USAID Open Doors Project
Nothing for Us
Without Us

GENDER, SEXUALITY AND SEXUAL ORIENTATION
TRAINING MANUAL

JANUARY 2019

USAID
FROM THE AMERICAN PEOPLE

fhi360
THE SCIENCE OF IMPROVING LIVES

FOREWORD

There are different definitions of key populations (KP) and the revised definition states that KP are people that are at a disproportionately higher risk of HIV. According to WHO, South African National AIDS Council (SANAC), UNAIDS and PEPFAR, KP include gay men, other men who have sex with men (MSM), sex workers (SW), transgender (TG) people, people who inject drugs (PWID) inmates and people confined in spaces. The above sub-populations often engage in higher-risk behaviors that increase their vulnerability to HIV. Key populations as a hidden group are often not captured in population based surveillance and thereby denying the public health experts with the required data to determine the impact of such exclusion in the national HIV response agenda.

The National HIV and AIDS strategic framework 2017-2021 recognises that addressing the HIV services needs of key populations—efficiently, effectively, and respectfully— is not just the right thing to do, in a human rights sense, it is also the smart thing to do from a self-interest perspective. The strategy therefore recognises that it is vital to develop a clear understanding of the dynamics of the epidemic within these populations and to develop effective responses, and implement them, on that basis. This is subject to identifying these populations clearly and without implied threat to them, and then addressing the cultural, legal, and structural barriers including gender and sexual orientation issues to meeting their HIV prevention and treatment needs.

Over the years some countries such as South Africa have developed important criteria that has enabled different players in health programming to determine what constitutes KP such as the legal framework, social justice, high HIV incidence and prevalence, limited access to and utilization of health services and data collection. The development and use of this manual is necessary to achieve a consistent and non-discriminatory service provision regardless of the obtaining local social and legal context.

Dr Robert Chiegil
Country Director/ZPCT IIB Chief of Party
FHI 360, Zambia

CONTENTS

1.0
INTRODUCTION

This Training Manual was largely developed for the use by the USAID Open Doors Project in Zambia. However, it is of use by other partners and interest groups. The USAID Open Doors project's goal is to increase access to and use of comprehensive HIV prevention, care and treatment services by key populations (KPs) in targeted provinces of Zambia. This project is being implemented in selected districts of Central, Copperbelt, Lusaka, North-Western and Southern provinces. The USAID Open Doors project has built on USAID's previous investments through Corridors of Hope (COH) project, which targeted female sex workers (FSW) and their sexual clients as a primary target audience. The USAID Open Doors project has extended its reach beyond FSW to other key populations such as gay and other men who have sex with men (MSM), and transgender persons (TG).

A study conducted by the Panos Institute Southern Africa in 2013 revealed that 24.1% of self-identified homosexual men tested positive for HIV. Some of the respondents cited several risk factors including multiple concurrent partnerships, lack of awareness of the risks of unprotected sex and effective HIV prevention methods, inconsistent condom and lubricant use, alcohol and drug abuse/misuse and unfriendly health services creating barriers to access to HIV prevention, care and support services for many MSM who usually need to use them and hostile legal environment. The risk of HIV infection among SW, MSM and TG persons is increased by stigma and discrimination and the consequent violence experienced from family members, law enforcement, health care providers and society at large for violating expectations of sexually acceptable behavior and contravening gender norms. This is contrary to the expectation from the national health policy and the preamble to the Constitution of Zambia as amended in 2016 which states that all Zambians have a basic right to health care and upholds the human rights and fundamental freedoms of every person.

In this vein, the USAID Open Doors Project's objectives are:

1. To Identify and address the key determinants of risky behavior among KPs in Zambia, particularly in the targeted areas.

2. Increase the availability of high-impact HIV and other health services for KPs.

3. Strengthen the capacity of local stakeholders to plan, monitor, evaluate and assure the quality of interventions for key populations.

These objectives will be achieved through a coordinated, focused and interlinked technical strategies to address barriers to HIV prevention, care and treatment services.

PURPOSE OF THE TRAINING MANUAL

The purpose of this Training Manual is to provide a standard approach to provision of gender and human sexuality sensitivity awareness training to service providers both from the Open Doors project, implementing partners, health providers from the public and private sector. The focus is to build capacity of the service providers at various levels in providing friendly, non-discriminatory and non- judgmental HIV prevention, treatment and care services to members of the Key Populations.

The Training Manual will also be used as a reference manual on various human sexuality issues, gender and diversity as they relate to key populations in Zambia

WHO WILL USE THIS TRAINING MANUAL?

This Training Manual is intended for USAID ODP staff members, implementing partners, community resource partners and stakeholders involved in key populations programming and training at national and sub-national levels in gender and sexual orientation training. The Training Manual is specifically targeted at those responsible for training and mentorship of health care providers, Community Volunteers (CV) and Peer Promoters (PP) who are the front liners in the program. The main content is directed to creating awareness on gender, gender identity, sexuality and sexual diversity issues affecting KP and equip them with practical approaches and skills in establishing KP friendly services using different delivery models as appropriate to the environment.

HOW TO USE THIS TRAINING MANUAL?

This training manual should be used as a guide to training and re-training of PPs, CVs and other health care providers for the Key Populations related projects. In addition to training, the manual can also be used as a reference guide for implementers. Topics included in this manual are focused on building knowledge and skills related to identification, recruitment and Social Behavior Change Communication (SBCC) for KP. However, it is recommended that other relevant topics that PP will be expected to deliver to KP such as basic facts on HIV and AIDS, HIV Testing Services (HTS), Sexual Reproductive Health/Family Planning, Cervical Cancer, Sexually Transmitted Infections (STIs) and Economic Strengthening can be included when need arises.

FORMAT AND ARRANGEMENT OF THE TRAINING MANUAL

This Training Manual is arranged in Modules covering key strategies for working with KP communities to enhance KP friendly HIV prevention, care and treatment services. Each module is arranged as follows: sessions, learning objectives, teaching methodologies, required teaching materials, description of the process and in conclusion Key take away messages are highlighted. This Training Manual is comprised of five (5) modules as follows:

Module 1: Human Sexuality and Diversity
Module 2: Stigma, Discrimination and Prejudice
Module 3: Safe Disclosure and Confidentiality
Module 4: Access to Health Care Services
Module 5: Psychosocial Support and Mental Health

MODULE 1
HUMAN SEXUALITY AND DIVERSITY

SESSION 1: DEFINITIONS OF TERMS

Acquired Immunodeficiency Syndrome (AIDS) a disease in which there is a severe breakdown of the body's cellular immunity, greatly lowering resistance to infection. The cause is the Human Immunodeficiency Virus, or HIV which is transmitted in blood and other body fluids.

[1]**Androgyny** refers to not having clear masculine nor feminine physical characteristics or appearance.

[2]**Antiretroviral Therapy (ART)** treatment of HIV, combination of antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease. ART also reduces transmission of HIV.

Asexual refers to a lack of (interest in and desire for sex) sexual attraction.

Bisexual a sexual orientation and identity. Bisexual people have an attraction to people of the same and opposite sex on various levels (emotionally, physically, intellectually, spiritually, and sexually). Not necessarily at the same time and not necessarily an equal amount of attraction.

Coming out the personal process of accepting and disclosing to others that one is lesbian, gay, bisexual, or transgender. Coming out is a process of how one wants to be identified.

Cis-Gender cisgender people are those whose gender identity matches their sex at birth. The Latin prefix cis stands for 'on the same side'.

Cross- dresser refers to a person who dresses or presents as the opposite sex for various reasons e.g. comfort or style, entertainment, comic effort, on stage or on screen purposes.

Dental Dams a latex sheath (square) that serves as a barrier of protection against the transmission of Sexually Transmitted Infections (STIs) during oral sex or tribadism (sexual practice where genitals rub directly against each other).

Discrimination the unjust or prejudicial treatment of different categories of people on the grounds of race, age, sex, sexual orientation, gender and gender identity and presentation.

Female Condom (Femidom or Woman's Condom) A protective barrier that is used during sexual intercourse as a barrier contraceptive and to reduce the risk of Sexually Transmitted Infections.

Finger Coat a close-fitting sheath worn on a finger, for protection of the finger or to avoid fluid exchange between two or more people.

FTM/Trans Man A transman, or female-to-male, starts his life with a female body, but his gender identity is male. Always use male pronouns in reference.

---

1   SAfAIDS LGBTI handbook
2   http://www.who.int/hiv/topics/treatment/en/

Trans masculine refers to transgender people who were assigned female at birth, but identify with masculinity to a greater extent than with femininity. This includes Trans men, Demi guys, multi gender people whose strongest gender identity is a masculine one, gender-fluid people who are masculine most often and any other non-binary gender who views themselves as significantly masculine.

MTF/Trans Woman A transwoman, or male-to-female, starts her life with a male body, but her gender identity is female. Always use female pronouns in reference.

Trans feminine refers to transgender people who were assigned male at birth, but identify with femininity to a greater extent than with masculinity. This can include trans women, demi girls, multi gender people who identify as female more than other genders, gender fluid and demi fluid people who are feminine and any other non-binary person who views themselves as significantly feminine.

Transitioning the process of changing one's physical presentation to align with one's gender identity. For transgender people this may sometimes include gender reassignment surgery, but not always. It could also include Hormone Replacement Therapy (HRT).

Transsexual a transgender person in the process of seeking or undergoing some form of medical treatment to bring their body and gender identity into closer alignment. Not all transgender people undergo reassignment surgery.

Transvestite an individual who dresses in the clothing of the opposite sex for emotional or sexual pleasure and has no desire to change or modify their body.

Transgender (TG) refers to a person whose biological sex (assigned at birth) does not match their gender identity.

Gay Umbrella term for the word homosexual. Also used to refer to a male - same sexual identity and orientation. Attraction between two males on various levels (emotionally, physically, intellectually, spiritually, and sexually). A gay man may not always be an MSM.

Men having Sex with Men (MSM) a sexual practice between males irrespective of sexual orientation or gender identity. An MSM can be heterosexual, bisexual, homosexual or transgender.

Lesbian female sexual identity and orientation which is an attraction between two females on various levels (emotionally, physically, intellectually, spiritually, and sexually).

Women having Sex with Women (WSW)a sexual practice irrespective of sexual orientation or gender identity. A WSW can be heterosexual, bisexual, homosexual or transgender.

[3]**Sodomy** anal or oral intercourse between human beings, or any sexual relations between a human being and an animal, the act of which may be punishable as a criminal offense.

Gender Socially constructed characteristics assigned that may vary according to the times and the society or group one belongs to, and which are learned or assigned to women and men. It is a broader concept than the mere biological differences between men and women, and includes masculine and feminine traits.

- **Masculine** is having qualities or an appearance traditionally ascribed to men.
- **Feminine** is having qualities or an appearance traditionally associated with women.

Gender Equality is where all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or prejudices.

Gender Equity refers to fairness of treatment for women and men, according to their respective needs. This may include equal treatment or treatment that is different but considered equivalent in terms of rights, benefits, obligations and opportunities.

Gender Expression refers to all the external characteristics and behaviors that are socially defined as either masculine or feminine.

Gender Identity refers to a person's innate, deeply felt psychological identification as male or female which may/may not match the person's biological sex assigned at birth (sex originally listed on a person's birth certificate).

Gender role socially constructed or learned behaviors that condition activities, tasks, and responsibilities viewed within a given society as "masculine" or "feminine".

Gender Queer an umbrella term for gender identities other than man and woman that are outside of the gender binary (male and female) and heteronormativity. Genderqueer people may think of themselves as both man and woman (Bi-gender), neither man nor woman (Agender), moving between genders (gender fluid), and/or third gendered.

Heterosexual Attraction between two people of the opposite sex on various levels (emotionally, physically, intellectually, spiritually, and sexually) where the sex of the attracted person is the key to the attraction.

Homosexual Attraction between two people of the same sex on various levels (emotionally, physically, intellectually, spiritually, and sexually) where the sex of the attracted person is the key to the attraction.

Homophobia fear of homosexual feelings, thoughts, behaviors, or people and an undervaluing of homosexual identities resulting in prejudice, discrimination, bias and/or hostility against homosexual individuals.

Human Immunodeficiency Virus (HIV) a retrovirus that causes AIDS by infecting helper T cells of the immune system.

Intersex a person born with ambiguous genitalia, or sex organs that are not clearly distinguished as female or male.

Intimate Partner Violence (IPV) According to the World Health Organization, intimate partner violence is behavior within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors.

Key Population (KP) These are groups that experience both increased impact from one of the diseases and decreased access to services. It also includes groups that are criminalized or otherwise marginalized.

LGBTI acronym for Lesbian, Gay, Bisexual, Transgender & Intersex.

Male Condom a protective barrier that is used during sexual intercourse as a barrier contraceptive and to reduce the risk of Sexually Transmitted Infections.

Outing telling people (e.g., through gossip) that someone else is LGBT or a gender or sexual minority or a sex worker without that person's permission, no matter the intention.

Pansexual refers to a person not limited in sexual choice with regard to biological sex, gender, or gender identity.

Prejudice refers to a preconceived opinion that is not based on reason or actual experience.

Sex a biological construct of a human being. "What's in the pants?" Male genitals - penis, testes, testosterone and genetic make-up and females – breasts, vagina, estrogen, progesterone and genetic make-up.

Sex role refers to the role or behavior that can only be fulfilled by a person of a particular biological sex.

Sex Worker is a woman, man or transgender person above 18 who receives money or goods in exchange for sexual services. The terms 'woman', 'man' and 'transgender person' also refer to sexually active adolescents.

Sexual Fluidity sexuality varying across time and situation. Fluidity refers to a more inclusive definition than the more limiting conventional labels we have become accustomed to using to define sexual identity. Sexual fluidity, quite simply, means situation-dependent flexibility in sexual responsiveness.This flexibility makes it possible for people to experience desires for either men or women under certain circumstances, regardless of their overall sexual orientation. In other words, though people appear to be born with distinct sexual orientations, these orientations do not provide the last word on their sexual attractions and experiences.

Sexual Practices all behavior that creates sexual pleasure, practiced by one or more than one person, individually, or together.

Sexual Orientation attraction between any two people on various levels (emotionally, physically, intellectually, spiritually, and sexually). Attraction to the other person's sex and or gender presentation is the point of emphasis.

Sexuality how people experience and express themselves as sexual beings, within the concepts of biological sex, gender identity and presentation, attractions and practices. Culture and religion have a huge impact on how individuals see themselves as sexual beings, especially within relations of power.

Sexually Transmitted Infection (STI) An infection that can be transferred from one person to another through any form of sexual contact.

Stereotype is when you judge a group of people who are different from you based on your own and/or others opinions and/or encounters.

[4]**Stigma** extreme disapproval of (or discontent with) a person or group on socially characteristic grounds that are perceived, and serve to distinguish them, from other members of a society.

Transphobia fear of, and/or hostility towards people who are transgender or who otherwise transgress traditional gender norms. Because our culture is often very transphobic, transgender people can often have internalized transphobia and experience feelings of insignificance and self-prejudice.

[5]**Lubricants** personal lubricants (lube) are specialized lubricants used during human sexual acts such as intercourse and masturbation, to reduce friction to or between the penis and vagina, anus, other body parts, or applied to sex toys to reduce friction or to ease penetration.

---

4   https://en.wikipedia.org/wiki/Social_stigma
5   https://en.wikipedia.org/wiki/Personal_lubricant

SESSION 2: HUMAN SEXUALITY

Learning Objectives	**1.** To introduce participants to the concept of human sexuality.
	2. To encourage participants to explore and embrace sexual diversity.
Duration	30 minutes
Materials	Flip chart, markers, sound speakers, projector

What is sexuality?

According to the World Health Organization (WHO) the working definition of sexuality is:

"Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors."

Personality: refers to individual differences in characteristic patterns of thinking, feeling and behaving. The study of personality focuses on two broad areas: One is understanding individual differences in particular, personality characteristics, such as sociability or irritability. The other is understanding how the various parts of a person come together as a whole.[6]

Values: beliefs of a person or social group in which they have an emotional investment (either for or against something).

Communication: communication is the 2-way exchange of opinions, news and information by writing, speech or gestures including body language and facial expressions and reactions.

Self-image: The perception that one has of oneself, including an assessment of qualities and personal worth.

Gender: refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed. While most people are born either male or female, they are taught appropriate norms and behaviors – including how they should interact with others of the same or opposite sex within households, communities and work places. When individuals or groups do not "fit" established gender norms they often face stigma, discriminatory practices or social exclusion – all of which adversely affect health. It is important to be sensitive to different identities that do not necessarily fit into binary male or female sex categories.[7]

Socialization: the process whereby an individual learns to adjust to a group (or society) and behave in a manner approved by the group (or society). According to most social scientists, socialization essentially represents the whole process of learning throughout the life course and is a central influence on the behavior, beliefs, and actions of adults as well as of children.[8]

---
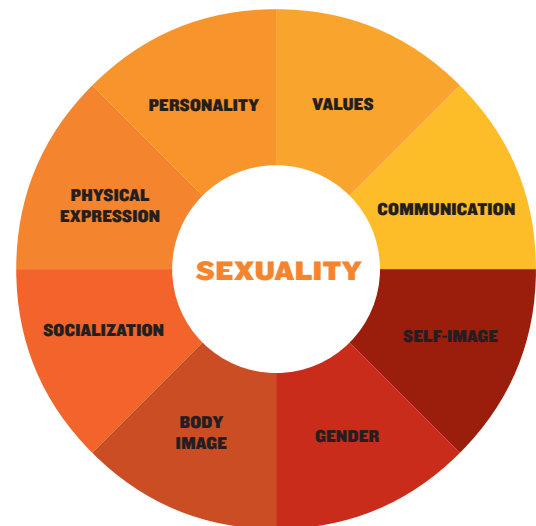
6   Source: Alan E. Kazdin American Psychological Association – Encyclopedia of Psychology
7   World Health Organization – Gender Equity and Human Rights
8   https://www.youtube.com/watch?v=UyiVwUvla6o&t=32s Source: Encyclopedia Britannica

Physical expression: also referred to as gender expression speaks to all of the external characteristics and behaviors that are socially defined as either masculine or feminine e.g. dressing, grooming, mannerisms, expressions, speech tones, etc.

Body image this is how you see yourself when you look in the mirror or when you picture yourself in your mind. It encompasses what you believe about your own appearance (including your memories, assumptions, and generalizations), how you feel about your body, including your height, shape, and weight, how you sense and control your body as you move, how you feel in your body, not just about your body.

SESSION 3: ASPECTS OF SEXUALITY

Learning Objective	To enlighten participants on the separate components surrounding human sexuality
Duration	20 minutes
Method	Flip chart, markers
Materials	Flip chart, markers

There are three aspects to human sexuality and these are:

  i. Behaviour (actions)

  ii. Feelings

  iii. Identity (Self Label)

Examples:

  a. **Some people:** have sex with both men & women (behavior) but still consider themselves basically heterosexual (identity)

  b. **Some people:** consider themselves bisexual (identity) and yet are in a monogamous relationship (behavior)

  c. **Some people:** consider themselves heterosexual (identity) and only have sex with people of the opposite sex (behavior) but sometimes are attracted to people of the same sex (feelings)

  d. **Some people:** consider themselves lesbian or gay (identity) and occasionally have sex with the opposite sex (behavior)

Exercise 1:
Understanding Sexuality
Play the video found at https://www.youtube.com/watch?v=k47AiatNvoM and ask participants what stands out for them from the video.

Ask them if they (or someone they know) have gone through such a process and what it was like. Find out from the room what they feel about human sexuality after going through this session.

SESSION 4: SEXUAL ORIENTATION

Learning Objectives	1. To introduce participants to various sexual orientations that exist
	2. To help participants explore their own sexuality and begin understanding that of others around them

Duration	30 minutes
Method	Flip charts, markers, sound speakers, projector
Materials	Flip chart, markers

What is sexual orientation?

An individual's physical and/or emotional, spiritual, intellectual, psychological attraction. Sexual orientation is about attraction and feelings. Attraction has many levels – sexually, physically, intellectually, emotionally and spiritually. Thus, it is not about sex!

Everyone has a sexual orientation. It is unclear what determines a person's sexual orientation. Often the question is asked "Where does homosexuality come from?" The answer - The same place as other sexual orientations

Recap video from session 3 and ask the following questions:

Step 1: after the video, ask participants what they thought as they watched the video.

Step 2: also ask participants what particularly stood out for them during the video.

Step 3: ask participants if they have any questions on any concept from the video or from the discussion before and conclude the session.

Learning Objective	At the end of this activity, the participants should be able to articulate and dispel myths around what is the cause of diversity with regards to sexual orientation.
Duration	30 minutes
Method	Brainstorm, discussion
Materials	• Chart paper (On one flip chart, write down one common myth or misconception) • Marker pens, Bolstik, sticky notes

FACILITATORS NOTE!!

