• Recognise the consequences of gender roles for access to rights and resources
• Question stereotypes related to sexuality

METHOD

• Guide discussion of the key concepts
• Use case study to examine gender norms
• Conduct group activities to help participants explore how gender identity is shaped
• Guide participants to trace influences on gender identity in their lives
• Facilitate assessment of access to resources
• Lead exploration of the dimensions of sexuality.

RESOURCES NEEDED

• Flipchart paper and pens
• Prestik
• Handout 5: Genderbread person
SESSION 1

SEX AND GENDER

In this module, we are going to explore the differences between sex, gender and sexuality. To start with, it is helpful to get an indication of the participants’ understanding of the terms sex and gender. The group activity below will show the associations the group makes with these terms, which are often misunderstood in any language.

GROUP ACTIVITY

Distribute 2 pieces of paper to each group. Ask group members to write down on one piece of paper all the words or phrases that they think of when they hear the word SEX.

Next, ask everyone in the group to write down on the other piece of paper all the words or phrases that they think of when they hear the word GENDER.

When they are finished, ask the groups to display the papers, on the wall or floor where everyone can walk around and see them. Put the ‘SEX’ papers on one side and the ‘GENDER’ papers on the other.

Ask participants what they observe about the 2 groups of words. Are some words used for both terms? Are any of the words used incorrectly? Do some words apply to both sex and gender?

Explain to the group that gender and sex are defined in many different ways, as displayed by their words, and they are closely connected. Then read out the following definitions and explanations.

SEX

Sex refers to biological differences, chromosomal and hormonal profiles, internal and external sex organs. One may be classified as male, female or intersex at birth.

Male – XY chromosomes, testes, penis, Adam’s apple, chest hair
Female – XX chromosomes, ovaries, vagina, clitoris, breasts
Intersex – Any mix of male and female chromosomes, of testicular or ovarian tissue, and atypical (inbetween what is typical) external and internal genitals.

(Intersex is not widely acknowledged or understood in South Africa because it has been taboo. At least 1% – one in 100 – of people worldwide are estimated to have some form of variation in their sex anatomy that may or may not be apparent at birth. At least one in 1000 people receive varying degrees of surgery to make their genitals appear more typically male or female).

Your sex at birth, as male or female, or intersex, is a biological fact across cultures. What that sex means in terms of your role in society as a girl or boy, a man or a woman can differ greatly between and within cultures. That is about gender.
GENDER

Gender refers to the characteristics (such as emotions), appearance and behaviours that individuals, families, cultural, religious and legal systems attribute to or associate with the sexes. Gender typically refers to masculine and feminine qualities as they are understood in a particular society.

What it means to be a man in any culture requires male sex plus whatever the culture defines as masculine characteristics and behaviour. Likewise, to be a woman means female sex and whatever the community defines as feminine characteristics.

In most societies, biological sex and gender are seen as binary – meaning there are only two and they are fixed. This binary approach also fixes roles, status, power, relationships, privilege and choices.

South Africa is a patriarchal society. Patriarchal means that power and leadership, authority, privilege and control of property and resources rest mainly with men. That status is passed on from a man to his eldest son. Fathers or father-figures hold authority over women and children. Patriarchy is the norm across the different cultural groups in South Africa. It is also the norm in many organisational and professional cultures.

In such societies, people who are intersex at birth, people whose gender identity is different from their sex at birth, and people who do not fit masculine and feminine stereotypes, are often under extreme pressure to conform to binary gender roles and behaviour.

Accepting, questioning or rejecting these gender roles can be dangerous because it threatens those in power. It impacts on the physical, emotional and psychological health of an individual. There are also impacts on society of limiting and controlling gender roles.

CASE STUDY

We discussed earlier the extreme consequences of intolerance of diversity and enforcement of gender norms, in the case of the suspected hate killing of ‘Vovo’ Swelindawo. There are frequent brutal attacks on women and on men simply because they do not conform. Invite someone to read through the scenario below.

Woman held hostage for wearing pants

Zandile Mpanza was held hostage, beaten, stripped and paraded naked through T Section in the urban township of Umlazi, KwaZulu-Natal, in July 2007 – for wearing trousers.

Mpanza was walking through the area to visit her boyfriend when local women accosted her. They said women were not allowed to wear trousers, according to a ‘ruling’ by local leaders. Mpanza was taken to the T Section headmen, assaulted and only released after the intervention of the local councillor.

The councillor said that Mpanza was unaware of the ban because she was not from the area. He called the police to escort her to her boyfriend.

The following year the Umlazi Equality Court ordered that the ban be lifted because it was unconstitutional. Mpanza opened a case against four men with the support of the Commission for Gender Equality and after nearly 4 years the men were convicted and sentenced for assault. Two other women had been assaulted for defying the ban earlier the same year.
In plenary, ask participants the following questions:

a) Why do you think the community leaders banned women from wearing trousers?
b) Why would women support such a ban and lead an attack on another woman?
c) What does this case say about gender roles?

GROUP ACTIVITY

Reflection on gender and culture
Ask participants in their groups to discuss the following questions and make brief notes on flipchart paper:

a) What are the characteristics of masculinity and femininity in your culture? Give examples.
b) In your culture, what value is attached to the status of being male or a female?
c) Who decided on these gender roles and values?
d) What is the purpose of these gender norms?
e) Who benefits from the way gender roles are assigned?
f) Can you think of examples where people have challenged gender norms? What happened?
g) What might be the benefits of changing gender norms?

FEEDBACK – ROLEPLAY
Invite group members to give feedback on any of these questions using roleplay, in the form of a conversation, a mime or a short drama. Allow 10 minutes of preparation and 5 minutes for each group to present, and a few minutes for others to ask questions.

After the feedback session, display the groups’ responses for review in the lunch break. Refer to the table below for further points about dominant ideas of masculinity and femininity.
‘Constructing’ gender roles

Gender is called a ‘construct’ because it isn’t produced biologically. It is put together using beliefs, values and experiences.

<table>
<thead>
<tr>
<th>MASCULINITY</th>
<th>FEMININITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masculinity refers to the set of characteristics conventionally associated with and believed to be desirable in men. The notion of being a man is understood differently in different cultural systems. In many South African settings, it tends to include such characteristics as strength, virility, sexual conquest, dependability, responsibility and protectiveness.</td>
<td>Femininity refers to the characteristics conventionally associated with and believed to be desirable in women. The notion of being a woman is understood differently in different cultural systems. In many South African settings, it tends to include characteristics such as virginity, motherhood, sexual submissiveness, responsibility and dependence.</td>
</tr>
<tr>
<td>This dominant form of masculinity is aggressive, competitive, powerful and often violent. Ideas of masculinity are influenced by family and cultural life, peers and the media, political and economic systems, livelihood opportunities and sexual relationships. Masculinity exists in relation to femininity. It subordinates women and other men through culturally and religiously enforced systems.</td>
<td>The dominant form of femininity is passive, sexualised, objectified. Ideas of femininity are influenced by family and cultural life, peers and the media, political and economic systems, livelihood opportunities and sexual relationships. Femininity exists in relation to masculinity. It subordinates younger women through culturally and religiously enforced systems.</td>
</tr>
<tr>
<td>Some men who do not meet society’s expectations of what it means to be a ‘real man’ are discriminated against. This includes gay men because the dominant masculinity strongly promotes heterosexism, the belief that everyone is or should be heterosexual.</td>
<td>Women who do not meet society’s expectations of what it means to be a ‘real woman’ are discriminated against. This includes lesbian women, women who do not or cannot have children, women who have children outside of social norms and women who engage in sex work.</td>
</tr>
<tr>
<td>Some men accept the rewards of dominant masculinity, without challenging the systems that suppress women and other men. Many men are ignorant of oppressive structures and accept them as given, just ‘the way things are’.</td>
<td>Some women benefit from dominant masculinity by enjoying a slightly higher status than women who challenge norms. Some actively participate in the systems that suppress women and other men. They may accept these systems as given or feel unable to change them.</td>
</tr>
<tr>
<td>Other men appear are excluded from the rewards of dominant masculinity even though they share many of its characteristics. This may be because they have no power to act in society, because of poverty, unemployment, racial discrimination or ethnicity.</td>
<td>Some women live outside the norms of ‘femininity’ because of poverty, unemployment, lack of support or discrimination. For example, women who are forced to undertake roles usually reserved for men.</td>
</tr>
<tr>
<td>There are men who actively challenge the dominant masculine norm, either because it excludes them or because they embrace equality and recognise the benefits to men and women of transformative and cooperative gender roles.</td>
<td>There are increasing numbers of women who actively challenge dominant gender roles because legislative, policy and economic reforms are promoting gender equality.</td>
</tr>
</tbody>
</table>

Gender identity

Gender identity is about how you as an individual identify yourself, as female, male, both or neither. Gender identity is not the same as gender role, which is often determined by society.

