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Protecting the rights of people living with HIV in the workplace

Gujarat State Network of Positive People (GSNP+)

CASE STUDY

The Gujarat State Network of Positive People (GSNP+) set out to learn more about the employment needs of people living with HIV and identified 341 individuals in need of work from among the network's members. GSNP+ and ICRW also surveyed 357 workers across five sectors and found high levels of stigma toward PLHIV, which would impede them from seeking or retaining employment. For instance, 42% of workers reported that people talk 'badly' about PLHIV at the workplace and the same percentage felt that a person living with HIV should not be allowed to continue working. Additionally, most workplaces lacked PLHIV anti-discrimination policies.

In order to create a supportive and non-discriminatory work environment for PLHIV, GSNP+ recognized the need to address the drivers and facilitators of stigma among more than one population/environment, specifically both workers (general population) and institutions (senior management and policies). This project was part of a larger effort to adapt and pilot test a global stigma-reduction framework to the Indian context.[1]

Project highlights

- The study gained buy-in from five industrial associations in the city of Surat to promote the employment opportunity for people living with HIV (PLHIV) and create an enabling environment among member businesses.
- 341 people living with HIV were identified as needing employment in Surat.
- 357 workers were surveyed on HIV knowledge and stigma-related attitudes.
- HIV and stigma sensitization trainings were held with senior leadership and 400 workers from 11 business houses.
- Seven workplace policies were developed to support the rights of PLHIV and create an enabling environment for their employment.

Implementation

Gaining entry

To foster the hiring of PLHIV and to combat stigma in the workplace, GSNP+ first approached 84 businesses, requesting a face-to-face meeting. They received a poor response – few agreed to meet a GSNP+ representative, mainly because of denial that there was any HIV-related problem. According to one manager, "We do not have HIV-positive staff in our industry."

GSNP+ changed its strategy and met with representatives of the five largest industry associations in Surat:

- Surat Diamond Association (SDA)
- Federation of Gujarat Weavers Association (FOGWA)
- Southern Gujarat Hotel and Restaurant Association (SHARA)
- Surat Builder Association, a subgroup of the Confederation of Real Estate Developers of India (CREDAI)
- South Gujarat Chamber of Commerce

At these meetings, GSNP+ dispelled myths about HIV, convinced association leadership of the value of PLHIV in the workforce and of support to sensitize bigger industrial houses towards HIV.

Conducting sensitization trainings

The five associations together provided the names of 200 companies and helped mobilize participation of representatives from within their own sectors for a sensitization meeting on the importance of a stigma-free workplace. Based on the outcomes of this workshop and on interest shown by individual companies, GSNP+ worked closely with 11 of these companies, holding sensitization trainings for senior leadership as well as for a total of 400 workers.

Key topics covered during the trainings were:

- Basic information about of HIV and AIDS
- HIV prevention and risk reduction
- HIV and AIDS at the workplace
- Stigma and discrimination at the work place
- HIV testing
- Care, support and treatment for people living with HIV
- Contact strategies – engaging directly with PLHIV – proved to be an important part of the trainings. Participation by PLHIV dispelled the strongly held misconception that they are weak and unable to work.

1. ICRW, UNDP and STRIVE, 2013. A global HIV stigma reduction framework adapted and implemented in five settings in India. 2013. Summary Report. ICRW.

> I never knew that an AIDS patient could appear so healthy. Looking at you, it does not even seem that you are ill."
>
> TRAINING PARTICIPANT AFTER HEARING AN HIV POSITIVE SPEAKER

Changing workplace policies and practices

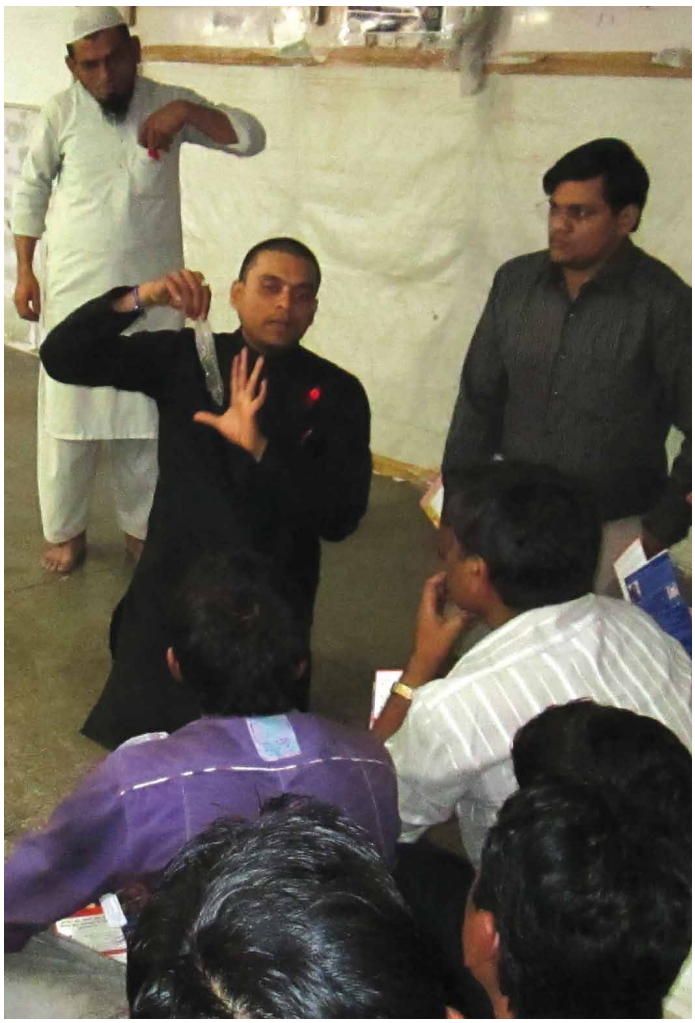
GSNP+ supported seven companies/business houses to update their human resource (HR) policies to protect the rights of PLHIV, using the workplace policy developed by the International Labour Organization as the basis. Meetings were held with individual companies to sensitize them on subjects such as PLHIV needs and the value of PLHIV in the workforce. Engaging with the business houses in this way helped in mobilizing participation in sensitization training, with the result that 400 staff members from these 11 companies, including HR departments, were sensitized on HIV-related stigma and discrimination as well as PLHIV issues. GSNP+ also worked with the corporate social responsibility (CSR) teams to identify ways in which the companies could support PLHIV in the workplace.