One myth is that homosexuality and bisexuality are seen as illnesses, which they are not. This may be due to a lack of understanding of human sexuality. Remember, there is no such thing as *"sexually normal"*, therefore, no one can be referred to as sexually abnormal. Nearly all people have insecurities about their gender, sexual orientation and sexual bodies at one point or another. This is because information is either limited or people do not know where to find the correct information. This is due to the shame that is often associated to homosexuality (because of heterosexism and homo prejudice).

Definitions

- Heterosexual
- Homosexual
- Gay
- Lesbian
- Bisexual
- Asexual
- Pansexual
- Sapiosexual

Distribute about 6 sticky notes to each participant beforehand.

Ask participants what they understand by the terms myth and misconceptions.

Stick up the pre-filled flip chart and encourage participants to share any other myths or misconceptions they may know of regarding why people have different sexual orientations. Stick the additional flip charts up (ideally have a total of 6 – more if need be).

Ask participants to reflect on the myths the group has come up with and for each myth, each participant should write on 1 sticky note why they believe that to be a myth and not a fact.

When all charts have been filled, go over the content with participants and let the group reach consensus on whether the myth is true or false regarding why people have different sexual orientations.

Highlight any responses that may not have been shared during the activity by participants. Clarify whether the participants have understood the content of the exercise and ask whether there are other additional contributions they may have.

Key Discussion Points:
- What myths and misconceptions and how they contribute to stigma, discrimination, prejudice and stereotypes
- How can we begin to dispel these myths and misconceptions?

Step 1: after the video, ask participants what they thought as they watched the video.

Step 2: also ask participants what particularly stood out for them during the video.

Step 3: ask participants if they have any questions on any concept from the video or from the discussion before and conclude the session.

SESSION 5: GENDER IDENTITY

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

Learning Objectives

1. Explore the concepts of gender, gender identity and also gender norms

2. State the difference between the terms sex and gender; and

3. Explain the concept of gender roles being determined by society

Duration	60 minutes
Method	Brainstorm, discussion
Materials	• Chart paper (On one flip chart, write down one common myth or misconception) • Marker pens, Bolstik, sticky notes

Advance Preparation:

• Copy *Handout 1: Definitions of Sex and Gender.*

Process: What is gender?

Gender refers to the socially constructed characteristics assigned that may vary according to the times and the society or group one belongs to, and which are learned or assigned to women and men. It is a broader concept than the mere biological differences between men and women, and includes masculine and feminine traits.

Gender can also refer to the *socially constructed roles, behaviors, activities, and characteristics that a given society considers appropriate for men and women.* People are expected to perform ascribed gender roles and have certain characteristics. Men are expected to be strong, play the role of breadwinner, marry, and have sex with women. Women are expected to be gentle, hard-working, marry, and have sex with men.

In the larger group ask the participants to brainstorm on what helps them to distinguish a male from a female (25 minutes)

Divide the whiteboard in two. Write MALE in one side and FEMALE in the other. Write all the statements the participants say where they correspond, e.g.:

MALE	**FEMALE**
Strong shoulders (S)	Wearing dress (G)
Wearing trousers (G)	Wearing makeup (G)
Beard (S)	Has breast (S)
Short hair (G)	Has wide hips (S)
Mustache (S)	Soft skin (S)
Wearing a shirt (G)	Long hair (G)
Muscles (S)	Has a vagina (S)
Has a penis (S)	Wearing hills (G)
Wears a tie (G)	Wears earrings

**Exercise 1:
Gender and sexuality
(15 minutes)**

For this exercise, play the gender and sexuality video found at https://www.youtube.com/watch?v=dF2YOw4xAd4

Note: ask participants to note down what stands out for them as they watch the video for discussion after.

After participants have provided diverse characteristics of males and females, with a different color mark with an "G" if the characteristic relates to Gender or an "S" if it relates to Sex (as shown above).

Distribute **Handout 1: Definitions of Sex and Gender** and ask participants if they have any question or further comments (10 Minutes).

Wrap up and Summary (5 minutes)

Reiterate the points raised in discussion: Many people think that our roles are determined by our biology – our sex – and cannot be changed. In fact, from the time boys and girls are born they are taught how to behave appropriately in their culture. This means that these behaviors are learned.

Gender has to do with widely shared ideas and expectations (norms) and roles that society decides men and women should play. These include ideas about "typical feminine" or "typical masculine" characteristics, abilities, and behaviors. These ideas are learned from family, friends, opinion leaders, religious leaders, culture, schools, the workplace, the media and advertising. For example, men are typically expected to be strong and unemotional while women are expected to be soft and nurturing.

Exercise 1: The Gender Question (10 minutes)

For this exercise, play the "girl and boy" boy that is found on YouTube at https://www.youtube.com/watch?v=pF1j22x-yU8

Ask participants to share what they think is going on in the video. Also ask them if this depiction is true or false (do we see this in our own society?)

Take away Messages

• Gender refers to the rules each society makes about how BOTH men and women should behave and the roles they should play.
• Sex refers to the physiological characteristics of a person.
• People often mistakenly believe men's and women's roles are determined by their biology/physiology – that is their sex.
• The gender roles society creates can be changed as individuals and communities adopt and learn new ways of doing things.

**Exercise 2:
Vote with
your feet"**

Learning Objective	Understand that personal experiences and values impact how we view and understand other people.
Time	45 minutes
Materials	Vote with Your Feet Example Bank, Flip chart paper, markers

Activity

1. Ask the group to stand in the center of the room. Explain that you are going to call out a statement. (A complete list of suggested statements is available in the Vote With Your Feet Example Bank in annex I). Tell the participants to step to the right if they agree with the statement, or step to the left if they disagree.

2. Call out the first statement. Repeat it to ensure that everyone heard it. After everyone indicates whether they agree or not, ask 2 or 3 participants from each side to explain why they voted the way they did.

3. Facilitate a brief discussion about their reasons. Read up to 5 statements.

4. Debrief the activity by explaining the following:

   • Even though we may be familiar with gender and the importance of gender sensitive
   • Programming for Key populations, some questions are still difficult for us to work with.
   • Our own experience with and beliefs on gender can have an impact on how weview and understand other people.
   • We need to keep this in mind as we ask staff and project beneficiaries to address gender issues affecting programming for Key Populations.

**Exercise 3:
Sex roles vs
Gender roles**

Step 1: Write the two words (Gender and Sex) on 2 flip chart papers and invite participants to share what they understand about the two.

Step 2: Once the correct definitions have been arrived at, ask participants to give examples of both sex roles and gender roles and write correct answers under each term.

Step 3: Once enough answers have been given, share any that may not have been mentioned and go through the response to elaborate on each.

Step 4: Wrap up the session by outlining the key take home messages from this session.

SESSION 6: GENDER NORMS

Gender norms are a culturally-defined set of roles, responsibilities, rights, entitlements, and obligations, associated with being female and male, as well as the power relations between and among women and men, boys and girls.

What is Gender Identity?

This refers to a person's innate, deeply felt psychological identification as male or female which may/may not match the person's biological sex assigned at birth (sex originally listed on a person's birth certificate).

It is an individual experience of gender, which may or may not always correspond with the sex assigned to that individual at birth.

This includes:

- Cis-gender
- Trans-gender
- Gender queer

Definitions
- Cisgender
- Trans-gender
- Gender queer
- Transvestite
- Cross dressers
- Gender queer

Exercise 1: My gender transition from female to male (FTM) (5 minutes)
Show video found at https://www.youtube.com/watch?v=RYuipbRGu5s for a story shared on how one person's journey was as he transitioned.

Discussion Exercise: Use diagram below to explain the concept of cis-gender

masculine gender identity

cis men   trans men

assigned male at birth (sex) ← GENDER QUEER OR NON-BINARY → assigned female at birth (sex)

INTERSEX

trans women   cis women

feminine gender identity

GENDER IDENTITY

WOMAN   MAN
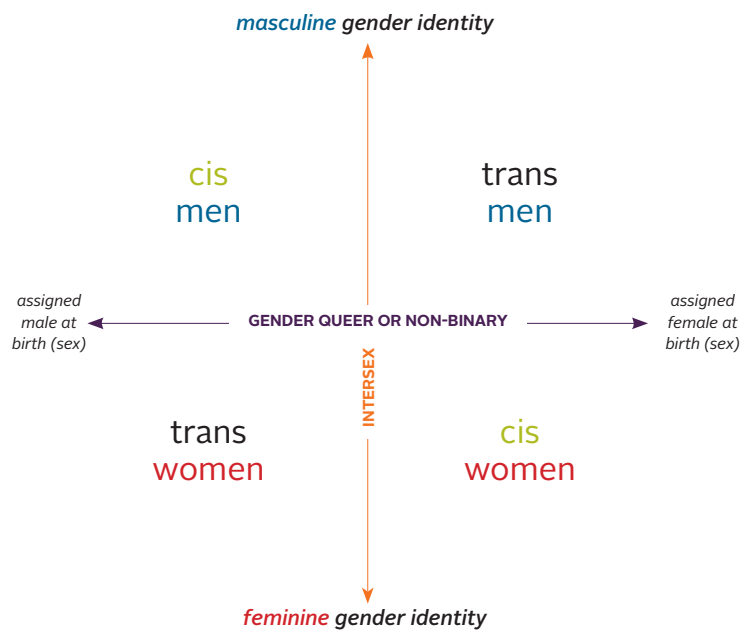
Discussion exercise (Local Terminology) (10 minutes)
What are some terms used to describe gender and sexual minorities in your country or culture?

SESSION 7: GENDER EXPRESSION

Learning Objective	To explore the concept of gender expression and what attributes surround it
Duration	120 minutes
Method	Presentation, Discussion, Exercise
Materials	flip chart, markers

What is gender expression?
Refers to all of the _external characteristics_ and behaviors that are _socially defined as either masculine or feminine._

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

In very basic terms, gender expression refers to how one portrays themselves to the outside world; how they define themselves to the external environment either through dressing, voice projection, how one walks, their body gestures, grooming, mannerisms, etc. Social or cultural norms can vary widely and some characteristics that may be accepted as masculine, feminine or neutral in one culture may not be assessed similarly in another.

It is important to note that one's gender expression may or may not match their sex, gender identity and/or sexual orientation.

GENDER EXPRESSION

FEMININE   MASCULINE

This exercise is meant to act as a summary of the above topics of biological sex, sexual orientation, gender identity and gender expression.

Step 1: on a flip chart, draw the image below including the brain, heart and genital area without labeling the components.

Step 2: ask participants what they understand each component means from the image you have just drawn.

Step 3: Label the components after the discussion with participants and emphasize on the importance of this summary.

Exercise I: The Gender Bread Man (20min)

Feminine and Masculine
Feminine traits are ways of behaving and presenting that our culture usually associates with being a girl, female or a woman. Masculine traits are ways of behaving and presenting that our culture usually associates with being a boy, male or a man.
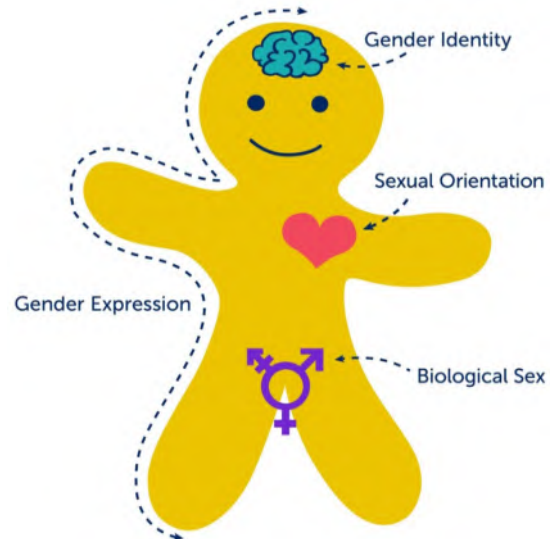
Words commonly used to describe femininity and masculinity

Feminine	Masculine
Dependent	Independent
Emotional	Non-emotional
Passive	Aggressive
Sensitive	Tough-skinned
Quiet	Vocal
Conceding	Competitive
Graceful	Clumsy
Innocent	Experienced/explorative
Weak	Strong
Suppressed	Expressed
Nurturing	Want to be a leader
Romantic/sentimental	subtle expressions of love
Modest	Self-confident
Self-critical	Hard
Gentle	Sexually aggressive
Sexually submissive	Sexually commanding
Accepting/embracing	Non-verbal actions
Not expected to make sexual advances	Expected to make sexual advances

The aim of this exercise is to comprehensively discuss the topics of biological sex, gender, sexual orientation and sexual practices in a participatory way with participants. We have used an adaptation of the Looking In Looking Out (LILO) approach in preparing this exercise.

Facilitators NOTE!!

Clearly, society's classifications of masculine and feminine are unrealistic. They may not capture how we truly feel, how we behave and present, or how we define ourselves. All men have some "so-called" feminine traits, and all women have some "so-called" masculine traits. We may show different traits at different times and situations in our lifetime. Our cultures teach women and men to be the opposi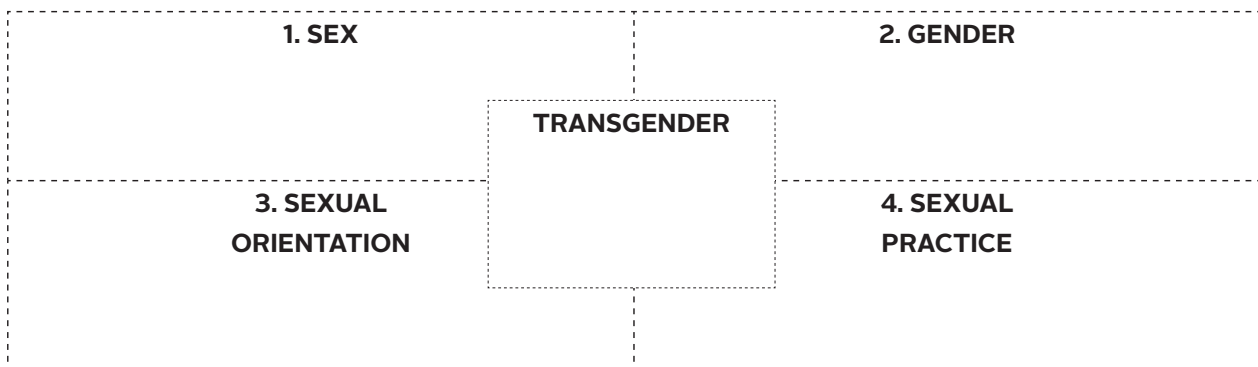te of each other in many ways. The truth is that we are more alike than different. Ideally men and women are designed to complement each other, other than contradict one another as society commonly portrays.

[9]Exercise 2: Binaries & Boxes – Or Not? (60 minutes)

Preparation: Prepare one flipchart as follows:

1. SEX		2. GENDER
	TRANSGENDER	
3. SEXUAL ORIENTATION		4. SEXUAL PRACTICE

Unpacking the Boxes (60 minutes)

In this session, the facilitator should encourage participants to draw from what they already know. A very important thing to say upfront is that the quadrants model is merely a framework to help us simplify and understand the complexity of these issues. It is not carved in stone, and not everyone will feel that they fit neatly into the boxes: things also change for people over a lifetime – there is fluidity. It is not possible to force everyone, in every situation, to fit into the "boxes". For this reason, we have chosen to make the walls of the quadrants permeable.

You could also mention that we will look at some of the "binaries" that are associated with describing gender and sexuality.

Ask: Does anyone know what a binary is?

A binary depicts something as having two parts – either masculine or feminine, homosexual or heterosexual.

Using binaries can help us to simplify and organize the world and they are very much a part of our culture. The trouble is that they can make something that is a little complex, or a "grey area" appear too simple, and they are therefore not always an accurate description. Part of this is to show how deeply imbedded these are in our culture, and yet how limited they really are to describe human sexuality and attraction.

Box 1: Sex as a Biological Concept (15 minutes)

Using the poster with the quadrants, say that you will now start by looking at the term SEX. In this context, it is a biological concept.

Ask: When I say the word SEX what comes to mind?

Allow the group to give their take on what the word means to them. Most will answer that it is something that happens between the sheets, some might give the correct answer. When participants mention "male" or "female", write it down with one below the other.

Ask: How do you know what sex somebody is?

Look in the pants – male has penis, female has vagina. Biological sex is about what's in the pants, as well as the hormonal and genetic make-up which indicates a person as being biologically male or biologically female.

Ask: Do you know of any other biological sex?

1. SEX	TRANSGENDER	2. GENDER
Male Female Intersex		
3. SEXUAL ORIENTATION		4. SEXUAL PRACTICE
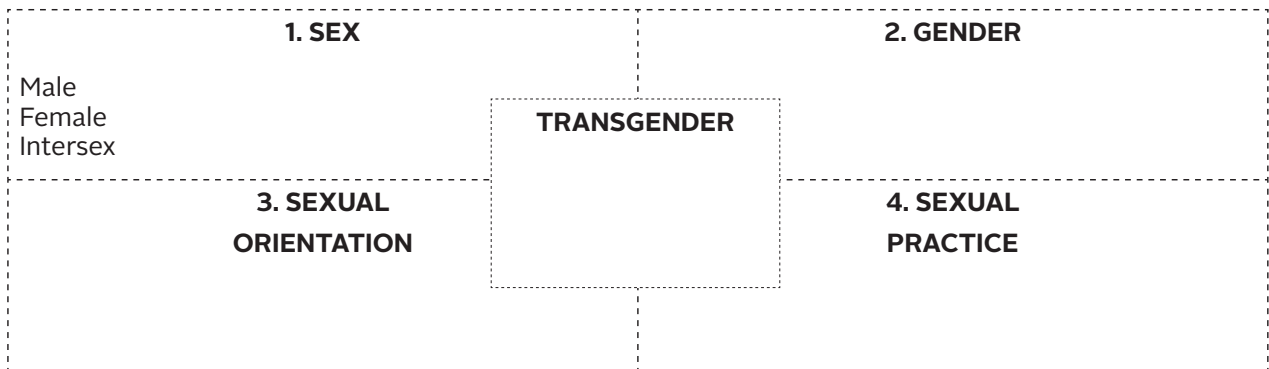
Explain: the word "intersex".

Intersex people used to be called "hermaphrodite", but it is an offensive and insensitive term, politically incorrect and one we should not use in any case.

There is no single form of being intersex. In some cases, the genitals are not clear at birth; in some cases, individuals discover much later in life that they are intersex. There are very many different ways intersex can manifest.

Years ago, and in some places today, when a baby was born intersex, the doctor would urge the parents to choose the sex of their baby. The genitals would then be surgically modified to fit the chosen sex. Cases were reported where the choice of the sex of the baby was that of a boy and where, later in life, at about puberty, the boy would develop breasts.

These days, parents are referred to endocrinologists. A choice is not made immediately, but the child is allowed to grow without "corrective" surgery and encouraged to make his or her own choice in terms of sex and gender identity. Having an intersex child can be very difficult time for parents especially that there is very little information and knowledge on intersex. It is a very sensitive issue and clients should be referred to the correct health care providers for assistance with various challenges that arise.

Intersexuality challenges the idea that there are only two sexes. But who knows, there may be even more than just male, female and intersex. There is still a lot that is not known about sex and cannot be explained, for this reason it is best to not be conclusive and absolute about what is currently known or accepted as a sex norm.

Another way of seeing sex is on a continuum with male and female on either end, and intersex in between.

MALE   INTERSEX   FEMALE

Please note that the line above is a continuum and people fall somewhere on it – not just in the named places the diagram above shows. Intersex would fall somewhere in between. An intersex person can fall more towards the female end of the spectrum, or more towards the male. And even males and females themselves can be more towards intersex than far on the ends of this spectrum.

Check with the group that all information is understood so far.

Use scenarios to further explain the continuum. Illustrate that an individual may be born male but be uncertain of whether they identify as male or not. An individual may be born female but know that they identify themselves as male. Some people may have found their identity and are happy with it and yet some people may need to talk to someone about how they feel and how to identify themselves. Feelings will differ along the continuum, but the important thing is to find a place where one is comfortable without any duress from society norms.

Box 2: Gender as a Social Construct

Say you are moving on now to the box that has GENDER written on it.

Ask: If sex is male, female and intersex, what is gender?

Most people express confusion between the terms sex and gender. Sex is a biological concept, we used to think gender was only a social construct.

However, we now realize that many who identify trans from their earliest years (as young as 2 years old) identify with the gender other than the sex they are born with. A construct is something that is – in the case of gender – put together by society, where meaning is placed on what it means to be male or female.

The following optional questions could be the basis for interesting conversation:

- Who is society?
- Who decided what a man or woman should or should not do?
- Why did society decide how men and women should be?