One’s gender identity can be the same as or different to the sex assigned at birth. Children become conscious of their gender identity by around the age of 3 years. Most people develop a gender identity that matches their biological sex. That is, they are born female and see themselves as a girl, they are born male and see themselves as a boy, or they are born intersex and develop a stronger sense of being a boy or being a girl.
For some people, their gender identity is different from their biological sex. This is referred to as being transgender. There is often a lot of pressure on people, from an early age, to make the way they dress, style their hair, speak and behave match their sex. Some transgender individuals change the way they look and present themselves to reflect their gender identity. Some undergo hormonal treatment and/or surgery to make their sex match their gender identity.

Gender identity – your sense of being male or female – is different to sexual orientation, which we discuss later.

**INDIVIDUAL ACTIVITY**

The next activity looks at how our own gender identity has been shaped. You are going to trace your life ‘path’. You can either use this graphic as your path or draw a path on flipchart paper.

![Path Diagram]

Ask participants to turn to the ‘path’ in their booklets. They can either use this graphic or draw a path on flipchart paper.

They should imagine the path starts at their birth and continues up until today.

They make a mark to show their earliest memory and then mark all the important events or stages of development in their lives.

Participants then identify critical points on their life journey that shaped their gender identity. These must be occasions or experiences that are directly linked to their roles as males or females.

These critical influences on gender identity can be labeled, or participants can use symbols (these symbols need to have a meaning to them, if not for other people).

The next task is to indicate whether they accepted or challenged the gender norm at any point in their life.

When the path of life is completed, ask participants to reflect on the following questions.
REFLECTION QUESTIONS:
a) What happened to you at each turning point?
b) How do you feel now about what happened then?
c) How has this influenced your views on being a man or woman?
d) If you could change anything about your gender role at any point, what would you change and why?

Ask if anyone would like to share their path of life.

LUNCH BREAK
SESSION 2

GENDER INEQUALITY AND SEXUALITY

GROUP ACTIVITY
Ask each group to identify a gender stereotype that they think is reinforced by any one of the following sources of influence. Do they think this affects people consciously or unconsciously? In what ways?

<table>
<thead>
<tr>
<th>Language – Local proverb or saying</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Music – lyrics to a song</td>
<td></td>
</tr>
<tr>
<td>Religion – quotation or teaching</td>
<td></td>
</tr>
<tr>
<td>Education – lifeskills</td>
<td></td>
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<tr>
<td>Media or social media – adverts, programmes or posts</td>
<td></td>
</tr>
</tbody>
</table>

Effects of gender inequality
The next part of the programme looks at effects of gender norms and gender inequality. It is based on a group assessment of access to and control over resources based on gender.

GROUP ACTIVITY
Assessment of access to, and control over, resources and benefits
The table below can be used as a tool to identify the resources people use in their lives and livelihoods, and to assess whether women or men have access to, and control over, these resources. Draw the table on flipchart paper and ask each group to list the following categories:

**Resources in the community**
- Resources women and men have access to
- Resources men and women have control over
- Resources only men have access to
- Resources only men have control over
- Resources only women have access to
- Resources only women have control over

**Benefits**
- What benefits do women and men receive from work?
- Over which benefits do they each have control?
Resources may include land, equipment, labour, tools, cash or credit, skills, education/training, self-esteem and time.

Benefits may include income, asset ownership, and provision for basic needs, education, political power and status.

<table>
<thead>
<tr>
<th>Resources</th>
<th>Women</th>
<th>Men</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labour</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Tools</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-esteem</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Women</th>
<th>Men</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asset-ownership</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provision of basic needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Political power</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Facilitate a short discussion about the effects of any unequal access to and benefit from resources.

Has the pattern of access and control over resources changed in the lifetime of the participants?

If so, who has benefited from the changes?

What are the benefits, if any, of transforming gender relations to promote equality?

List on the flipchart any benefits to **Men, Women, Society in general**.

Then move on to the session on **sexuality**.
SEXUALITY

BUZZ ACTIVITY

The group should now be more comfortable talking about sex. Invite participants to call out words that they associate with sexuality. Emphasize that there are no wrong answers – you are asking people to call out whatever comes to their mind when they hear the word sexuality.

Write up all the words and phrases on the board or flipchart.

Now invite the participants to help group the words to highlight the different aspects of sexuality. Use different colour pens to circle words that relate to:

- EMOTIONS & THOUGHTS
- PHYSICAL SENSATIONS
- BEHAVIOUR
- RELATIONSHIPS
- REPRODUCTION

Ask the group what they observe when they try to do this? Do they see how the different aspects are linked? Is there any aspect of life that is not connected to sexuality?

Use the text below to explain the meaning of sexuality in detail.

- Sexuality is distinct from gender but the two are linked. Human sexuality refers to a person’s capacity to have sexual feelings, attraction, desires and pleasure. This may be expressed in thoughts and fantasies, sexual activities, roles and relationships. Physical and emotional aspects of sexuality include strong bonds of love, trust and attraction between people. The biological dimension of sexuality relates to the drive to reproduce. Sexuality also has spiritual and social aspects.

- An individual’s sexuality is influenced by explicit and implicit rules imposed by the society in which s/he lives. These rules and expectations vary according to gender, age, economic status, culture, religion and education, among other things.

- Power is fundamental to both sexuality and gender. Power determines how people can express their gender identity and sexuality, with whom people can have romantic or physical relationships, whose pleasure is given priority and whether, when, how and with whom sex takes place.

- The power balance in patriarchal gender relations favours men. Male pleasure has priority over female pleasure. Heterosexual interactions are normalised over homosexuality.

Sexual orientation

Sexual orientation is about feelings. It refers to the ways in which people are romantically or sexually attracted to other people in relation to their gender and sex. Sexual orientation and gender identity are separate, distinct parts of a person’s overall identity. While young children usually have a strong sense of their gender identity, most do not become aware of their sexual orientation until a few years later, as they approach puberty.
Sexual orientations include:
- **Lesbian** – attraction of someone who identifies as female to another female
- **Gay** – attraction of someone who identifies as male to another male
- **Bisexual** – attraction of male or female individuals to both males and females
- **Straight (heterosexual)** – attraction of a female to a male or a male to a female
- **Polysexual** – attraction to multiple genders. A polysexual person may identify as male, female, transgender or intersex and be attracted to someone of more than one gender or sex.
- **Pansexual** – attraction to all genders and sexes
- **Asexual** – not having feelings of sexual attraction towards any gender or sex

**Sexual activity**

Sexual activity is about **behaviour**. It is about the ways in which people experience and express their sexuality, by themselves and with others. Sexual activity is NOT the same as sexual orientation. For example, some men have sex with other men but do not identify as gay.

- Knowing that someone is lesbian, gay, straight or any other sexual orientation does not tell us that they are sexually active or what sexual activity they engage in, with whom, how often or in what circumstances.
- Human beings of any sexual orientation engage in a spectrum of sexual activities – in order to attract and court others, to sexually arouse themselves and/or others, to experience sexual pleasure, and sometimes to reproduce.
- Human beings of any sexual orientation may also be celibate – not engage in any sexual activity, for a period of time, or ever.
- Human beings of any sexual orientation may engage in sexual activity that is harmful to themselves or others, that is criminal or not accepted in their cultural or religious community.

**INDIVIDUAL ACTIVITY**

1. If you see a man holding hands with a woman in a restaurant, can you tell when they last had sex and what they did? Do you even think about it? Why?
2. If you see a man holding hands with a man in a restaurant, can you tell when they last had sex and what they did? Do you even think about it? Why?
3. If there is any difference in your answers, note the reason/s.

**A spectrum of human sexuality**

Many different cultures around the world recognise that human beings do not exist in a binary (either-or) state in terms of sex, gender, gender identity, sexual orientation or sexuality. For example, the indigenous Māhū of Hawaii acknowledge a third gender, as an intermediate state between man and woman, or a “person of indeterminate gender”. The traditional Dineh in the US acknowledge four genders: feminine woman, masculine woman, feminine man, masculine man. The hijras of India, Bangladesh and Pakistan have legal status as a ‘third gender’. North American Indigenous cultures have special roles for Two Spirit people. There were traditional third-gender roles in African societies such as the Mbo people of the Democratic Republic of Congo.

These concepts are not common in mainstream western culture and thinking, which undermined indigenous knowledge systems in colonised countries.

In societies where gender roles are strictly enforced, people can become very uncomfortable, confused, fearful and angry if people do not stick to their roles.
PARTNER ACTIVITY

Ask participants in pairs to discuss the Genderbread Person in their books for a few minutes. Do they think this is a helpful way to look at the issues? Does it make sense when they think about themselves, or about people they know who do not fit typical gender roles? They are not being asked to adopt this view but to know that there are different ways of viewing sex, gender and sexuality.

Looking at sex, gender and sexuality as spectrums, instead of binaries can help us to recognise how we all ‘fit’ the spectrum even if we don’t fit the box.