Key outcomes

- Greater support for working together on generating employment for PLHIV.
- Seven companies updated their HR policies in line with those recommended by the International Labour Organization.
- Three companies are now supporting care and support for PLHIV using Corporate Social Responsibility funds.
- The project was show-cased by three media organizations, covering TV, radio and print.

Lessons learned

- Gain the support of gatekeeper organizations first; in this case, the industry associations.
- Engage the associations directly in outreach efforts.
- With individual companies, sensitize management first and then work with individuals in the workforce.
- Allow sufficient time to gain entry to workplaces. It can be a slow process, yet can lead to long-term support.



> In our hotel industry there is a lot of employee turnover. In such cases, we could think of getting the unemployed PLHIV into the stream."
>
> PRESIDENT, HOTEL ASSOCIATION, SURAT

> We can organise certified training programmes on the skills to be acquired in the construction business especially for PLHIV. This will aid them in seeking jobs in the civil construction sector."
>
> HR MANAGER, RAJHANS GROUP

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Tackling the structural drivers of HIV

The study was led by ICRW with funding from UNDP. This case study was produced by GSNP+, ICRW and STRIVE. STRIVE is supported by UKaid from the Department for International Development. However, the views expressed do not necessarily reflect the department's official policies.

Reducing stigma to improve engagement in HIV care among men who have sex with men

The Humsafar Trust

CASE STUDY

Men who have sex with men (MSM) are particularly vulnerable to HIV as well as to other physical and psychological health concerns. MSM experience multi-layered stigma and discrimination as a result of their perceived or real HIV status and their same-sex behaviour. Because of social and cultural non-acceptance of their sexuality and fear of being ridiculed, MSM experience internalized stigma, which manifests as guilt, depression, lack of confidence and unwillingness to discuss their sexual lives. This not only influences their mental health but also, combined with enacted or perceived stigma by health care providers, can impede the utilization of health services by MSM. Through a process of research and joint discussion of findings, this project created a foundation for combating stigma at both the individual and institutional levels. It was part of a larger effort to adapt and pilot test a global stigma reduction framework to the Indian context.[1]

Implementation

The study was conducted by The Humsafar Trust (HST), a community-based organization in suburban Mumbai devoted to male sexual health. Its objectives were to:

- Review existing hospital policies that have a bearing on stigma and discrimination
- Determine attitudes and practices of health workers with regard to MSM and people living with HIV
- Understand the nature of internalized stigma among MSM and how that acts as a barrier to health seeking behaviour
- Initiate a consultative process to combat stigma in the health care setting as well as internalized stigma among MSM.

Methods

The study used qualitative and quantitative methods to collect data, as shown in the table below

METHODS AND SAMPLE	PURPOSE
• Survey interviews with health workers in one private (n=95) and one public hospital (n=100)	• Understand the gaps between hospital policies and workers' attitudes and behaviours toward MSM and PLHIV
• Interviews with Dep. Heads of Dermatology, Medicine, Preventive Social Medicine, Psychiatry and Surgery in one private and one public hospital • Observation of hospital practices	• Understand existing policies and practices to protect minorities from stigma and discrimination and health workers from nosocomial infection
• 1 focus group discussion with 7 HST staff • 1 focus group discussion with 6 MSM	• Understand the nature of internalized stigma and other factors leading to low access to health services by MSM
• Consultation involving 28 participants (4 Dep. Heads, 8 health workers, 5 members of a PLHIV network; 10 MSM and 1 transgender from the community)	• Review and discuss the findings in order to develop an action plan for combating institutionalized stigma in health care settings and internalized stigma among MSM

1. ICRW, UNDP and STRIVE, 2013. A global HIV stigma reduction framework adapted and implemented in five settings in India. 2013. Summary Report. ICRW.