The following two terms should be identified and written up on the flip chart:

- Masculine
- Feminine

1. SEX		2. GENDER
Male Female Intersex	**TRANSGENDER**	Masculine identity Feminine identity
3. SEXUAL ORIENTATION		4. SEXUAL PRACTICE
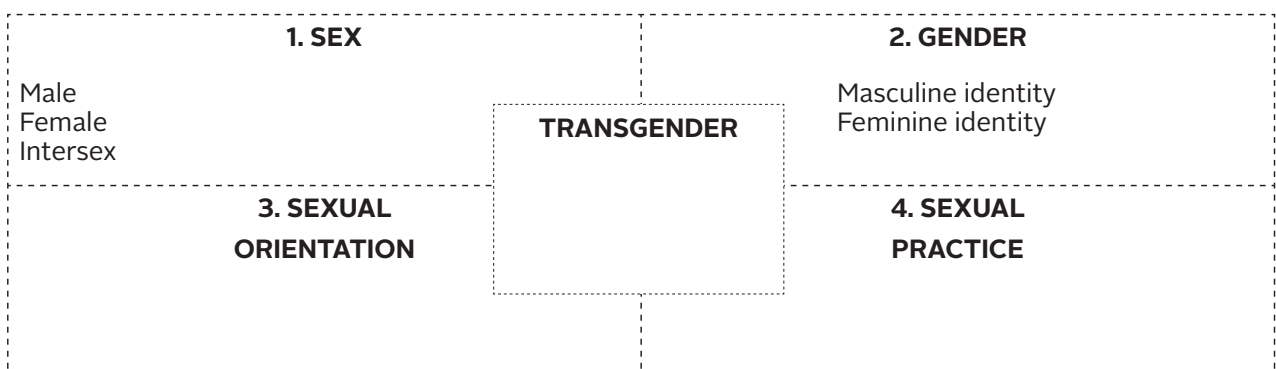
Continue the discussion around how one is expected to be in the masculine identity and the feminine identity and write these in the appropriate place.

Finish off this concept by emphasizing that humans are born with a sex, NOT with a gender. Gender is what human beings are "taught", what is expected of male bodied people and female bodied people.

One way of analyzing Gender would be on a continuum like this (draw on the flipchart).

Male	Androgynous	Female
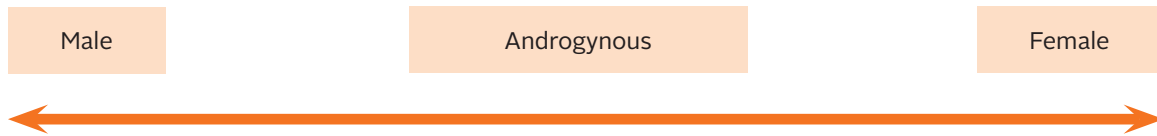
Very few people only show masculine or feminine traits, but some people are more masculine, with a few feminine parts, or the other way round.

Androgyny has been used to describe someone who presents themselves in ways that are neither totally masculine nor totally feminine. However, there is a new way of using this word psychologically. An androgynous person can show both feminine and masculine traits. (you can ask a few participants to share where they fall on the spectrum in 1 minute) .

Exercise 3: Gender demonstration

Another interactive way of demonstrating the above spectrum is to use some tape to make a long line on the floor. Write up the words "masculine", "feminine", etc. on A4 paper and stick these down on the ends of the tape. Ask people to make a judgement about where they fit in here and ask them to go and stand on the continuum where they would like to place themselves. Then they can see where they are in relation to their friends and neighbors!

Middle Box: Transgender

Ask who can explain what transgender means. Warn people that this is a highly complex area, and that it is important to tread lightly and listen carefully to those who are transgendered in the room.

It is a broad term that encompasses cross dressers, intersex people, transsexuals and those who defy what society tells them is appropriate for their gender.

Say that essentially Transgender is the umbrella term for two different words – transsexual and transvestite. Write these up in the middle box and explore what other terms fall under transgender and explain what they each mean.

1. SEX	TRANSGENDER	2. GENDER
Male Female Intersex	Transsexual (MTF & FTM)	Masculine identity Feminine identity
3. SEXUAL ORIENTATION	Transvestite Drag Queen Cross Dressers	**4. SEXUAL PRACTICE**
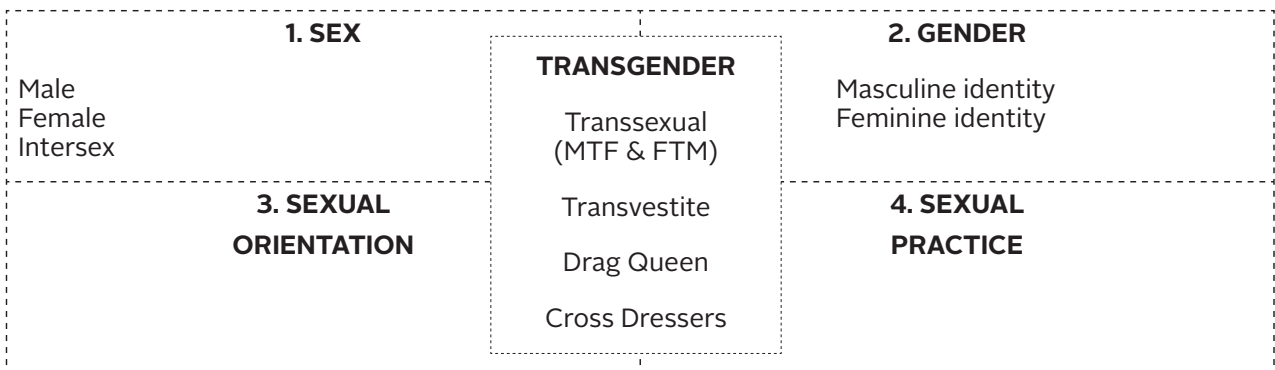
Emphasize that transsexuals are people who transition, or are in the process of transitioning, from one sex to another. They are usually in the process of seeking or undergoing some form of medical treatment to bring their body and gender identity into closer alignment. **NOT ALL TRANSGENDER PEOPLE UNDERGO REASSIGNMENT SURGERY.**

Reiterate the concept of Gender Identity which refers to how someone feels about themselves in the world as a woman or a man: a person's sense of themselves as male or female. While most people's gender identity matches their biological sex, this is not always the case. For instance, someone may be born biologically male, yet has a female gender identity. Also emphasize that a transsexual person can be of any sexual orientation.

Box 3: Sexual Orientation

Ask: What do you think sexual orientation is?

Do you have a sexual orientation?

Do all people have a sexual orientation?

What are the different sexual orientations that you know? (write down what will be listed on the flip chart)

Sexual orientation is about attraction and feelings. Attraction has many levels – sexually, physically, intellectually, emotionally and spiritually. **Thus, it is not all about sex!**

FACILAT NOTE!!

VERY IMPORTANT! It is important that participants understand that gender identity and sexual orientation are not the same, although they share the same experience of prejudice and discrimination. Gender identity is about how someone feels about themselves in relation to being a man or a woman, not who they love or are attracted to.

1. SEX	TRANSGENDER	2. GENDER
Male Female Intersex		Masculine identity Feminine identity

3. SEXUAL ORIENTATION
 	
Heterosexual
Homosexual
  Gay
  Lesbian
Bisexual
Asexual
Pansexual
etc.
	Transsexual (MTF & FTM)
	
	Transvestite
	
	Drag Queen
	
	Cross Dressers
		4. SEXUAL PRACTICES
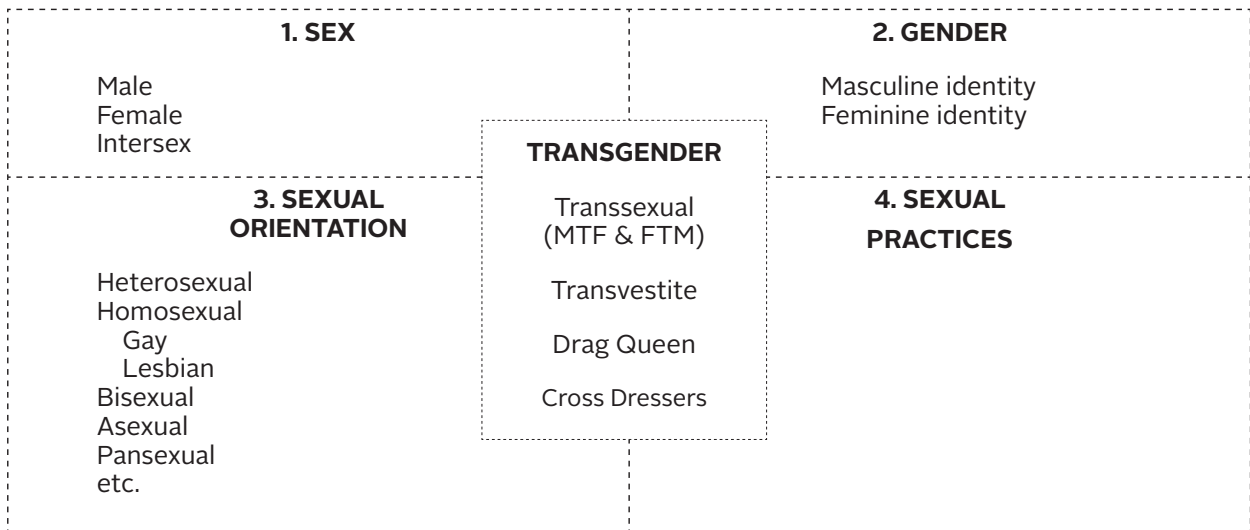
Discuss an example of what happens in life: A child is born with a penis; society teaches the baby to be masculine and have relationships with the opposite sex. Society assumes he must be straight. Another assumption: if you are female, you must be feminine, and therefore straight.

Box 4: Sexual Practices

In this box, ask participants to list all the body parts they can think of that are used as people engage in different sexual practices and write them down in box 4.

Discuss the issue of guilt and shame associated with certain sexual practices, e.g. the "anal taboo". Originally anal sex was seen as a gay sexual practice. We are often aware of more and more women who include anal sex, both giving and receiving, in their sexual repertoire.

An important thing to remember is that most of the sexual practices mentioned on the chart carry risk for sexually transmitted diseases, including HIV. Who we have sex with is not important; how safely we have sex with others is important.

```
┌─────────────────────────────────┬─────────────────────────────────┐
│  1. SEX                         │  2. GENDER                      │
│                                 │                                 │
│  Male                           │  Masculine identity             │
│  Female          ┌──────────────┴─────┐ Feminine identity         │
│  Intersex        │  TRANSGENDER       │                           │
├──────────────────┤                    ├───────────────────────────┤
│  3. SEXUAL       │  Transsexual       │  4. SEXUAL                │
│     ORIENTATION  │  (MTF & FTM)       │     PRACTICES             │
│                  │                    │                           │
│  Heterosexual    │  Transvestite      │  Mouth                    │
│  Homosexual      │                    │  Tongue                   │
│     Gay          │  Drag Queen        │  Vagina                   │
│     Lesbian      │                    │  Penis                    │
│  Bisexual        │  Cross Dressers    │  Anus                     │
│  Asexual         └──────────────┬─────┘  Toes                     │
│  Pansexual                      │        Ears                     │
│  etc.                           │        Eyes                     │
│                                 │        Fingers                  │
│                                 │        Nipples                  │
│                                 │        etc.                     │
└─────────────────────────────────┴─────────────────────────────────┘
```
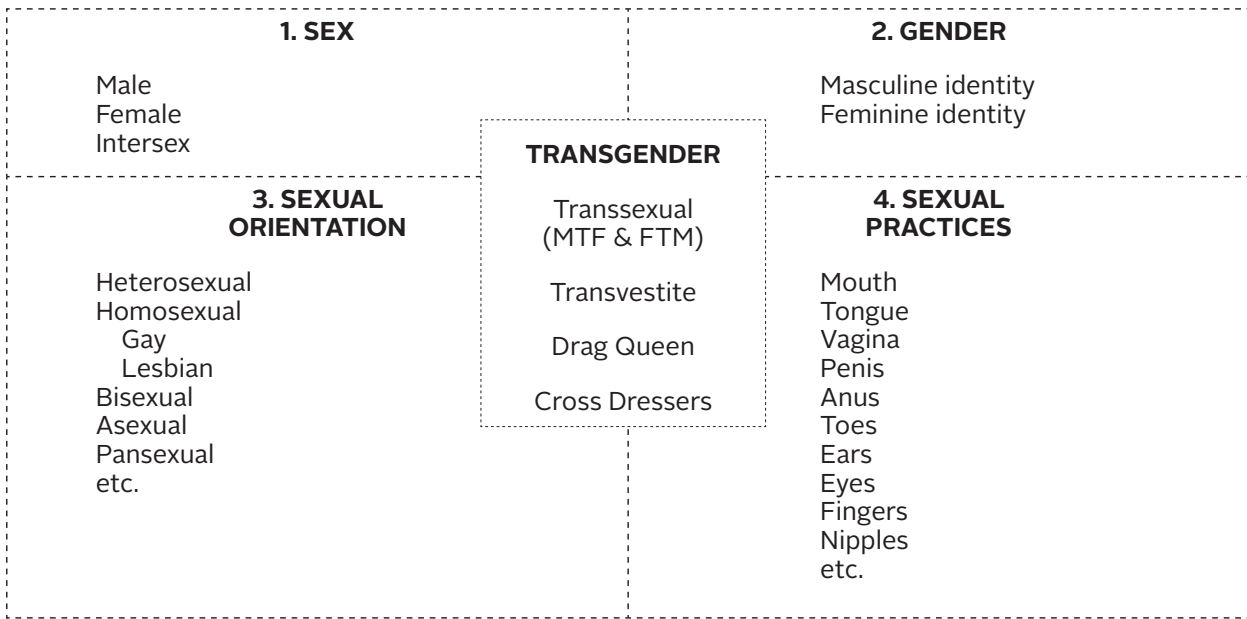
Linking the boxes

Begin to link each box by asking participants on the possibilities of combinations. For example:

- *A male who is masculine and heterosexual married to a heterosexual woman, likes anal sex*
- *A female who is feminine and homosexual and has penis-vagina sex*
- *A male who is masculine and homosexual and has penis-vagina sex*
- *A male who is feminine and heterosexual and has penis to mouth sex*
- *A female who is masculine and heterosexual who has anal sex*
- *A male who is feminine and heterosexual and has anal sex*

Note: use different colored markers if possible to show the various combinations

Emphasize:

i.   That biological sex and gender identity have nothing to do with one's sexual orientation.

ii.   That any person regardless of their sex, gender, sexual orientation can use any body part to have sex and they can practice any type of sex.

iii.   There is no such thing as "gay sex" or a gay person's body parts.

Ask: Why the boxes are made of broken rather than solid lines?

Because sex, gender, sexual orientation and sexual practices are fluid. They can change and adjust over a person's life and may not always be constant.

Wrap up session (10 minutes)

Invite participants into a closing discussion and ask the following questions:

- What have you learnt from this module?
- What is your understanding of human sexuality after going through this module?
- How can you help others with the knowledge you have acquired?
- How relevant is this topic to your individually and also to your work?

Take away messages

- Human sexuality is a complex topic and is not a once off event is a person's life. It is also not cast in stone and is a fluid process that may manifest in different ways over a lifetime.
- Sex and Gender are not the same. While sex is a biological construct, gender is a social construct in that our society, our environment sets standards that are expected for either males and females.
- Gender identity and Sexual orientation are not the same. While gender identity is who you identify as despite your biological sex, sexual orientation is who you are attracted to on various levels.

MODULE 2
STIGMA, DISCRIMINATION AND PREJUDICE

SESSION 1: STIGMA AND DISCRIMINATION

Learning Objectives	1. To understand the meaning of "stigma and discrimination" and the difference between the two
	2. To discuss ways of identifying stigma and discrimination related to KPs
	3. To State the different types of stigma and discrimination
	4. Explain strategies to address stigma and discrimination experienced by KPs
Time	270 minutes (4 hours)
Method	Presentation, interactive knowledge sharing, exercises
Materials required	Projector, flip charts, makers, pens, Bolstick and papers

Exploring discrimination

The unjust or prejudicial treatment of different categories of people on the grounds of race, age, sex, sexual orientation, gender and gender identity and presentation.[10] Non-discrimination is the right of all human beings to be equal in dignity and be treated with respect and consideration to participate on an equal basis with others. All human beings have the basic right to access services and equal treatment regardless of their real or perceived sexual orientation, gender identity, expression and/or their choice of work. To ensure non-discrimination, it is necessary to treat men who have sex with men (MSM), sex workers (SWs) and transgender (TGs) differently per their different circumstances and needs to ensure tailored service provision.

Identifying Discrimination

When identifying discrimination there are four main questions to consider:
- Grounds of discrimination that then leads to next question on "what".
- What: This question goes back to the definition of discrimination and related concepts-It speaks to the prohibited conducts of discrimination.
- Where: This speaks to materials within the laws and areas of life that prohibits discrimination.
- Why: When discrimination occurs, it means that an individual is being treated differently- the question is why? Could the treatment be justified?[11]

Facilitators Instructions

Exercise 1: 45mins

Ask the participants to break into groups and ask them to discuss the following question. After the discussion, ask each group to present on their findings.

Discussion guide
Identify prohibited forms of discrimination with regards to sexual orientation, gender identity, expression and sex work in Zambia and discussion. Participants to be allowed to state using both domestic and international law provisions.

---

10   Source: Your know much more booklet, SAfAIDS
11   Source: Introduction to Equality, The Equal Rights Trust

List of protected forms of discrimination in Zambia

- Race
- Colour
- Ethnicity
- Descent
- Sex
- Pregnancy
- National or social origin
- Economic status
- Age
- Health status, including HIV/AIDS
- Parenthood
- Civil, family or career status
- Language
- Religion or belief
- Political or other opinion
- Birth
- Nationality
- Association with a national minority
- Disability
- Genetic or other predisposition toward illness

Sexual orientation and Gender Identity - *The Zambian law protects against any form of discrimination but it is not explicit on these.*

Discrimination undermines human dignity and affects the equal enjoyment of a person's rights and freedoms.

Forms of Discrimination

Discrimination could come in many forms. However, the common ones are but not limited to:

- Direct Discrimination
- Indirect Discrimination
- Harassment
- Failure to make reasonable accommodation

Direct Discrimination

Direct discrimination occurs:

- When the discrimination is related to one or more prohibited conducts e.g. ex-prisoners
- When a person or group of persons is treated less favorably than another person or group of persons
- In a comparable situation (discrimination based on association)
- When a person is subjected to detriment e.g. harm, damage, torture etc.

Indirect Discrimination

Indirect discrimination occurs:

- When a provision, criterion or practice (written or unwritten, formal or informal) discriminates on prohibited grounds e.g. a job advert in the newspaper that is only looking for women- *this could also be justified discrimination*
- A person is discriminated because they possess a status or characteristic associated with prohibited grounds e.g. ex-prisoners

Reasonable accommodation

Reasonable accommodations are modifications or adjustments to the tasks, environment or to the way things are usually done that enable individuals with disabilities to have an equal opportunity to participate in an academic program or a job (U.S. Department of Education, 2007).

Stigma

Stigma refers to the strong negative feelings or significant disapproval that is linked to a specific person, group, or trait. For example, in the past stigma has developed towards individuals with mental illness or diseases such as HIV. Stigma can be experienced both internally and externally. External stigma is experienced when it results from the actions of others. Internal stigma is experienced inwardly by an individual who is being stigmatized. It can result in low self-esteem, shame, and low moral worth when the person begins to believe and relate to the stigma they are experiencing.[12]

Stigma often comes as a result of personal beliefs and values. Stigma can also be an attitude of different treatment or considering of others in most negative and undesirable way. In every society or community, there are beliefs and values that are perceived to be negative and they determine what is morally wrong and/ or right. These beliefs and values are born out of religious and cultural aspects.

Example: Chanda is a 25-year-old young woman who is studying Psychology and has discovered that she is pregnant by an old married man. Because of the situation Chanda has found herself in, her parents have stopped paying for her college fees and asked her to move out of the house.

Types of Stigma
- Internal Stigma
- External Stigma

Internal Stigma

This is negative attitudes towards oneself; it is also the expectation of discrimination from the external environment-result of external stigma. It can result in low self-esteem, shame, and low moral worth when the person begins to believe and relate to the stigma they are experiencing.[13]

Examples and signs of internal stigma

"Mary is a loyal and dedicated house wife who has tested HIV positive. She believes the stereotype that individuals with such diagnoses are promiscuous and bad people in society, she has applied the belief to herself and shies away from starting treatment and informing her husband about her status."