The Genderbread Person project produces graphics to help describe different aspects of sex, gender and sexuality.
MODULE 3: CULTURE AND STIGMA REDUCTION

LEARNING OUTCOMES
By the end of this module participants will be able to:

• Explain the concept of culture
• Analyse cultural influences on attitudes towards gender identity and sexuality
• Think critically about how culture evolves and adapts
• Identify ways in which cultural norms can contribute to or reduce stigma
• Understand and participate in processes to shift stigmatising cultural norms

METHOD
• Facilitate discussion of dimensions and layers of culture
• Brainstorm what influences the process of change
• Guide a discussion of individual and cultural attitudes towards gender identity and sexuality
• Facilitate group activities to analyse harmful cultural practices
• Lead a role play exercise to model advocating to shift cultural norms.

RESOURCES NEEDED
• Small cards – at least six per participant
• Prestik
• Copies of statements on sexuality (enough for each pair to have a copy of one statement)
• Handout 6: Words and thoughts
SESSION 1

WHAT IS CULTURE?
Start the session with this brainstorm on the question What is Culture?

BRAINSTORM

Distribute cards and ask participants to write each term they associate with culture on a separate card. Allow 5 minutes for this. Invite people to take turns calling out what they have written and stick their cards on the board/wall. Cards with the same word can be stuck on top of each other. Summarise the inputs by reading out the most commonly stated words or phrases. Work with the group to come up with a simple definition of culture that could apply to any group or organisation. Repeat the definition and then use the text below to run through some of the dimensions of culture. This is a vast topic so be open to suggestions and questions about what is included under the umbrella ‘culture’.

Culture
Culture refers to the shared beliefs, practices and ways of life that make individuals a community. Central features of a cultural group may include language, religion, rites of passage, relationships with each other and the environment, livelihoods, style of dress, types of food, music and dance. Culture also refers to the beliefs, practices and systems that give organisations and institutions their particular identity. For example, a school has a culture, a company has a culture, health facilities and other services have cultures, and so do banks, NGOs and governments.

Cultural heritage
Cultural heritage is made up of the knowledge, experience, meanings and symbols, notions of time and history, roles, material objects and possessions that are acquired through the individual and collective striving of a group or organisation and passed on from one generation to the next.
DIMENSIONS OF CULTURE

HERITAGE
LANGUAGE
EDUCATION
ARCHITECTURE
FOOD
MUSIC
LITERATURE

NORMS
 PATTERNS OF RELATIONSHIP
 PATTERNS OF COMMUNICATION
 PATTERNS OF HANDLING EMOTIONS
 APPROACHES TO CONFLICT AND
 PROBLEM-SOLVING

SYSTEMS PATTERNS OF DECISION MAKING
SOCIAL ORGANISATION AND STATUS (ACCORDING TO AGE,
GENDER, CLASS, OCCUPATION AND SOCIAL NETWORKS).
SOCIALISATION CHILD-REARING RITES AND RITUALS

BELIEFS
VALUES CONCEPT OF TIME AND HISTORY
CONCEPT OF ORIGINS AND ANCESTRY
CONCEPTION OF JUSTICE

Layers of culture:

- National
- Regional
- Local
- Organisational
- Intersections
  (things in common)
GROUP ACTIVITY

Ask participants to form 4 groups and give each group one of the following questions:

a) National level – is there a ‘South African’ culture? What is it?

b) Regional - what are the ethnic cultures within South Africa?

c) Local - What is the culture in your community?

d) Organisational - What is the culture in an organisation that you are familiar with – eg your local clinic, or a famous company, such as Spur, or a bank.

Allow 10 minutes for discussion.

In plenary, take feedback from each group.

Invite the other groups to make comments and ask questions.

GROUP ACTIVITY

Facilitate a short discussion on the intersections – or links – between these different layers. Prompt the group if necessary with these questions:

• What are the links between these layers of culture?

• Are there dominant attitudes that apply in all of them?

• For example, what is the attitude to gender equality, to LGBTI people, to immigrants?

Cultural norms

Cultural norms are the ‘normal’ or accepted ways of behaving, relating and doing things within the group or organisation. When people initially come together in a group, they do so because they see a need or a benefit. For example, they might come together to cultivate land, raise livestock or defend territory or resources against another group. Or they might form a group to raise money for a cause, or to start a business, a stokvel or a choir.

In order to be successful, the members need to pull together and stick to agreements. They share a vision and they protect their group from outside influences and threats.

Over time some people might feel they are suffering, or not getting the benefit they expected and so they can’t or don’t want to conform. They start to do things their own way, or try to change the way others do things, take over leadership or ‘go solo’. As a result, they might be excluded, or the cultural norms might change.

Cultural norms also change because conditions change. Examples are adopting a different lifestyle because a trend develops of moving from a rural community to the city to get a job, or changing the way circumcision is practised to reduce the risk of HIV.

Culture and stigma

When people live outside their cultural norms, they may be temporarily cut off from their roots. Or they may be completely rejected. When people are stigmatised they become vulnerable to exploitation and abuse. The case study below provides an example of this.
Sex workers claim police clients fail to protect them

‘They (local police) are the biggest clients to us, but when the people make riots here, they make it seem like we are the most disgusting people around,’ says Nikki*, a sex worker in Rosettenville, south of Johannesburg.

Nikki and her colleague Busi* operate from one of three houses which were attacked by community members at the weekend. Locals marched to the house on Sunday and threw their belongings onto the street, where they set fire to them. They alleged that the houses they attacked were were drug dens and brothels run by Nigerian nationals.

Nikki and Busi criticised the police for failing to protect them from the crowds, even though no drugs or other illegal substances were found in their house.

The women told reporters that police officers were some of their biggest clients.

‘There are many police officers that I communicate with on my phone. Some are even asking me out…Some even say, “If a client is giving problems, just call me”. They will come and solve the matter for me.’

*Not their real names. Case study adapted from news reports of protests in February 2017.

The next activity looks in more detail at the question of cultural norms and stigma in relation to LGBTI people.

You need copies of the statements below to hand out for this activity.

PARTNER ACTIVITY

‘What we believe in our culture’

When we think about cultural norms in your community, are there certain behaviours that are considered unacceptable or disrespectful of the culture? Being gay or lesbian is often said to be un-African and un-Christian and many countries have laws against homosexuality. People do not always say why being gay is considered problematic or what would happen if LGBTI people were to be accepted. We are going to examine some statements on sexuality based on cultural beliefs.

Divide the participants into pairs. Ask each pair to take a folded slip of paper with one of the following unseen statements:

‘In this community ...Because of our beliefs, we know that a woman must be in a relationship with a man.’

Mr. Big, participant in a young men’s focus group discussion on sexuality and culture, KwaZulu-Natal

‘When it comes to gays and lesbians (kusashlahalela kabi)...our understanding is that a man should be in love with a woman...’

Lay counsellor on sexual and reproductive health, Gert Sibande District, Mpumalanga
On the issue of not conforming to gender norms:

‘Society in rural areas has not yet come to terms with such things... unlike in the urban areas where people do not care; in the rural areas it is still an issue... how you dress... portray yourself... speak to elders... is held under the banner of culture...’

Interviewee, Eshowe

‘He hides himself and date girls while he is not into them.’

Beat, participant in a young men’s focus group discussion on sexuality and culture, Flagstaff, Eastern Cape

‘It is still unusual I wouldn’t lie, at times it’s hard to accept the orientation of your child, we don’t know how we can make it possible for us to accept or how we can teach our children in the community to understand different sexual orientations... we don’t know how we can sit them down and talk to them and tell them that we are not different at all it’s just our choices of lifestyles that are different.’

Caluza, participant in an older women’s focus group discussion on sexuality and culture, Pietermaritzburg, KwaZulu-Natal

‘This is a problem from a young age... some girls even date each other especially those in boarding schools they stay all by themselves and they end up doing naughty things and you can see that this girl should have a boyfriend...

‘Even that girls should have their own school it is not right. They must go to school together with boys so as to learn life. But parents think that when girls are all by themselves they will behave like girls whereas they are not you will find boys being naughty doing things with other boys and the other one is acting like a girl...

‘I myself was once proposed to by another girl promising me everything. I was confused about how is she doing that to me. But afterwards I saw she changed and became a boy and also changed back to be a girl again. I was glad she changed back to her original sexual orientation...’

Ma Luthuli, participant in an older women’s focus group discussion on sexuality and culture, eNkanini (Eshowe), KwaZulu-Natal

‘A woman has much more love to give than a man. They sometimes seek love from other women because of suffering too much from men or maybe she is tired of men...’

Balungile, participant in an older women’s focus group discussion on sexuality and culture, Pietermaritzburg, KwaZulu-Natal

‘But some of the gays they tried proposing to girls and it didn’t work out, so that is why they end up being in the wrong team...’

Thabane, participant in young men’s focus group, Gert Sibande District, Mpumalanga

‘What I think is that the community must be taught about gays and lesbians... People must know that a person is not self-created; it is not what you choose to be...’