Project highlights

- The project identified important gaps in knowledge about HIV transmission among health workers.
- Fear of getting infected through casual contact was common among paramedical staff, particularly among those in a private hospital.
- Many health workers held attitudes of 'blame and shame' towards people living with HIV (PLHIV) and MSM.
- Reported support for enacted stigma was much higher among staff in the private hospital than the public hospital.
- Health workers acknowledged the existence of stigmatizing and discriminatory practices in their hospital.
- Structural barriers to stigma reduction were identified (e.g. materials needed to practice Universal Precautions were not readily available).

Characteristics of the survey sample

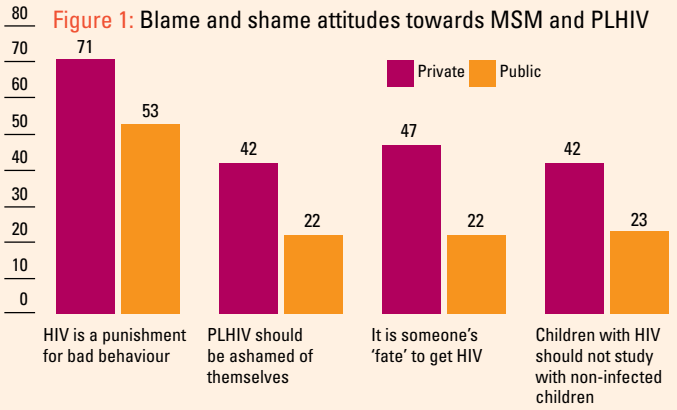
The sample in each hospital consisted of four cadres of staff: doctors, nurses, housekeeping and lab staff. The sample for each cadre was drawn using random sampling and reflected its proportion in each hospital. About half of the private hospital sample was housekeeping staff, 30% were doctors and the rest were nurses and lab technicians. In the public hospital there were more doctors and nurses and fewer housekeeping staff. The sample in both hospitals consisted of slightly more men than women. The public hospital sample was older and had about four times as many years of experience as those in the private hospital.

Key outcomes

- **Important gaps in knowledge about HIV transmission exist among paramedical workers.** More than 90% of all respondents recognized blood as a transmission route. For other bodily fluids, however, there were sharp differences between the medical and paramedical staff. Over 90% of the medical staff in both hospitals had correct knowledge of HIV transmission through semen, vaginal fluid and breast milk. Yet far fewer paramedical staff in both sites correctly identified semen (56%), vaginal fluid (62%) and breast milk (55%) as transmission routes.
- **Fear of getting infected through casual contact is common among paramedical staff, particularly among those in the private hospital.** About half (47%) of paramedical staff from both hospitals feared touching the sweat of an HIV-positive person. Many paramedical staff in the private hospital were also fearful of taking blood pressure (25%), changing bed pans (30%) and changing the clothes of an HIV-positive patient (32%). Among the medical staff (private hospital), fear was greatest when sharing utensils with an HIV-positive person and touching his/her sweat (20%).

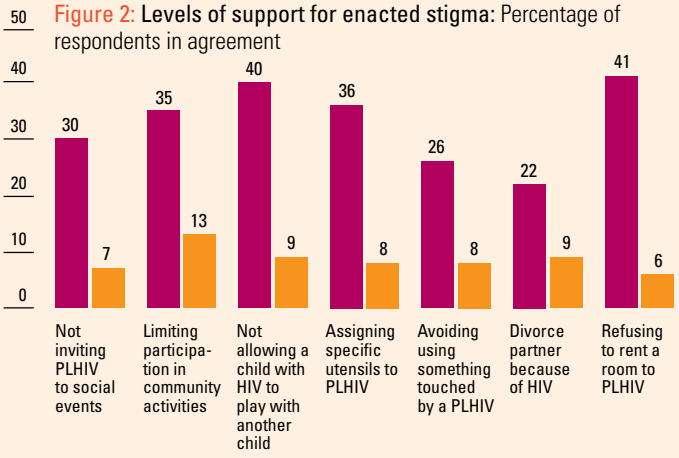
- **Many health workers hold attitudes of 'blame and shame' towards PLHIV and MSM.** Overall, the statements of attitudes of blame and shame were endorsed more by paramedical than by medical staff in both hospitals. See Figure 1.