"Society says homosexuals are demon possessed, they are rapist, they are mentally sick etc. John is a 21-year-old boy who is sexually attracted to other boys, but because he believes everything society says about such people he attempts to commit suicide and says he does not deserve to live."

- **Self-exclusion** from services (including health services) or opportunities. Self-exclusion may occur when a stigmatized individual avoids opportunities due to fear of being further stigmatized, or the individual feels unworthy of those opportunities.
- **Perceptions of self:** A person who is experiencing internal stigma may have low self-esteem, sense of self-worth or other self-confidence issues, including low self-efficacy or a low perception of their ability to conduct a specific task, like accessing health care.
- **Social withdrawal:** Often a person who is experiencing internal stigma may disengage from their social networks.
- **Overcompensation.** Overcompensation may occur when a person who is feeling internal stigma feels the need to overly contribute to a situation to make up for their perceived stigmatization. This could happen when a stigmatized individual is overly grateful when someone is kind to them.

---

12   Source: Department of Health REPUBLIC OF SOUTH AFRICA
13   Source: Department of Health REPUBLIC OF SOUTH AFRICA

- **Mental health issues:** Internal stigma may cause a person to become depressed or develop mental health issues. For example, a stigmatized person may develop generalized anxiety disorder because of continual stress and anxiety from his or her perceived stigma.
- **Substance abuse:** Substance abuse may be the result of internal stigma because a stigmatized person may turn to drugs or alcohol in order to cope with his or her stigma.
- **Suicide, or attempted suicide.** Sadly, some individuals may not be able to cope with their internal stigma and may turn to suicide in order to escape the pain of their stigma. In some circumstances, sex workers may resort to trying to kill themselves to escape the pain of stigma.

External Stigma

External stigma is mostly very clear to identify. External stigma is also referred to as social stigma where people around give distinguished treatment of one group or person from one group or person. In some cases, people may not even be aware that they are being stigmatized against. Therefore, it is important to identify some of the signs of external stigma:

- **Avoidance:** Avoidance occurs when individuals spend less time with or do not want to be around stigmatized people. This might include a person who begins to avoid a close friend because he or she is stigmatized.
- **Rejection:** Rejection occurs when individuals are no longer willing to associate or welcome stigmatized people in their lives. This might include a family member rejecting a stigmatized relative and no longer allowing that person to live with them.
- **Moral judgement:** Moral judgement happens when individuals begin to see a stigmatized person as immoral or when they use their values to justify stigmatizing someone. This might occur when an individual becomes stigmatized because he or she does something that conflicts with the religious beliefs of others.
- **Stigma by association:** Stigma by association occurs when those who associate with a stigmatized person are also stigmatized themselves. This may occur to someone who remains a close friend with a stigmatized person.
- **Gossip:** Gossip happens with individuals begin to speak negatively about other people who are stigmatized. Gossip could occur within a social circle when one of the members becomes stigmatized.
- **Unwillingness to employ:** Someone may be exhibiting external stigma when he or she is unwilling to hire an individual who would otherwise be qualified for the job, only because of certain characteristics that may be stigmatized.
- **Abuse:** When a person physical, emotionally or verbally abuses someone, they may be doing so because of stigma they may have toward that person.
- **Victimization:** Victimization occurs when someone is blamed for problems that are unrelated to them and singled out for cruel or unjust treatment. People who are stigmatized may often be victimized.

Take away messages

- Stigma refers to the strong negative feelings or significant disapproval that is linked to a specific person, group, or trait.
- Stigma often comes as a result of personal beliefs and values. Stigma can also be an attitude of different treatment or considering of others in most negative and undesirable way.
- When exploring discrimination ask the what, where and when questions.
- Discrimination undermines human dignity and affects the equal enjoyment of a person's rights and freedoms.

SESSION 2: HARASSMENT

Harassment constitutes discrimination when unwanted conduct related to any prohibited ground takes place with the purpose or effect of violating the dignity of a person or of creating an intimidating, hostile, degrading, humiliating or offensive environment.

<u>Note:</u> Harassment occurs when conduct has either the purpose or the effect of violating dignity or creating a particular environment.

Example of Harassment

A female sex worker goes to a friend's wedding ceremony where she sits in isolation. Whilst witnessing the ceremony other family members and friends make remarks about the bride, implying that she is a sex worker and using derogatory names.[14]

**Exercise 1:
45mins**

Facilitators Instructions

*For each of the following examples ask participants to please consider whether the following is a case of **direct discrimination or indirect discrimination.** In particular, consider (i) who is the victim; (ii) what is the relevant ground; (iii) what is detrimental"; and (iv) what is the correct comparable situation?*

Discussion guide

1. A sports club refuses to accept as a member anyone over 50 years.

2. When a woman tells her boss she is pregnant he congratulates her. When she begins her maternity leave he writes to her saying "Business is bad so I need to reduce staff, and as you are not working now anyway, I am sorry but I am terminating your employment from next month."

3. A dentist wanting to protect herself refuses to accept any patient who is HIV positive.

4. An employer refuses to give a job to a well-qualified lesbian job applicant after their employees say that they are not willing to work with a lesbian.

5. After one worker at a factory from a particular ethnic group is arrested for attempting to steal from the factory, all employees from that ethnic group but no other employees are searched every day as they leave the factory.

6. A woman who looks after her sister's child who has severe learning difficulties is told by a restaurant that she and the child must sit at one of the outdoor tables. A few minutes later she overhears a woman with a non-disabled child being offered the choice of sitting outside or inside the restaurant.

**Exercise 1:
40 mins**

George, 34, enters therapy after becoming increasingly uncomfortable at his office. His co-workers have begun to make frequent negative comments about him being gay, and he has been subjected to many offensive jokes about his sexual orientation. He tells his therapist that this hostility frequently undermines his work and that although he likes his job, he thinks that quitting may be the only solution. After exploring possible steps and solutions with the therapist, he decides to politely confront any co-worker who make an offensive remark and help them understand how their comments are ignorant and hurtful. With his therapist's encouragement, he also decides to make his boss aware of the situation, a step he was previously too nervous to take. George's boss is understanding and quickly schedules a diversity training and begins to take other steps to ensure a more comfortable office environment for all individuals. Through these actions, George is able to feel more confident about who he is, and his performance at work improves as a result of his increased confidence and comfort in the work environment.

---

14   Source: Introduction to Equality Law, The Equal Rights Trust

Facilitator's Instructions

Ask participants to break into small groups and give them hand outs of George's story to read through and answer questions below.

Discussion guide

1. Identify at least 3 effects the negative comments had on George.

2. What action did George take after exploring possible steps with his therapist?

3. Discuss why the co-workers frequently made negative comments about George's sexual orientation.

4. Discuss the positive effects of a diversity training in a work place.

5. If you are the boss or manager of an organization, what steps would you take to create a work environment that is free from stigma and discrimination within and outside workplace.

SESSION 3: DEFINING BELIEFS, VALUES AND ATTITUDES

Learning Objective	The session aims to set an understanding that people have attitudes, values and beliefs that cause negative reactions towards issues or things that they do not understand. It also sets an understanding of what is meant by prejudice.
Duration	1hr 30 minutes
Materials/teaching aids	Projector, flip charts, makers, pens, Bolstick and papers.

Summary/Key take away messages: At the end of this session people will:

- Be able to recognise their own and others' prejudicial attitudes, values and beliefs.
- Be aware of the negative consequences of prejudice.

Values – an individual's, a family's, or a society's principles or standards of behavior.

Attitudes – the way of thinking or feeling about someone or something typically reflected in a person's behavior.

Beliefs – the trust, faith, or confidence a person places in someone or something.

Prejudice- based on our values, beliefs and attitudes we often judge people, without fully understanding all the issues around their situation. So we can say that often we "prejudge" people (which is where the word prejudice comes from). Prejudice can be defined as unjustified or incorrect attitude (usually negative) towards an individual based solely on the individual's membership of a particular group.[15]

**Exercise 1:
25 mins**

Facilitators Instructions:

Ask participants to give examples or experiences of stigma for question one and two (b).

For question 2 (b) and (c), ask at least four individual participants to volunteer

Discussion guide

1. As a SW, MSM, TG identify some of the stigma that occurs in health care facilities and the causes.

2. Identify your own personal values, beliefs and attitudes by:

    a. describing your most important values?

    b. list five most important beliefs that you have?

    c. identify for each of these values and beliefs, when you developed them, and why?

MODULE 3
SAFE DISCLOSURE AND CONFIDENTIALITY

Module objective	The objective of this Module is to empower KPs with the knowledge they require to successfully go through the safe disclosure process with minimal risk.
Learning objectives	1. To understand the meaning of "Safe disclosure", why it is important and how it can be used in the coming out process.
	2. To understand how various factors, affect the coming out process negatively or positively.
	3. To understand the transgender emergence process and how one can relate to the personal stages of the coming out process.
	4. To help KPs understand the gender emergence process and how the process as well as shared experiences can help one's process of 'coming out'.
Time	160 minutes (2 hours 40 minutes)
Method	Presentations, Games, Interactive knowledge sharing, exercises
Resources	Flip chart or power point presentation, large room or open space, markers, colored board paper

SESSION 1: INTRODUCTION TO SAFE DISCLOSURE

The Safe disclosure process allows participants to understand all issues related to keeping their sexual orientation, gender identity, and sexual practices a secret or revealing it to others. Safe disclosure and confidentiality is about respecting and withholding private information. Confidentiality should be upheld and protected always. This process will help KP determine how and when to 'come out' to other people. It goes further to also look at the different levels of coming out and how to deal with them. (Approximate time 5 minutes).

Game
Disclosure game.

Facilitators Instructions
Ensure that the training room/space can accommodate all participants standing in two rows, looking at each other, with about two meters of space available between them.

Game Instructions (Approximate time 15 minutes)
Tell the participants to stand up and, if required, put chairs aside or go outside. Let the participants all stand on one side of the room/space. Tell them that they are going to do an exercise about revealing and keeping secrets. Make sure you stress the fact that they can hide the truth; if a participant does not want to be honest, they don't have to.[16]

---

16   Source – Game adapted from LGBT Handbook SAFAIDS

"I am going to give instructions now. If it applies to you, take two steps forward. While you walk look and see who else is walking with you and who stays behind. On my command, 'walk back', you may walk back to join the group that stayed behind. Again, remember if you don't want to be honest, you don't have to take two steps forward; you can simply stay put."

Also, ask the participants not to over analyze the question, but to decide to walk or not as soon as the question is posed. Refrain from answering any questions while the questioning is proceeding. You can add or delete statements, make them safer or more daring according to the group. Don't be nervous to say the most daring sentences - everybody is allowed to hide the truth!

Say the following sentences and give participants the time to walk, wait a few seconds before giving the "Walk back" command:

- Everyone who is wearing trousers/pants, walk.
- Everyone with brown eyes, walk.
- Everyone who lives in a township, walk.
- Everyone who has a child, walk.
- Everyone who does not have a partner, walk.
- Everyone who feels overweight, walk.
- Everyone who has ever cheated on a partner, walk.
- Everyone who had an abortion or helped someone get an abortion, walk.
- Everyone who has ever, even once, had unsafe sex, walk.
- Everyone who has ever had an HIV test, walk.
- Everyone who has regular unsafe sex, walk.
- Everyone who has been threatened or beaten by an intimate partner, walk. Everyone who has threatened or beaten an intimate partner, walk.
- Everyone who has ever, even once, felt attracted to someone of the same sex, walk.
- Everyone who has ever, even once, had sex with someone of the same sex, walk
  Stop this exercise after 5 minutes and ask everyone to return to their seats in the plenary. Have a feedback discussion without offering any information about the content of the group discussion Before moving on to the KP-specific content

⭐

TIPS

If KP individuals are included in this activity, please note that this activity can also stimulate intense emotions of, either memories of coming out, and fear of not. It's important to have a co-facilitator who will deal with those who might become emotional and step out of the activity.

(Approximate time 15 minutes)
Take 10 minutes to ask participants what they thought of the exercise using any of the questions:

- How did it make you feel?
- What kind of thoughts went through your mind while doing the exercise?
- For those who have walked alone at times, how did it feel?
- What is the connection between the exercise and KP people?

If someone wants to share a personal remark, allow for that. Emphasize that KPs often live with a secret, and many keep this secret for a long time. Remind participants that telling someone the secret or disclosing their sexual orientation could, for some, be life threatening, however also remember that it's a human right not to disclose as some people choose to.

Knowledge sharing plenary (Approximate time 10 minutes)
Ask 2 volunteers to give narratives of their experiences with secrets
Let participants ask the person narrating their experience questions
Ask participants to provide solutions and security tips in an event where a person does not know what to do about the situation or how they dealt with a security threat (threat of being outed).

SESSION 2: SAFETY, SECURITY AND CONFIDENTIALITY

'Disclosure, also known as coming out' is the process of revealing one's sexual orientation, gender identity and sexual practices to others. During the process of safe disclosure, 'safe' refers the fact that this process should allow the KP to remain free of harm at any point during the process. 'Security,' according to the oxford dictionary refers to the state of being free from danger, threat and harm. Harm could include physical, mental, psychological, or emotional harm. During the process of safe disclosure and confidentiality, 'confidentiality' refers to the fact that all information pertaining to the KP should be dealt with discreetly and in strict privacy. This information could be HIV or STI testing and counselling information, sexual orientation, gender identity and sexual practices of which the health care provider is required by law to keep in the strictest confidence (only to be shared if need be and with the client's permission e.g. with co-workers to properly and correctly diagnose an illness). Several factors should be considered in order to qualify disclose and 'safe' and 'confidential'.(Approximate time 5 minutes).

SESSION 3: THE 'COMING OUT' PROCESS

Types of disclosure

Disclosure can sometimes be referred to as 'coming out'. It can either be partial or full. Partial disclosure is when words like SW, MSM, and TG are intentionally avoided during disclosure. This is ideal when one is not ready for full disclosure. Full disclosure is when all information pertaining one's gender identity, sexual orientation and sexual practices is used freely. This approach is advisable only when a person has gone through all the stages of safe disclosure outlined below and is comfortable that they will not put themselves at any risk as a result of their disclosure.

What is 'coming out'?

Facilitator's instruction

Ask if people have heard of this term, if they know what it means or what they think it means.

Coming out is short for 'coming out of the closet' and means that you tell somebody else that you are lesbian, bisexual, transgender, sex worker or a gay man. This is not an isolated moment but a lifelong process and happens again and again. It starts with coming out first to yourself- accepting who you are and getting into a comfortable space and continues with every person you are comfortable disclosing this information to. When you move house, change jobs, or join a club, you will have to decide again whether to disclose or not.

Share some things to note about "coming out" with the participants or/and play the 4-minute video link: https://www.youtube.com/watch?v=UyiVwUvla6o&t=32s. If there is s time to, allow participants to discuss the video.

- There is no specific age advisable for when to 'come out' in partial or full disclosure. Sometimes there is no need to come out at all
- 'Coming out' will depend on whether one has realized their sexual orientation, gender identity or not
- Discovering that one has a different sexual orientation or gender identity can be traumatic
- Self-discovery of sexual orientation or gender identity can be a stressful and lonely time
- 'Coming out' is a choice and not a must, it should not be forced
- It is very difficult to share a 'secret' or to come out to a health care provider who is known to be judgmental, discriminatory and who doesn't treat clients' information as confidential
- Coming out is a deeply personal process for a transgender, sex worker, intersex or bisexual individual.
- Some never tell; they are too afraid of rejection or of being hurt in other ways
- The coming out process should be respected and supported by health care providers
- Not everyone in the life of the KP individual is informed at once
- It is advisable to start this process only when one is ready to understand one's own gender identity and sexual orientation

(Approximate time 10 minutes)

Exercise 1: "Coming out" key points[17]

Facilitators Instruction

Use pieces of colored board paper with the words/pictures below written down or printed on each board paper. Find a corner on the wall where you can stick 2 board papers each with one of the following words/pictures. Divide the group into five groups and ask each group to come up with a key note point by associating the 'coming out' process with each picture/word. They can ask themselves the question along-side each picture/word and answer it by proving the key note point. e.g. Associate PEOPLE with 'coming out'. The association could be: "People should not force you to come out".

Exercise instructions (Approximate time 15 minutes)

- **Time** *What does time have to do with coming out?*
- **Confidentality** *What does health care worker confidentiality have to do with coming out?*
- **Trauma** *What does trauma have to do with coming out?*
- **Stress** *What does stress have to do with coming out?*
- **Deeply Personal** *What does health care deeply personal have to do with coming out?*
- **Readiness** *What does readiness have to do with coming out?*
- **Sexual Orientation** *What does sexual orientation have to do with coming out?*
- **Informing** *What does informing everyone have to do with coming out?*
- **Voluntary** *What does volunteering (willingness) have to do with coming out?*
- **Choice** *What does choice have to do with coming out?*

Interactive discussion

How to qualify safe disclosure.

Facilitators Instructions

Ask the group the following lead questions and let them discuss and come up with their own criteria of qualifying safe disclosure based on their experiences.

Discussion guide (Approximate time 15 minutes)

- When should disclose be made?
- Why should disclosure be made?
- Where should disclosure be made?
- Who should disclosure be made to?
- How should disclosure be made?

Summarize by asking the group to list some of the important things to know about *'coming out'.* Use the notes below to counter check if all main factors have been covered:

When should disclosure be made?
It should be noted that disclosure is a process and not an event but a process. It is advisable for disclosure to only be made when a KP has sufficient knowledge and understanding and is comfortable about their gender identity and sexual orientation. Another important thing is that one must also consider their economic stability.

TIPS

- Never rush into "coming out"
- Contact a person or support structure; it becomes easier to come out and it gives confidence and pride in yourself knowing that you are not alone. Support structures can be;
  - A trusted friend - test the waters by introducing a topic related to SOGIE before pouring your heart out and observe their reaction to the topic.
  - Ask a teacher or KP worker such as TBZ, FOR, TLI, WAFE for support
- Ask yourself why it is now the best time to come out? If you've got other stresses going on in your life such as exams, work, school, friends, family etc., it may not be the best time.
- What do you hope people's reaction will be? If people aren't as supportive as you'd like them to be, do you really need the added pressure of their baggage while you are getting to grips with what you want to say?

Economic instability can put an individual at further risk because of their vulnerability. There is no specific right or wrong time. This depends on one's state of mind and one's state of being.

Why should disclosure be made?
Disclosure should only be made when the KP decided that they want to make it without being forced into doing so.

Where should disclosure be made?
Disclosure should only be made in an environment that is considered safe and will not expose the KP to any risk.

Who should disclosure be made to?
Discloser should only be made when one is sure that the person receiving the information has sufficient knowledge about gender and sexuality or is open-minded enough to receive the information without prejudice. The KP must be certain that disclosure will not endanger them in any way.

(Approximate time 5 minutes)

Where should disclosure be made?
Discloser should only be made when one is sure that the person receiving the information has sufficient knowledge about gender and sexuality or is open-minded enough to receive the information without prejudice. The KP must be certain that disclosure will not endanger them in any way.

SESSION 4: TRANSGENDER EMERGENCE
The phases of coming out can be broadly categorized into (i) Internal, and (II) external.[18]

The internal phase
This is the initial phase of coming out can be characterized by feelings of being different, realization, confusion and denial. It starts with a vague idea of being 'different'. This can happen at quite a young age, but more likely at the beginning of puberty (adolescence). Certain things are experienced such as, a person considering the notion they are Lesbian or Gay. One may never even have heard of these terms but may simply be experiencing unusual feelings. Initially they may often deny this to themselves (denial stage). Then they may move to blaming themselves and thinking that's it their fault why they feel that way about themselves. Soon, they then begin to think about it, read about it and slowly come to accept it.

For many young people, this is a lonely and depressing time, compounded by rejection and exclusion, a good number of them resort to committing suicide.

The external phase
The external phase is often characterized by the process of telling others and discovering a new lifestyle.

During this phase one may come to a form of self-acceptance and may tell someone else for the first time – usually someone close (an ally), like a best friend or their mother. However, this phase requires a lot of patience to allow the people one has come out to, to process the information- It also comes with shock and denial for them. Some of the things that may be experienced during this phase are that, one may start to discover a new world (if they show it; others may come out to some people but still choose to lead their lives very privately). one may start to make new friends and over time find a first special friend or lover. This person often becomes a factor and a strong ally.

It is only in the external stages when one's sexual orientation becomes visible for the outside world. Visibility to the outside world can sometimes take years of living in the internal phase. Each person comes out in different ways under unique circumstances. Some people move faster than others through the different phases. Some may never even get to the point at which they can tell others or feel they can be openly lesbian or gay. This all depends on the level of self- acceptance, self-value and the level of support in the social environment. Hence the importance of self-acceptance. Caution must however be taken as this is the stage at which one can experience condemnation and stigmatization.