Owami, participant in an older women’s focus group discussion on sexuality and culture, eNkanini, (Eshowe), KwaZulu-Natal
Explain that each of these statements was made by community members in discussions as part of a research project in different parts of South Africa. The people interviewed were asked about their observations and beliefs in relation to sexual orientation. We are going to analyse the statements to see what they tell us about culture and stigma.

Ask each pair to answer the following questions:

1. On whose behalf is the person speaking?
2. Are they giving an opinion or stating a fact?
3. Is the statement about identity or behaviour?
4. Is the statement offering a solution to a perceived problem?
5. Do you think the statement shows a lack of information?
6. Does the statement promote stigma or challenge stigma?
7. Do you agree with the statement, or parts of it? Why?
8. Would you expect the majority of people in your community to agree with the statement?

Allow 15 minutes for discussion.

Display the first statement on the flipchart or board.

Ask one pair who discussed this statement to read it aloud and share their answers.

Invite other pairs who discussed the same statement to add their input.

Then invite the rest of the group to ask questions or make comments.

Repeat this feedback process with the rest of the statements depending on the time available.

Summarise the feedback and check that the following points are captured:

- Opinions are not always based on facts. (Eg Some people hide their real sexual identities, suppressing their attraction to same-sex persons until they feel safe to do so; thus they are seen to be living ‘bisexual’ lives or changing their sexual orientation, when they might in fact identify as gay or lesbian.)

- Opinions differ strongly.

- People make judgments about behaviour as being right or wrong without explaining the benefit or harm attached to the behaviour.

- There is often confusion between sexual orientation and sexual behaviour.

- There is a desire to have clarity about issues of sexuality and gender.
We are socialised from an early age to respond to different ideas and actions in accordance with belief systems and cultural norms. We tend to have emotional and prejudicial responses to words and images based on what we have been taught and what we have experienced.

Distribute Handout 6: Words and thoughts. Tell participants to keep it face down. Explain that they should read the first word and then, in Column A write the first thought that comes to mind when they see the word. They should be honest – they do not have to share the list with anyone. In Column B, write the meaning of the word, in their home language.

<table>
<thead>
<tr>
<th>A – first word I thought of</th>
<th>B – translation/meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td></td>
</tr>
<tr>
<td>Boyfriend</td>
<td></td>
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<tr>
<td>Circumcision</td>
<td></td>
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<td>Condom</td>
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<tr>
<td>Daughter</td>
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<tr>
<td>Faithful</td>
<td></td>
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<tr>
<td>Father</td>
<td></td>
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<tr>
<td>Gay</td>
<td></td>
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<td>Homosexual</td>
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<td>Husband</td>
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<td>Immigrant</td>
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<td>Intersex</td>
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<td>Lesbian</td>
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<td>Marriage</td>
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<td>Masturbation</td>
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<td>Mother</td>
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<td>Multiple sex partners</td>
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<td>Orgasm</td>
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<td>Polygamy</td>
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<td>Pregnancy</td>
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<td>Promiscuous</td>
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<tr>
<td>Rape</td>
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<td>Sex</td>
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A – first word I thought of | B – translation/meaning
--- | ---
Sex worker | 
Sexually transmitted infection | 
Son | 
Sugar Daddy | 
Sugar Mommy | 
Teen pregnancy | 
Transgender | 
Transgender | 
Truck driver | 
Virginity | 
Wife | 

**Culture and habits**

We all get into the habit of thinking about things and doing things in a certain way. Life would be impossibly complicated if we had to rethink the same things every day. Sometimes we do things a certain way because it suits us, sometimes because we are told to and sometimes because all the evidence shows it is the most effective way. In plenary, discuss with the participants the following questions:

1. Where do cultural norms come from?
2. Who and what makes them norms?
3. Are they behaviours that everyone in a cultural group accepts, or are they imposed by people in authority?
4. What is the difference between culture and habit (things people have got used to doing)?
5. Do people exploit or distort culture to benefit themselves?

Ask for examples or provide examples to stimulate discussion. One example for Q4 might be the issue of polygamy (marrying more than one woman according to a set of traditions) compared to multiple concurrent partnering (being in the habit of having many sexual relationships without informing or supporting the partners). An example for Q5 could be the culture in capitalist societies/business of directors being paid many times more than workers.

In the session after lunch we will look at harmful cultural practices and how practices can change to be protective.

**LUNCH BREAK**
SESSION 2

ENDING HARMFUL PRACTICES

GROUP ACTIVITY

Cultural change

This picture from the National Geographic website shows young girls in Sierra Leone participating in a Bondo ceremony. Historically the ceremony included genital mutilation. In the Masanga community, the ceremony has been adapted to retain cultural significance without physically harming the children.

By attending an alternative Bondo ceremony that does not include genital mutilation, these girls in the Masanga community receive free education guaranteed by Masanga Assistance Education, a Swiss nonprofit. A woman known as the Bondo devil, a high authority in the secret society, participates in the ceremony.

Ask the participants in groups of 7-10 people to think about whether there are any practices in their cultural communities that are considered acceptable but are harmful or discriminatory?

Ask them to discuss why these practices are maintained (what is their purpose and value/benefit) and what would happen if they were amended or abandoned.

Tell the groups to consider these questions in putting together a scenario or case study that shows how culture is dynamic.

The scenario should illustrate either:

• how a cultural practice has adapted to changing conditions, to prevent or reduce harm;
• or how a cultural practice could or should be changed to prevent or reduce harm.
• Each group can choose a topic, or you can suggest issues related to gender, sexuality and HIV/AIDS such as virginity testing, traditional and medical male circumcision practices and ilobolo.

The groups should present their scenarios in the form of a conversation, as follows:

• One person describes the current practice and why it is continued;
• A second person says why the practice is harmful or discriminatory, and how it could be changed;
• Other group members support one side or the other with information and opinions.

Allow 15-20 minutes for discussion and preparation.

Allow 5 minutes for each group to present.

Note: It is not important to reach agreement on any changes to cultural practices but to establish the principle of culture being dynamic.

Next we are going to look at processes of change and how these can support efforts to reduce stigma.
THE CHANGE PROCESS
Introduce the topic of change by asking the 2 questions in plenary, taking feedback and making sure to cover the points that follow.

1. What motivates the process of change?
   a. It can be in response to the threat of a problem or the promise of a benefit

2. Change is complicated. Why
   a. It involves people.
   b. People are creatures of habit
   c. Change upsets habits.

Even when people accept the need or reasons for a change, they tend to resist it.

An important factor in change being accepted is whether the change was made by us, with us, or happened to us.

CHANGE that happens TO US:
CHANGE WITH US:

- Change happens with us
- Acceptance
- Understanding

CHANGE BY US:

- Change is made by us
- Support
- Excitement

- Cooperation
- Learning
- Involvement

Interest

Excitement

Involvement

Learning

Support

Excitement

Learning

Support
Deciding to change

The first step towards making change is accepting that it is necessary and will lead to improvements, for oneself and others.

In plenary, ask participants if they can see any reasons why we should change our attitudes and behaviour in relation to sex, gender, sexuality and HIV/AIDS.

Brainstorm the ‘push’ and ‘pull’ factors – why current attitudes might be problematic and how change might be beneficial.

GROUP ACTIVITY

Ask participants in their groups to discuss the following issues and list key points.

1. Attitudes and practices that are stigmatising
2. How stigma leads to the violation of people’s rights
3. How reducing stigma can help stop sexual and gender-based violence

Take feedback on Q1 from the first group and then invite the other groups to contribute points that were not covered.

**Checklist:** Patriarchal attitudes to girls and women, labelling and stereotyping of pregnant teens, LGBTI people, men who have sex with men, sex workers, immigrants and others.

Do the same for Q2

**Checklist:** ‘Normalises’ unfair and unequal treatment (discrimination), eg marginalisation, exclusion from services, harassment, pressure to change.

Then do the same for Q3.

**Checklist:** Leads to recognition of people being equal, removes the basis for blaming and punishing, promotes reporting and challenging of sexual and gender-based violence.

Finally take feedback on Q4 in the same way. Q4 is intended to get an idea of people’s understanding of the connection between stigma reduction and HIV prevention, which is covered in the next module.

Summarise the benefits of changing norms in relation to stigma reduction and stopping sexual and gender based violence.

If there is agreement that we need to shift cultural norms (across all layers and dimensions of culture) to overcome stigma, the big question is: How can this be done?

Shifting cultural norms

The two main questions we look at here are:

- **How can cultural norms be shifted?**
- **Who can do it?**

We are going to explore these questions through a roleplay and looking at a case study.
Ask the participants to work in their groups. Each group is to set up one of the following roleplays:

1. Presentation to your local community – Accepting our LGBTI children.
2. Meeting with clinic committee – Seeking non-judgmental contraceptive services for young girls.
3. Meeting with traditional leadership – Challenging the phenomenon of ‘blessers’.
4. Interview on community radio station – How stigma leads to violence.

Allow 15 minutes to discuss and prepare. Groups choose the roles based on who they think would have to be involved (e.g., presenter, members of community, leadership, committee members, radio phone-in audience).