Figure 1: Blame and shame attitudes towards MSM and PLHIV



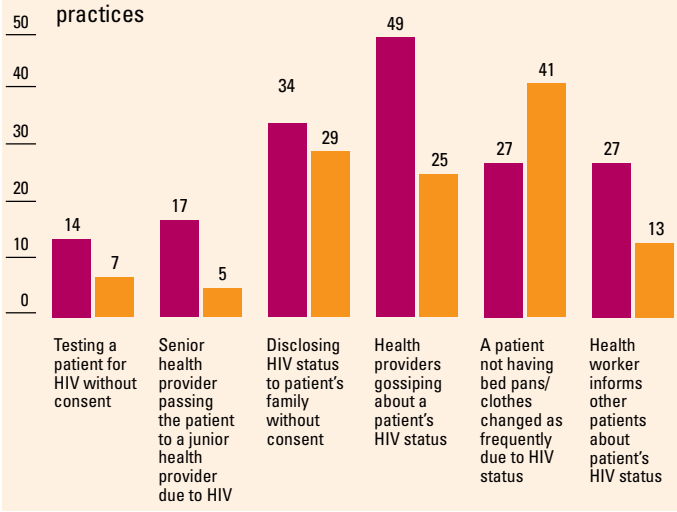
- **Support for enacted stigma behaviours was much higher among staff in the private hospital than the public hospital.** The survey assessed how reasonable or unreasonable different behaviours were toward people living with HIV. Across all the indicators shown in Figure 2, a much greater proportion of respondents from the private hospital supported enacted stigma towards toward PLHIV than from the public hospital.

Figure 2: Levels of support for enacted stigma: Percentage of respondents in agreement



- **Health workers acknowledged the existence of stigmatizing and discriminatory practices in their hospital.** See Figure 3. For all of the indicators except changing bed pans/clothes, the stigmatizing and discriminatory practices were reported more often by health workers in the private hospital than the public hospital. Doctors and nurses, as well as paramedical staff, reported observing stigmatizing and discriminatory behaviours. Observation in hospital wards revealed other examples. In both hospitals, files were marked 'UP' (Universal Precaution), 'positive' or 'sero-positive' and the beds of patients infected with HIV were kept in separate locations. Staff used double gloves, masks and goggles for extra precaution while handling infected patients.

Figure 3: Reporting of stigmatizing and discriminatory hospital practices



Sharing findings

A half-day consultation was conducted to share the findings of the study with staff at both study sites in the presence of members of the MSM community as well as an MSM PLHIV network. Overall, health workers found it difficult to accept the level of prevailing stigma as documented in the study, whereas the MSM and PLHIV representatives confirmed most of the results and elaborated on some of their own health-seeking experiences. After a good deal of debate and discussion, the hospital staff admitted the need to address their stigmatizing attitudes and behaviours, such as markings on files and wards. The senior administrator of the public hospital ordered the removal of such markings following the consultation. There was agreement on the need for capacity building of health workers to include content on sexuality and sexual minorities and on the involvement of members of the MSM community as trainers on these issues.

Lessons learned

- Addressing values and judgments around morality, gender and sexuality should be an integral part of HIV training of hospital staff.
- Work is needed at an institutional level in order to create an enabling environment for MSM and PLHIV to seek care and treatment.
- Working with health care providers requires a good knowledge of the heath care system's protocols and procedures along with buy-in from top management.
- A consultative approach to disseminate the findings helped in creating ownership of the results and pressure to enact change at an institutional level.
- Contact strategies, like the one used in the consultation, can be applied in the health setting to help health providers change negative attitudes towards key populations such as MSM.

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Tackling the structural drivers of HIV

The study was led by ICRW with funding from UNDP. This case study was produced by The Humsafar Trust, ICRW and STRIVE. STRIVE is supported by UKaid from the Department for International Development. However, the views expressed do not necessarily reflect the department's official policies.

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Gaurav: Reducing HIV-related stigma among female sex workers

Karnataka Health Promotion Trust (KHPT)

CASE STUDY

HIV-positive sex workers are a highly marginalized group in India because of their HIV status and because their work is considered immoral and illegal. As a result they experience intersecting stigmas that impede their health and livelihood options. Using a community-based participatory approach, this project aimed to improve the quality of life of HIV-positive female sex workers (FSWs) by addressing the stigma and discrimination they face. The initiative was conducted in Bagalkot and Belgaum districts in north Karnataka and was part of a larger effort to adapt and pilot test a global stigma reduction framework to the Indian context.[1]

Understanding the problem

The project began with a three-day participatory workshop with 24 FSWs. The workshop revealed that participants and their peers experience internalized, anticipated and intersecting stigma. A mapping exercise (see Figure 1) illustrated the many places in the community where sex workers, including those who are or are presumed to be HIV-positive, experience stigma, including in the home by family members.

Figure 1. **Community map showing places where sex workers and HIV-positive sex workers face stigma and discrimination.**

The team also conducted a baseline survey with 240 FSWs and in-depth interviews with five FSWs and five family members. The data showed high levels of HIV-related stigma among respondents and confirmed social judgement, lack of awareness of stigma and fear of infection through casual contact as its key drivers. For example, nearly two-thirds (64%) of FSWs surveyed thought that people with HIV should be isolated and 67% felt that families of people with HIV should be ashamed. Respondents held many misconceptions about how HIV is transmitted, such as through mosquitoes, sharing utensils, sweat and shaking hands. Additionally, the data highlighted the stigma around sex work (e.g. 64% have not disclosed their profession to anyone) and stigmatizing and discriminatory behaviour experienced by respondents in the health care setting including being given less care and attention than other patients, having to wait longer for care, receiving unnecessary referrals and being denied services. Overall, the findings point to the need to work at multiple levels with sex workers and family members.

Project highlights

- High levels of discriminatory attitudes and social judgment were observed among female sex workers.
- It is feasible and acceptable to integrate a multiple-level approach focusing on intersecting stigmas into existing targeted interventions.
- Intensive counselling of HIV-positive female sex workers helped women overcome internalized stigma and foster resilience.
- Strengthening the capacity of targeted interventions in stigma reduction enhances the sustainability of such efforts.

Implementation

Building capacity of targeted intervention staff

The project was integrated into five targeted interventions (TIs), covering 75 villages. Using ICRW stigma-reduction tool kit exercises that were adapted to this particular context, the project team trained TI staff, including programme managers, outreach workers and counsellors to understand issues around stigma and discrimination, and on methods of conducting facilitated discussions with community stakeholders, family members and HIV positive sex workers. In addition the training strengthened counselors' skills, especially in the area of rapport, empathy and reflective listening. It also helped them to recognize and challenge their own values and attitudes towards HIV positive sex workers and develop strategies for working with FSWs in a more positive way.

Group sessions with FSWs and family members

The trained TI outreach workers and counsellors used group sessions to engage sex workers and family members in discussions around HIV stigma. Held over a period of three to four months, the

1. ICRW, UNDP and STRIVE, 2013. A global HIV stigma reduction framework adapted and implemented in five settings in India. 2013. Summary Report. ICRW.

sessions consisted of role playing, sharing personal stories, drawing pictures, analyzing case studies and having interactive discussions. The sessions' themes included forms and causes of stigma, stigma and gender, misconceptions about HIV transmission, stigma in the family and community, the rights of HIV-positive people and seeking treatment. Altogether, 22 group sessions with approximately 348 FSWs and three sessions with 123 family members were conducted.

Counselling

A total of 157 HIV-positive sex workers received individual, intensive counselling, covering such topics as coping mechanisms, building self-esteem, effective ways of disclosing one's HIV status to family, the rights and responsibilities of people with HIV, assertiveness and death and dying. As many sex workers are anxious about their children, some sessions focused on how to plan for the future for themselves and their children. In addition, 23 family members also received counselling.

> "I am regularly attending the group sessions. What I have learnt … is that we should not look at the HIV-positive people differently. If we stigmatize them it will hurt them badly. Personally I have made lot of changes. Before, I was scared to talk, touch or sit close to them. I was afraid of getting infected. But now I know that all these are false. Now I have the courage to confront these fears and whenever I come across anybody doing similar things I go and educate them. Whatever knowledge I got I have shared with my daughters"
>
> MAHADEVI, HIV-NEGATIVE FEMALE SEX WORKER

> "Presently I am on ART and I regularly go to get medicines. I was counseled seven or eight times by the counsellor who gave me moral and mental support to cope. When I shared my life story for the first time, she is the one who gave me all the courage, knowledge and psychological support. Now I am confident and realize that by sharing I get relief and some peace of mind. Now I eat well and never worry about my HIV status
>
> KHATIZA, HIV-POSITIVE FEMALE SEX WORKER

Lessons learned

Reducing stigma towards HIV-positive FSWs requires a multi-level approach consisting of concurrent interventions with individuals (FSWs) and families. The family and FSW group sessions provided an opportunity to tackle the drivers of HIV stigma in a participatory manner. The individual counselling sessions helped women overcome internalized stigma and build resilience. Together, the multi-level approach contributed to improvements in relationships, including increased support to HIV-positive FSWs from family members.

To be effective, activities and tools are needed to address intersecting stigmas. In this case, stigma associated with sex work intersected with HIV-related stigma.

TI programmes are a feasible and appropriate platform for integrating stigma-reduction efforts. However, getting the support of TI programmes for training and engaging staff takes time, as stigma is not the main focus of TI programmes. However, once staff are trained and mobilized, integration into TI programmes offers a pathway to sustainability for stigma reduction programming.

Mobilizing FSWs for group and family sessions in urban areas is a challenge. Sex workers are often mobile and come from different places, making their participation and that of family members in multiple sessions problematic. The model developed for this pilot study was more easily applied in less urban settings.

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KHPT
Karnataka Health Promotion Trust

STRIVE
Tackling the structural drivers of HIV

UKaid
from the British people

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Stigma Busters: Empowering and enabling local governance to work towards stigma-free Gram Panchyat Swasti Health Resource Centre

CASE STUDY

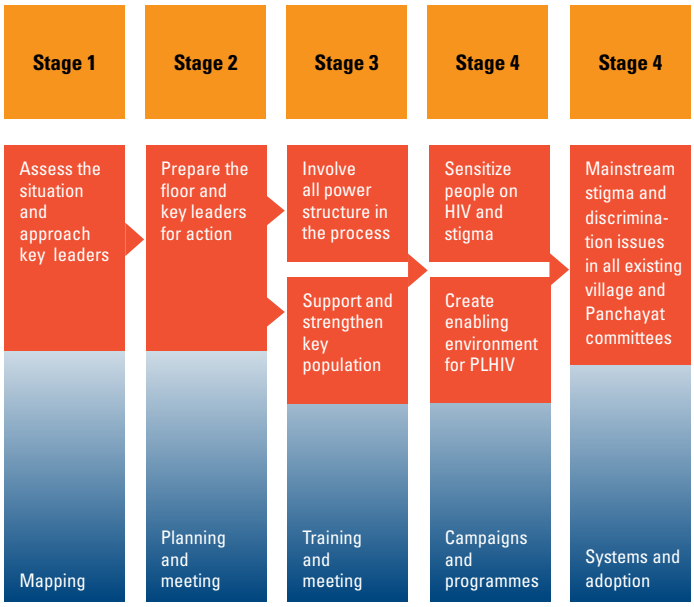
Because of high levels of stigma and discrimination, people living with HIV (PLHIV) rarely participate openly in community-level political and social discussions that affect the implementation of programmes, schemes and policies. Until now, the potential for Panchayat Raj Institutions (PRIs), India's local governing bodies, to influence community perceptions and responses around HIV-related stigma had not been utilized. This project was successful in training and mobilizing Gram Panchayat (GP) members to lead stigma reduction efforts in five communities and to create a platform for ongoing dialogue between the Panchayat and PLHIV. This initiative was part of a larger effort to adapt and pilot test a global stigma reduction framework to the Indian context. [1]

Implementation

Knowing the community

Swasti conducted a mapping exercise to understand the power structure within the Panchayat system and the roles, needs and aspirations of its members as well as of other key stakeholders. These included health department representatives, teachers, Anganwadi workers, the police and other local leaders. Swasti also conducted a baseline survey among Panchayat members, other community stakeholders and PLHIV to understand their level of awareness about HIV-related stigma as well as their attitudes and perceptions toward PLHIV. They found high levels of misconceptions about HIV, yet a strong willingness to take action against stigma and discrimination.

Figure 1: Model design and process



Project highlights

- This was the first programme in India to target and engage the Gram Panchayat (GP) system in HIV-related stigma reduction efforts in rural communities.
- Panchayat members and community leaders took on the role of 'Stigma Busters'.
- The project succeeded in creating a sustainable space and time within the existing GP platforms for discussion between Panchayat members and people living with HIV.
- While the key focus on transformation was GP members, the project also build a cadre of community members to monitor action and to support GP members to perform their role.
- The District AIDS Prevention and Control Unit and the District Administration expressed interest in replicating the model in other Panchayats.

RESPONDENTS CATEGORY	NO. OF RESPONDENTS
Grama Panchayat members and staff	22
Other key stakeholders (health service providers, teachers, AWW, police, PDS, local leaders)	30
People living with HIV	14
Total	**66**

Skill transformation

The project team aimed to institutionalize capacities to deal with stigma and discrimination within communities including the local Panchayat and service infrastructure. This would ensure a steady and sustained pool of active members during and beyond the study period. A sensitization training workshop was conducted separately for Panchayat members and other stakeholders. A total of 44 individuals across five villages participated, engaging in discussions on the facts around HIV and AIDS, forms of stigma, facilitators and actors who stigmatize, manifestations of stigma and discrimination and the roles and responsibilities of community leaders to reduce stigma against PLHIV. Additionally, 14 PLHIV were trained in leadership skills and 12 community members trained to be 'Stigma Busters', which included the use of a community monitoring mechanism to report stigma against PLHIV.

Swasti found that what triggers the participation of the Panchayat in a community issue is "pride, visibility and benefits to their electorate".

1. ICRW, UNDP and STRIVE, 2013. A global HIV stigma reduction framework adapted and implemented in five settings in India. 2013. Summary Report. ICRW.

Ensuring collective decision making and meaningful roles

The project team fostered the co-creation and joint implementation of a plan of action against stigma and discrimination. The Panchayat played the leadership role while giving other stakeholders meaningful roles to play, such as setting the agenda, allocating resources and active participation in implementation. The existing fora of the Gram Panchayat such as members' meetings and Gram Sabhna (village meetings) were used for planning, implementing and monitoring the initiative.

Taking action

The Gram Panchayat members, in collaboration with other stakeholders, Swasti and community youth, conducted a stigma reduction campaign in each of the five villages. Panchayat members passed a formal resolution against stigma and discrimination directed at PLHIV, which was painted on walls in the five villages. They formally endorsed the current stigma reduction initiative and engaged the media to publicize their efforts. These activities served to sensitize people about HIV and stigma, while creating an enabling environment for PLHIV.

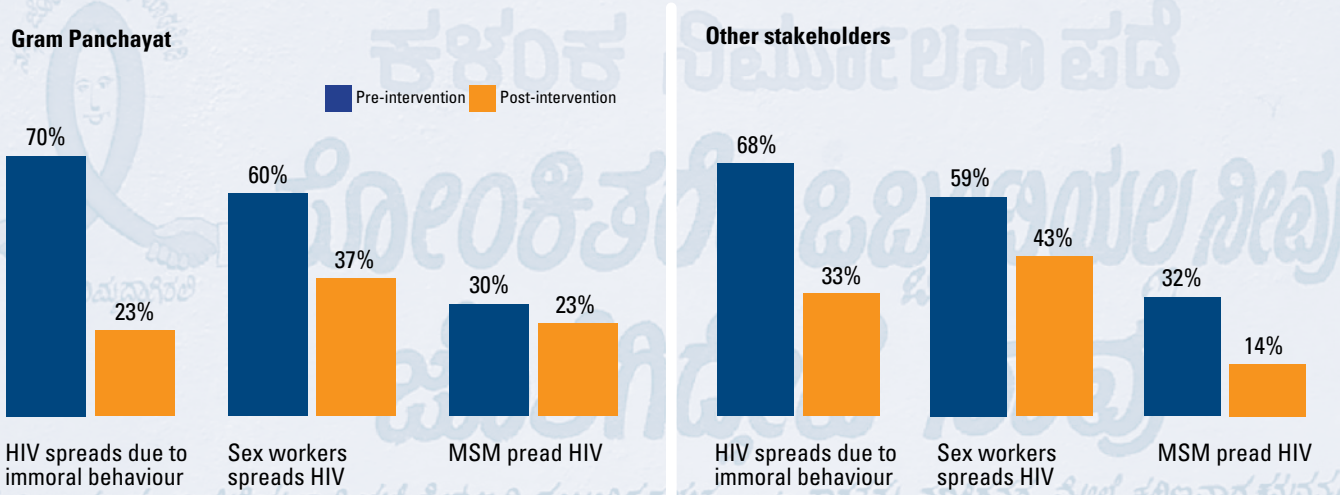
Key outcomes

Pre- and post-surveys with Panchayat members (N=22) and other community leaders (N=30) suggest improvements in knowledge, awareness and attitudes. For example, knowledge of the four modes of HIV transmission among Panchayat members increased from 14% to 57%. There was a similar level of improvement among the other stakeholders. Although high at baseline, awareness of stigma in both groups rose after the intervention. Additionally, there were substantial reductions in blaming different groups for spreading HIV (Figure 2).

Lessons learned

- Panchayat members have great influence in the community and can be excellent role models for fostering reductions in stigma. However, strategic guidance and implementation support will enable GP to move faster from intent to sustainable action.
- It is essential to have a transparent framework of engagement with GP, clarifying the intention of supporting GP and its subsidiaries to become successful entities, as this will foster trust between Panchayat members and a facilitating organization such as Swasti.
- To work effectively with PRIs, implementing organizations and researchers should remain neutral and should not intervene in PRI internal affairs.
- Due to self-stigma, PLHIV may not take a leadership role at the onset, highlighting the importance of empowering individuals while working with community structures.
- Holding regular discussions on the issue in Panchayat platforms is important for sustaining interest in the long term.

Figure 2: Changes in perceptions around the spread of HIV



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Swasti 10 YEARS OF EXCELLENCE

STRIVE Tackling the structural drivers of HIV

UKaid from the British people

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Integrating a youth-based stigma and discrimination reduction curriculum in higher education

St Xavier's College

CASE STUDY

Stigmatizing attitudes towards people living with HIV (PLHIV) are common among young people. Yet there are few opportunities for youth to be exposed to interventions that address the key drivers of stigma and discrimination, namely lack of awareness of stigma and its harmful consequences, social judgment and fear of infection through casual contact. This project demonstrated that higher education can be an effective entry point for stigma reduction, by working with several groups and environments, in this case the faculty, students and college. This initiative was part of a larger effort to adapt and pilot test a global stigma reduction framework to the Indian context.[1]

Implementation

Creating a cadre of master trainers

To institutionalize and sustain stigma reduction within an educational setting, the project team first gained buy-in from college management. After this, they trained a cadre of faculty members as master trainers who in turn would train students. A three-day training was held for 17 faculty members from various disciplines to address gaps detected prior to the training, such as a lack of knowledge about HIV and stigmatizing attitudes. The faculty training focused on the meaning, forms, causes and consequences of stigma as well as myths and misconceptions around HIV and AIDS. To help the faculty understand HIV-related stigma, the training first explored stigma and discrimination based on caste, gender and socioeconomic status. The training exercises helped faculty members to question their own attitudes and overcome any reluctance to start conversations with their students on sensitive topics such as sex, sexuality and condoms. Overall, faculty members felt that the training was important and would prove useful for the students.

Training the students

Sixty-four students across different disciplines took part in a three-day workshop facilitated by the master trainers. All the second year graduation students were informed about the programme and were asked to volunteer. About 75 students volunteered of whom 64 attended the workshop. More girls than boys participated in the training.

> "I used to be scared of HIV before, but after the training I feel it is not something to fear. I participated in this training because I felt that as a professor, if I am more aware, I can help reduce the stigma around HIV among my students."
>
> FACULTY MEMBER

Project highlights

- The project developed and tested a youth-appropriate stigma reduction curriculum in a college setting.
- The team built institutional capacity by training college faculty on reducing HIV-related stigma.
- The project convinced college management of the value of a stigma reduction curriculum.
- The study found an overall positive shift in attitudes towards key populations as well as towards people living with HIV.
- Students who had been through the sensitization process spread the message of stigma reduction to 300 of their peers on campus.

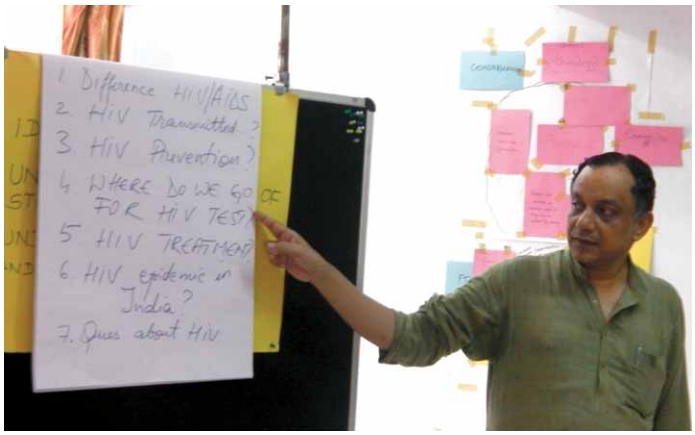
Box 1: Examples of workshop sessions[2]

Naming stigma through pictures: This exercise helped students identify, understand, articulate and question stigma as a social construct.

Stigma tree: This exercise had students visually map and reflect on the routes or causes, forms and effects of stigma. It made students analyze how it feels to be stigmatized and its various effects such as depression, loneliness, isolation and self-destruction.

Value clarification: In this session, students reflected on their levels of moral judgment around stigma and questioned their beliefs. For instance, there were clear ambiguities around statements such as 'women should tolerate violence', 'premarital sex is a choice' and 'women who carry condoms are usually sex workers'.

The workshop covered the forms, drivers and manifestations of stigma. Stigmatizing attitudes and value judgements about PLHIV and key populations were confronted through discussion and debates. (See Box 1 for examples.)



1. ICRW, UNDP and STRIVE, 2013. A global HIV stigma reduction framework adapted and implemented in five settings in India. 2013. Summary Report. ICRW.

2. These sessions were adapted from the following toolkit: ICRW and UNDP, 2013. 'Reducing Stigma in HIV: Training Module for Youth. Facilitator's Guide', New Delhi: ICRW.

Contact strategies to confront negative attitudes

Students and faculty visited community-based organizations (CBOs) working with PLHIV and key populations, including men who have sex with men (MSM), transgender individuals and female sex workers (FSWs) in the cities of Ahmedabad, Surat, Rajkot and Baroda. The majority of students had never knowingly interacted with a female sex worker and had social judgements about their profession. Most students held misconceptions about transgender people and almost no student/faculty reported ever having knowingly spoken with a man who has sex with men. Before the training, only a third of students agreed that MSM have the same rights as heterosexuals; 19% thought that being gay was immoral. The visits fostered collective reflection and greater acceptance.

Spreading the message of stigma reduction

With support from college management and the faculty, the trained students conducted a campaign among 300 college peers featuring:

- their own kits on stigma reduction
- a short film on HIV-related stigma
- engagement with other students to share their learning.

Key outcomes

Pre- and post-intervention surveys with the students revealed important attitudinal improvements:

- Blaming attitudes towards PLHIV regarding 'wrong' or immoral' behavior declined from 21% to 5%.
- Agreement that "PLHIV should be 'ashamed' of themselves" reduced from 67% to 35%.
- There was an overall positive shift in attitudes towards key populations.
- Students were more open to discussing sexuality and sex and felt that it was important to do so.
- The proportion of students who tested for HIV increased from 9% to 19%.

Lessons learned

Engage people at multiple levels. The project found that it was important to start with the 'gate keepers,' in this case senior management at the college, to ensure buy in. Training faculty members as change agents helped to mainstream stigma reduction and promote sustainability.

Use multiple approaches to shift attitudes and norms. The project employed a variety of activities, including workshops, contact strategies with key populations and sensitization campaigns. Peer-led approaches that use students as role models and change agents are important in an educational setting.

Address intersecting stigmas. Including stigma based on caste, class, economic status and religion helped individuals to understand and relate to the stigma and discrimination faced by PLHIV.

> "I did not know that even small children, like a little baby I met at the Reliance center, could be infected."
>
> "I do not see any difference between them [MSM] and us, so who are we to accept them or reject them?"
>
> "I have learnt so much from this 17-year-old boy who is living with HIV. He takes care of everything at home; he studies, works and supports his grandmother. I take too many things for granted in my life. I get it so easy."
>
> STUDENTS AFTER CONTACT VISITS

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