---

18   Source: "Could my child be gay? Information for parents and guardians. Triangle Project, 2005-Triangle Project: Cape Town

"Transgender Emergence – a developmental model" [19]

The process of developing a gender identity and sexual orientation is a normal experienced by everyone, but for those who do not fit the heterosexual norm, the process is complicated by cultural expectations that are at odds with your core sense of self. This model can be useful in assisting those who are coming to terms with their own difference and are moving from a state of denial and self-hatred to one of self-respect and gender congruence (balance or "fit").[20]

Most of these stages can be managed without professional assistance, however it is important to know that the stages are not expected to strictly occur in this order (this is why they are not numbered 1 – 6) but can be quite complicated with stages interchanged or combined sometimes. For example, one might disclose or come out to some people quite early in the process, but to others, only later.

Take the participants through the following stages, drawing them up on the flipchart as you go. What could be useful is to just describe the stages, and then come back and ask participants for suggestions of what might help an individual in each stage. You could   share with them the 6-step practical guide to safe disclosure outlined below. Each stage in the Gender emergence model corresponds with the various step in the 6-step practical guide to safe disclosure.

The different stages of Gender emergence
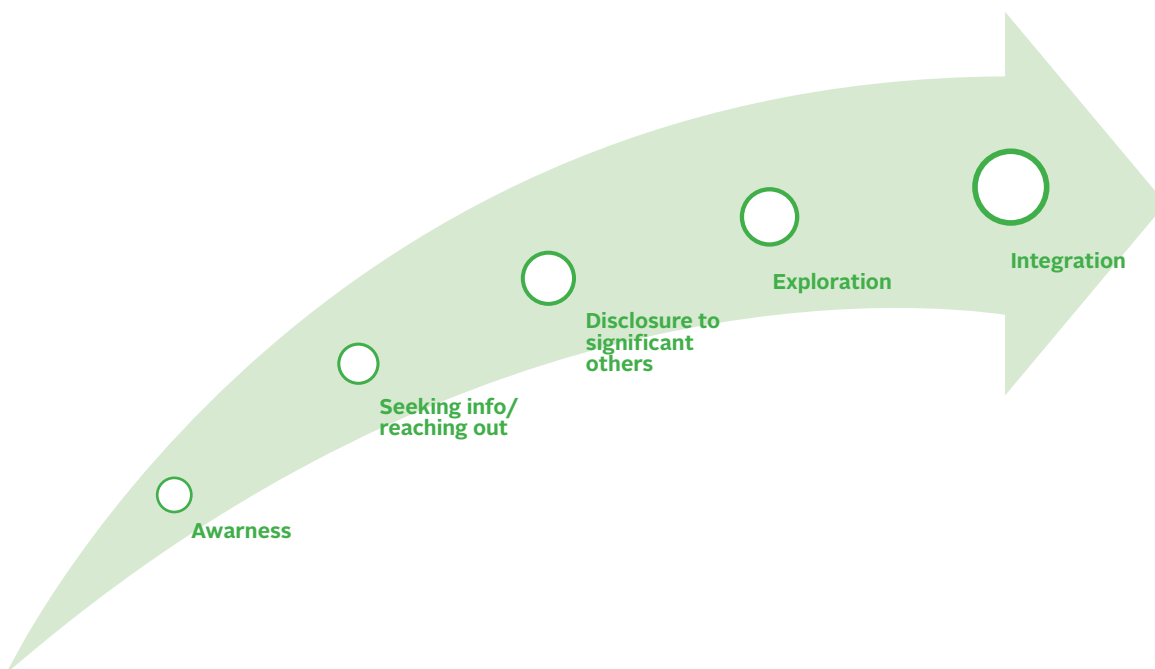
The stages of the gender emergence model can briefly be described as follows.

Awareness – in this stage a person begins to be aware that they feel different from others and that this might be related to gender identity or sexual orientation. This stage is often coupled with great distress including self-denial of one's own identity, experience of first love interest and confusion. A supportive person at this stage to listen is helpful.

Seeking information and reaching out – in this stage a person may seek relevant knowledge, education and support about sexual orientation or gender variation through books, TV programmes, movies (portraying LGBTI relationships), magazines and pamphlets as well as contacting KP organizations. *(A contact list of local KP organizations can be availed to the participants for reference).* Acquiring accurate information at this stage is important.

---

19   Source: Model adapted from "Transgender Emergence – a developmental model" from the Safe Zones@Wits Training Manual published by the University of the Witwatersrand.
20   Source: LILO Identity facilitators manual

Disclosure to significant others – this involves disclosing gender difference or sexual orientation to significant others: spouse, partner, family members, parents and friends. This may be a difficult time Exploration (internal and external) of identity and self-labelling - this stage may involve the exploration of various gender identities or sexual preferences. Knowing others who are open to various possible gender identities and sexual expressions is useful. This may involve exploring options for transition regarding identity, presentation and body modification (transgender) or a tentative expression of an alternative sexual orientation (e.g. - I thought I was gay, but now I realize I am also attracted to women, perhaps I am bisexual?) This is often a very dangerous phase for people as they can be experimental with relationships and/or abuse alcohol/drugs so that they reduce their inhibitions. It is hugely helpful to have an ally or allies who remain open to the process, and encourages the external expression of this exploration. However, they also need to be reminded about not putting themselves at risk.

Exploration (internal and external) of identity and self-labelling - this stage may involve the exploration of various gender identities or sexual preferences. Knowing others who are open to various possible gender identities and sexual expressions is useful. This may involve exploring options for transition regarding identity, presentation and body modification (transgender) or a tentative expression of an alternative sexual orientation (e.g. - I thought I was gay, but now I realize I am also attracted to women, perhaps I am bisexual?) This is often a very dangerous phase for people as they can be experimental with relationships and/or abuse alcohol/drugs so that they reduce their inhibitions. It is hugely helpful to have an ally or allies who remain open to the process, and encourages the external expression of this exploration. However, they also need to be reminded about not putting themselves at risk.

Integration – the person is able to integrate and synthesize gender identity and sexual orientation with other aspects of identity and personal preference. They know who they are in addition to being either a SW, MSM or TG. They engage less in risk taking activities. On-going access to resources, information and the KP community will support individuals in the quest towards integration. This stage of the process can take place for the rest of our lives.

(Approximate time 20 minutes)

Simulation exercise
Six tips one can use to come out safely.

Facilitators instructions
Ask participants to divide into 6 groups. Give each group 1 of the six tips listed below and ask them to simulate a scenario around that stage 9on the gender emergence model), using their own personal experiences.

Give the groups 10 minutes to rehearse their scenario and ask them to reconvene to role play their scenarios to the rest of the group. Depending on how much time you have, give each group 5 minutes to role play and allow participants to comment and contribute to dealing with faced challenges. If time is limited, ask groups to volunteer.

The corresponding stage on the Gender Emergence Model is put in brackets along-side each of the six tips below:

1. **Self-identity** *("Awareness")* Realize your own sexual orientation or gender identity and be comfortable with it. You can achieve this by being clear about your own feelings about the matter, avoid feelings of guilt as they can cause internal stigma that may lead to depression

2. **Self-acceptance** *("Seeking information and reaching out")* This important step that determined ones' progress to subsequent steps is characterized by a sense of being comfortable with one's self, the absence of self-condemnation and/or guilt. Acquire lots of information at this stage

3. **Disclosing to a person within your inner circle** *("Disclosure to significant others")* The first person to disclose to after the self-awareness and acceptance should be carefully chosen and be someone you trust possibly a significant other to avoid being outed by someone with no loyalty.

- Be clear on your own feelings
- Be comfortable with the issue as those you are sharing with will be aided in their own renewed acceptance of you
- Be time-conscious and aware of the health, mood, priorities, and problems of those with whom you would like to share as well as your own
- Be prepared for surprise, shock or disappoint from the other person
- Be sure never use this information as a weapon or to get back at someone by making them feel to blame for your issue
- Be sure to reassure the other person that you are still the same person and will continue to relate to them as before
- Be sure not to react in anger or defense.
- Be sure to remember that they are also probably in the process of coming to terms with what you have told them; allow them to re-examining their myths and stereotypes about the issue
- Be sure to be equipped with all the information as they might ask you questions

4. **Disclosure to a person outside your inner circle** *("Exploration (internal and external) of identity and self-labelling")*
   Allow your family and friends sufficient time to process the information you have given them as it may have come unexpectedly and without sufficient information on gender and sexuality. Family should ideally be informed before the wider public or media as it may be uncomfortable for them to answer questions about you without you having given them that information yourself. Do not expect or demand immediate acceptance. Look for ongoing, caring dialogue.

5. **Disclosing to family and friends**
   The importance of eventually sharing with family and friends is to avoid them hearing about it from third parties as this may cause them to feel betrayed or un important, or even them receiving inaccurate information. Some issues to consider as you share with family and friends
   One must give family the opportunity to ask questions for further dialogue. However, identify one person within the family that could support you when sharing the information to other family members. This process can get very emotional and it may be helpful to have someone speak on your behalf

6. **Disclosing in public** *("Integration") (Approximate time 30 minutes)*
   This disclosure can be at two level and can also be referred to a stage where one is ready to integrate comfortably into society without fear of discrimination: public environment where there are other people with similar sexual orientation, gender identity and sexual practices as yourself, i.e. SW, MSM or TG who may not all be within your inner circle. a public environment with a mixture of people with varying sexual orientations including heterosexuals and KPs but none are within your inner circle. Disclosing with the first group can take the approach discussed above on disclosing to family and friends, while caution should be taken when disclosing to the second group.

Activity: Pros and cons of coming out
Facilitators Instructions (Approximate time 20 minutes)

Divide the group in two and ask them to discuss the benefits and disadvantages of coming out.
Ask one group to discuss benefits and the other to discuss disadvantages.

Divide the group in two and ask them to discuss the benefits and disadvantages of coming out.
Ask one group to discuss benefits and the other to discuss disadvantages.

Activity instructions

Give them 10 minutes to discuss and write down their contributions. Each group should assign a person who will give a presentation to the plenary session on their findings based on the information shared throughout the topic. Each group should be given 2 minutes to present and allow 8 minutes for feedback from the rest of the group. Consolidate the benefits and disadvantages presented including the following if they have not been highlighted: Allows one to cope better with their gender and sexuality issues Increases one's self esteem.

Wrap up session instructions (Approximate time 10 minutes)

Option 1: Use an exercise where you ask each participant to write a key point they found important to them and have them write it down on a piece of A4 card and share it with the group.

Additional suggestions for summary key points:[21]

Option 2: Divide the group in 4 and ask participants to summarize the session key points for each sub topic:

- Introduction to safe disclosure
- Safety, security and confidentiality
- Factors that qualify safe disclosure
- Phases of 'coming out' (Transgender emergence model)

Suggested summaries corresponding with each of the topics above could be:

- Coming out is a delicate process that requires sufficient time and information and could also be a life-long process
- Coming out is a deeply personal process for KPs and they have the right to have their information kept confidential by health care workers and others
- Trust is an important aspect in determining who to come out to
- If not dealt with correctly the coming out process can cause self-condemnation and guilt which may lead to depression

> ⭐
> ## TIP
> An individual might choose to keep their sexual orientation a secret, which might at first feel safe, but living a secret life can also hurt in the long run. That individual should be encouraged to talk to a professional who is KP affirmative and totally supportive.

21   Source: LGBTI Handbook - Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS),

MODULE 4
ACCESSING HEALTH CARE SERVICES

Overall Module Objective	To create awareness on factors that increase HIV/AIDS vulnerability for KPs and strategies that can be used to address them.
Learning Objectives	By the end of this module, participants will be able to: 1. Discuss the factors increasing vulnerability to HIV/AIDS among KPs 2. State the barriers to accessing health care services 3. Come up with the strategies to improve uptake of health services
Time	2¹ᐟ² hours
Method	Brainstorming, Discussion, Presentations
Required resources	Projector, flip charts, makers, pens, Bolstick and papers

SESSION 1: INTRODUCTION TO FACTORS INCREASING HIV/AIDS VULNERABILITY

Method	Brainstorming, Discussion, Presentations
Materials Required	Flip chart paper, markers, Bostic, projector and screen

Facilitators Instructions

Explain to the participants that:

HIV stands for human immunodeficiency virus. It weakens a person's immune system by destroying important cells that fight disease and infection. No effective cure exists for HIV. But with proper medical care, HIV can be controlled. Some groups of people are more likely to get HIV than others because of many factors, including their sex partners, their risk behaviors, and where they live.

This session will help you understand what it means to be vulnerable to HIV, what causes vulnerability, and the factors that increase HIV vulnerability.

Remind participants that their active participation will lead to coming up with strategies to reduce the risk of getting HIV.

Explain to the participants that to be vulnerable means: able to be easily physically, emotionally, or mentally hurt, influenced, or attacked.

For example

- I felt vulnerable, standing there without any clothes
- Tourists are more vulnerable to attack, because they do not know which areas of the city to avoid

Or simply able to be easily hurt, influenced, or attacked

For example

- Older people are especially vulnerable to cold temperatures even inside their homes

Being vulnerable to HIV simply means being at risk of getting or transmitting HIV.

Factors that make key populations vulnerable to HIV and AIDS

Gender-based violence (We shall learn more later as we have a session on this).

Among KPs, corrective rape may be used in some instances among TGs

- Transmission of sexually transmitted infections (STIs) including HIV
- Childhood sexual abuse

Conflict situations

There is increased risk of HIV in conflict situations. KPs are more vulnerable in conflict and refugee situations because of:

- Population displacement
- Lack of access to health care
- Increased sexual and Gender-Based Violence

Young KPs

Half of all new infections worldwide occur in young people aged 15-24. Young people are more at risk of HIV because they are less economically empowered, they have limited employment opportunities, they experience social exclusion and conflict that affect their safety, health and wellness.

Key Populations

Key populations (KPs) who include Sex workers (SWs), men who have sex with men (MSM), and transgender persons (TGs) are among the most vulnerable to sexually transmitted infections (STIs) including HIV. Just like the general population, key populations (KPs) engage in behaviors that put them at risk for HIV and other STIs, such as a high number of sexual partners and engaging in unprotected sex. Having a high number of sexual partners exposes one to the high risk of HIV/STI. As one increases the number of sexual partners, some may become so regular that even using preventive barriers may stop thereby exposing oneself or a larger community to HIV/STI infections. Unlike the general population, however, KPs also experience added social and structural factors that contribute to their greater risk of HIV/STIs. For example, KPs experience high levels of social stigma which creates barriers to accessing health care services. Additionally, KPs are involved in sexual behaviors that increase their vulnerability to STIs including HIV/AIDS such as anal sex and having sex without using a condom. There are fewer health care services that are sensitized to provide care and support for KPs.

Factors that make Key Populations vulnerable to HIV and AIDS

The sexual acts and substance abuse that the KPs may be engaged in make them vulnerable to HIV/AIDS or other STIs. Substance abuse exposes one to the risk of contracting HIV/STIs. It is common knowledge that under the influence of alcohol, one may have unprotected sex with one or many partners within a short period of time.

According to Johns Hopkins, the reasons for higher HIV and STI rates among gay men and other MSM have been linked to social discrimination and homophobia. There is a range of contextual factors that leaves gay men and other MSM more vulnerable to HIV. These contextual factors are important for health providers to understand so that they can deliver better care for their clients. Below are some of them:

Cultural, religious, and political stigmatization: Gay men and other MSM may delay or avoid seeking health- or HIV-related information, care, and services as a result of perceived homophobia within the health care system and community. If an individual's disclosure of their sexual behavior results in harassment or outright rejection, this individual will be less likely to disclose information regarding their health or sexuality in the health care setting.

Poor availability of – or access to – condoms, condom-compatible lubricants, and other HIV-related prevention technologies: In many settings, gay men and other MSM still do not have access to comprehensive HIV prevention services or even basic materials like condoms and condom-compatible lubricants. If condoms are used consistently and correctly, they are highly effective in preventing the sexual transmission of HIV and STIs. Condom-compatible lubricants should be used in order to reduce the chances of condom breakage. However, in many settings, even where the condoms are available, access to condom-compatible lubricants and other newer prevention technologies remains a problem.

Mental health and psychosocial factors: Stress and other mental health challenges may lead to increased risk-taking behaviors and reduced health-seeking behaviors, which may result in increased rates of HIV and other STIs.

How can one reduce the risk of getting HIV through sexual contact?
Not having sex is the best way to prevent getting or transmitting HIV. If one is sexually active, here are several highly effective actions that one can take to reduce the risk of getting HIV, and the more of these actions one takes, the safer one can be:

Choose less risky sexual behaviors
Sexual activities carry different levels of risk for getting or transmitting HIV. HIV is mainly spread by having anal or vaginal sex without a condom or without taking medicines to prevent HIV. Anal sex is the riskiest type of sex for HIV transmission. It's possible for either partner—the insertive partner (top) or the receptive partner (bottom)—to get HIV, but it is much riskier for an HIV-negative partner to be the receptive partner. Vaginal sex also carries a risk for HIV transmission, but it is less risky than anal sex. Oral sex poses little to no risk of getting or transmitting HIV.

Use condoms consistently and correctly
When used consistently and correctly, condoms are highly effective in preventing HIV. Overwhelming scientific evidence from the Chicago AIDS Foundation indicates that latex condoms stop the spread of HIV and therefore save lives. Latex condoms, used consistently and correctly, are 98-99% effective in preventing HIV transmission. (http://www.aidschicago.org/resources/legacy/condoms/ltoyw_fact.pdf)

Reduce the number of sexual partners
The number of sex partners you have affects your HIV risk. The more partners you have, the more likely you are to have a partner with HIV whose viral load is not suppressed or to have a sex partner with a sexually transmitted disease. Both of these factors can increase the risk of HIV transmission.

Talk to your doctor about pre-exposure prophylaxis (PrEP)
PrEP is a way for people who do not have HIV but who are at substantial risk of getting it to prevent HIV infection by taking a pill every day. Studies have shown that PrEP is highly effective for preventing HIV from sex if it's used as prescribed, but PrEP is much less effective when it isn't taken consistently.

PrEP should be considered if:

- you are HIV-negative and in an ongoing sexual relationship with an HIV-positive partner
- you aren't in a mutually monogamous relationship with a recently tested, HIV-negative partner and you are
- a gay or bisexual man who has had anal sex without a condom or has been diagnosed with a sexually transmitted infection (STI) in the past 6 months; or
- a heterosexual man or woman who does not regularly use condoms during sex with partners of unknown HIV status who are at very high risk of HIV (e.g. people who inject drugs or women who have bisexual male partners).

Screening and treatment for other STIs
Get tested and treated for other sexually transmitted infections (STIs) and encourage your partners to do the same. If you are sexually active, get tested at least once a year. STIs can have long-term health consequences. They can also increase your chance of getting HIV or transmitting it to others.

Stay on treatment if you are HIV-positive (Adherence)

If your partner is HIV-positive, encourage your partner to get and stay on HIV treatment. ART reduces the amount of HIV virus (viral load) in blood and body fluids. If taken consistently and correctly, ART can keep people with HIV healthy for many years, and greatly reduce their chance of transmitting HIV to sex partners.

SESSION 2: FACTORS AFFECTING UPTAKE OF HEALTH SERVICE BY KEY POPULATIONS

Method	Brainstorming, Discussion, Presentation
Required resources	Flip chart paper, markers, Bostic, projector and screen

Facilitators Instructions:

Remind participants that their active participation will lead to coming up with strategies to improve health care service uptake for KPs.

Introduce the concept of "Accessing health care service". Explain that "accessing health care service" is the process of receiving appropriate treatment regardless of who you are. This helps us to have our health condition checked and treated in a timely manner.

Explain that we are going to talk about factors affecting uptake of HIV services by KPs.

Access to health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. But many a time, KPs face barriers when accessing health service.

Barriers to Health Service Access

1. What are some of the barriers that people (men, women and children) face to getting treatment or support for their physical or psychological injuries?
   a. Coverage – locations or availability of health care services
   b. Services – what services are available
   c. Timeliness – How long does it take to access the health services; and
   d. Workforce – Number of health care providers and their attitude.

2. Are the barriers different for people based on whether or not they are a MSM, Sex workers, or Trans-gender, man or a woman?

3. How about attitude of health care providers?

4. What are some of the interventions or approaches that can help reduce these barriers?

Discriminatory laws and policies

Discriminatory laws and policies leads to people shying away from seeking health care services when they are infected, thus, exposing them to high risks of HIV/STI infections. Discriminatory laws contribute to KPs fearing accessing health care services as they fear being arrested by the police. Criminalization of consensual same sex activities is a barrier to accessing health care services. KPs would rather go to a "safe environment" and access health care service.