Invite each group to present in turn and after each roleplay, take constructive feedback from the other groups. Ask them to consider how appropriate and effective the presentation was, and how it could be improved.

Case study

In many cases, shifting attitudes and behaviour takes a long time and requires ‘buy-in’ from many different groups in society. Ask the participants if they think it is possible for one person to make a difference. If they think it is, take a few examples. Then go through the following case study in plenary. At the end, ask what difference the person telling the story observed for the teen mom she spoke to.

Case study teen pregnancy

‘Guilt and shame kill motivation, kill hope. It kills people’

‘I had a chat with one of the moms. She’s in Grade 11, has a little boy of just over a year. She cried as she told me how they’re struggling for food – her mom is unemployed and all of them have been hungry. She feels stupid for getting pregnant, she said.

Some people believe that I should have told her that she was stupid. When faced with a crying and ashamed young mother, desperate to give her child a good life, I don’t see how calling her stupid would be of any use whatsoever.

So we spoke about looking ahead. We spoke about the options for claiming maintenance from the dad. She doesn’t want to, as he’s not interested in baby at all and she doesn’t want him in their lives. However, for the sake of her boy, it might be an option that she’s forced to consider.

I told her to look at her school marks from last year (all level 7 marks – so 70-80 % and up). I told her to remember that she wants to be a journalist. I told her to look at what she has already accomplished – to look at her little boy and see this gorgeous, healthy, happy child who she has raised. Other people would not have managed what she has managed, would not have achieved what she has, would not love their child as she does. This is something to be proud of. This is something to live for and be motivated by.

This mom has nothing to be ashamed of. She has only to keep going, to not give up and keep moving forward. She felt better afterwards, and I’m glad. Guilt and shame kill motivation, kill hope. It kills people.

So no – I will not ever be saying that she was stupid. She made a decision once which may not have been the right one at the time. As we all do. And here she is, dealing with it, as those same people demand that she do.’

Adapted from a story featured on a young mothers’ support group website: https://youngmomsupport.co.za/archives/2877

The last few activities have focused on the need to reduce stigma from a rights-based perspective. In the next module, we will look at the need to reduce stigma as part of an effective HIV prevention strategy.
MODULE 4: STIGMA REDUCTION FOR HIV PREVENTION

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

• Accurately describe HIV, the ways it is transmitted and how it causes AIDS;
• Explain the spectrum of sexual activities and their risk for HIV transmission;
• Understand the social and cultural drivers of HIV;
• Advocate effectively for comprehensive HIV prevention including stigma reduction.

METHOD

• Question current knowledge among participants
• Facilitate discussion of sexual behaviour and HIV prevention
• Guide analysis of stigma as an obstacle to testing and treatment
• Assist participants to develop practical responses to stigma.

RESOURCES NEEDED

• Handout 7: Key populations
• Post-course questionnaire
SESSION 1

UNDERSTANDING HIV AND AIDS

‘HIV is a virus. Stigma is a deadly disease.’

BRAINSTORM

In plenary, ask if people can define HIV. Check the key points below are covered.

What is HIV?

Human

Affecting people

Immunodeficiency

Failure or inability of the body’s system of protection from or resistance to disease

Virus

An organism too small to see with the human eye that gets inside the living cells of the body and reproduces, causing infection and disease.

What does HIV do?

Ask if people can say how HIV works. Check the key points below are covered.

HIV attacks the body’s immune system. It targets the CD4 cells (T cells), which help the immune system fight off infections. CD4 cells are like the body’s defence force. HIV kills them off. Unlike other viruses, the human body can’t get rid of HIV without help. If the HIV is not treated, it reproduces and kills more and more CD4 cells until the body can’t fight off infections and disease. These infections or infection-related cancers take advantage of a very weak immune system so they are called ‘opportunistic infections’. If the immune system becomes so badly damaged that the body keeps getting opportunistic infections, the person has AIDS.

What is AIDS?

Ask if people can define AIDS. Check the key points below are covered.

<table>
<thead>
<tr>
<th>Acquired</th>
<th>Picked up or got from somewhere (people are not born with it)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunodeficiency</td>
<td>Failure or inability of the body’s system of protection from or resistance to disease</td>
</tr>
<tr>
<td>Syndrome</td>
<td>A range of signs, symptoms and diseases.</td>
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</tbody>
</table>
What does AIDS do?
AIDS leads to death from opportunistic illnesses such as TB or pneumonia if the person does not receive treatment to reduce the HIV in their body.

Emphasise that no one should die from AIDS because:
- HIV infection can be prevented
- HIV infection can be detected with a simple blood test
- Drugs are available that can keep the levels of HIV in the blood so low that the body can fight off other infections
- Opportunistic infections can be effectively treated and HIV brought under control even once a person becomes sick.

If people living with HIV do not take ARV treatment, they can expect to go through these three stages of untreated HIV progression:

STAGE 1: Acute infection
When a person is first infected with the HI virus they may experience symptoms similar to severe flu. This is often referred to as acute retroviral syndrome.

During this stage, the immune system responds by producing antibodies against the HI virus.

The person is at high risk of transmitting the virus to a partner through unprotected sex in this stage because the viral load is so high.

STAGE 2: Chronic infection
This stage is also called ‘asymptomatic’ because people have no symptoms or might have mild symptoms such as skin rashes or fever.

the HIV virus continues to reproduce at very low levels. If you take ART, you may live in this stage for several decades because treatment keeps the virus in check. If you are not on ART, this stage lasts an average of 10 years.

you are not yet on ART, then eventually your viral load will begin to rise and your CD4 count will begin to decline. As this happens, you may begin to have symptoms of HIV.

STAGE 3: AIDS
The immune system starts to weaken noticeably and the body is vulnerable to opportunistic infections.

Without treatment, people who progress to AIDS typically survive about 3 years. Once you have a dangerous opportunistic illness, life-expectancy without treatment falls to about 1 year. However, if you are taking ART and maintain a low viral load, then you may enjoy a near normal life span.
HIV transmission

How does a person get HIV?

The HIV virus is present in certain body fluids in people infected with HIV. These fluids are blood, semen, pre-seminal fluids, rectal fluids, vaginal fluids, and breast milk. HIV is spread from one person to another through contact with these fluids. HIV can pass into the bloodstream through a mucous membrane (thin coverings in the mouth, nose, throat, vulva, opening of the penis and anus), or through an abrasion or cut, or through a needle.

HIV transmission happens mainly through sexual activity. It can also happen through childbirth and breastfeeding, through sharing injection drug equipment and accidental needle injuries.

The risk of contracting HIV depends on the type of activity.

**PARTNER ACTIVITY**

Ask participants in pair to discuss all the different sexual acts they know about. Ask them to list the activities and place them in order of risk for HIV infection – No 1 = most risky.

Allow 10 minutes discussion and then invite pairs to call out one activity from their list. Use the list below to make sure all main activities and risk factors are covered.

Types of sexual activity and HIV risk

**Vaginal intercourse** – vaginal penetrative sex during which a man puts his penis into a woman’s vagina carries a risk of passing on HIV and several other STIs. This can happen even if the man doesn’t ejaculate (come). Even shallow insertion of the penis into the vagina (sometimes called dipping) carries risks for both partners. This is because infections can be present in fluid secreted from the penis and vagina pre-ejaculation (pre-come).

**Anal intercourse** – anal sex during which a man puts his penis into the anus of a woman or a man has a higher risk for HIV transmission than many other types of sexual activity. This is because the lining of the anus can easily be damaged, allowing HIV to get into the bloodstream.

**Oral sex** – sucking or licking the vagina, penis or anus carries a risk of passing on HIV and other STIs. The risk is lower than anal or vaginal sex without a condom. However, the risk is increased if there are any cuts or sores in or around the mouth, genitals or anus. The risk of infection is also lower when you receive oral sex than when you give someone oral sex.

**Fingering or hand jobs (hand-to-genital contact)** – inserting one or more fingers into a partner’s vagina or anus. Fingering is low risk for spreading HIV, but there is still a risk. If there are any cuts or sores on the fingers, or in the vagina or anus, no matter how small, HIV or other STIs can get through.

**Dry humping or genital rubbing** – rubbing bodies against each other for sexual pleasure while wearing clothing does not carry any risk of HIV infection. Doing this without clothes is also safe if there is no exchange of bodily fluids.

**Thigh sex – ukusoma in Zulu** – is a type of non-penetrative sex, which involves a male placing his penis between his partner’s thighs and thrusting to create friction. This does not carry risk of HIV transmission as long as no bodily fluids are exchanged.

**Sensual massage** – rubbing of your partner’s body, or mutual rubbing, to achieve orgasm without intercourse, is free of HIV risk as long as no bodily fluids are exchanged.

**Masturbation** – self-stimulation of the sex organs is considered the safest form of sex in the prevention of HIV because you cannot infect or reinfect yourself!
How does a person avoid getting HIV?

PARTNER ACTIVITY

Adopt the same approach as before. Ask participants in the same pairs to list HIV prevention strategies. Use the text below to confirm and add to what the participants say.