Sex work and same sex practice is illegal in Zambia such that MSM may fear to report anal warts for fear of being prosecuted. According to the Friends of Rainka (FOR), addressing the needs of MSM in Zambia is a contentious issue because same sex practices are illegal in the country and efforts by government to provide services to this population are seen as a direct conflict with government policy. The human rights record for Zambia especially for LGBTIs remains a challenge. In Zambia, it is illegal to engage in LGBT sexual activities as the Penal Code

criminalizes what it terms as "Acts against the order of nature".[22] According to the law, it prohibits same sex relations and calls them "unnatural offences". In the new draft Constitution that is being worked on, there is a recommendation on same sex relations under Article 47(5) that states that marriage between the same sex is prohibited. Against this backdrop, having a health system that caters to the specific health needs of the LGBT community and without discrimination is a challenge especially for the health providers.

Stigma and discrimination

With regard to men who have sex with men, studies have shown that same-sex practices are stigmatized in much of sub-Saharan Africa. In the cross-sectional relationships between discrimination, access to and use of health care services, and HIV knowledge among men who have sex with men (MSM) assessed in Malawi, Namibia, and Botswana, it was observed that overall, 19% of men screened positive for HIV infection. Ninety-three percent knew that HIV is transmitted through anal sex with men. However, only 67% had ever received information of how to prevent this transmission. Few (17%) reported ever disclosing same sex practices to a health professional and 19% reported ever being afraid to seek health care. Men reported ever been denied health care services (5%) and 21% had ever been blackmailed because of their sexuality. Strong associations were observed between experiences of discrimination and fear of seeking health care services. Characterizing the relationship between stigma and health care seeking practices and attitudes can inform the development and implementation of HIV interventions for African MSM.[23]

Stigma and discrimination from communities, families and health care providers can reduce health care service access. This may lead to the increase in the usage of unorthodox prevention and care remedies by KPs.

The barriers to accessing health services by KPs may lead to:

- Unmet health needs
- Delays in receiving appropriate care
- Inability to get preventive services
- Hospitalizations that could have been prevented
- Sometimes this may lead to death of someone

Key populations (KPs) are expected to have access to health care services in a timely manner by friendly and non-discriminatory staff members.

---

22   Source: Zambian Penal Code - Cap 871, Sections 155 and 156,
23   Source: Fay et al: 2011

SESSION 3: GENDER BASED VIOLENCE

Introduction

Gender Based Violence (GBV) is defined as any act which results in physical, sexual or psychological harm or suffering to women, men and children. GBV is a human rights violation with wide spread consequences for both the victim and society in general. GBV takes place in the home, community, place of employment or broader society and is perpetrated by loved ones, acquaintances, or strangers. It has been estimated that at least one in every three women around the world has been beaten, coerced in to sex, or otherwise abused in her lifetime.

GBV is recognized as a global health, human rights, and development issue that transcends geography, class, culture, age, sexual orientation, race and religion.

The session aims to increase awareness on the negative impact that GBV has on health and wellbeing of individuals, families, communities and the nation at large with a special focus on Key populations. Subsequently, it aims to increase the reporting of GBV and promote support seeking behavior within the clinical and social support services more commonly available in the communities.

The following sessions will focus on Intimate Partner Violence in discussing gender violence among Key Populations.

To help people understand Intimate Partner Violence, start by defining gender based violence then narrow the discussion to intimate partner violence.

Gender-Based Violence

Learning Objectives	By the end of the session, participants will be able to: 1. Define Gender based violence (GBV), and 2. Identify and Explain the various forms of GBV
Time	1.5 hours
Method	Brainstorming, Discussion, Presentation
Materials	• Markers • Newsprint/Flipchart • Tape/sticking gum

Advance Preparation:

• Be aware of the different cultural, social and religious practices of the participants and consider how these practices may affect their attitudes towards and beliefs around gender-based violence.

Process:

The participants will discuss the various forms of GBV that are common in their community.

a. Brainstorm (15 minutes)

Ask participants to brainstorm about violence in their community.

What types of violence are prevalent in your communities?

What types of violent acts are associated with intimate relationships?

What types of violence are targeted at men?

What types of violence are targeted at women?

What type of violence is targeted at children?

What type of violence is targeted at KPs?

List participant's responses on newsprint.

Present the definition of GBV to participants.

Definition of GBV:

Gender Based Violence (GBV) is any act which results in physical, sexual or psychological harm or suffering to women, men and children. GBV takes place in the home, community, place of employment or broader society and is perpetrated by loved ones, acquaintances, or strangers.

Give the participants a few minutes to read over the definitions, and then ask them if they would like to add anything to the list of violent acts that have already been mentioned.

b. Discussion (30 minutes)

Begin by telling participants that GBV is a major health problem and an integral factor in determining an individual's vulnerability to HIV infection, his or her ability to access care, support or treatment, and the ability to cope when infected or affected. Men, women and children who have suffered GBV may not be tested, pick up test results, disclose their status, come for treatment, or adhere to treatment because they fear beating, divorce and abandonment if their partner or families and friends learn that they are HIV positive.

How does the community where you live or work respond to violence against men? Against women? Is there a difference? Why or why not? What do you think are some ways that we can better address violence against men, women and children within the family, the community or the workplace?

Wrap up and Summary (5 minutes)

Review the main topics that were discussed, and reiterate that gender-based violence affects the entire community, including families and the workplace. Gender-based violence can be difficult to talk about or address because it is often hidden, or it is accepted that men have power over women, even if they sometimes abuse that power.

Take away messages

- GBV is any act that results in or is likely to result in physical, sexual or psychological harm or suffering to women or men.
- It is important to help the community members to recognize gender-based violence in all its forms and stop it.
- GBV can negatively affect uptake of HIV/AIDS and other health services.

Forms of Gender Based Violence (GBV)

Time	45 minutes
Materials	• Markers • Newsprint • Tape/ sticking gum

Advance Preparation:

- Be aware of the different cultural, social and religious practices of the participants and consider how these practices may affect their attitudes towards and beliefs around gender based violence.

Lecture

Using the lecture method explain to the participants the four forms of GBV.

What Are Forms of Gender Violence?

Gender violence takes four forms:

Physical: Hitting, slapping, punching, kicking, scratching, choking, pulling hair, biting, stabbing or hitting with a weapon, cutting, burning, throwing objects, throwing gasoline or acid into face, forcing wife to abort a child, or dowry killings.

Emotional: Insulting, belittling, scolding, jealousy or suspicion, threatening, shaming and blaming the wife for having no children, having a girl, not raising children properly, etc., or threatening the wife for questioning the husband's extra-marital affairs.

Economic: Controlling all household spending, withholding necessary household money, wasting family money (e.g., drinking, playing cards), preventing wife from earning money, forcing wife to do work against her will, grabbing the money she has earned, forcing a wife/daughter to do excessive work, or dowry harassment, leaving a husband because he is not in gainful employment

Sexual: Forcing a woman to have sex against her will (marital rape), forcing partner to practice oral/anal sex, inflicting pain during sex, preventing wife from using birth control, refusing to use a condom when partner has concerns about sexually transmitted infections (STIs), including HIV. Sexual violence also includes rape, sexual teasing and coercion at work places or schools, and incest.

Ask participants:

- Which form of GBV is common in your community?
- Which form of GBV is mostly targeted at women and why?
- Which form of GBV is mostly targeted at men and why?
- Which form of GBV is mostly targeted at children and why?
- How does the community where you live or work respond to violence against men? Against women? Against children?

What do you think are some ways that we can better address violence against men, women and children within the family, the community or the workplace?

Wrap up and Summary (5 minutes)

Review the different forms of gender-based violence. Inform participants that these forms of GBV affects the entire community, including families and the communities and workplaces. Gender-based violence can be difficult to talk about or address because it is often hidden, or it is accepted that men have power over women, even if they sometimes abuse that power.

Take away messages

- There are four forms of GBV (Sexual, economic, physical and Psychological)
- These forms of GBV affects the entire community, including families and workplaces

- It is the role of everyone in the community to prevent and report GBV

Intimate Partner Violence (IPV)

	By the end of the session, participants will be able to:
Objectives	**1.** Define Intimate Partner Violence (IPV), and
	2. Identify the various forms of IPV.
Time	1.5 hours
Materials	• Markers • Newsprint • Tape/ sticking gum

Advance Preparation:

- Be aware of the different cultural, social and religious practices of the participants and consider how these practices may affect their attitudes towards and beliefs around Intimate Partner Violence.

Process:

Present the definition of IPV to participants.

Definition of IPV:
According to the World Health Organization, intimate partner violence ("IPV") is behavior within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, and psychological abuse and controlling behaviors. IPV can frequently occur over a span of years and has been described as an emerging public health priority.

Brainstorm (40 minutes)

1. Ask participants to brainstorm about intimate partner violence in their communities and list the responses on the flipchart.

2. List the types of violence that are prevalent among intimate partners in your communities?

3. Using a different color marker, indicate what form of violence each of the type of violence they have listed, whether it is sexual, economical, physical or psychological.

4. From your list, indicate the types of violence that are usually targeted at men/masculine partners and also indicate the types of violence are usually targeted at women/feminine partners.

5. Ask the participants to count the types of violence that are usually targeted at women/feminine partners and write down the number.

6. Then ask the participants to count the types of violence usually targeted at men/masculine partners and write down the number.

7. Using the numbers written down and their own experience, ask participants to indicate who suffers more intimate partner violence between the masculine and feminine partners.

8. Why do those partners suffer more intimate partner violence?

9. List ways for addressing IPV within the family, the community, the workplace or at the health facility?

Information (5 minutes)

Begin by telling participants that IPV is a major health problem, and places a burden on the health system and the communities. Partners who have been victims of IPV use health care services more often than those who have not, and many partners who have been abused are unable to carry out their regular activities in the home and community.

Small Group Work: Myths and Misinformation about Rape (40 minutes)

Have participants break into small groups of four to five participants.

Distribute to each group **Handout 3: Rape: Myth or Fact?**

Ask each group to decide whether or not each item is a MYTH or a FACT. Allow 15 minutes for groups to discuss, then reconvene as a larger group to review the handout.

After you have reviewed the myths and facts about rape, ask participants:

- What did you think about these myths?
- Are these myths about rape common in our society?
- What can we do to help others understand that they are myths, and not facts?

Wrap up and Summary (5 minutes)

Review the main topics that were discussed, and reiterate that intimate partner violence affects the entire community, including families and the workplace. Intimate partner violence can be difficult to talk about or address because it is often hidden, or it is accepted that men/masculine partners have power over women/ feminine partners, even if they sometimes abuse that power.

Take away messages

- IPV is behavior within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, and psychological abuse and controlling behaviors.
- It is important to help the community members to recognize intimate partner violence in all its forms and stop it.
- Intimate partner violence can affect an individual's uptake or adherence to HIV/AIDS and other health services.

Consequences of Intimate Partner Violence

Objective	By the end of the session, participants will understand the psychological, health and social consequences of Intimate Partner Violence (IPV).
Time	1.5 hours
Materials	• Markers • Newsprint / Flipchart • Tape/ sticking gum

Advance Preparation:

- Identify several sources of support for victims of IPV, such as rape crisis centers, legal assistance, and medical assistance.
- If possible, obtain a list of the types of support that are available in your community for women, men so that you can distribute this information to participants.

Process:

This session will introduce participants to the multiple effects and consequences of IPV. Participants will identify existing resources including facilities and social support networks for survivors.

a. **Brainstorm (20 minutes)**

   Draw three columns on a piece of newsprint. Label one column physical health, the second psychological (or mental) health and the third family and community health.

   Ask participants to brainstorm the immediate effects of IPV as well as the long-term consequences. Participants should consider the effect on the individuals who are victims of IPV, as well as how IPV affects the family and the community. As participants to identify effects and consequences, decide

whether or not the effect is related to the individual's physical health, mental health or the health and wellbeing of the family and community.

b.   Small Group Work (30 minutes)

Have participants break into three small groups. Assign one group consequences to physical health, the second group consequences to mental health and the third group consequences to the health and well-being of the family and community.

Have participants take 15 minutes to discuss ways that these consequences can be addressed and/or treated. After 15 minutes, have each group report back their findings to the larger group.

Fatal outcomes		Nonfatal outcomes	
Physical injuries and chronic conditions	*Sexual and reproductive health complications*		*Psychological and behavioral outcomes*
• Murder of males and females • Suicide • AIDS-related illnesses and death • Maternal death	• Fractures • Chest injuries • Permanent disability • Gastrointestinal disorders • Lacerations and abrasions • Eye and ear injuries • Burns • Gynecological disorders	• Sexually-transmitted infections, including HIV • Unwanted pregnancy • Pregnancy complications • Miscarriage / low birth weight • Sexual dysfunction • Unsafe abortion	• Depression and anxiety • Eating and sleep disorders • Drug and alcohol abuse • Poor self-esteem • Post-traumatic stress disorder • Self harm • Unsafe sexual behavior

Information

Share with the participants the following additional information on consequences of IPV:

a.   Discussion (20 minutes)

Summarize the small group work findings by pointing out that there are multiple consequences of IPV that affects the health and wellbeing of partners. It is important for individuals to be treated for any physical or psychological injury they might suffer, and to get the support that they may need to prevent it from happening again. However, it is often difficult for people to get the treatment and support they need.

- What are some of the barriers that sex workers, MSM and trans-gender face to getting treatment or support for their physical or psychological injuries?
- Are the barriers different based on whether or not they are a MSM, Sex worker, or Trans-gender, man or a woman?
- How do these barriers to treatment for individuals affect the family as a whole?

- What about the community?
- What are some ways that you can help people overcome some of these barriers?

b.   Identification of Resources in the Community (10 minutes)

We all have a responsibility to recognize and confront IPV when we see it happening to someone. We can also assist by helping partners who are victims of IPV to get the assistance they may need, whether it is medical treatment for injuries, counseling for psychological trauma.

Take a moment to think about where you could refer a KP colleague, friend or neighbor who needed support. List responses on newsprint (you may have to initiate the discussion by naming a few places or individuals that you know about). If you have a handout of local resources for victims of IPV, distribute it now.

Wrap up and Summary (5 minutes)

Review the discussion: IPV contributes to high rates of HIV, sexually transmitted infections, stress, injury, mental illness, and even death and injury to women/feminine partners – and sometimes men/masculine partners. Traditional gender norms that support male/masculine superiority, tolerates violence, particularly against women/feminine partners, and excuse perpetrators enables IPV to exist.

Communities, families and Individuals must take steps in their home and communities to stop Intimate Partner Violence and help victims get care and treatment.

Take way messages

- Intimate Partner Violence is a community health problem that can lead to HIV/AIDS, STIs, mental illness and even death
- It is important to help survivors get treatment and support, educate people of the consequences of IPV, and work with the community to stop such violence

HANDOUT 3: Rape: Myth or Fact?

MITO	YES	NO
Rape is just sex		
Feminine partners encourage masculine partners to rape them		
A partner who has been raped should just forget it		
You can tell a rapist by the way they look		
Partners who get raped fantasize about being raped		
Only bad partners get raped		
Rape is just unwanted sex, so it really isn't a crime		
Rape only occurs outside and at night		
Rape is an impulsive, spontaneous act		
Rape is usually committed by a stranger		
Rapists are usually sick or insane		
Rape is an uncontrollable act of passion, because the rapist cannot control him/herself.		
Partners ask for rape by the way they dress or act		

Handout 3-A: Answer Key to Rape: Myth or Fact?

MITO	YES	NO
Rape is just sex Rape is an act of violence. While sexual attraction may be influential, rape is often motivated by power, control and anger.		
Feminine partners encourage masculine partners to rape them The majority of rapes are planned. Opportunity is the most important factor as to when a rape will occur.		
A partner who has been raped should just forget it A partner who has been raped should be offered an opportunity to talk about the assault with a close family member or friend and a knowledgeable professional. Partners who do not talk about the rape have a more difficult time recovering.		
You can tell a rapist by the way they look There is no way to identify a rapist. A rapist may appear friendly, normal and non-threatening.		
Partners who get raped fantasize about being raped No. While partners may fantasize about aggressive sex, these fantasies can be controlled and turned off if they become threatening. In rape, a partner being raped usually can't control or stop the violence.		
Only bad partners get raped Partners who have been raped are often viewed with suspicion and doubt. Some people prefer to believe that a victim is responsible because she or he puts him/herself in danger (such as being out late or drinking alcohol, having many sexual partners).		
Rape is just unwanted sex, so it really isn't a crime Rape is not just unwanted sex, it is a violent crime. Many rapists carry a weapon and threaten the victim with violence or death.		
Rape only occurs outside and at night Rape can occur anytime and anyplace. Many rapes occur during the day and in victims' home.		
Rape is an impulsive, spontaneous act Rape is usually planned by the rapist. A rapist will rape again and again.		
Rape is usually committed by a stranger Many victims in fact know their rapist. It may be a relative, co-worker, date or friend.		
Rapists are usually sick or insane Few rapists are diagnosed as mentally ill. Most are well-adjusted, but may be more likely to express anger through violence and rage.		
Rape is an uncontrollable act of passion, because the rapist cannot control him/herself Rape is a planned act of violence, not a spontaneous act of passion. Partners can control their sexual impulses. Rapists are motivated by power, anger and control.		
Partners ask for rape by the way they dress or act Rapists look for partners who they think are vulnerable, not those who dress/act in a particular way. No partner, whatever his/her behavior, deserves to be raped.		

SESSION 4: STRATEGIES TO INCREASE UPTAKE OF HEALTH SERVICES BY KEY POPULATIONS

Method	Brainstorming, Discussion, Presentation, Group work
Materials required	Flip chart paper, markers, Bostic, projector and screen

Facilitators Instructions

Remind participants that their active participation will lead to coming up with strategies to improve health care service uptake for KPs.

In order to improve the uptake of health services among KPs, the following steps should be taken:

KP Sensitization

KPs should be encouraged to seek health services whenever they need them. They should be sensitized about the available health facilities where they can seek help and the available counsellors they can seek help from. KPs should strengthen their networks so that they are up to date with information by belonging to existing KP community based organizations (CBOs) or forming new ones where they are absent.

Advocacy and Information sharing

KP CBOs should continue with advocacy if the KPs are to access health care services without fear or discrimination. KP CBOs should create a platform through which information should be shared. Some KPs may lack information such as information on rights to access services, knowledge on where to find KP friendly health facilities, knowledge on periodic testing and screening and where to access these services. By sharing such information, KP uptake of health care services is expected to increase.

Capacity building at health institutional level

Retraining and orienting health care providers including other members of staff working at health institutions in handling of the KPs would improve the uptake of health care services. All staff should exercise high levels of confidentiality, privacy and respect to their clients if the health uptake of the health care services is to improve. For the health care staff, the curriculum of the health care providers should be reviewed to include handling of KPs.

Having enough peer promoters

Having friendly and trusted peer promoters (PPs) will attract KPs to open up to them and be linked to available health care services. The PPs should be of the same sector with similar attributes with the clients that they are to mobilize for health care services.

Economic Strengthening skills

Health care services do not come cheaply. KPs should be equipped with economic strengthening skills so that they can access health care services that may require them paying for such services. For example, they should have the saving and lending skills that they can utilize for self-sustaining including paying for health care services. Capacity building of economic strengthening skills should start with the KP CBO for sustainability and continuity.

Take away messages
- Improving health care services calls for having rigorous efforts on the part of the providers and the clients.
- Pull factors that will create demand for health care services and the push factors that will motivate clients to seek health care services should be addressed
- Non-judgemental and KP friendly health care providers play a critical role in increasing the uptake of health services by KPs

Group Activity

Divide the participants into four groups ask them to choose a chairperson and secretary and ask them to do the following which they should come and present when it is time up:

1. Allow participants to share experiences on times when they have found themselves vulnerable and how they dealt with it.

2. Participants to list down suggestions on how to increase their own uptake of health care services (Allow them 30 minutes to develop their plan).

3. Participants to create their own campaign and think through a lot of issues that may affect the way SWs, MSM, and TGs access health services. Divide the participants into 4 groups. Ask them to act as a local clinic in the area with high HIV prevalence but with very few SWs, MSM, and TGs coming forward to seek health services. Ask them to develop a publicity strategy campaign or ad campaign that will encourage SWs, MSM, and TGs to be tested for HIV (Allow them 30 minutes to develop their plan).

Discussion: Once time is up, allow each group to make their presentations. Encourage the other groups to pose questions. After the other groups ask questions, point out aspects that you as the facilitator found particularly positive. Clarify any aspects that may be problematic.

Summarize key findings: After all the groups have presented, point out particularly important aspects of the campaigns, and highlight the importance of being welcoming to the KPs.

MODULE 5
PSYCHOSOCIAL SUPPORT AND MENTAL HEALTH

Overall Module Objective	This module is intended as reference material, and as a foundation on which the other modules build. Much of the information may be familiar to participants, but the module gives them an opportunity to reflect on and discuss issues to do with psychological support which may otherwise be taken for granted.
Learning Objectives	By the end of this session, participants will be able to: 1. Recognize psychosocial challenges among at- risk Key Populations and provide support and referrals 2. Explain the concept and importance of psychosocial support 3. Explore/describe human needs, and how they shape behavioural and psycho-social interventions available for MSM, sex workers, and TGs 4. Discuss good principles of a community-based psychosocial support program 5. Discuss mental health, screening, referrals and treatment.
Time	45 minutes
Method	Brainstorming, Discussion, Presentations
Materials	Use Flip Charts and markers to be used for facilitation and documentation of deliberations

Suggested process

Session one (45 Minutes): Introduce the concept of Psychosocial support.

Divide participants in groups, and each choose a human need for their group discussion and presentation.

After ALL the presentations are made. Brainstorm with the use of follow-up questions below:

1. *Ask them to mention/list the cluster of needs they think is easiest to see?*

2. *Human beings need ALL their needs met, this is called HOLISTIC support, now who can provide HOLISTIC support to human beings?*

3. *Ask them if KPs also require the mentioned human needs and why?*

FACILITATORS NOTE!!
Share key note points to know about Psycho-social support and needs of a human being - Feedback session with participants

Discussion point

Let participants explore and understand the importance of their need, rights and how these affect their well-being.

Explain and together with the participants explore specific KP's needs, through a plenary session:

   i.   Human rights violation's effect on the environment and individual behaviors

   ii.   Overview of behavioural and community based psycho-social interventions

Review and revision Give a summary of the whole session inviting participants to revisit any parts of the session where they feel additional attention might be usefully given.

The summary will be done at the end of each session to allow the trainer to check understanding, as well as to ensure that all points have been covered adequately. If you have a mixed group, then take care not to allow.

Overview

Key populations - sex workers (SWs), gay men and other men who have sex with men (MSM), and transgender people (TG), — are disproportionately affected by HIV. At the same time, the stigma, discrimination, and threat of criminal prosecution faced by key populations around the world pose serious barriers to their ability to access quality, rights-based health care.

Need to be respected as human beings.

- Need for acceptance
- Need for good health services
- Need to equal treatment without discrimination
- Need for protection

These Critical events, such as stigma/ discrimination, denial of human rights and health epidemics occur with social and psychological consequences that often undermine people's ability to carry on with their lives. Characteristic of the problems faced by human beings is a feeling of loss, i.e.:

- Loss of personal relations and material goods
- Loss of opportunity to generate an income
- Loss of social cohesion
- Loss of dignity, trust and safety
- Loss of a positive self-image
- Loss of trust in the future.

SESSION 1: PSYCHO-SOCIAL SUPPORT

The basic concepts of the psychosocial approach are provided. Basic terms and concepts are explained in this part; Needs of human beings and central questions affecting KPs from the psychosocial perspective are discussed. It also looks at KPs behavioral and psycho-social interventions.

What is Psycho-social Support?

- Psycho refers to the unseen emotional and spiritual process that takes place within an individual's mind.
- Social refers to the relationship between an individual and those who live around him/her.
- Support is to keep something from falling, sinking, or slipping; to help it bear a weight and maintain. Similarly supporting a person or family is to help them bear and withstand their circumstances, to prevent them from collapsing under pressure or the weight or their situation.

Psychosocial Support (PSS) is thus the total help given to an individual which takes into account the psychological (or unseen aspects) of a person and his or her social life. It gives human beings the skills to cope with stress or difficult situations. PSS doesn't have to be an expensive project – it is more about giving your time and attention to KPs!

Psychosocial well-being is part of the mental health spectrum. Psychosocial support for Key Population and Peer Promoters is discussed in this session.

- ALL human beings have unique psychosocial needs which are different for those of children and adults.
- Remember: ALL Key Populations need support coping with normal developmental issues, such as wanting to fit in with peers.
- In addition to the psychosocial needs and challenges that all human being face, Key Populations may also experience HIV related stressors, vulnerabilities, and challenges that can result in the need for extra support.
- Key Populations may require extra support in the following areas, (Among Others):
  - Understanding and coming to terms with their own HIV-status
  - Understanding and coming to terms with their sexual orientation and identity
  - Coping with cycles of wellness and poor health
  - Long term adherence to both care and medicines
  - Disclosure to friends, family members and sexual partners
  - Sexual and reproductive health, including disclosure to partners, practicing safer sex, using family planning
  - Anxiety over physical appearance and body image
  - Developing self-esteem, confidence, and social isolation
  - Accessing education, training, and work opportunities

The five categories of needs of Human beings are: Physical, Emotional, Spiritual, Mental and Social. See the diagram below for examples under each category.

Diagram on Psycho-social Support

- **Mental:** The mental needs of human beings incorporate three aspects:

    1. Formal education (schooling)

    2. Informal education (opportunities for observational knowledge)

    3. General skills (life skills, general knowledge, etc)

The above three are essential for human beings' integration into a community without feeling stigmatized or different; to develop a sense of belonging; form friendships and community ties; acceptance; identity; acknowledgement from peers and opportunities for social interaction. They also need to learn socially acceptable behavior through feedback from others, how to access help and learn their limits.

- **Spiritual:** Human beings need a belief in a higher being, which enables them to develop a hope for their future. This also facilitates a sense of connectedness to deceased parents and ancestors. They also need to develop trust and security in their survival. This gives them hope to keep trying, to be courageous and to persevere. They can trust in the higher being to help them in difficult situations.

SESSION 2: BEHAVIOURAL AND PSYCHO-SOCIAL INTERVENTION

Overview of behavioural and community based psycho-social interventions

Psychosocial support is community based. It is not individual psychotherapy. This work is facilitated through the efforts of the affected population (KPs) and by working with existing programs whenever possible.

The Operational Guidelines' on behavioural intervention component include; peer education and outreach, sexual health screening, risk reduction counselling and skills building, Promotion of health care seeking behaviours such as the utilisation of HIV, STI, and TB screening and treatment, adherence counselling and retention in care. Additionally, other support components include the screening and treatment for drug and alcohol abuse.

The Objectives of Community-Based Psychosocial Work when working with KPs, it is important to have well-defined objectives. The primary goals of community-based psychosocial work are: - to assist affected people (KPs) attain stable life and integrated functioning - to restore hope, dignity, mental and social well-being and a sense of normality.

The behavioural and psychosocial interventions are designed to work in combination with specific support structures such as; peer support groups, clinical counselling and peer counsellors which will be discussed at length in this session;

Peer Support Groups: The Clinical Counsellor and Peer Counsellors will facilitate daily peer support groups to provide social and emotional support to KPs. Support groups operates under a cognitive-behavioral model and focus on decreasing psychological distress, while also improving quality of life. In accordance with our harm reduction approach, the peer support groups will contain an educational component focused on promoting strategies to minimize the exclusion and harms experienced by KPs.

Clinical Counselling: Building upon the peer support groups, the Clinical Counsellor provides one-on-one counselling and support (under a cognitive-behavioral model) to KPs. Where appropriate, the Clinical Counsellor work along with our peer promoters in addressing social determinants of mental health (e.g., securing safe, affordable housing and linking KPs to economic strengthening initiatives).

Peer Counsellors: The Peer Counsellors provides ongoing psychosocial support to KPs through existing network organization's drop-in services. Peer Counsellors/ Peer promoters also facilitates referral to the peer support groups and/or clinical counselling for KPs attending drop-in services wanting to receive additional support.

SESSION 3: MENTAL HEALTH

Objectives	By the end of this session, participants will be able to: 1. Define mental health 2. State factors contributing to poor mental health among Key Population (MSMs and TGs) 3. Describe some common mental health problems affecting MSMs and TGs 4. Describe basic strategies for approaching mental health issues affecting MSM and other key populations.
Time	1 hour
Method	Lecture/discussion, small group discussion, plenary sessions
Materials	Flip chart, VVIP cards, markers

Process

Divide participants in small groups and allocate each group a topic to respond to the session objectives-

- Definition of Mental Health
- Factors contributing to poor mental health of MSMs and TGs
- Common mental health problems affecting MSMs and TGs
- Strategies for addressing mental health issues affecting MSM

Allow each group to present their discussion to plenary.
Identify key points and issues from the discussion

Summary and take home points

- MSM is not a mental disorder but a normal expression of human sexuality.
- The most effective and appropriate therapeutic response that results in maximum mental health benefit is provider-initiated support, acceptance, and validation of same-sex sexual orientation.
- Stigma, discrimination, and homonegativity contribute significantly to the negative mental health outcomes of MSM.
- Appropriate affirmation of same-sex behavior and counseling can minimize the effects of stigma and assist gay men and other MSM in their wellbeing.
- Support from community based organizations or groups can be protective against social isolation and harmful effects of homophobia.
- Healthcare providers have a responsibility to provide equitable care to gay men and other MSM regardless of their personal religious or moral beliefs.

Overview

Many MSM and gay men can maintain resilience and maintain good health despite facing severe discrimination and marginalization while others present with mental health challenges. Social discrimination has been identified as a key factor leading to poor mental health outcomes among MSM across diverse settings. Discrimination manifests itself in many ways including personal hardships like harassment, ridicule, rejection and violence. Higher level structural factors include discriminatory policies or violations of human rights.

Definition of Mental Health

"Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to her or his community".
(World Health Organization, updated August 2014)

Factors contributing to poor mental health among MSM.

Criminalization

Seventy-seven countries currently criminalize same-sex sexual behav¬ior between consenting adults. Penalties range from fines or impris¬onment to death. These discriminatory laws are more common in countries in Sub-Saharan Africa, the Caribbean, and the Middle East. Beyond violating basic rights, criminalization has made gay men and other MSM more vulnerable to poor health outcomes, decreased ac¬cess to health services, and created iniquities in access to and affordability of needs like housing and work. Consequences of criminalization include:

- Underrepresentation of gay men and other MSM in the development and implementation of policies and programs.
- Lowered client participation in and discouragement of staff from working in programs for gay men and other MSM.
- Lack of surveillance and resources for research concerning gay men and other MSM.

Discrimination within healthcare settings

Gay men and other MSM often experience stigma and discrimination in healthcare settings, either because of their real or perceived same-sex behavior. These stigmatization experiences occur during regular check-ups, testing, diagnosis, drug dispensing, and dental procedures, among others. In some settings, non-verbal gestures and disparaging remarks have been witnessed in the healthcare system.

Gay men and other MSM who face stigma or discrimination from their healthcare provider are less likely to discuss their sexuality openly and are more likely to provide incomplete or inaccurate sexual histories, making it difficult for the provider to provide optimal care. Healthcare providers have the responsibility to provide equitable care to all individuals, including gay men and other MSM, regardless of their personal religious or moral beliefs.

Reparative therapies

Reparative therapies, also known as conversion therapies, are a group of harmful interventions whose aim is to change an individual's sexual orientation from homosexual to heterosexual. Any attempts to reform or "cure" someone's sexual orientation using these "therapies" will not only fail, but may cause harm, including depression, anxiety, suicidality, and, in some cases, a loss of sexual feeling altogether. In cases where clients themselves express the desire to change sexual orientation, the most effective and appropriate therapeutic response that results in maximum mental health benefit is provider-initiated support, acceptance, and validation of same-sex sexual orientation.

Family rejection

In many cases, family members who do not accept an individual's sexual orientation request reparative therapies, as they are not fully aware of the harms such interventions can cause.

In situations where a family member has difficulty accepting someone's sexual orientation, healthcare providers should provide sci¬entific data around the normality of same-sex orientation and connect the family member to local resources to help them accept their family member without feeling guilt, shame, prejudice or judgment.

Difficulty in coming out (NB: Refer to Module 3: safe disclosure)

Coming out refers to a period when an individual becomes aware of their sexual orientation and recognizes that they are sexually attracted to members of the same sex. Coming out is not merely related to the disclosure of one's sexual orientation, but is a complex emotional and psychological process that may take months or years. The coming out process often involves a period of confusion that ends in the formation of a sexual identity with which the individual is comfortable. During this time, some experience personal crises related to their

sense of self, especially if they feel their sexual orientation con¬flicts with their own, society's, or their family's expectations of them. Feelings of shame, guilt, and fear may be overwhelming, and risk for depression and suicidality may be heightened.

Deciding how and when to come out is ultimately the decision of the individual. Coming out is healthy and is correlated with less stress. However, it may not be appropriate for someone to come out in settings where disclosing one's sexual orientation can result in violence or in further stigmatization. Healthcare providers must remain sensitive to the safety concerns of their gay and other MSM clients in the context of disclosure and must strictly uphold confidentiality agreements.

Maturing and late adulthood

Aging can be a stressful process for anyone. However, it gains significance for gay men and other MSM. One study of 2,560 LGBT people aged 50 to 95 showed that older gay men and other MSM are less likely to be partnered or married, more likely to live alone, and more likely to have fewer children than their non-MSM peers. Compounding this is the fact that many subcultures within the gay or MSM community place great value on youth, body beauty, fitness, virility, and potency, resulting in both explicit and implicit ageism.

These factors mean that the aging gay man or other MSM may have less social and financial support, and that they are at higher risk for social isolation, which has been linked to poor mental and physical health outcomes, cognitive impairment, premature chronic disease, and death. For instance, the previously mentioned study also found higher rates of disability and mental health issues in older LGBT people than their heterosexual peers. Twenty-nine percent of gay male and 36percent of bisexual male older adults exhibited symptoms of depres¬sion as well as elevated rates of anxiety. The results for suicide were particularly alarming with 37 percent of gay men and 39 percent of bisexual men having seriously considered suicide and many reporting that these considerations were related to their sexual orientationorientation (MSMGF 2012).

Common Mental Health Problems affecting MSM

Anxiety

Anxiety is a normal emotion and is closely related to fear. However, when anxiety becomes excessive, it is difficult to control, and affects an individual's everyday life, it becomes a disorder and must be adequately managed. Some symptoms of anxiety disorders include:

- Fear, uneasiness, and worry
- Sweating
- Shaking
- Racing heart
- Nausea
- Dizziness
- Shortness of breath
- Chills or hot flashes

Evidence shows that gay men and other MSM are at increased risk for anxiety disorders, likely because they often must conceal their sexual behaviors or identities because of fear, shame, or guilt. In one study, 33 percent of black MSM reported feeling anxiety. In another in India, 24 percent of MSM experienced anxiety. Studies show that MSM often have lower self-esteem than non-MSM men and may experience additional social anxiety as well.

Depression

It is normal for most people to have "ups and downs". Depression, however, is far more than simply a bad mood. It is a prolonged mood disorder that may drastically affect an individual's daily life. Some symptoms of depression include:

- Feeling sad, hopeless, worthless, guilty, or bad about oneself
- Being unable to enjoy things that would usually be pleasurable
- Feeling apathetic and lacking motivation to act
- Feeling tired and having no energy
- Feeling lonely and cut off from other people
- Difficulty in concentrating
- Sleeping badly – either sleeping too much or too little
- A change in eating habits – either eating too much

HIV-related stress disorder

Some instances associated with HIV that can cause this response, are:

- Trauma associated with receiving an HIV diagnosis
- Beginning HIV treatment
- Lack of access to treatment
- Fear of disclosing HIV status to partner, family, or friends
- Treatment-related side effects
- Distress caused by life-long treatment
- HIV-related discrimination and marginalization
- Treatment related side effects
- Distress caused by life-long treatment
- HIV related discrimination and marginalization

Sexual problems

Sexual problems may be common in some gay men and other MSM.33 These may include issues related to:

- Desire
- Sexual aversion
- Excitement and arousal
- Orgasm
- Sexual pain disorders
- Sexual compulsivity

Additional sexual problems in gay men and MSM are related to anal sex, HIV and sexually transmitted infections, erectile dysfunction, dif¬ficulty in ejaculation, and lack of sex drive or interest in sex.

Eating disorders

The connection between physical health and body image is fun¬damental. How we feel about our bodies affects how we treat our bodies, particularly with regard to what we choose to eat. Studies have found a relationship between body image dissatisfaction and dietary lifestyle, overeating, over-exercising, and the development of eating disorders.

Physical and sexual violence

Physical and sexual violence against gay men and other MSM remains an ignored area within clinical science research and practice around the world. However, male-on-male rape, other forms of sexual assault, and domestic violence between same-sex partners are seen in many settings worldwide. Gay men and other MSM, especially those who are visible in their communities, are often subject to harassment, physical violence, and rape.

Gay men and other MSM who have suffered violence may be unwilling to speak openly about these issues because of shame, fear, or guilt. They also may not report these crimes because of negative attitudes or indifference from law enforcement officials.

Strategies for addressing mental health issues affecting MSM

Trained mental health professionals are best able to assess and treat mental health concerns presented by gay men and other MSM. Providers who are not adequately trained in mental health should not attempt to diagnose a client's mental health status. However, all healthcare providers should be familiar with the factors that affect mental health of gay men and other MSM as well as with commonly presenting issues within a given clinical setting.

SESSION 4: MENTAL HEALTH AND DRUG SCREENING

- Patient Health Questionnaire (PHQ-9)
- Generalized Anxiety (GAD)
- Screening, Brief Intervention and Referral to Treatment (SBIRT)

GAD Questions

Over the last 2 weeks how often have you been bothered by the following problems?

A trained provider can take the following steps to address mental health issues affecting MSM:

1. Provide affirmation of same-sex sexual orientation.

2. Recognize the factors that lead to distress in the lives of gay men and other MSM.

3. Provide accurate and up-to-date scientific information regarding the normality of same-sex orientation to clients and their family members.

4. Familiarize themselves with a range of coping skills and strategies to suggest to help clients manage stress.

5. Prepare themselves to provide tools and resources from the community. This should include linkages to community-based organizations and gay-led groups. Providers should also have a list of local mental health professionals who are sensitive to the needs of gay men and other MSM and can provide ethical high-quality care.