To reduce your risk of HIV infection, or avoid infecting a partner:

Know your status and know your risk. Testing for HIV and other STIs is important for all people exposed to any risk. This enables you to access prevention and treatment services without delay. Testing with partners and knowing each other’s HIV status is important for ongoing risk reduction.

You can test free at government clinics, you can test at pharmacies and since 2016, you can buy a home test kit in the same way that you would by a pregnancy test kit.

Use condoms, femidoms, finger condoms or dental dams correctly every time you have vaginal, oral, or anal sex.

If you don’t have HIV but are at high risk of becoming infected with HIV, find out about Pre-exposure prophylaxis (PrEP). PrEP is recommended for sex workers and people who cannot negotiate condom use. It is also recommended for women who have HIV-positive and want to get pregnant. PrEP involves taking a specific HIV medicine every day to reduce the risk of transmission due to exposure to HIV. PrEP should always be combined with other prevention options, such as condoms.

Take ARVs as Post-exposure prophylaxis (PEP) if you are exposed to to HIV because you are raped, or if you had sex without a condom with a person who is infected, or you have been accidentally exposed to HIV in the workplace. To be effective, PEP must be started within 3 days after the possible exposure to HIV. PEP involves taking HIV medicines each day for 28 days.

Men can undergo circumcision to reduce their risk of HIV infection from penetrative sex. Voluntary medical male circumcision (VMMC) is a simple, low-risk procedure to remove the foreskin and has been shown to reduce the circumcised man’s risk of HIV infection by 60%. It does not reduce the risk of the man passing HIV to his partner. It is still critical to use condoms to prevent HIV. Some communities that practise traditional circumcision have incorporated HIV prevention measures into the practice. Others allow boys to undergo VMMC before participating in other aspects of initiation.

Don’t inject drugs. If you do, use only sterile injection equipment and water and never share your equipment with others.

Prevention of Mother to Child Transmission. The World Health Organisation Guidelines recommend that lifelong ARV treatment should be provided to all pregnant and breastfeeding women living with HIV regardless of CD4 count. Treatment should be maintained after delivery and completion of breastfeeding for life. All infants born to HIV-positive mothers should receive a course of ARV treatment as soon as possible after birth.
The short text below provides a quick overview of the terms used. Present the information and check that everyone is clear about what HIV does to the immune system.

**The immune system**

The human immune system has several components that work together to protect the body from bacteria, viruses, fungi and allergens.

Some of the cells that make up the immune system have specific receptors called CD4 receptors.

HIV can infect cells that have this receptor. Once a cell has been infected by HIV, it causes an autoimmune response, which means the immune system tries to contain the problem by destroying the infected cells.

The virus gradually infects and causes the destruction of more and more CD4 cells. Over time, the number of CD4 cells – the CD4 count – drops dramatically.

**CD4 count test**

The CD4 count test is a measuring tool that shows how damaged the immune system is.

A sample of blood is taken and the number of CD4 cells in it are counted.

A normal CD4 count ranges from 800 -1200 cells per every cubic millimetre of blood.

When the CD4 count falls below this range, the infected person may need treatment to prevent them from becoming ill.

**Viral load test**

This test is conducted in a laboratory to measure the concentration of the virus in the blood.

The virus replicates rapidly in the beginning stages of infection.

Once a person is on ARV treatment, this test can measure the effectiveness of the treatment, and whether the client is adherent to the treatment.

**Anti-retroviral Drugs (ARVs)**

Anti-retroviral drugs work by slowing down the replication of the HI Virus.

The drugs do not remove the virus from the body.

ARVs change HIV/AIDS from a terminal disease to a manageable chronic disease.

In 2016, the South African government adopted the ‘test and treat’ guidelines of the World Health Organisation (WHO). That means that as soon as a person tests HIV positive, they start taking ARVs. This has been shown to be the best way to manage the virus.

By starting ARVs as soon as possible, taking them every day as prescribed, and doing all the things any of us should do to safeguard our health, people living with HIV should do exactly that – live with it.
Treatment adherence

Once a person living with HIV begins ARV treatment, they need to stay on it for life – or until a cure is found.

Although the treatment options today are much simpler, easier to take and generally have fewer side effects than those available 20 years ago, there are still reasons why people find it difficult to take their medicines as prescribed.

This is not a problem that is exclusive to HIV/AIDS. People living with a range of chronic conditions need to take medicines every day to keep those conditions under control and maintain their health status.

In plenary, ask participants to think of other chronic conditions that require people to take daily or regular medication and make changes to their diet and lifestyle.

What are these conditions? What kind of lifestyle changes do people with these conditions need to make?

You can use this list to prompt or add to the group's suggestions:

- Diabetes
- Asthma
- Hypertension (high blood pressure)
- Food allergies
- Epilepsy
- Arthritis

**GROUP ACTIVITY**

**BARRIERS TO ADHERENCE**

In addition to the adherence barriers that people with other chronic conditions face, people living with HIV also have to deal with stigma.

Explain that participants will work in groups to deepen their understanding of barriers to adherence, including stigma.

Each group will be given one of the short case studies below. They should discuss it and then answer the questions that follow:

**CASE STUDY 1**

Tshanduko is a married woman with a young child. She discovered she was HIV positive when she was pregnant and disclosed to her husband. She received counselling about the importance of adherence and is motivated to stay well for her child. However, she is not taking her medication every day. Her husband refuses to test, denies that he could be HIV positive and blames his wife for bringing disease to the home.

**CASE STUDY 2**

Wandile is 11 years old. He was born HIV-positive and his parents died when he was 6. He lives with his mother’s older sister and her husband, their 6 children and 2 grandchildren. Wandile was not told how his parents died and no one has disclosed to him that he is HIV-positive. Children at school have started asking him why he is taking medication. He has asked his aunt but she hasn’t given him a clear answer.
Amahle is a miner. He works away from home and only sees his family a few times a year. He works for a big company, which provides health services. He was getting ARV treatment through his company but they have now transferred him to the local municipal clinic. It takes one hour to travel there, he has to wait most of the day because there is a separate queue.

Ayibongwe has recently moved to an informal settlement. He scrapes a living collecting and selling cardboard. He was diagnosed with HIV after suffering from TB. He is on ARVs and TB medication. He does not have an address and so has battled to be registered at the nearest clinic.

QUESTIONS

1. What might stop this person from taking their medication as prescribed?
2. How if at all is stigma a barrier to adherence?
3. What could be done to motivate or support the person to adhere to treatment?

Allow 15 minutes for group discussion and then take feedback in plenary.

Possible reasons for non-adherence (checklist):

- Denial (by husband) □
- Disclosure □
- Distance □
- Stockouts □
- Attitude of clinic staff □
- Attitude of family □
- Side effects □

LUNCH BREAK
SESSION 2

STIGMA REDUCTION AND HIV PREVENTION

During this course, we have explored issues relating to diversity, stigma and discrimination. We have looked at how gender stereotypes and cultural norms can cause or reinforce stigma on the grounds of sex, gender and sexuality. We have seen how stigma and discrimination are focused on particular groups, such as:

- Girls and women
- LGBTI people and MSM
- PLWHA
- Sex workers and
- Immigrants

This has a negative effect on the health and well-being of those groups. It can contribute to:

- Violation of rights to dignity and equality and
- Low self-esteem, depression, stress
- Denial of services or inability to access appropriate services
- Undiagnosed and untreated illness
- Exclusion
- Vulnerability to assault, GBV
- Increased risk of HIV
- Exclusion from schools, places of worship

Governments and donors often talk about focusing on ‘key populations’ and marginalised groups because of the prevalence of HIV among particular groups. The groups we have spoken about are among key populations – girls and women, LGBTI people and MSM, PLWHA, sex workers and immigrants. These groups are scapegoated as being to blame for social ills including spread of crime, breakdown of families, spread of disease, erosion of cultural values.

There is no evidence that a group of people is more responsible than another group for any of these problems. They are the result of ACTIONS not identity.

HIV is mainly spread through unsafe sexual practices, primarily because people do not know their own status or that of their partner/s and do not take steps to reduce their risk, or because they are victims of, or engage in rape and exploitative sexual relations. These activities are not specific to a certain group.

This means that discriminating against groups of people based on generalisations is not going to help prevent the spread of HIV. In fact, it can fuel HIV.

In this section, we look at how that can happen.
What fuels the spread of HIV?
Read out the quotations below and ask the participants if they agree with them.

‘Sugar daddies, if they come promise us expensive clothes and nice stuff, yes I'll go for that in exchange for unprotected sex. ‘H-I-V’ is not written on (people’s) foreheads – there is no way I can tell that this sugar daddy is HIV positive.’

‘I think this is caused by men sleeping around then coming back to us their women to infect us. They refuse to use condoms because they know that their voice is heard (much more) than ours.’

Young women in their twenties from Johannesburg.

Even if there is agreement that sugar daddies, or blessers, and men sleeping around is fueling the spread of HIV, this is not the whole answer.