	Not at all	Several Days	More than Half Days	Everyday
Feeling nervous, anxious, or on edge	O	1	2	3
Not being able to stop or control worrying	O	1	2	3
Worrying too much about different things	O	1	2	3
Trouble relaxing	O	1	2	3
Being so restless that it is hard to sit still	O	1	2	3
Becoming easily annoyed or irritable	O	1	2	3
Feeling afraid as if something awful might happen	O	1	2	3

PHQ-9 Scoring

Minimal depression 0-4	≤	The score suggests the patient may not need depression treatment
Mild depression 5-9		
Moderate depression 10- 14	5-14	Physician uses clinical judgement about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression 15-19	>14	Warrants treatment for depression, using antidepressant, psychotherapy and / or a combination of treatment

GAD Scoring

Score	Interpretation
5	Mild anxiety
10	Moderate anxiety; ≥10 Possible diagnosis of GAD; confirm by further evaluation
15	Severe anxiety

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people.
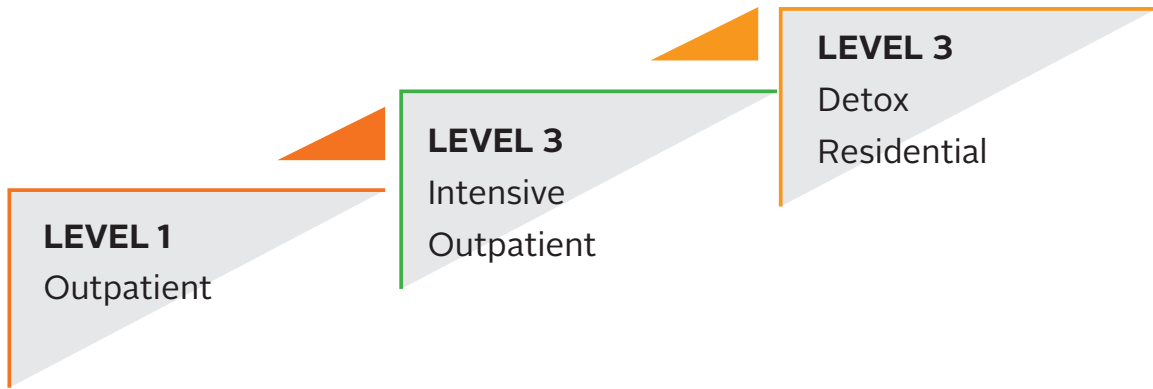
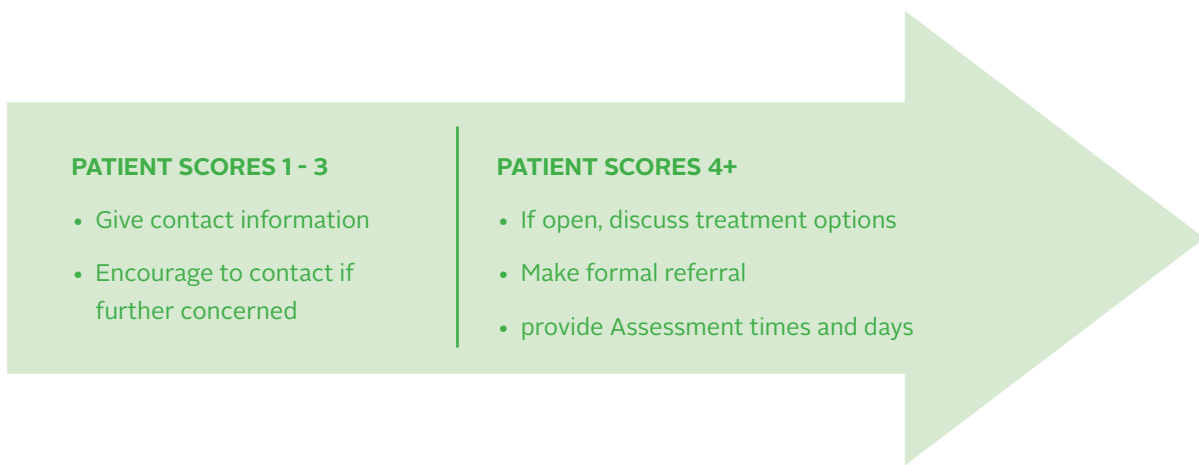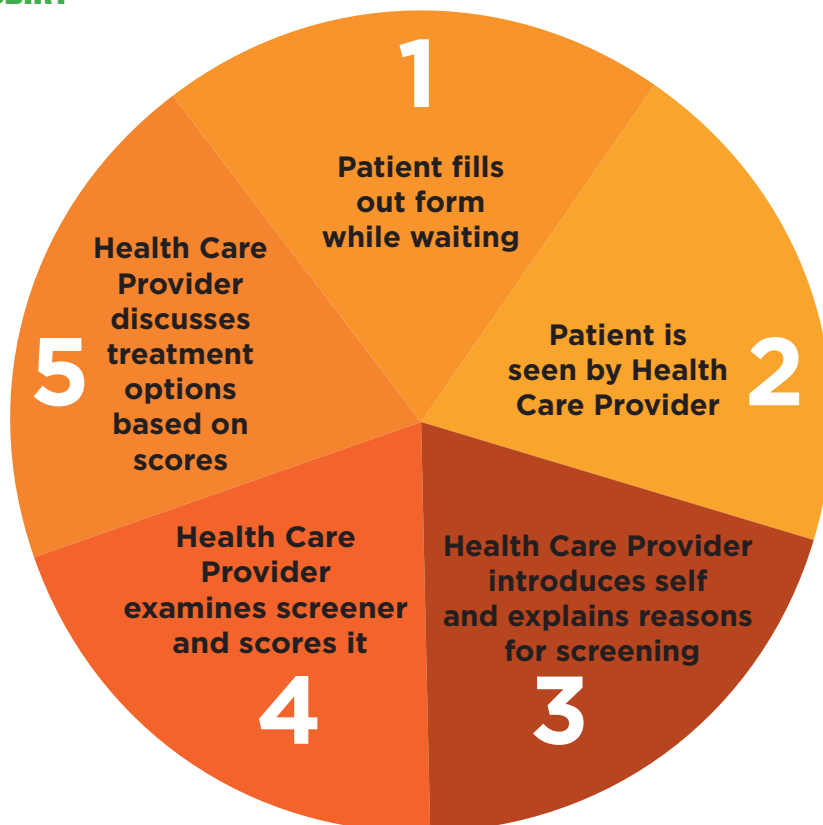| Not at all	Somewhat difficult	Very difficult	Extremely difficult
_____	_____	_____	_____

SBIRT Scoring

Substance Abuse Screening Assessment			
Have you ever used drugs other than those required for medication?	Yes	No	Not Applicable
Are you able to stop drinking or using drugs when you want to?	Yes	No	Not Applicable
Have you ever had 'flashbacks' because of drinking or using drugs?	Yes	No	Not Applicable
Do you feel bad or guilt about your drinking or use of drugs?	Yes	No	Not Applicable
Do people ever complain about your drinking or using drugs?	Yes	No	Not Applicable
Have you neglected your family because of your drinking or using drugs?	Yes	No	Not Applicable
Have you ever engaged in illegal activities in order to get drugs or alcohol?	Yes	No	Not Applicable
Have you ever experienced withdrawal symptoms (felt sick) when you stopped drinking or using drugs?	Yes	No	Not Applicable
Have you had medical problems because of your drinking or using drugs?	Yes	No	Not Applicable

LEVEL 3
Detox
Residential

LEVEL 3
Intensive
Outpatient

LEVEL 1
Outpatient

Total Scores and Treatment

PATIENT SCORES 1 - 3

- Give contact information
- Encourage to contact if further concerned

PATIENT SCORES 4+

- If open, discuss treatment options
- Make formal referral
- provide Assessment times and days

Screening Process
PHQ-9, GAD & SBIRT

1 Patient fills out form while waiting

2 Patient is seen by Health Care Provider

3 Health Care Provider introduces self and explains reasons for screening

4 Health Care Provider examines screener and scores it

5 Health Care Provider discusses treatment options based on scores

IMPACT OF DRUG USE AND HIV

Substance abuse: is the excessive use of a substance, such as drugs or alcohol, which results in clinical and functional impairments.

Although HIV and AIDS can affect anyone, the risk of infection is significantly higher in patients suffering from substance abuse, whether the risk is of direct exposure through needles or increased likelihood of high risk behaviour due to loss of judgement.

Furthermore, some abused substances can also influence disease progression and interfere with the effectiveness of treatment.

Complications and Risk: increased risk of falls, accidents, sharing needles (leading to abscesses, hepatitis C, or HIV), and sexual promiscuity (leading to HIV, STIs, and unwanted and high risk pregnancies).

Overdose: Some drugs boost heat rates, which can tax the heart to such a degree that a heart attack can develop. And sometimes, the drugs produce a profound lack of muscle control, which can lead to a stopped heart.

Altered Rates of Perception: They might see things others cannot see, or they might hear voices others cannot hear.

Accidents and Legal Issues: Under the influence of drugs, individuals may run into traffic, attempt to operate machinery, or take on some other task that can lead to an accident. Sometimes, people under the influence commit violent acts, and they face law enforcement action.

CO-OCCURRENCE

- Those who present with symptoms of a substance abuse or addiction are about twice as likely to also experience symptoms of a mental health disorder compared to those who do not struggle with drug and alcohol use.
- Some people are just wired so they are deeply attracted to the high created by the drug and alcohol use. This may be due to prenatal development, early childhood exposures, accident, injury or any number of possible things that could change the chemical makeup and function of the brain even slightly.

MENTAL HEALTH AND HIV

- Depression can reduce motivation to seek health care, impair adherence to treatment, decrease quality of life, and increase mortality.
- The neuropsychiatric effects of the virus can lead to dementia and motor disorders that further affect the quality of life.
- Mental illness can be a risk factor for HIV infection. Certain psychiatric disorders, including substance abuse, increase vulnerability to HIV infection (e.g. lack of condom use, multiple sexual partners, and injection drug use).

MENTAL HEALTH AND STIGMA

- Social exclusion that accompanies severe mental illness increases vulnerability to infection, leading to exchange of sex for money or goods and coercive sexual encounters. Cognitive deficits – may impair judgement and ability to negotiate safe sexual encounters.
- The lack of community access to mental health care adds additional risks to health as a consequence of the double burden (and stigma) of comorbidity.

REFERRALS AND SUPPORT GROUPS

- Referrals to mental health counsellors and psychiatrist for treatment
- Referral to Serenity Harm Reduction Zambia (SHARPZ)
- Church support vs SHARPZ or treatment facilities
- Support groups at clinic such a Chreso Ministries Clinic
- Transportation – bus fare to treatment facility in a few cases

SOBRIETY/HARM REDUCTION – TREATMENT FOR MENTAL HEATH AND SUBSTANCE USE IS IMPORTANT TO ADHERENCE

- Integrated treatment is a comprehensive rehabilitation program that offers all the medical, therapeutic, and holistic resources necessary to help clients heal physically, mentally, emotionally, and spiritually.
- No matter what the mental health diagnosis, but especially if co-occurring disorders are the issue, integrated care is recommended.

ANNEX I
VOTE WITH YOUR FEET: EXAMPLE BANK

Statements on Gender Roles

- A woman's place is in the home.
- The most important thing a woman can do is have babies.
- A man is only valued for his ability to make money and provide for his family.
- A man is more of a man once he has fathered a child.
- Women are naturally better parents than men.
- Men will feel threatened if too many women are in leadership roles.
- For women to succeed in the workplace, special benefits and dispensations must be made available to them.
- The burden of accommodating women's needs in the workplace is too costly.
- Gender equitable relationships should not be the goal of an FP/RH program.
- Female-controlled contraceptive methods perpetuate gender inequality in sexual
- relationships (because responsibility for contraceptive protection remains on women).
- It is unfair and inappropriate to expect service providers to mitigate power dynamics between the couple seeking services.

Statements on Men and Reproductive Health

- Increasing men's participation in family planning and reproductive health programs will only further increase men's power over women.
- Family planning will always be a more important issue to a woman than to a man because she is the one who can get pregnant.
- Men are more concerned about STIs than women are.
- Clinics should concentrate on serving older, married men because adolescent males are highly unlikely to seek clinical services.
- Men are uncomfortable going to a female-oriented health facility or being treated by a female clinician.
- In today's world, a boy child is more valued than a girl child.
- A woman can do any kind of work a man can do.
- Family planning is a woman's responsibility Bank.
- Sexuality is more important for men than for women.
- A man is a real man if he has fathered a child.
- It is normal for a man to watch the children and cook.
- A man has the right to have sex with his wife even if she does not want to.
- A man has the right to hit a woman.
- It is easier to be a man than a woman in today's world.
- A man should not have to compromise sexual pleasure for contraception or health.

Statements on HIV/AIDS

- An HIV-positive woman should avoid getting pregnant if at all possible.
- Gender equitable relationships should be the goal of an HIV/AIDS program.
- HIV behavior change efforts would have greater success if they addressed sexual pleasure.
- MSM are more vulnerable to HIV because, in most countries, they cannot marry.

- A more "sex-positive" sociocultural environment—meaning an environment that promotes greater acceptance of sexuality and sexual desires—would decrease HIV risk and vulnerability.
- In a generalized epidemic, it is not important for HIV programs to focus on transgender people because they tend to be a small proportion of the population.

Statements on Gender and Sexuality

- Men are more concerned about sexual performance than women.
- Sexual pleasure is more important to men than to women.
- These days, it's ok for a girl/woman to initiate sex.
- Oral sex is more intimate than intercourse.
- People who have multiple sexual partners concurrently are irresponsible.
- It is empowering for a woman to use her sexuality as a bargaining tool (e.g., by offering or withholding sex with her partner or another person).
- A sex worker is a victim.
- People in same-sex relationships have equal rights in my community.
- The ability to express one's sexuality and sexual diversity freely is key to contributing fully to society.
- A woman should have sex only with someone she loves.
- A man should have sex only with someone he loves.
- Sex is more important to men than to women.
- A woman should be a virgin at the time of marriage.
- It is okay for a man to have sex outside of marriage if his wife does not know about it.

Statements on GBV

- Women are just as likely to perpetuate norms around violence as men are.
- In certain circumstances, women provoke violent behavior.
- Gender-based violence is too culturally sensitive an issue to be addressed in reproductive health projects.
- Men sometimes have a good reason to use violence against their partners.
  (This statement typically generates more discussion in overseas settings.)

Statements on Safe Motherhood

- Increasing men's participation in antenatal care will only further increase men's control over women's fertility and health.
- Safe motherhood will always be a more important issue to a woman than to aman because she is the one who will give birth and care for the baby.
- Many health workers are uncomfortable counseling men on safe motherhood issues.
- Men are uncomfortable going to a female-oriented health facility.
- The most important thing a woman can do is to have babies and care for them.
- A man is most valued for his ability to make money and provide for his family.
- Women are naturally better parents than are men.
- A man is more of a man once he has fathered a child.

ANNEX II
PRE- AND POST-ASSESSMENT

Unique Identifier number _____

Instructions

1. This survey is anonymous please do not put your names.

2. Insert a 4-digit unique identifier number in the right-hand corner of every page this questionnaire.

3. Select the answer that best describes your Knowledge or experience.

Part A: Human Sexuality and Diversity

1. What does the letters **LGBTI** stand for?
   a. Lesbian, Gay, Bisexual, Transgender and Intersex
   b. Legal, Games, Beyond, Trace, and increase
   c. Lesbian, Games, Bisexual, trace and informed

2. What does KP stand for and who are KPs?
   a. Knowledge of people (students, nurses and doctors)
   b. Know your people (men, women and foreigners)
   c. Key Populations (MSM, TGs and SWs)

3. What does the letters MSM stand for?
   a. More sending Message
   b. Men who have sex with Men
   c. Male sex male

4. What does **SOGIE** mean?
   a. Society, Organisation, Gay, Intersex/Education
   b. Sex, Organs, gender, Information/example
   c. Sexual Orientation and Gender identity/Expression

5. What is the difference between homosexual men and MSM?
   a. They are the same
   b. MSM are born like that and homosexuals decide to become homosexual
   c. Homosexual men are attracted to other men on different levels while for MSM it is a sexual behavior

Unique Identifier number _____

6. Who is a sex worker?
   a. A person who offers sexual services in exchange of money or gifts
   b. A person who stands in the streets looking for sex
   c. A person who have sex with other people's partner

7. Who is a Transgender person?
   a. A person who wants to be a boy when they were born a girl or the other way around
   b. A person who identifies as the opposite sex/gender rather than the one they were assigned at birth
   c. A Transgender is a boy girl

8. What do you think is the cause of discrimination against MSM, Transgender persons and Sex Workers?
   a. Lack of Knowledge on LGBTI related issues
   b. Because it is a sin to be MSM, Transgender or Sex Worker
   c. Preachers' sermons at churches
   d. It is against the Zambian culture

9. What is the difference between sexual orientation and sexual practices?
   a. Sexual Orientation is who you are attracted to on different levels while sexual practices is how your sexual plays- involves body parts that are used to have sex
   b. They are the same
   c. Sexual orientation is a talent and sex practices is hobby

10. What is the difference between sex and gender?
   a. Sex is intercourse between two people and gender is male or female
   b. Sex is a biological makeup of a human being (state of being male, female or intersex)-What is underneath the clothes while gender is what is feminine or masculine roles assigned to men and women in society
   c. They are the same

11. Is being MSM, Transgender or a sex worker illegal in Zambia? Please explain your answer:
   _____
   _____
   _____

What do you think are the barriers to access to health for MSM, Transgender and sex workers in Zambia? Please explain your answer:
   _____
   _____
   _____

Unique Identifier number _____

12. Name at least three commodities that can be promoted to ensure safer sex practices am MSM, Transgender and sex workers?

_____

_____

_____

Part B: Stigma and Discrimination

13. Give two examples of the following forms of discrimination
 a. Direct discrimination
 b. Indirect discrimination

_____

_____

_____

_____

14. What is Stigma?
 a. the strong negative feelings or significant disapproval that is linked to a specific person, group, or trait.
 b. Failure to create reasonable accommodation
 c. When a person is subjected to torture

15. Give two example of the following forms of stigma:
 a. Internal Stigma
 b. External stigma

_____

_____

_____

16. What is Harassment?
 a. When an employer refuses to give a job to a well-qualified candidate.
 b. Unwanted conduct related to any prohibited ground takes place with the purpose or effect of violating the dignity of a person or of creating an intimidating, hostile, degrading, humiliating or offensive environment.
 c. When a person forces to have sexual intercourse with someone who has not consented

17. What is prejudice based on?
 a. Social status
 b. Religion
 c. Beliefs, values and attitudes

Unique Identifier number _____

Part 3: Safe Disclosure and Confidentiality

18. What is the meaning of disclosure or coming out?

a. The process of revealing one's sexual orientation, gender identity and sexual practices to others.

b. The process of testing for HIV.

c. The process of reporting gender based violence.

19. When should disclosure be made?

a. When you are 18 years and above

b. When you have a lot of money

c. When a KP has sufficient knowledge, and understanding and is comfortable about their gender identity, sexual orientation, sexual practices and health status, including HIV.

20. Is there a specific time or age for one to come out?

a. Yes, when one has a job

b. Yes, so that people accept you

c. No, sometimes there is no need to come out at all. It is a choice and not a must.

21. Name two tips of coming out?

_____

_____

_____

22. Who should one come out to?

a. Parents and siblings

b. People with sufficient knowledge about gender and sexuality or people who are open minded

c. Teachers at school

Part 4: Accessing health care services

23. What makes KPs vulnerable to HIV and other STIs?

a. Risky sexual practices and substance abuse and Discrimination and Stigma

b. The state of being a KP

c. Lack of employment

24. Give two examples of mental health illnesses?

a. HIV and Syphilis

b. Stress and Depression

c. Excitement and joy

25. How can one reduce the risk of getting HIV through sexual contact?

a. Discriminate against people with HIV

b. Use condoms with Lubricant consistently and correctly

c. Reduce the number of sexual partners

26. Name three barriers to health care access

_____

_____

_____

Unique Identifier number _____

27. What is gender based violence?
- **a.** Violence towards women
- **b.** Any act which results in physical, sexual or psychological harm or suffering to women, men and children.
- **c.** Discrimination towards children

28. Name four forms of gender based violence?
- **a.** Physical, Economic, Sexual and Psychological
- **b.** Discrimination, Stigma and Prejudice
- **c.** Values, Beliefs and Attitudes

29. What type of violence is targeted at KPs?

_____

_____

_____

30. What is intimate partner violence (IPV)?
- **a.** Violence towards Children
- **b.** Violence based on sexual orientation and gender identity
- **c.** Behavior within an intimate relationship that causes physical, sexual or psychological harm

31. What can be done to help KP communities overcome IPV?
- **a.** Establish support structures for victims of IPV
- **b.** Report cases of IPV to the authorities
- **c.** Keep quiet about cases of IPV

Thank you for taking part in the assessment

ANNEX III
BIBLIOGRAPHY

1. Ben Brown, Zoe Duby, and Delene Van Dyk (2013): Health care provision of men who have sex with men, sex workers, and people who use drugs. An Introductory Manual for Health Care Workers in South Africa. 1st Edition

2. Fay, H., Baral, S.D., Trapence, G. et al. AIDS Behav (2011) 15: 1088. doi:10.1007/s10461-010-9861-2

3. FHI 360 (February, 2010): Healthy Images of Manhood: A Facilitator Training Manual for Public and Private Sector Workplaces. USAID financed Manual

4. FHI 360 (January 2017): Mapping and Size Estimation Data, Plot 2374, ZNFU Complex, Tiyende Pamodzi Road, Off Nangwenya Road, Showgrounds, Lusaka, Zambia

5. Friends of Rainka(FOR): LGBT Access to Health Services: An Advocacy Toolkit. Tools for Planning and Implementing a Successful Advocacy Campaign for LGBT access to HIV & STI Treatment Care and Support

6. HIV/AIDS and Gender-Based Violence (GBV) Literature Review, August, 2006

7. http://dictionary.cambridge.org/dictionary/english/vulnerable

8. https://www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/sexual-risk-factors/

9. http://www.aidschicago.org/resources/legacy/condoms/ltoyw_fact.pdf

10. http://www.e-alliance.ch/en/m/hivaids/prevention/what-makes-some-populations-more-vulnerable-to-hiv/index.html

11. http://www.k4health.org

12. https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

13. Janni J. Kinsler, Mitchell D. Wong, Jennifer N. Sayles, Cynthia Davis, and William E. Cunningham. AIDS Patient Care and STDs. August 2007, 21(8): 584-592. doi:10.1089/apc.2006.0202

14. Johns Hopkins: Promoting the health of men who have sex with men worldwide: A training curriculum for providers. Bloomberg School of Public Health

15. Promoting the Health of Men Who Have Sex with Men Worldwide: A training curriculum for providers (MSMGF 2012)

16. Positive Vibes LILO KP Training Manual

17. SAfAIDS LGBTI handbook

18. UNFPA Gender and HIV/AIDS Resource Pack (2006)

19. World Health Organization – Gender Equity and Human Rights

20. http://americanaddictioncenters.org/health-complications-addictions/

21. http://americanaddictioncenters.org/co-occurring-disorders/

22. http://www.ncbl.nlm.gov/pmc/articles/PMC281555/   http://www.apa.org/pi/disability/dart/toolkit-three.aspx

23. http://www.who.int/hiv/topics/treatment/en/

24. http://legal-dictionary.thefreedictionary.com/sodomy

25. https://en.wikipedia.org/wiki/Social_stigma

26. https://en.wikipedia.org/wiki/Personal_lubricant