South Africa has the biggest and most high profile HIV epidemic in the world, with just over 7 million people estimated to be living with HIV in 2016. (StasSA)

South Africa also has the largest antiretroviral treatment (ART) programme, largely financed by government.

The country has made great strides towards managing the epidemic. From the 1980s to the early 2000s, HIV/AIDS was viewed as a death sentence. Without treatment some 330 000 people died – men and women, boys and girls who should have been the healthy, energetic, hopeful face of a free South Africa. Up to 30% of babies born to HIV-positive mothers were infected with the virus and faced orphanhood and an early death. In those days, HIV carried terrible stigma.

Most people did not know their HIV status – many dreaded finding out because they could not be treated. HIV was seen as a plague. If someone looked thin and sickly, or had sores, people would assume they had AIDS. People living with HIV/AIDS were thrown out by their partners and families, chased away from work and school, set apart in clinics, gossiped about, harassed, even murdered.

Today, people living with HIV can expect to go onto treatment as soon as they are diagnosed. They can expect to lead healthy, productive, fulfilling lives and to die of old age rather than disease. Many people live openly with HIV, telling their stories, providing counselling and support to others. ARVs not only prevent people from becoming sick but greatly reduce the risk of passing the virus onto another person.

But the battle to overcome HIV is not over. Overall 12.7% of the South African population has HIV. The prevalence varies greatly between provinces and different groups of people. That is not because there is something peculiar about those provinces or groups of people but because the conditions and circumstances that put people at risk are different. We are going to look in more detail at the challenges facing different groups.
Distribute Handout 7: Key populations. This provides information about four groups, as below, who are particularly vulnerable to HIV. Ask each of the participant groups to read and discuss one of the categories. Ask them to consider three questions:

1. How is stigma and discrimination fueling HIV/AIDS among this group?
2. What can members of the group do about this?
3. What can Community Mentors (peer educators) do to sensitise or educate other members of the community to the circumstances of this group?

Allow 20 minutes for discussion.
Take feedback from each group in turn.

a) Women, adolescent girls and HIV in South Africa

“We live under oppression. I am scared to lose my husband. At the end of the day, he says, ‘we don’t use condoms because you are my wife’ and it stays like that. We are always oppressed because there is no way we can say no to men.”

Interviews with young women, Johannesburg.

Young women and adolescent girls (aged 15 – 24) in South Africa are up to eight times more likely to be living with HIV than boys and men in that age group. Almost a quarter of all new infections occur amongst females aged 15 – 24. There are several reasons why girls and women are more likely to contract HIV than boys and men:

- **Biology.** The vagina has a greater exposed surface area than the penis. Vaginal intercourse causes tiny tears in the vaginal lining. The lining of the vagina contains certain types of cells that HIV can easily...
enter. Semen remains in the vagina for a prolonged period. Younger women are even more vulnerable to HIV infection due to immaturity of the opening of the womb.

- **Violence.** Girls and women in South Africa face a high risk of rape and sexual assault. Cuts or abrasions make it easier for HIV to get into the blood. It has been estimated that 20–25% of new HIV infections in young women result from GBV.

- **Gender inequality.** Girls and women even in consensual relationships often face pressure to have sex without a condom.

- **Limited access to services.** Girls and single women find it difficult to access HIV prevention services. Cultural norms assume that they are not/should not be sexually active. If they are sexually active, services are more geared to pregnancy prevention than HIV prevention.

- **Older men with multiple partners.** Girls and women are likely to have older sexual partners, who are more likely to have other sexual partners and if they are not using condoms there is an increased risk of contracting HIV.

- **Poverty.** Girls and women living in poverty are vulnerable to exploitative and abusive relationships due to being economically dependent on men.

### b) Men who have sex with men (MSM)

Men Who Have Sex with Men (MSM) are heterosexual men who engage in sexual behaviour with other men. They are not emotionally or romantically attracted to other men and do not identify as gay or bisexual. They engage in sex with men for physical pleasure and not to form relationships.

The World Health Organisation estimates that HIV prevalence among MSM in the African region is around 14.9% (2015). HIV prevalence among men who have sex with men (MSM) in South Africa is estimated at between 22% and 48%.

- MSM face high levels of social stigma and homophobic violence due to traditional and conservative attitudes.

- MSM tend not to disclose their behaviour to partners and find it difficult to talk about it to healthcare workers. This increases their risk of passing on the virus and limits their access to HIV prevention and other services.

### c) LGBTI+ people

South Africa is the only country in sub-Saharan Africa where gay rights are recognised and protected. Laws and policies guarantee equity and social justice, and forbid discrimination based on sexual orientation and gender identity.

A 2016 study (Progressive Prudes. The Other Foundation) found that 55% of South Africans would accept a gay family member; 51% said gay people should have the same human rights as others; and two thirds supported keeping the constitutional protections against discrimination on the basis of sexual orientation.

However, 72% of people said same-sex sexual activity was morally wrong. 18% either had, or would consider, verbally abusing someone who is not gender conforming – and nearly 10% had, or would consider, physically abusing them.

- LGBTI people are at risk of contracting HIV through sexual assault.

- They also find it difficult to access appropriate HIV prevention and other health services. This is partly because of stigma and direct discrimination but also because services are geared towards condoms and family planning.
d) Sex workers and HIV

_The police officer raped me, then the second one, after that the third one did it again. I was crying after the three left without saying anything. Then the first one...let me out by the back gate without my property. I was so scared that my family would find out._

_Female sex worker, Cape Town, interviewed for a report by the Women's Legal Centre on Human Rights Violations by the Police Against Sex Workers in South Africa (2012)_

There are estimated to be 130 000 to 180 000 people engaged in sex work in South Africa. Sex work means the agreed exchange by adults of sex or sexual acts for a negotiated reward. Sex work may be done formally or informally, for cash or other forms of payment. The term sex work is used because it simply describes a category of economic activity. The term prostitution can be seen as judgmental because of its association with ‘unworthy’ or ‘corrupt’ exchange.

Many people are openly judgmental about sex work; they believe that is morally wrong. Sex work is often misunderstood to mean human trafficking, sex slavery, pornography and child abuse. Sex work is illegal in South Africa but none of these crimes is sex work.

Some people argue that sex work should be kept illegal and women should be ‘rescued’ from it because it is ‘degrading’ and ‘humiliating’. Of course, no one should have to do any type of work that they find degrading or humiliating. On average, a sex worker can earn six times more than a domestic worker in South Africa.

For many women, and a smaller number of transgender people and men, sex work provides an income that enables them to meet their basic needs, support children and family members, and sometimes to further their education and move into other work.

Sex workers argue that they should have a choice to be paid for providing sexual services, and to do so in safe and hygienic conditions.

There is a campaign in South Africa for the decriminalisation of sex work. This would help to stop harassment by the police, and enable sex workers to report abusive clients.

- Sex workers face high levels of stigma and discrimination, which increases their vulnerability to HIV/AIDS.
- Sex workers find it hard to access sexual health services because of the attitudes of health care workers at many clinics. Some clients insist on sex without a condom. The police confiscate condoms as evidence of engagement in sex work.
- Educational organisations have reported difficulties in delivering HIV prevention services to sex workers due to ongoing police harassment. One study found that up to 70% of women who sold sex had experienced abuse by the authorities.
- Because sex work is against the law, many sex workers are vulnerable to abuse by clients, by the public and by the police. A study in Cape Town found that 12% of street-based sex workers had been raped by the police.
- Some inject drugs, exacerbating their vulnerability to HIV infection.
- Nationally, HIV prevalence among sex workers is estimated at almost 60%, with higher levels of infection in big cities.

Recognising how stigma and criminalisation drive HIV/AIDS among sex workers, the South African National AIDS Council (SANAC) has launched a National Sex Worker HIV Plan, 2016-2019, which aims to ensure equitable access to health and legal services for sex workers.
Transactional sex

‘It starts at home. If my boyfriend don’t give me money, I will find someone outside who will give me money. I will have to pay him with sex and forget that I can contract HIV if I no longer stick to my partner because of money.’

Interviews with young women, Johannesburg.

There has been a lot of discussion in South Africa about ‘transactional sex’. This is generally not the same as sex work. In sex work there is usually payment for specific sexual acts performed at a certain time and place by arrangement. Transactional sex usually involves people in a sexual relationship in which one, typically the woman, engages in sex with her partner, typically a man, in return for money, material goods, other gifts, status as a girlfriend or other benefits. There may be an expectation to engage in sex on demand over the period of the relationship. There may also be an expectation to provide a certain level of benefits in order to continue the relationship.

Transactional sex can drive HIV because it frequently involves older men in positions of relative wealth and power who can exert pressure on younger partners to engage in unsafe sexual practices.

Reducing stigma

a) improve the lives of people who are stigmatised
b) ensure more people know the facts about HIV
c) ensure more people test and access treatment
d) speed up the progress towards the global goal of:

Zero New HIV Infections, Zero Discrimination, and Zero AIDS-Related Deaths
PARTNER ACTIVITY

ROLES IN REDUCING STIGMA

Invite the participants to choose one of the topics below and work in pairs to discuss the role that the people in question can play in reducing stigma in a culturally sensitive way. Take feedback from each pair and invite whole group to consider how the ideas for stigma reduction can be implemented in their areas.

a) Men challenging gender stereotypes and providing role models

<table>
<thead>
<tr>
<th>Question</th>
<th>Prompts</th>
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</thead>
<tbody>
<tr>
<td>How do men contribute to gender stereotypes?</td>
<td>Multiple partners, absent fathers</td>
</tr>
<tr>
<td>How are men affected by gender stereotypes?</td>
<td>Pressure to earn, provide, pay</td>
</tr>
<tr>
<td>How can men challenge these stereotypes?</td>
<td>Engaged fathers, sexually responsible</td>
</tr>
</tbody>
</table>

b) Religious leaders challenging stigmatising beliefs and attitudes

<table>
<thead>
<tr>
<th>Question</th>
<th>Prompts</th>
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<tbody>
<tr>
<td>How do religious leaders fuel discrimination?</td>
<td>Selective quotations, myths, silence</td>
</tr>
<tr>
<td>How do we know there is potential for change?</td>
<td>Some leaders do speak out?</td>
</tr>
<tr>
<td>How can religious leaders shift norms?</td>
<td>Openly embracing diversity, challenging stigma based on religion</td>
</tr>
</tbody>
</table>

c) Custodians of culture as champions for change

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<thead>
<tr>
<th>Question</th>
<th>Prompts</th>
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<tbody>
<tr>
<td>How do traditional leaders fuel stigma?</td>
<td>Rejection of LGBTI</td>
</tr>
<tr>
<td>Examples of positive change?</td>
<td>Working with health dept to make circumcision safer</td>
</tr>
<tr>
<td>Opportunities?</td>
<td>Promote protective practices</td>
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d) Peer educators challenging labelling and stereotyping

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<thead>
<tr>
<th>Question</th>
<th>Prompts</th>
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<tbody>
<tr>
<td>Do CBO staff share stigmatising attitudes?</td>
<td>Same community, same socialisation</td>
</tr>
<tr>
<td>What works best to change this?</td>
<td>Information, training, new perspectives</td>
</tr>
<tr>
<td>How to reach more people?</td>
<td>Workshops, radio</td>
</tr>
</tbody>
</table>
e) Women standing in solidarity with other women and girls

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<thead>
<tr>
<th>Question</th>
<th>Prompts</th>
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</thead>
<tbody>
<tr>
<td>Why do women blame women?</td>
<td>Attacks on schoolgirl mistresses, judging women who do/ don't have children</td>
</tr>
<tr>
<td>Are there examples of women standing together?</td>
<td>Child marriage, blessers</td>
</tr>
<tr>
<td>How do women demand justice?</td>
<td>Rape, hate crimes</td>
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f) Service providers dealing with needs before identities

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<thead>
<tr>
<th>Question</th>
<th>Prompts</th>
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<tbody>
<tr>
<td>How do nurses and doctors discriminate?</td>
<td>Assumptions, judgments</td>
</tr>
<tr>
<td>How could they reduce risky behaviour?</td>
<td>Appropriate services, recognition of needs</td>
</tr>
<tr>
<td>Who can influence them?</td>
<td>Patient groups, clinic committees</td>
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</table>

g) Educators focusing on facts

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<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>What is the state of sex education in schools?</td>
<td>Denial, focus on abstinence, sex for marks</td>
</tr>
<tr>
<td>Could condoms in schools help?</td>
<td>Resistance, fear, lack of info</td>
</tr>
<tr>
<td>Are there examples of good practice?</td>
<td>Schools with no pregnancies, rape, bullying</td>
</tr>
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</table>

h) Police protecting everyone's rights

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<tr>
<th>Question</th>
<th>Prompts</th>
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<tbody>
<tr>
<td>How do the police deal with sexual violence?</td>
<td>Abuse of sex workers, lack of support for survivors of GBV and hate crime</td>
</tr>
<tr>
<td>What constraints do they face?</td>
<td>Pressure to make arrests. Cases withdrawn</td>
</tr>
<tr>
<td>How can the police protect rights?</td>
<td>Reducing harm, respect, equality</td>
</tr>
</tbody>
</table>
Post-training Questionnaire

1. NAME ____________________________________________________________

2. ORGANISATION ____________________________________________________

3. POSITION ________________________________________________________

4. Now that you have completed the training, would you say that any of the following groups of people are viewed or treated negatively in your community? (Tick all that apply)

   a) BOYS/MEN WHO DO NOT UNDERGO CIRCUMCISIION
   b) BOYS/MEN WHO MAKE SCHOOLGIRLS PREGNANT
   c) BOYS/MEN WHO UNDERGO TRADITIONAL CIRCUMCISIION
   d) GIRLS WHO HAVE SUGAR DADDIES OR BLESSERS
   e) LGBTI PEOPLE
   f) MEN WHO ARE SUGAR DADDIES OR BLESSERS
   g) MEN WHO HAVE SEX WITH MEN
   h) REFUGEES AND/OR MIGRANTS
   i) SCHOOLGIRLS WHO ARE PREGNANT
   j) SEX WORKERS
   k) SURVIVORS OF VIOLENCE/RAPE SURVIVORS

   YES □ NO □ DON’T KNOW □

5. Why do you think this is?
   a) IT IS DUE TO IGNORANCE □
   b) IT IS BECAUSE PEOPLE LIKE TO BLAME OTHERS □
   c) IT IS BECAUSE CULTURE TEACHES PEOPLE TO REJECT THESE INDIVIDUALS □
   d) IT IS BECAUSE RELIGION TEACHES PEOPLE TO REJECT THESE INDIVIDUALS □
   e) IT IS BECAUSE THE BEHAVIOUR OF THE GROUPS I NOTED/TICKED IS MORALLY WRONG □
   f) IT IS BECAUSE THE BEHAVIOUR OF THE GROUPS I NOTED/TICKED SPREADS HIV □
   g) IT IS BECAUSE THE BEHAVIOUR OF THE GROUPS I NOTED/TICKED CAUSES HARM TO OTHERS □
   h) OTHER (PLEASE EXPLAIN) □
   i) I DON’T KNOW □
6. How do you feel about this? Tick the answer that is closest to how you feel.
   a) I THINK IT IS CORRECT TO DISCRIMINATE AGAINST PEOPLE WHO DON’T FOLLOW CUSTOMS AND RELIGIOUS RULES IN THE COMMUNITY – THEY BRING IT ON THEMSELVES
   b) I THINK IT IS NORMAL TO DISCRIMINATE AGAINST PEOPLE WHO DON’T FOLLOW CUSTOMS AND RELIGIOUS RULES IN THE COMMUNITY
   c) I THINK IT IS NORMAL TO BLAME PEOPLE WHO ARE DIFFERENT
   d) I DON’T AGREE WITH DISCRIMINATING AGAINST PEOPLE
   e) I FEEL STRONGLY THAT DISCRIMINATING AGAINST OTHERS IS WRONG
   f) DISCRIMINATION NEEDS TO BE STOPPED IF WE ARE TO OVERCOME HIV/AIDS
   g) DISCRIMINATION NEEDS TO BE STOPPED IF WE ARE TO OVERCOME HIV/AIDS AND GENDER-BASED VIOLENCE

7. Do you feel to able to inform and educate people in your community about discrimination?  Tick the answer/s closest to how you feel.
   a) NO. I DON’T HAVE ENOUGH INFORMATION MYSELF
   b) NO. I DON’T HAVE THE SKILLS TO EDUCATE PEOPLE
   c) NO. I LACK THE CONFIDENCE TO SPEAK OUT ON THIS ISSUE
   d) NO. I DON’T THINK PEOPLE WOULD LISTEN
   e) NO. I DON’T THINK IT IS NECESSARY
   f) YES BUT I NEED MORE INFORMATION
   g) YES BUT I NEED MORE TRAINING
   h) YES BUT I NEED MORE CONFIDENCE
   i) YES. I AM ALREADY DOING THIS EFFECTIVELY

8. How if at all have you benefited from this training? Tick all answers that apply
   YES    NO    DON’T KNOW
   a) I HAVE GAINED INFORMATION THAT WILL HELP ME IN MY WORK TO REDUCE STIGMA
   b) I HAVE GAINED SKILLS THAT WILL HELP ME IN MY WORK TO REDUCE STIGMA
   c) I HAVE GAINED CONFIDENCE TO SPEAK OUT ON THE ISSUES OF STIGMA AND DISCRIMINATION
   d) I AM BETTER ABLE TO EXPLAIN STIGMA IN RELATION TO GENDER, CULTURE AND HIV/AIDS
   e) I AM BETTER ABLE TO CHALLENGE STIGMA IN RELATION TO GENDER, CULTURE AND HIV/AIDS

Comments: