TWO DAY WORKSHOP

HEALTH WORKER QUALITY OF CARE TRAINING:

Key Population Stigma Reduction

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Health Worker Quality of Care Training:

Key Population Stigma Reduction

CONTENTS

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OVERALL TRAINING OBJECTIVES

1. To foster an understanding of how stigma and discrimination towards men who have sex with men and other key populations affects the HIV epidemic
2. To increase understanding of the different identities of sexual minorities
3. To increase understanding of how stigma and discrimination towards men who have sex with men impedes access to health services

AGENDA

DAY 1	**OBJECTIVES**
Session One (A–C)	**(2 hours)**
A. Welcome and Warm-up	■ To introduce the training ■ To help participants feel at ease and agree on group norms for the training ■ To find out participants' expectations and fears about the training
B. Introductions, Pre-Course Assessment, Hopes and Fears, Objectives	
C. Naming Stigma and Discrimination Through Pictures, and identifying stigma in personal contexts	■ To identify different forms of stigma in different contexts ■ To identify how stigma affects individuals, families, and communities ■ To explain why stigma happens ■ To discuss examples of stigma from the trainees' own communities and work contexts
Break	

DAY 1	OBJECTIVES
Session Two (D–E)	**(2.5 hours)**
D. Naming Stigma and Discrimination in the Health Facility, and the Effects of Stigma on the HIV Epidemic E. Reflecting on Our Own Experience of Being Stigmatised	■ To have trainees describe some of their personal experiences of being stigmatised ■ To identify some of the feelings involved in being stigmatised ■ To identify forms of stigma that prevent key populations (men who have sex with men [MSM] and other sexual minorities) from accessing services ■ To encourage trainees to begin thinking about how to improve the way they treat key populations in their health facility ■ To see how stigma or the fear of being stigmatised affects people living with HIV (PLHIV) and key populations
Lunch Break	
Session Three (F–I)	**(2.5 hours)**
F. The Blame Game G. Breaking the Sex Ice: Anonymous Sex Survey H. Interview Skills Practice: Talking About Sex I. Discussion of our agreed upon norms and practices for the health facility setting) J. Homework: Key Population True/False	■ To identify labels people use to stigmatise PLHIV and key populations ■ To understand the impact of name calling, labelling, and language ■ To recognize why trainees should start to challenge the use of these stigmatizing words ■ To explore how we feel about sex and some of the barriers to talking more openly about it

DAY 2	OBJECTIVES
Session Four (A–D)	**(4 hours)**
A. Warm-up B. Homework Review	■ To foster friendly connections among the group, contributing to a lively and positive tone during the training ■ To review concepts from previous sessions and clarify myths and misconceptions
C. Our Multiple Social Identities	■ To frame identity as the sum of countless characteristics that make up each person—of which gender and sexual orientation are only two. ■ To understand and apply the terms biological sex, gender expression, gender identity, and sexual orientation, and related terms and concepts.
D. Understanding the Concepts of Gender and Sexual Diversity	
Break	
Session Five (E–F)	**(2.5 hours)**
E. Understanding Different Identities (Continuum)	■ To describe how biological sex, gender expression, gender identity, and sexual orientation exist on continuums ■ To explore the relationship between separate continuums, including that they are interrelated but NOT interconnected ■ To explore attitudes about gender and sexual minorities ■ To understand how values and beliefs influence behaviour and may be linked to stigma
F. Exploring Beliefs and Attitudes (Value Clarification)	
Break	
Session Six (G–J)	**(2.5 hours)**
G. Confidentiality H. Understanding MSM Panel Discussion I. Review and discussion of our health facility environment norms and practices J. Post-Course Assessment	■ To increase trainees' understanding of what it is like to be identified as MSM in Barbados ■ To understand some of the main challenges members of MSM populations face ■ To identify some of the key barriers that MSM clients face when accessing health services ■ To identify what health workers can do as individuals to reduce stigma

Day 1

Session One (A–C)

A–B. Opening the Workshop

Note to facilitators:

The start of the workshop is critical; this is your chance to welcome participants, put people at ease, and establish a friendly atmosphere. The facilitator must make people feel safe and comfortable enough to explore topics that may be new and unfamiliar. Creating a non-judgmental atmosphere allows the participants to learn and discuss the material with an open mind. Be prepared, have materials ready and the room set up, and welcome any participants who arrive early. Plan your opening welcome speech and the warm-up exercise to help break the ice.

Objectives

- To introduce the training
- To help participants feel at ease and agree on group norms for the training
- To find out participants' expectations and fears about the training

Time

1 hour

Preparation and Materials

Arrange the room. Start with a semi-circle of chairs, if possible (no tables).

Decide on your warm-up exercise; write the questions for the hopes and fears exercise on flipcharts.

Steps

1. **Welcome participants and introduce the facilitators**
   To open the training, give a simple greeting and introduce the facilitation team.
2. **Exercise: warm-up introduction**
   Below is one example of a warm-up introduction.

Walk Around Warm-up

Ask participants to walk around the room, mingling freely. Warn them that when you shout, Stop! They should wait for instructions. Give different instructions each time, and make sure participants walk around between the instructions. E.g., Find someone and greet them as if you haven't seen them for 10 years; find someone and compliment them about what they are wearing; find a partner and do a dance together.

For the final instruction, ask them to find a partner and tell each other about themselves, including who they are, where they work, things they enjoy, etc. The participants will then introduce each other to the group.

3. **Pre-course assessment**
   Hand out the pre-course assessment (see annex 1) and emphasize that it is not an exam. You are just trying to find out what participants know and believe. You can tell participants that they will be asked to complete the questionnaire again at the end of the training.
4. **Exercise: hopes and fears about the training**
   a. **Buzz in pairs.**
      Ask, what are some of your hopes/expectations for the training? Give participants a few minutes to discuss them with the person next to them.

   b. **Round robin.**
      Move around the semi-circle and ask each pair to give you one point they have discussed. The co-facilitator then records the points on a flipchart.

   c. **Ask participants to change seats/partners.**
      Participants then discuss the following with their new partner: What are some of your fears about the training?

   d. **Round robin.**
      The co-facilitator collects one point from each pair and records it on the flipchart.

   e. **Review hopes and fears.**
      Read through the hopes and fears recorded on the flipchart and address any points that need clarification.

   f. **Present training objectives.**
      Present the overall objectives of the training and compare them to the hopes of the participants.
5. **Overview of agenda**
   Each participant should have a copy of the agenda. Present the agenda briefly, mentioning the topics that will be covered over the course of the training. You can go into more detail about day one. Ask if there are any questions so far.
6. **Group norms/contract**
   Most people will have been in workshops before and will understand the theory of group norms or a group contract. You can write up some simple statements (e.g., about confidentiality, punctuality, participation, cell phones, etc.) and ask if everyone agrees to work together under these guidelines. For fun—and to show seriousness—ask everyone to sign the flipchart.

7. **Code of practice for our own health facility**
   Explain that throughout the workshop participants will be invited to identify norms and practices that they may agree to put in place after the training. In some countries, this has led to the development of posted "codes of conduct" or "codes of practice" that help guide staff to provide stigma-free services. You might share a sample of the Saint Kitts and Nevis. Tell the group that following the training exercises, you will be soliciting their ideas about points that might be agreed upon as expectations for services at their health facility.

C. Naming Stigma and Discrimination through Pictures (See Annex 8)

Note to facilitators:

In this activity, participants look at pictures showing stigma and discuss what each picture means to them. This exercise helps participants to "name" stigma in an objective rather than personalized way. Participants identify different forms of stigma in different settings.

This is a good activity to "break the ice," get everyone interested in the issues around stigma and discrimination, and build a common vocabulary around stigma.

Participants can also use the pictures to discuss stigma with their colleagues, families, and friends—a form of follow-up. Make photocopies of the pictures and hand them out to the participants.

Special note on the terms "stigma" and "discrimination": HIV-related stigma is a powerful social process in which people or groups either living with or associated with HIV and AIDS are devalued. This stigma often stems from the pre-existing and intersecting stigmatization of PLHIV and men who have sex with men (MSM). Discrimination follows from stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status.

Discrimination is unfair or unjust treatment (act or omission) of an individual based on him or her belonging to, or being perceived as belonging to, a particular group (UNAIDS 2014). [1]

During this training, we use the word "stigma" to indicate both stigma and discrimination because we think of discrimination as an end point of the process of stigmatization.

Objectives

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

- Identify different forms of stigma in different contexts
- Identify how stigma affects individuals, families, and communities
- Explain why stigma happens
- Discuss examples of stigma from their own communities and work contexts

Time: 45 minutes

1 http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_stigma_en.pdf

Preparation and Materials

Display pictures of stigma on the wall. Write questions about pictures on the flipchart or make handouts (see Annex 8: Naming Stigma and Discrimination through Pictures).

Steps

1. **Exercise: naming stigma and discrimination through pictures**

   a. **Divide into pairs.**
   Ask each pair to walk around and look at as many pictures as possible. Then, when they have viewed all the pictures, ask each pair to select one picture. Ask them to discuss the following:

   - What do you think is happening in the picture in relation to stigma?
   - Why do you think it is happening?
   - Does this happen in your own community/work setting? If so, discuss some examples.

   b. **Report back.**
   Ask each pair to hold up their picture for everyone to see or have them tape it to the wall. Then ask them to explain its contents. Record points on the flipchart.

Example Responses

Picture—Doctor talking to nurse beside patient's bed

What is happening? The health workers are keeping a distance from the patient and gossiping about him. The nurse is overprotecting herself when treating the patient. Excessive use of gloves and mask makes the patient feel rejected.

Why? They may have insufficient knowledge about how HIV is transmitted, or they may have the knowledge but not trust it.

Does it happen? Yes—some nurses use gloves when unnecessary. There is no need for gloves when taking a patient's temperature or blood pressure. People living with HIV (PLHIV) are put at the end of the waiting list for surgeries and refused the use of private rooms. One nurse asked the family of a PLHIV to "remove your guest" from the ward.

Picture—Father is kicking his son out of the house

What is happening? The father is angry and disapproves of and rejects his son for being gay. The mother is crying and saying, "He was not raised that way." The son (who may or may not identify as a gay man and may or may not be an MSM) is upset and feels rejected. This stigma is based on fear and shame.

Why? The parents feel fear, shame, and embarrassment about what the neighbours will say.

Does it happen? Yes—some MSM are kicked out of the house and forced to live alone. Some may identify as gay and may get married to make their families happy.

c. Process the points made.
Ask the following questions:

- What are the major forms of stigma we have seen?
- Why do we stigmatise MSM?
- What are some of the effects of stigma?

d. Summarize the main points.
Draw out the main points from the discussion. Make some of the points below to add key things that may be missing:

- Sometimes we treat people badly. We isolate or reject them, or we gossip about them and call them names. When we isolate or make fun of other people, this is called "stigma." Another word for stigma commonly used in the Caribbean is "prejudice."
- Stigma is a process whereby we create a "spoiled identity" for an individual or group of individuals that attributes a lower value to the person or group. We identify a difference in a person or group—for example, a behavioural difference (e.g., same-sex relationships), physical difference (e.g., physical disfiguration), or social difference (e.g., poor or a migrant)—and then assign negative connotations to that difference, thereby marking that difference as something negative, a sign of disgrace.
- In identifying and marking differences as "bad," we create an "us" and "them" to distance ourselves from a person or group. This allows and justifies our mistreatment of and discrimination against the person or group. The end result is that stigmatised people often lose status and access to basic human rights, resources, and services because of these assigned "signs of shame," which other people view as showing that they have done something wrong (e.g., sinful or immoral behaviour).
- Stigma is a powerful social process of devaluing a person or group that often ends in discrimination, which is an action—unfair and unjust treatment, e.g., PLHIV or MSM not hired, a sex worker kicked out of the house, key populations refused treatment at the clinic, or HIV status or sexual behaviour publicly revealed.
- Stigma hurts people. When we stigmatise, it makes people feel bad, lonely, ashamed, and rejected. They feel unwanted and lose confidence. As a result, they may take less care in protecting their health (e.g., stop using health facilities and condoms). People who are stigmatised sometimes accept the negative image of themselves; this is sometimes called internal stigma or self-stigma.
- HIV-related stigma hurts everyone and drives the HIV epidemic underground. PLHIV or key populations may become silent out of fear of experiencing stigma and discrimination and may not get tested for HIV, seek health services, or disclose their status—and as a result, HIV may be more likely to be transmitted.
- Action ideas: Take the pictures home and discuss them with family members and friends. Help others see what HIV stigma means in our lives—how it happens and how it hurts people.

Break

Session Two (D–E)

D. Naming Stigma and Discrimination in the Health Facility and the Effects of Stigma on the HIV Epidemic

Note to facilitators:

This exercise looks at the experience of key populations such as MSM in accessing health facilities, e.g., how MSM are treated, the specific forms of stigma and discrimination they face, how it makes them feel, and the effect of stigma on their health-seeking behaviours.

It will help to prepare health workers to identify stigma and discrimination in their own work setting. The aim is to help health workers assess stigma in their own workplace frankly and openly.

It also helps participants understand how stigma towards people living with HIV (or suspected to have HIV) and MSM fuels the HIV epidemic.

To prepare for the exercise use, use one of the case studies to start the process of describing stigma in the health facility—and then get health workers to add other examples of stigma they have observed in their own facility.

Review the case studies and adapt to the local context, as necessary.

Objectives

By the end of this session, participants will have

- Identified forms of stigma that prevent MSM from accessing services
- Started to think about how to improve the way they treat MSM in their health facility
- Seen how stigma or the fear of being stigmatised affects PLHIV and MSM

Time

1.5 hours

Preparation and Materials

Familiarize yourself with the case studies. Be prepared to ask questions to help generate discussion.

Steps

1. **Exercise: case study**
    a. Read or ask a participant to read the case study to the group.

Case Study: Stigma and Discrimination towards MSM in the Health Facility

One day, I started to get painful sores around my anus. I went to the clinic to get tested and obtain possible treatment, but I was worried about how I would be treated by the clinic staff. So I told the nurse that I was constipated and that it was very painful. The nurse didn't say anything, but she left the room and a few minutes later returned with two other nurses.

The nurses looked at me, whispered to each other, and then left. When the first nurse returned, I challenged her and said, "I've been waiting a long time. Could you examine me please?" In a defensive tone she said, "You'll just have to wait." I felt offended because of how she responded, but I didn't say anything and decided to continue to wait.

After waiting for almost 40 minutes, the nurse told me to go to examination room two. Shortly thereafter, a doctor entered and without even examining me asked, "How did you get this STI in your anus?" I explained that I had a sore in my anus that was making me uncomfortable and I just want it to be treated. He responded by mumbling, "I wonder what you expected from your unnatural behaviour. I normally treat STIs in the front, not through the back door." He then told me to take off my pants. I did so, and he looked at my butt from an unusually long distance. (I wondered if he could actually see the sore.)

He began asking me questions about my sex life. "Does your girlfriend know that you have an infection?" "Have you been sleeping with men too?" I told him that I just wanted to be tested and treated, not interrogated about my sex life. He responded by saying, "If you were uncomfortable with your sex life, then maybe you shouldn't be doing the things you are doing!" He then mumbled, "People like you need prayer." He then told me to wait in the room and that he would be back shortly.

As soon as he stepped out, I put on my pants and left the clinic. I felt so humiliated. I haven't felt so horrible in a long time… I don't think I will ever go back to that clinic for treatment, not even for a bellyache. I should have listened to the rumours I heard about this clinic. Now I know better.

b. Summarize the case as a group.
Ask participants for a summary of what happened in the case. Ask participants the following:

- Is the situation realistic?
- What would you do differently from the healthcare provider in the scenario?
- What steps could be taken to prevent recurrence?

2. Exercise: card storm
This is a group activity.

a. Ask participants to work in groups of three or four.
Hand out several cards and a marker to each group. Ask participants to think of all the different forms of stigma towards MSM that happen in a health facility. They should write one point per card. Attach the cards to the wall randomly.

b. Cluster the points.
After a few minutes, ask two or three participants (those who have stopped writing on cards) to help cluster the cards with similar points. Ask them to read through the different clusters.

c. Process the case study.
Help the participants to process the case study by asking the following:

- What types of stigma can you identify?
- What do you see from all these forms of stigma?
- Why are stigma and discrimination towards MSM happening in the health facility?

Write the points on the flipchart.

3. Exercise: case study

a. Divide participants into groups of 4 or 5 persons.
Give each group a case study (see below). Ask them to read the case study and discuss the questions in their groups.

b. Report back and process the case study.
Ask each group to report back, reading their case study aloud and sharing the points from their discussion.

4. Discussion
Stimulate discussion by asking the following questions:

- What are the effects of stigma and discrimination on MSM?
- How does stigma result in the spread of HIV?
- What can we do to change this and make our facilities more friendly/accessible?
- What can we do to reduce and eliminate stigma and discrimination against MSM?

Code of Practice for Our health facility: What might we include in our agreed upon norms and practices in our own facility related to the effects of stigma? (Record points on flipchart.)

5. Summarize the discussion.
Summarize this session using points from the discussion. You can also add the following:

- Stigmatizing MSM fuels the HIV epidemic. It makes MSM hide their sexual behaviour and as a result, they may take less care about their sexual health, increasing their risk of HIV exposure.
- Stigmatizing MSM defeats your own mandate as a health worker. If you stigmatise MSM, they will stop using the clinic and their health will be negatively affected.
- Health workers' code of conduct requires us to treat all clients without exception.
- If we are to fight HIV, we have to stop negatively labelling MSM; they are not "bad people." In many parts of the world, MSM are accepted as part of the community. This removes the moral condemnation and the source of the stigma that is so damaging.
- Instead of stigmatizing MSM, we need to show care, compassion, and acceptance—so that MSM can lead a

healthy life and act in their own and other people's best interests.

- Stigma or the fear of stigma stops PLHIV and MSM from
  - Accessing health services, getting tested for HIV and STIs, getting information on how to avoid HIV transmission, and getting condoms and lubricant
  - Openly discussing their sexuality with health workers and providing complete information about their sexual practices
  - Accessing treatment (antiretroviral therapy or treatment of opportunistic infections)
  - Using other services, for example, when a pregnant woman living with HIV is discouraged from HIV testing and making use of the prevention of mother-to-child transmission program
  - Disclosing to their partners
  - Protecting their own health and the health of their sexual partners, for example, by insisting on condom use with partners, using clean needles and syringes for drug use, and accessing treatment to reduce viral load
  - Disclosing their HIV status and getting counselling, care, and support Because of stigma, PLHIV and other key populations are afraid to tell others about their HIV status. As a result, they may have difficulty negotiating condom use and accessing services, support, and treatment for HIV, and therefore may be at more risk for transmitting HIV to their partners.

Case Studies

Kevin started to have sex with men when he was a teenager and managed to hide this from his family. He knew that being a man who has sex with men was natural for him, but he was worried that his family would find out and make his life miserable.

When he grew older he lived in the same town as his family, but he lived on his own. His family suspected that he might be gay, but they didn't bother him until he was 30, when they started to pressure him to get married. He decided to marry, feeling he had no choice.

Soon after getting married, he found out that one of his previous male sexual partners had tested HIV positive, so he started to worry about his own status. What would people think if he was HIV positive? Would his wife find out that he has sex with men? How would he be treated?

He went to the health facility to take an HIV test, but the counsellor made him feel very uncomfortable. He asked lots of irrelevant questions about Kevin's sex life. When Kevin mentioned having had sex with other men, the counsellor responded by saying, "But you don't look like one of those. You seem like a nice young man, plus you're married. That's not right." Kevin left the health facility without taking the test because he felt offended.

He was so worried that his wife would find out about his male sexual partner or even that he was cheating, so he decided to just continue having sex with her without using condoms, especially since she had been trying so hard to have her first baby.

Questions for Discussion

- Could you please summarize what happened in the case study?
- What would you do as a health worker/counsellor in this situation?
- What changes do you think need to happen to prevent this situation from happening again?

Jade had been working as a sex worker for the last 6 months after her father kicked her out of the house. Jade had been assigned as male at birth but later identified as a woman.

One day, Jade went to the clinic because she thought she had contracted an STI. The nurse recommended that she bring her boyfriend in for testing since he may have been exposed as well. Jade told her that she didn't have a boyfriend. The nurse then asked her how she contracted the STI. Jade told her that while she was with a client a few nights ago, the condom burst and she didn't realize it. The nurse was shocked and looked at Jade with scorn. The nurse then mumbled, "I wouldn't be surprised if I see you again next week." Jade then asked, "Why did you become a nurse? Clearly you are not qualified for this job! I am making an honest living just like you, Miss. And I have respect for my clients. I should report you to management although they are probably just as judgmental as you." Jade left the clinic without making a complaint or receiving treatment.

Questions for Discussion

- Could you please summarize what happened in the case study?
- What would you do as a health worker in this situation?
- What changes do you think need to happen to prevent this situation from happening again?

Alesha was a transgender woman and became very sick with nausea and diarrhea. After seeing the doctor, she was admitted to a male ward in the hospital. Alesha asked to be allowed to go in the female ward, but the nurses refused her request. In the male ward, a lot of people were staring at Alesha and kept asking her if she was a "he" or a "she." One doctor even suggested that Alesha should be referred to the Department of Psychiatry and Mental Health. Alesha felt depressed and isolated and decided she would leave the hospital as soon as she could.

Questions for Discussion

- Could you please summarize what happened in the case study?
- What would you do as a health worker in this situation?
- What changes do you think need to happen to prevent this situation from happening again?

E. Reflecting on Our Own Experience of Being Stigmatised

Note to facilitators:

This is one of the most important exercises in the guide because it draws on personal experiences of stigma. Participants reflect on their own experience of being stigmatised and how it felt. These feelings help participants get an insider's view of stigma—how it hurts and how powerful those feelings are. The idea is to use this experience to help participants to empathize with stigmatised groups.

This exercise requires a lot of trust and openness within the group, so it should not be used at the start of stigma education. It should be used after participants are beginning to open up with each other and are ready to share some of their own experiences and feelings.

The exercise looks at stigma in general, not stigma towards PLHIV or stigma towards key populations. This is why the instructions for the exercise are to think of a time in your life when you felt isolated or rejected for being seen as different from other people.

Introduce the exercise carefully to help participants overcome their initial discomfort about sitting and reflecting on their own and sharing their own experiences with others.

Emphasize that the sharing is voluntary—no one is forced to give their story—and emphasize the importance of confidentiality. Remind participants about the ground rule that what is shared should stay in the room. Encourage group members to listen carefully to each other's stories.

This exercise can trigger painful memories for some participants. Participants are being asked to think and talk about strong feelings. You should be ready to deal with the emotions raised.

Objectives

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

- Describe some of their own personal experiences of being stigmatised
- Identify some of the feelings involved in being stigmatised

Time

1 hour

Preparation and Materials

Arrange chairs in a circle.

Steps

1. **Exercise: individual reflection**

   a. **Ask participants to sit by themselves.**
   Then say, think about a time in your life when you felt lonely or rejected for being seen to be different from others. Ask them to think about what happened and how it felt.

   b. **Share in pairs.**
   Say, Share your experience with someone with whom you feel comfortable. Give the pairs a few minutes to share their stories with each other.

   c. **Share in plenary.**
   Sit in a closed circle. Invite participants to share their stories in the large group. This is voluntary; no one should be forced to give his/her story. People will share if they feel comfortable. If it helps, give your own story to get things started. As the stories are presented, ask, how did you feel? How did this affect your life?

   d. **Process the exercise.**
   Ask, what have we learned from this exercise?

   e. **Summarize the discussion.**
   Summarize the main points participants made during the exercise. In giving your summary, you may use some of the following points if they have not already mentioned by participants:

- This exercise helps us to get an inside understanding of how it feels to be stigmatised—that is, shamed or rejected. It helps us understand how painful it is to be stigmatised.
- Stigma destroys our self-esteem. It makes us doubt ourselves and our self-worth.
- Everybody has felt ostracized or been treated like a minority at different times in their lives. You are not alone. We have all experienced this sense of social exclusion.

Lunch break

Session Three (F–I)

F. The Blame Game: Things People Say about PLHIV, MSM, Sex Workers, etc.

Note to facilitators:

This exercise is not designed for those who are stigmatised; it is designed for those whose attitudes we are trying to change—service providers, teachers, community and political leaders, media workers, and others. This exercise helps participants verbalize stigma towards different types of people. The language can be very strong, so people need to understand why they are being asked to make lists of stigmatizing words for different marginalized groups.

The title of this exercise, "The Blame Game: Things People Say about PLHIV, MSM, Sex Workers, etc.," allows participants to express their own stigmatizing labels for other groups under the cover of attributing them to "other people." So while some words are those commonly used by the community, other words are those actually used by participants themselves.

In doing this exercise, we should make it clear that we are using these words not to insult people, but to show how these stigmatizing words hurt.

In debriefing after this exercise, it is important to focus on how participants feel about these names, rather than focusing on the words themselves. This helps to avoid the laughter that may come from embarrassment. The whole point of this exercise is to help participants recognize how these words can hurt.

Objectives

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

- Identify labels used by people to stigmatise PLHIV and key populations
- Understand the impact of name-calling and labelling
- Recognize why they should start to challenge the use of these stigmatizing words

Preparation and Materials

Make a list of groups that might experience stigma in health facilities, e.g., PLHIV, MSM, sex workers, people who use drugs, transgender people, etc. Using this list, then prepare the flipchart stations—blank sheets of flipchart paper on the walls of the room, with the name of one of these groups written at the top of each sheet.

Steps

1. **Warm-up exercise: switching chairs game**
   Set up the chairs in a circle. Going around the circle, assign roles to each person based on the groups listed on the

flipcharts (PLHIV, MSM, sex worker, drug user, transgender, etc.). Continue until everyone has been assigned a role. Then explain how the game works. *Say, I am the caller, and I do not have a chair. When I call out two roles—for example, PLHIV and MSM, all the PLHIV and MSM have to stand up and run to find a new chair. I will try to grab a chair. The person left without a chair becomes the new caller—and the game continues. The caller may also shout, "Revolution!" When this happens, everyone has to stand up and run to find a new chair. Then shout, "PLHIV and MSM!" and get the PLHIV and MSM to run to a new chair.* Then start the game.

2. **Debriefing exercise: things people say (rotational brainstorm)**

   a. **Divide into groups based on the roles used in the game.**
   E.g., all PLHIV in one group, all MSM in one group, etc. Ask each group to go to their flipchart station. Hand out markers and ask each group to write on the flipchart what comes to mind when they think about PLHIV, MSM, transgender, and sex worker. After two minutes, shout, Change! Ask groups to rotate in a clockwise direction and add points to the next flipchart sheet. Continue until groups have contributed to all flipcharts and end up back at their original list.

   b. **Report back.**
   Bring everyone together into a large circle. Ask one person from each group to stand in the middle of the circle and read out the names on their flipchart, starting with "I am a (n) [insert name of the stigmatised group] and this is what you say about me...."

   After all lists have been read aloud, ask the following questions:

- What do you think about these words?
- How do you feel about them?
- What do we learn from this?

   Code of practice for our health facility: What are the take away messages about language? What do we expect from each other in our own health facility? (Record points on flipchart.)

3. **Summarize the discussion.**
Review the following points with the group:

- We are socialized or conditioned to judge other people. We judge people based on assumptions about their sexual and other behaviours, country of origin, or other features which may be different.
- Sex is taboo—something shameful that we should not talk about. So we often shame and blame people whose sexual behaviour is different from ours.
- These are disadvantaged/vulnerable groups who are lacking in power. They are stigmatised partly because they have limited power to resist these labels. They are often isolated and try to hide from being open in society.
- These labels show that when we stigmatise, we stop dealing with people as human beings. We forget their humanity (by using mocking or belittling words) and this gives us a feeling of power and superiority over them.
- Stigmatizing words can be very strong and insulting. They have tremendous power to hurt, to humiliate, and to destroy people's self-esteem.

G. Breaking the Sex Ice: Anonymous Sex Survey

Note to facilitators:

This exercise is not designed for those who are stigmatised; it is designed for those whose attitudes we are trying to change—service providers, teachers, community and political leaders, media workers, and others.

This exercise helps participants verbalize stigma towards different types of people. The language can be very strong, so people need to understand why they are being asked to make lists of stigmatizing words for different marginalized groups.

The title of this exercise, "The Blame Game: Things People Say about PLHIV, MSM, Sex Workers, etc.," allows participants to express their own stigmatizing labels for other groups under the cover of attributing them to "other people." So while some words are those commonly used by the community, other words are those actually used by participants themselves.

In doing this exercise, we should make it clear that we are using these words not to insult people, but to show how these stigmatizing words hurt.

In debriefing after this exercise, it is important to focus on how participants feel about these names, rather than focusing on the words themselves. This helps to avoid the laughter that may come from embarrassment. The whole point of this exercise is to help participants recognize how these words can hurt.

Objective

To explore how we feel about sex and some of the barriers to talking more openly about it

Time

1 hour

Preparation and Materials

1. At least two facilitators are needed for this exercise—one facilitator at the front of the room to read the questions and the other facilitator at the back of the room to collect the answer slips and quickly record the results on flipcharts.
2. Prepare 10 small slips of blank paper for each participant.
3. To save time, write out the questions on flipcharts with space to write the answers. For example:
    1. Can you talk openly about sex to close friends?

        Yes

        No

Steps

1. **Exercise: icebreaker**

Use an activity that includes movement.

2. **Exercise: anonymous sex survey**

   a. **Describe the survey.**
   Say to participants, we are going to do a simple survey about sex. It is completely anonymous. No one will know your answers. There are 10 questions. For each question, I want you to answer yes or no. Write the answer to each question on a separate slip of paper.

   b. **Read each question aloud.**
   After reading each question aloud, give participants about a minute to write their answer. Collect the slips after each question and record the results on a flipchart. Do not present these results until all questions have been asked.

   c. **Process the exercise.**
   Ask the group, how did it feel to do this survey?

   d. **Present the answers.**
   Present the answers one at a time and give participants a chance to discuss the results. You can probe by asking questions like, is this you would expect? What do you think of these results? Encourage a lively discussion as participants "break the sex ice."

H. Interview Skills Practice: Talking About Sex

Note to facilitators:

This exercise uses role-play to help participants practice talking more openly about sex with clients.

Try to circulate around the small groups to find out how the practicing is going.

Organize gentle feedback after the large-group practice, focusing on what worked well.

Objectives

- To provide an opportunity for participants to practice talking about sex more openly with clients
- To explore what helps us to feel more relaxed about asking questions about sex and sensitive issues

Time

1 hour

Preparation and Materials

Make a copy of the client briefs (included at the end of this section) for each participant.

Steps

1. **Exercise: buzz and brainstorm**

   Ask participants to discuss the following question with the person next to them:

   What would help us to overcome some of the barriers that prevent us from talking openly about sex to MSM and transgender clients?

   Take one answer from each pair and record it on the flipchart.

2. **Exercise: role-play**

   a. **Decide on roles.**
   Ask each pair to decide who will be the client in the role-play and hand out a brief to each of the "clients."

   b. **Practice in small groups.**
   Give the groups five minutes to practice a consultation, which should involve talking and asking questions about sex.

   c. **Practice in the large group.**
   Ask each group to show short segments of their role-plays to the larger group. Limit the time to three to four minutes per group. You just want to get a "snapshot" of some language and techniques they are using. After each role-play, ask the group doing the role-play:

   - What worked well?
   - What would you do differently next time?

   d. **Process the exercise.**
   When all groups have presented their role-plays, ask:

   - What have we learned from the role-plays?
   - Is there any other information we need to feel more comfortable talking about sex with transgender clients?

   Code of conduct: What should we include in our code of conduct about talking about sex? (Record points on flipchart.)

3. **Summarize the discussion.**
   To summarize the discussion, use the points the training participants have brought up. Then add the following:

   - In order to feel more comfortable about talking about sex, we may have to explore our own feelings about it. We can do this by talking to people we trust, practicing with friends, and reflecting alone on our own experiences.
   - To give good, clear information about HIV and HIV prevention, we need to be able to ask clients sensitive questions about sex and relationships. We can explain to clients why this is necessary to help break down the taboo.

- It is better to ask if you are not sure what type of sex a client is having, or if you think them—or you—may not have understood the risks they are taking. Creating a dialogue in a space where clients feel safe to talk openly is one of the best steps towards creating an effective prevention intervention.

The following are sample client briefs that can be used to inform the role plays.

1. You are a young man. You have a girlfriend but occasionally have sex with men. You are worried about HIV and want to talk to the health worker about how to protect you from becoming infected. You are worried he or she won't understand your situation.
2. You are an older transwoman and work as a sex worker, selling sex to men. You are careful to always use condoms, but you think you may have contracted an STI. You have come for a check-up and to discuss safer sex practices.
3. You are a gay man who has been in a steady relationship for 3 years. Your partner is married but has told you that he really just wants to be with you. However, you have heard that he also sleeps with other men sometimes, and you want to start using condoms. You have come to get an HIV test and to ask about how to practice safer sex.
4. You are a gay man and think you may have contracted an STI. You have had bad experiences at clinics before, so you just want to get some treatment and leave as quickly as possible. You also want to get information on how to protect yourself from STIs.
5. You are a young man who has sex with men who is HIV positive. You have recently met someone whom you really like and hope to be with for a long time. However, you are worried about passing on the virus, so you want to find out how you can have sex safely with your new partner.

I. Discussion of Code of practice for our health facility:

Note to facilitators:

Review any key take away messages that should be maintained in our own health facility practices. What do we expect from each other in our own health facility? Are there additional points we want to list? (Show the points that were already mentioned and noted on the flipchart. Add any additional items.)

J. Homework–Key Population True/False (see annex 3)

Note to facilitators:

Give each participant a copy of Annex 3. Ask them to do their best to complete this before the following day. Explain that you will discuss this the following day. Make sure participants know this is not going to be collected, but it is for their own learning.

Day 2

Session Four (A–D)

A- B. Warm up and Homework Review

Note to facilitators:

Start the day with a simple warm-up game or song to bring everyone together. Review the homework (see annex 3) and ask if there are any questions.

C. Our Multiple Social Identities: The Power Flower (See Annex 4, handout – Our Multiple Social Identities)

Note to facilitators:

This exercise helps participants recognize that we all have many identities, e.g., nationality, race, ethnicity, gender, etc., and that often these identities are used as a focus for stigma. Stigma and discrimination are part of a process of imposing dominant identities.

Objectives

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

- To frame identity as the sum of countless characteristics that make up each person—of which gender and sexual orientation are only two.

Preparation and Materials

Draw the power flower on a flipchart sheet and tape it to the wall. Hand out copies of the power flower

Time

1 hour

Steps

1. **Introduce the power flower:** [2]
   Ask, what are some of our different social identities as human beings? As participants respond, record the identities on the inner circle of the flower and ask participants to do this too. (See the picture of the power flower later in this section for an example).

> **Possible Social Identities**
>
> Nationality. Male/female. Age. Race. Class. Ethnicity. Marital status. Religion. Occupation. Employed/unemployed. Education. Language. Birth position. Socioeconomic status. Income (rich or poor). Ability/disability. Physical features. Having children (or not). Political affiliation. Health status. HIV status. Sexual orientation. Sexual experience. Rural/urban.

2. **Explore our own social identities.**
   Ask each person to record his/her own social identities in relation to each factor in the flower. This is an individual task. Assure participants that they will not be forced to share this product.

3. **Explore whom we stigmatise (exercise: card storm).**
   Divide into pairs, hand out markers, and ask, whom do we stigmatise? Ask participants to write single points on cards and tape them to the wall. Then ask a few participant pairs to eliminate any repetition.

> **Example Responses**
>
> PLHIV. MSM. Sex workers. People who inject drugs (PWID). Migrants. Prisoners. Indigenous people. Street children. Homeless people. Poor people. Illiterate people. People of a different color. People with disabilities. Young people. Old people. Pregnant teenagers. Women who have children from different fathers. Women without children. HIV-positive pregnant women.

4. **Process the exercise.**
   Ask the group the following questions:

   - Why do we stigmatise these groups?
   - How does having more than one stigmatised identity affect a person?

   Review the following points in response to the questions:

2 From the USAID- and PEPFAR-funded Health Policy Project's 2013 document, Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide. Washington, DC: Futures Group, Health Policy Project.

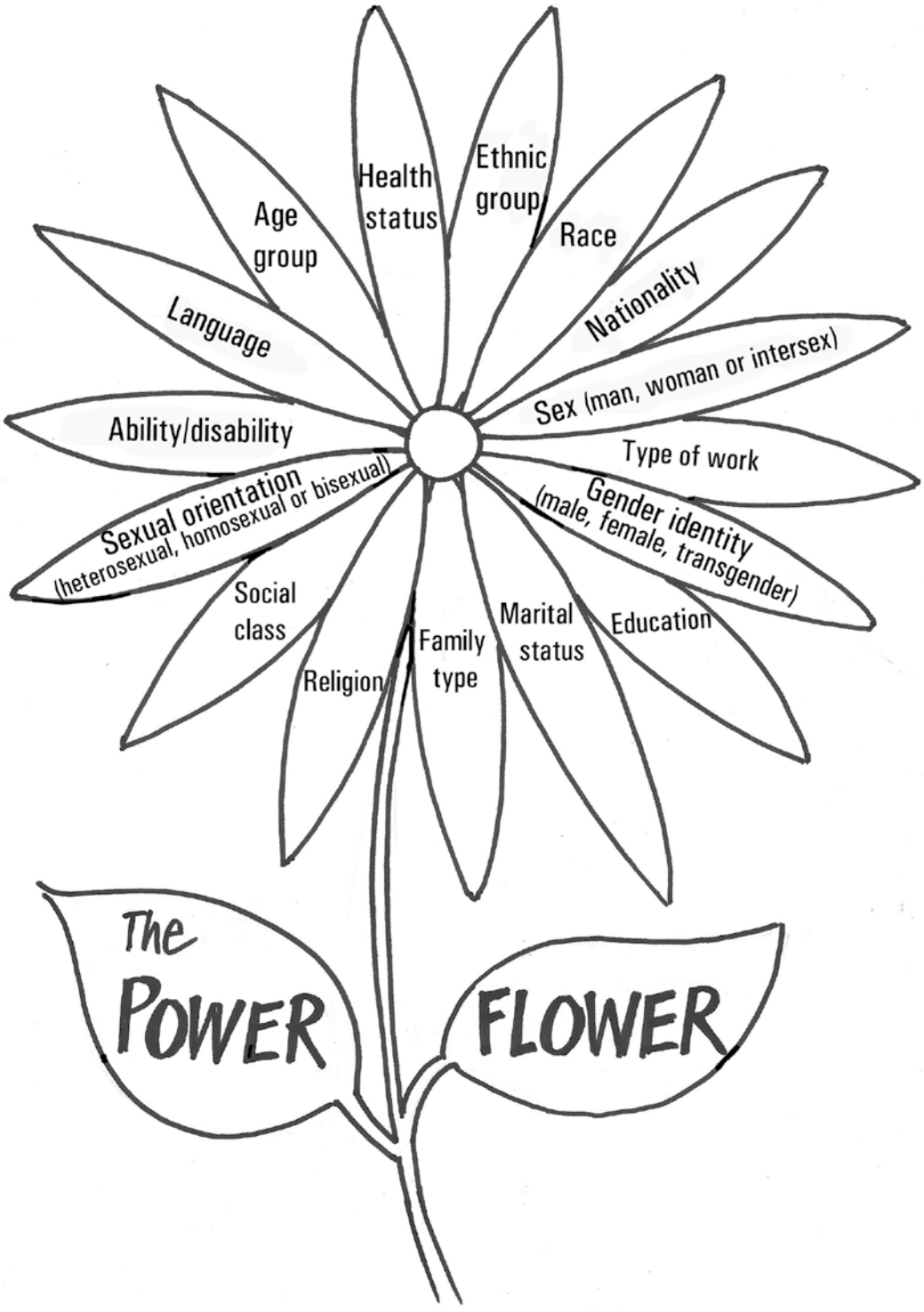
Why Do We Stigmatise?

- Tradition/culture/religion: We have been socialized to stigmatise.
- Fear of people we know little about: We stigmatise those with different identities than ours
- We like to judge others: We reject anything that seems different or not normal.
- Control/power: Stigma allows us to have power over others.
- Superiority complex: We like to feel we are superior to others.
- Judging others for immorality: We judge people who break social norms.

What is the effect of a person having more than one stigmatised identity, e.g., an MSM who is HIV positive?

- Increases the level of stigma
- Forces the person to hide all of their stigmatised identities or selectively hide identities

5. **Summarize the discussion.**
   Include the following points in your summary of the discussion:
   - All of us have many social identities—e.g., nationality, race, class, ethnicity, biological sex, age, marital status, gender identity, gender expression, sexual orientation, language, religion, education, occupation, children or no children, ability/disability, or health status.
   - Key populations are marginalized and stigmatised on the basis of some of these identities or characteristics. They are forced to live in a world dominated by identities with which they do not identify. As marginalized groups, they are expected to conform to those identities, and when they do not, they become targets for stigma and discrimination.
   - In thinking about key populations, we often limit ourselves to thinking about one of their characteristics, e.g., sexual orientation, occupation (in the case of sex workers), disability, etc. In other words, we do not treat them as whole people who have a full set of identities. We treat them as having only one identity—their stigmatised identity. We make this single feature the basis for their entire identity.
   - In focusing on this single identity, we stop treating key populations as human beings. We forget their humanity, and this gives us a feeling of power and superiority over them. We focus on one aspect of a person's identity and become blinded, not recognizing the entire rich package of a human being.
   - Thus, we need to change our tendency to think about key populations as having a single identity and instead look at them as people with a full set of identities. They are our children, our brothers or sisters, our friends, workmates, church members, and community members, and not just MSM, or sex workers, or PWID. We need to respect members of key populations by treating them like anyone else.
   - There are also layers of stigma. People who experience HIV stigma may also be stigmatised on the basis of other stigmatised identities. For example, a woman could be stigmatised as a woman, a sex worker, a PWID, a PLHIV, a woman without children, a mother who has children from different fathers, or an HIV-positive woman who is pregnant. Each layer of stigma magnifies the level of stigma. This makes it even more difficult for a woman to access health and other services and to get out of an often hidden, marginalised existence.


Health status
Ethnic group
Age group
Race
Language
Nationality
Sex (man, woman or intersex)
Ability/disability
Type of work
Sexual orientation (heterosexual, homosexual or bisexual)
Gender identity (male, female, transgender)
Social class
Marital status
Education
Religion
Family type
The POWER FLOWER

D. Understanding the Concepts of Gender and Sexual Diversity [3]

Note to facilitators (see also Annex 5, Handout on Frequently Asked Questions about Diversity to this section? Also a reference to Annex 6, Handout on what is Sex? What is Gender?):

This exercise focuses on understanding different concepts around gender and sexuality. It involves matching concepts and definition cards. Before beginning the exercise, make sure that you are clear on what the concepts mean and can explain how they interrelate.

Objectives

- To foster friendly connections among the group, contributing to a lively and positive tone during the training, and possibly strengthening connections in the workplace after the training
- To frame identity as the sum of countless characteristics that make up each person—of which gender and sexual orientation are only two
- To understand and apply the terms biological sex, gender expression, gender identity, and sexual orientation, and related terms and concepts

Time

2 hours

Preparation and Materials

Prepare cards with the terms and definitions listed in the table below. Each card will have either a term or a definition. Review the definitions so that you may explain the terms if necessary.

Term	Definition
Biological sex	A medical term used to refer to the chromosomal, hormonal, and anatomical characteristics that are used to classify an individual as female or male or intersex
Intersex	An umbrella term that refers to a variety of chromosomal, hormonal, and anatomical conditions in which a person does not seem to fit the typical definitions of female or male

3 These concepts and the continuum are taken from the Health Policy Project's Gender & Sexual Diversity Training guide. Available at http://www.healthpolicyproject.com/pubs/398_GSDGuide.pdf

Term	Definition
Gender expression	The external display of one's gender through a combination of appearance, disposition, social behaviour, and other factors, generally measured on a scale of masculinity and femininity
Gender norms	A culturally defined set of roles, responsibilities, rights, entitlements, and obligations associated with being a woman or man, and the power relations between and among women and men, boys and girls
Gender identity	A person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth
Transgender	An umbrella term that refers to an individual whose gender identity is different from the sex assigned at birth
Sexual orientation	An enduring emotional, romantic, or sexual attraction primarily or exclusively to people of a particular gender
Heterosexuality	An enduring emotional, romantic, or sexual attraction primarily or exclusively to people of a different gender. People who are heterosexual often identify as "straight."
Homosexuality	An enduring emotional, romantic, or sexual attraction primarily or exclusively to people of the same gender. People who are homosexual often identify as "gay" or "lesbian."
Bisexuality	An enduring emotional, romantic, or sexual attraction primarily or exclusively to people of more than one gender. People who are bisexual often identify as "bisexual."
Asexuality	An enduring absence of sexual attraction. People who are asexual often identify as "asexual."

Source: http://www.healthpolicyproject.com/pubs/398_GSDGuide.pdf

Steps

1. **Introduce the topic.**
   Say, there are several terminologies that are associated with sexual orientation and gender diversity that we may, or may not have heard about. It is useful to become familiar these terms as we learn more about different sexualities and identities.
2. **Mix and distribute cards.**
   Mix the cards so that they will be in a random order. Ask the group to stand in two lines facing each other. One group will have the terminology cards, and the other group will have the definitions. Depending on the number of participants, give each participant from one to three cards.
3. **Find your matching partners.**
   Ask participants to find their matching partner(s)/cards by mixing and mingling and reading each other's cards. The goal is to find the term and definition that match.
4. **Report back.**
   Ask each group to read their cards aloud. Make sure that they have matched the terms and definitions correctly. Supplement with any additional information using contributions and experiences from the group.

Session Five (E-F)

E. Understanding the Continuums:

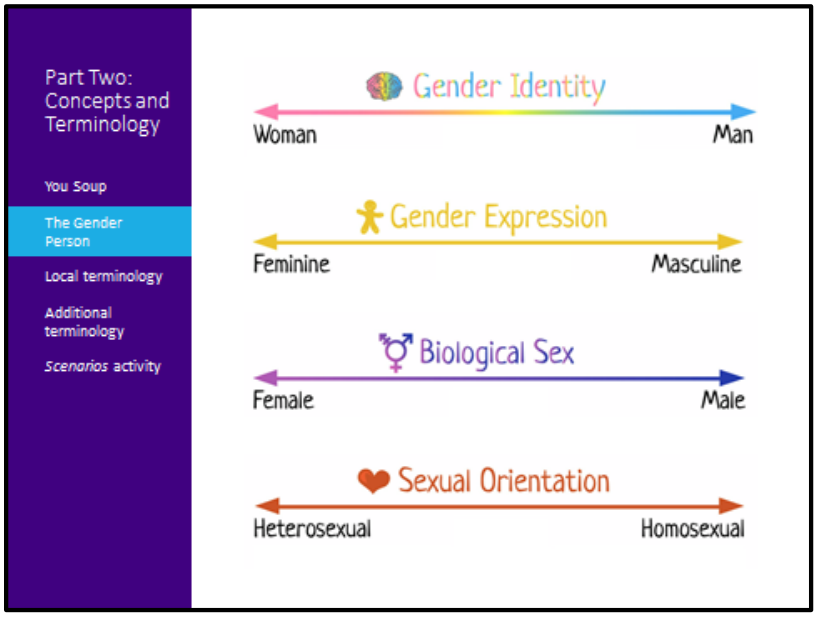
Objectives

- To understand how biological sex, gender expression, gender identity, and sexual orientation exist on continuums
- To explore the relationship between separate continuums, including that they are interrelated but NOT interconnected

Steps

1. **Explain the continuums.**
   Explain to participants the information that follows:

   Biological sex, gender expression, gender identity, and sexual orientation all exist on separate continuums. We are all at different points on the continuum. [4]



The four continuums are interrelated in that one may influence the other. For example, one's biological sex influences one's gender identity. One's sexual orientation might even influence one's gender expression. However, where a person falls on one continuum does not determine where they fall on another. The continuums are not interconnected.

For example, just because someone is born biologically female, it does not mean that the same person will have a female gender identity or expression.

4 http://www.healthpolicyproject.com/pubs/398_GSDGuide.pdf

2. **Summarize.**
   Ask participants if there are any further questions. Then review the key points listed below:

   - Biological human diversity is much more complicated than most people think.
   - We should try to avoid making assumptions about a client's identity or sexual orientation. The best strategy is to create an open and welcoming service where clients feel free to give as much information as they wish.
   - Understanding the terminology and concepts helps us to appreciate gender and sexual diversity and have a greater understanding of our clients.
   - We can aim to be "allies" in our support for equal treatment and services for all clients.

F. Beliefs About Gender and Sexual Minorities (Value Clarification)

Note to facilitators:

This is a value clarification exercise. Health workers are given a number of statements about gender and sexual minorities and must decide if they agree or disagree.

This exercise generates lots of discussion and needs a good facilitator to allow everyone a chance to give his/her opinion while achieving a meaningful result. Emphasize that there are no "right" or "wrong" answers.

Objectives

By the end of this session, participants will have explored their attitudes and beliefs about gender and sexual minorities.

Time

30 minutes

Preparation and Materials

Review the questionnaire and ensure that you have enough copies.

Steps

1. **Arrange the chairs.**
   Arrange the chairs in a staggered way so that no participant is facing another.
2. **Exercise: value clarification**
   Hand out the value clarification questionnaire (see annex 7). Then ask participants to sit and reflect on the sheet and fill it in. (Allow 10 minutes)
3. **Compare in pairs.**
   Have participants sit in pairs and identify one similarity and one difference in their values. They should then discuss

how they might feel or act knowing the difference.

4. **Discuss in the large group.**
   After everyone has finished the comparison in pairs, come back together in the large group and discuss the following questions:
   - Do you have any thoughts or comments about the questionnaire?
   - How do our own values and beliefs influence our behaviour and attitudes towards other people?
   - How might our values affect the way we work with clients?
   - Which values do we observe? Which do we wish to hold on to and why?
   - How are values and judgments linked to stigma?

   Our facility Code of practice: Do we want to include any points about values in our facility code of practice? Ask for specific examples. (Record points on flipchart.)

Session Six (G–J)

G. Confidentiality

Note to facilitators:

This is a simple yet very powerful exercise. If you have time, try out the drama with the group.

Objectives

By the end of this session, participants will be able to describe

- An individual's right to confidentiality
- The potential effects of a health worker violating confidentiality

Time

30 minutes

Preparation and Materials

Prepare enough small squares or strips of paper for each person. Make the paper large enough to fit a couple of written sentences.

Steps

1. **Exercise: trust game**

a. **Write down a secret.**
Ask participants to think of a secret they would not want anyone else to know. Ask them to write the secret on a piece of paper, fold it up, and not show it to anyone. Now ask each person to pass their paper to the left. Nobody should open their papers.

b. **Discuss trust.**
Ask:

- How does it feel to have your own secret in someone else's hands?
- How does it feel to have someone else's secret in your hands?

c. **Return the secrets.**
Ask participants to return the papers to their owners. Participants can then destroy their papers.

d. **Process the exercise.**
Ask participants:

- What does this tell us about confidentiality?
- What should be kept confidential?
- What rules should we have about confidentiality?

Code of conduct: What should we say about confidentiality in our code of conduct? (Record points on flipchart.)

2. **Summarize secrecy and confidentiality.**
Secrecy and confidentiality are often viewed as the same thing, but they are different.

Secrecy is information known to you alone—it is not shared. If your HIV status were a secret, it would mean that you would not tell anyone.

Confidentiality is information that is managed by the person who owns the information. It is shared with others on a controlled basis. For example, you decide with whom you are willing to share this information, with the expectation that access to it will be restricted (respected) according to your wishes. Knowing that your HIV status is confidential means that you have control over who knows your HIV status.

We all like to think that we are trustworthy. But clients are unlikely to trust you just because you are a health worker. Whoever you are, trust has to be built and maintained.

This is the basic idea of confidentiality, that you only tell others whom you trust about certain information that is sensitive, e.g., your HIV status, your sexuality. You trust (expect) that they will keep this information confidential—not share it with others.

All health workers, irrespective of their employment status, are required by their own ethical codes of practice (and often by law) to keep the information they learn about their patients confidential.

Every person has the right to confidentiality—the right to decide what aspects of his or her life are private and what can be released into the public domain (a bit like Facebook). This includes the right to confidentiality regarding a person's HIV status.

A health worker may discover things about a patient, such as his sexual orientation, that are considered private. The health worker should keep this information confidential.

3. Review points for code of conduct.

H. Understanding MSM Panel Discussion

Note to facilitators:

The panel discussion can have a big impact on participants' understanding and attitudes towards transgender populations.

The personal stories from resource persons—in this case MSM and transgender people—have a powerful impact. It is often the first time health workers have listened to MSM talk about their lives and their experiences of being stigmatised.

The "secret questions" are simply preparation for the panel discussion that follows. Participants write down any questions they would like for the panellists to address during the discussion.

If you can organize a break immediately after the secret questions, this will allow you to organize and edit the questions and brief the panellists.

Objectives

By the end of this session, health workers will be able to:

- Deepen their understanding of what it is like to be an MSM in Jamaica
- Understand some of the main challenges facing members of MSM populations
- Identify some of the key barriers that MSM clients face when accessing health services

Time

10 minutes (secret questions)

50 minutes (panel discussion)

Preparation and Materials

1. **Secret questions**
   Have available several small slips of paper for each participant to write their questions on and a container in which to collect them.

2. **Panel**
   In advance of the training, invite three to four MSM to serve as panellists. Try to invite panellists from a range of backgrounds, if possible. Expect that they may need to be reimbursed for travel and other costs.

   Your job as facilitator is to brief the panellists, guide the panel discussion, ask the questions, and ensure that everyone on the panel gets a chance to talk.

   Make sure that the panellists are well prepared by giving them an outline of participants' questions before the discussion starts.

   Brief the panellists as follows on how to present their stories and information:

   - Respond to participants' questions and give examples drawn from your own lives.
   - Talk about how you have been treated in health facilities and how it made you feel.
   - Tell your stories in a factual way without blaming or criticizing health workers. This will ensure that the health workers do not become defensive.

   Arrange a table at the front of the room for the panel discussion.

Steps

1. **Explain the panel discussion.**
   Explain to the participants that after the break there will be a panel discussion with members from the MSM community who have agreed to participate to raise awareness about issues involving MSM. This is an opportunity for participants to ask any questions they feel will help to increase their understanding of the needs of MSM clients. Ask them to write one question per piece of paper and assure them that the questions are anonymous. It might be appropriate to remind participants to keep the questions respectful and general, rather than personalized. They should not ask questions they would not be prepared to answer themselves.

2. **Collect the questions.**
   Ask participants to fold their slips of paper and place them in the container.

3. **Prepare the questions for the panel.**
   During the break, prepare the questions for the panel along with your co-facilitator. Sort the questions into different categories, rephrase or reject any that sound offensive, and decide on the order in which to ask the questions. Aim to have around 10 questions, plus a few extra to ask if time allows. Show the questions to the panellists so that they may prepare their answers if needed.

4. **Hold the panel discussion**
   Hold the panel in the style of a television talk show. Keep the atmosphere light and friendly to put the panellists at ease and to help them feel relaxed about sharing their experiences.

   Introduce the panellists or let them introduce themselves. Then explain that the aim of the panel is for participants to listen to the panellists as they answer the questions and share their experiences.

   Allow the panel to discuss for up to an hour, taking short breaks as necessary so that the audience can sustain their ability to listen. During any breaks you can also check in with the panellists. If it feels appropriate and if time allows, the audience can ask further questions at the end.

Make sure to allow time for each panellist to talk about their experiences using health facilities and any stigma and discrimination they have faced.

Our facility code of practice: Are there any new points from this discussion that you want to add to the code of conduct? (Record points on flipchart.)

I. Summing up our facility code of practice

Before closing the meeting, be sure to share a sample code of conduct from another country (see thumbnail of Saint Kitts and Nevis code of conduct to the right). Share a summary of the points participants offered during the training. Agree on next steps for finalizing points made for the code of conduct in a poster. This can be done in a meeting or by email.

J. Post-Course Assessment (see Annex 1)

Close the workshop with an activity such as an evaluation round. Ask each participant to say one word or do one action to show how they feel.

Then have the participants to fill out the post-course assessment (annex 1), which is identical to the assessment they filled out at the beginning of the training.

Annex 1: KPCF Pre- and Post-Course Assessment

Dear participants: We would like for you to complete this questionnaire at the start and end of the training workshop. The questionnaire is completely anonymous. The trainers will not know who gave which answers.

1. **Name a cause of stigma and discrimination towards men who have sex with men (MSM).**

   _____

   Don't know ☐ (Please check the box if you do not know.)

2. **Name three effects of stigma and discrimination against men who have sex with men.**

   _____

   _____

   _____

   Don't know ☐ (Please check the box if you do not know.)

3. **Name three forms of stigma and discrimination towards men who have sex with men that occur in health facilities.**

   _____

   _____

   _____

   Don't know ☐ (Please check the box if you do not know.)

4. **Why is it important to reduce stigma towards men who have sex with men?**

   _____

   _____

   _____

   Don't know ☐ (Please check the box if you do not know.)

5. Do you strongly agree, agree, disagree, or strongly disagree with the following statements?

a. Men who have sex with men who get HIV through sex deserve it because of their immoral behaviour.

☐Strongly agree ☐Agree ☐Disagree ☐Strongly disagree

b. Preventing an HIV epidemic is more important than condemning men who have sex with men.

☐Strongly agree ☐Agree ☐Disagree ☐Strongly disagree

c. Men who have sex with men should be allowed to fully participate in social events in our community.

☐Strongly agree ☐Agree ☐Disagree ☐Strongly disagree

d. Sex between two men is wrong.

☐Strongly agree ☐Agree ☐Disagree ☐Strongly disagree

e. People should accept men who have sex with men just like other people.

☐Strongly agree ☐Agree ☐Disagree ☐Strongly disagree

6. Please note if these statements are true or false, of if you do not know.

a. Becoming gay does not just happen. Rather, men decide or learn that they want to be gay.
☐ True ☐ False ☐ Don't know

b. Men who have sex with men are all the same. You can identify them by the way they dress and behave.
☐ True ☐ False ☐ Don't know

c. Men who have sex with men have an increased risk of getting HIV and other STIs because of having unprotected anal sex.
☐ True ☐ False ☐ Don't know

d. Men who have sex with men make use of the same sexual practices as other couples.
☐ True ☐ False ☐ Don't know

e. Men who have sex with men do not want long-term partners; they only want casual sex.
☐ True ☐ False ☐ Don't know

f. Men who have sex with men may also have sex with women.
☐ True ☐ False ☐ Don't know

g. Withholding or providing differential or substandard care for a client believed or known to be a man who has sex with men is a violation of the client's human rights.
☐ True ☐ False ☐ Don't know

h. When resources are limited, they should not be wasted on men who have sex with men.
☐ True ☐ False ☐ Don't know

7. I am comfortable providing health services to clients who are:

_____ HIV-positive

_____ Men who have sex with men

_____ Sex workers

_____ People who use drugs

8. Match the terms with the definitions below by marking the letter (A, B, C, D, or E) next to the definition that each term corresponds to.

a. Biological sex
b. Gender expression
c. Gender identity
d. Sexual orientation
e. Gender

1. _____ A medical term used to refer to the chromosomal, hormonal, and anatomical characteristics that are used to classify an individual as female or male or intersex

2. _____ Emotional, romantic, or sexual attraction primarily or exclusively to people of a particular sex

3. _____ A culturally defined set of roles (economic, social, and political 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

4. _____ The external display of one's gender through a combination of appearance, disposition, social behaviour, and other factors, generally measured on a scale of masculinity and femininity

5. _____ A person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth

Annex 2: Anonymous Sex Survey

1. At least two facilitators are needed to run this exercise—one facilitator at the front of the room to read the questions, and the other facilitator at the back of the room to collect the answer slips and quickly record the results on a flipchart.
2. Explain that the survey is anonymous. "No one will know how you respond."
3. Hand out 12 slips of paper to each participant.
4. Read aloud each question below and tell participants to record one answer on each slip of paper. Then they should fold it up. Collect the slips after each question and record the results on a flipchart. Do not present these results until all the questions have been asked.
5. After people have answered all 12 questions, present and discuss the results. Then ask:
   a. *How did you feel answering the questions?*
   b. *What did you learn from the exercise?*

Example Questions

#	Example Questions and Example Results	Yes	No	Total
1	Can you talk openly about sex to close friends?			
2	Do you enjoy sex?			
3	Have you ever masturbated?			
4	Have you ever participated in vaginal sex?			
5	Have you ever participated in oral sex?			
6	Have you ever participated in anal sex?			
7	Have you ever had a sexually transmitted infection (STI)?			
8	Have you ever taken an HIV test?			
9	Did you use a condom the last time you had sex?			
10	Have you ever paid for sex?			

#	Example Questions and Example Results	Yes	No	Total
11	Have you ever been paid for sex?			
12	Have you ever been attracted to someone of the same sex?			

Ask participants what they learned from the exercise. Some of the responses from participants may be similar to things that participants have shared in the past.

What did you learn from the exercise?

The survey helped us reveal our own sexual experience without embarrassment.

It was easier because it was anonymous. People were laughing—so it loosened people up.

It forced us to reveal what we don't want to talk about in public.

We were able to bring out our own sexual experience without feeling embarrassed.

We often feel uncomfortable talking about sex, so this may block our communication with groups such as MSM and sex workers.

Annex 3: Homework: True/False Questions About Key Populations

What Do You Know about MSM?

1. Becoming MSM does not just happen. Men decide or learn that they want to be MSM.
2. If you hang around with and become friends with MSM, you will also become an MSM.
3. MSM are mentally ill, but they can be cured.
4. Sex between two men is against religion.
5. Sex between two men is a product of western influences.
6. Sex between two men is motivated by love, sexual pleasure, and/or economic exchange.
7. MSM are all the same. You can identify them by the way they dress and behave.
8. In many countries it is illegal for men to have sex with men.
9. MSM have an increased risk of getting HIV and other STIs because of having unprotected anal sex.
10. MSM make use of the same sexual practices as other couples.
11. MSM do not want long-term partners; they only want casual sex.
12. MSM may also have sex with women.
13. Safe sex for MSM is different from safe sex between a man and a woman.
14. MSM are not at risk of getting HIV so they do not have to practice safe sex.
15. There is no stigma against MSM; they stigmatize themselves.

Answers

1. **Becoming a man who has sex with men does not just happen. Rather, men decide or learn that they want to be MSM.**

   FALSE. Wanting to have sex with other men is part of some men's nature. It is like being right handed or left handed. It is inborn and cannot be explained or predicted. It is not known what makes some men desire men, while other men desire women. Some studies suggest that there are genetic influences, while other people believe it is a mixture of genetics and social influences. A man who has sex with men cannot simply be taught to be sexually attracted to women. There is no scientific evidence to prove that people can change their sexual orientation through exerting their will.

   Men have sex with men for many different reasons. Some men, who may call themselves homosexual or gay, are attracted to other men and enjoy having sex with them. Other men have sex with men in all-male environments, like prisons, where there are no women available and they want to release sexual tension. Some men have sex with other men because they need money and can earn money by having sex with men. Some men are married to women and have

sex with wives, but they also have sex with men out of desire.

2. **If you hang around with and become friends with MSM, you will also become an MSM.**

   FALSE. Simply spending time with or being close to an MSM will not cause you to become an MSM. Being MSM does not pass from person to person like a disease, nor can people be talked into a sexual orientation that is not their own.

3. **MSM are mentally ill, but they can be cured.**

   FALSE. Being MSM is not a mental illness. In the past, psychiatrists tried to show that men wanting to have sex with other men was a mental illness, but they failed. Starting in 1973, the medical profession no longer treated being gay as an illness. However, some parents still wrongly send their sons who are gay to clinics or psychologists to be "cured." If being MSM was accepted by everyone, no one would feel the need to "cure" it.

4. **Sex between two men is against religion.**

   TRUE/FALSE. Religions have different views and interpretations of men having sex with men. Islam and some Christian churches consider men having sex with men to be a sin. Some religions consider it a weakness that can be cured, whereas others feel it is an acceptable and normal sexual orientation.

   In all religions there is a difference between texts and daily practice. Some people read the holy books literally and use these texts to condemn MSM. Others use the texts as a source of inspiration, but in daily life they accept MSM as human beings. Others emphasize that religious teachings mention compassion and tolerance of other people. There are many MSM who find ways to keep their faith and be who they are. There are many religious people who are faithful to their religions and accepting of MSM.

5. **Sex between two men is a product of western influences.**

   FALSE. Historical research shows that homosexuality existed in Asia and Africa long before Europeans arrived in these regions. Research has shown that 5 to 10 percent of people in every community in the world are attracted to people of the same sex. Historically, men who have sex with men have existed in all countries of the world—it may have been secret, but they existed. Today it is relatively more open. It is estimated that there are MSM living in every community, but because of stigma and discrimination, the majority are in hiding.

6. **Sex between two men is motivated by love, sexual pleasure, and economic exchange.**

   TRUE. The same things that motivate sex between a man and a woman motivate men to have sex with other men. The reasons may include love and companionship, sexual pleasure, and as a way of earning money in exchange for sex.

7. **MSM are all the same. You can identify them by the way they dress and behave.**

   FALSE. As with all people, MSM are individuals who look and behave in different ways. Some MSM wear their hair longer and dress in a feminine way, whereas others may have short hair and dress and act like other men. In some cases, MSM are married and have families, or act one way in public and another way in private. Many MSM dress and act no differently from men who do not have sex with men. It is impossible to tell whether someone is a man who has sex with men just by the way they look and behave.

8. **In many countries it is illegal for men to have sex with men.**

   TRUE. In many countries the penal code prohibits men from having sex with other men.

9. **MSM have an increased risk of getting HIV and other STIs because of the common practice of unprotected anal intercourse.**

   TRUE. At least 5 to 10 percent of all HIV infections worldwide are due to anal intercourse between men. Unprotected anal intercourse carries a higher risk for contracting STIs, including HIV, than vaginal intercourse. This is because the rectum tears very easily, leaving openings for HIV to be transmitted. Anal sex also requires a lot of lubrication and a condom to be practiced safely. Water-based lubricant, which is safe to use with condoms, is often not accessible. Oil-based lubricant, e.g., Vaseline, will cause the condom to deteriorate and break. MSM can reduce the risk of contracting HIV by practicing safe sex.

10. **MSM engage in the same sexual practices as other couples.**

    TRUE. MSM use many of the same sexual practices as heterosexual couples, including kissing, masturbation, touching, anal sex, and oral sex. These activities are not restricted to sex between a man and a woman or sex between two men but are commonly practiced by both groups. Some of us, for example, assume that all MSM practice anal sex, but in fact, many do not. Many heterosexual couples also practice anal sex.

11. **MSM do not want long-term partners; they are only interested in casual sex.**

    FALSE. Many people think that MSM are only interested in sex and that their relationships are shallow, only based on physical attraction rather than love. But in fact, MSM are equally capable of deep, long-term, loving relationships, as non-MSM are with women. Some MSM may have lots of sexual partners, and some MSM have only a single partner and a permanent relationship.

12. **Men who have sex with men may also have sex with women.**

    TRUE. Some MSM enjoy sex with both men and women. Other MSM may prefer sex with other men, but have sex with women to hide their MSM status. In many cases, MSM are married and have sex with their wives in addition to having sex with other men.

13. **Safe sex for MSM is different from safe sex between a man and a woman.**

    FALSE. The concept of safe sex for MSM is no different than the concept of safe sex for sex between a man and a woman. In both cases, the aim is to prevent the exchange of bodily fluids and blood through use of barrier methods, such as condoms, dental dams, etc.

    It is recommended that strong condoms and water-soluble lubricant be used for anal sex to prevent condoms from breaking. (The same technologies are recommended for heterosexuals having anal sex.) Condoms should also be used for oral sex practiced on a man.

14. **MSM are not at risk of getting HIV, so they do not have to practice safe sex.**

    FALSE. HIV or STIs can be transmitted from one man to another man or woman through unprotected oral, anal, or vaginal sex, so MSM should use protection.

15. **There is no stigma against MSM; they stigmatize themselves.**

    FALSE. Stigma towards MSM does exist in society and it may include discrimination in hiring practices, arbitrary harassment by police, or being excluded from family decisions and activities, among many other forms of stigma. The stigma and discrimination experienced by MSM may lead to self-stigma. Living in a society where MSM are often condemned, rejected, and isolated, MSM may internalize some of the negative attitudes from the community and develop feelings of shame about who they are. Self-stigma is induced by stigma that exists in the larger society.

Annex 4: Handout — Our Multiple Social Identities

- All of us have many social identities—nationality, race, class, ethnicity, biological sex, gender identity, gender expression, sexual orientation, age group, language, religion, education, type of work, marital status, having children/no children, family type, ability/ disability, or health status.
- Key populations are marginalized and stigmatized on the basis of some of these identities or characteristics. They are forced to live within a world dominated by identities which exclude them. As marginalised groups, they are expected to conform to those identities and when they don't, they become targets for stigma and discrimination.
- In thinking about key populations, we often limit ourselves to thinking about one of their characteristics, e.g., biological sex, sexual orientation, gender identity, use of drugs, occupation (in the case of sex workers), status as prisoners or migrants, disability, etc. In other words, we don't treat them as whole people, with a full set of identities. We treat them as having only one identity—their stigmatized identity.
- In focusing narrowly on this single identity, we stop dealing with key populations as human beings. We forget their humanity and get a feeling of power and superiority over them.
- So we need to change our ways of thinking about key populations as having a single identity and look at them as people with a full set of identities. They are our children, our brothers or sisters, our friends, workmates, church members, and community members, and not just men who have sex with men, or sex workers, or people who use drugs. We need to respect them by treating them like anyone else.
- There are also layers of stigma. People who experience HIV stigma may also be stigmatised on the basis of other stigmatized identities. For example, a woman could be stigmatised as a woman, a sex worker, a person who uses drugs, a person living with HIV, a woman without children, or as an HIV-positive woman who is pregnant. Each layer of stigma magnifies the level of stigma. This makes it even more difficult for stigmatized people to access health and other services and to get out of their hidden, marginalised existence.

Annex 5: Handout — Frequently Asked Questions About Diversity

How do two men have sex?

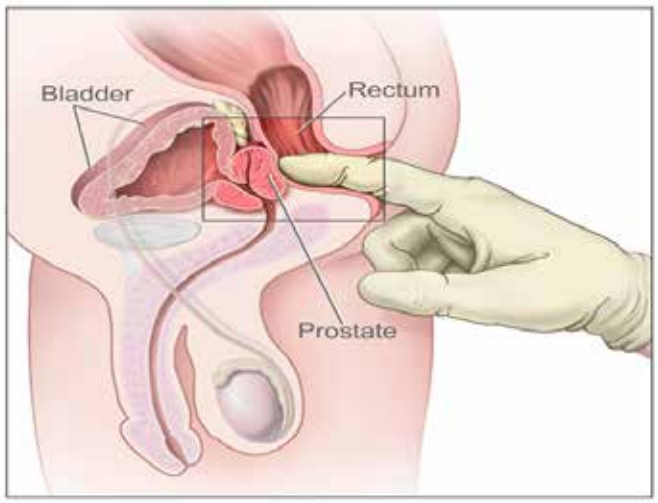
People have sex for a variety of reasons, including love, pleasure, stress relief, showing affection, and deepening a bond. Many think of vaginal penetration by a penis when they hear the word "sex," but there are more activities that constitute sex. MSM engage in many of the same sexual practices as heterosexual people, which could include oral sex, kissing, touching, rubbing, foreplay, anal sex, mutual masturbation, etc.

How do two women have sex?

See answer to the previous question. Two women may have sex in the same variety of ways as any other two people. If penetration of the vagina or anus is desired, a finger or dildo might be used.

Does anal sex hurt?

No, with practice. The anus and rectum are not designed for penetration, so it can be uncomfortable at first and take some getting used to. The sphincter is a muscle that wraps around the anus; like any other muscle, it needs to be trained to do something new. A lot of water-based or silicone-based lubricant is highly recommended. Once the receptive partner is able to relax and be comfortable with the experience, it can be pleasurable for both people. For men in particular, the prostate, a gland located next to the rectal wall just a few centimeters inside the anus, is an erogenous zone. Penetration by another's penis, finger, or object is the best way to reach it. Once penetration becomes familiar to the body, it is a completely healthy and enjoyable experience. If anal sex hurts, relax and be patient with yourself and your partner.



What does it mean to be gay?

Men who call themselves gay are physically, emotionally, and sexually attracted to and fall in love with other men. Women who call themselves gay or lesbian are physically, emotionally, and sexually attracted to and fall in love with other women. Their sexual feelings towards people of the same sex are normal and natural for them. These feelings usually emerge when they are teenagers and continue into and throughout adulthood.

How do I know if I'm gay?

Our sexual identities develop over time. You may not know what to call your sexual feelings. You don't have to decide how to label yourself right now. Most adolescent boys, for example, feel intensely sexual during the years around puberty, usually between 11 and 15, when their bodies start changing and their hormones begin flowing in new ways. Your sexual feelings may be so strong that they are not directed towards particular persons or situations but seem to emerge without cause. As

you get older, you will learn more about who you are and to whom you're attracted, which is uniquely different for all of us.

What causes homosexuality?

Perhaps a better question is "What determines sexual orientation?" The factors that determine sexual orientation are complex. There is a growing understanding that human beings have a basic sexuality that is expressed in relationships that are homosexual, bisexual, or heterosexual. The distinctions between these categories are fluid and may overlap. Although the causes are not known, some researchers believe that one's basic sexual orientation is predisposed at birth.

Is homosexuality healthy?

Studies have shown that people's sexual orientation has no bearing on their mental or physical health and emotional stability. Mental health professionals agree that homosexuality is not a choice, and is not a mental disorder that needs to be treated. The thing that does have an unhealthy affect on lesbian, gay, bisexual, transgender, and intersex (LGBTI) people is when their loved ones or society try to change or demonize them.

Isn't homosexuality immoral?

Anthropologists report that lesbians and gay men have been part of every culture throughout history. In some cultures, homosexuality has even been praised and celebrated. Many cultures and religions have demonized homosexuality at times when populations were thinning and procreation was encouraged, or at times when being different from the norm was seen as something detrimental to the community. Today these ideas are seen as both absurd and also highly damaging to the healthy growth of any society or community. The absolutely only thing that makes same-sex relationships different from heterosexual ones is the gender of the two people in the relationship.

Is being gay or lesbian normal?

Yes. It's perfectly natural for people to be attracted to members of their own sex. Lesbians and gay men are represented in every socioeconomic class, educational level, and race. People of any sexual orientation can participate in family life and even raise children.

Scientific experts agree that a person's sexual orientation is determined at a very young age, maybe even at birth, and is not a choice. It's normal and healthy to be yourself, whether you're gay or straight. What's really important is that we learn to like ourselves and accept each other's differences.

Isn't being lesbian or gay against religion?

A common myth about LGBTI equality is that it is universally opposed by people of faith. Leading Christian denominations are home to passionate debate about LGBTI issues and equality. Some people interpret religious texts in a way that limits the purpose of sex to having children (procreation). This kind of interpretation limits the ongoing value of physical intimacy for everyone and condemns people who do not or cannot have children as much as it condemns LGBTI people. Most religious books mention compassion as the most important state of mind.

Many religious people have made the decision to accept gay and lesbian people and to treat discrimination as irrational and hateful. The United Methodist Church, the Episcopal Church, the Presbyterian Church USA, and others continue

to openly debate issues of gay and lesbian inclusion, the blessing of same-sex unions, and the ordination of gay clergy, with growing support for full inclusion. Both Archbishop Desmond Tutu and the Dutch Reformed Church have publicly apologised for the persecution of lesbian and gay people by the Church in Southern Africa. For more information, visit www.welcomingresources.org

When do gay men and lesbians first know?

Because of strong societal pressures to be heterosexual, some people don't identify as gay, lesbian, or bisexual until later in life, perhaps even after they have been heterosexually married for years.

What is the difference between "sexual preference" and "sexual orientation"?

Preference implies choice, whereas orientation does not. Sexual orientation is a term used instead of sexual preference by most gay, lesbian, and bisexual people because it better represents their life experiences.

I don't believe in bisexuality. Don't they just need to pick a side?

Most bisexuals are absolutely certain that they are attracted to both sexes; there is no confusion. Many people identify as bisexual for their entire lives, which proves it is not just a phase. It is natural for people who are coming to terms with their sexuality to feel confused, but for many, bisexuality is a lifelong, committed sexual orientation.

For those who identify as bisexual for a short period of time, that does not make it any the less valid as a sexual orientation. Life is a continuous process, and few of us remain exactly the same over long periods of time. We are in a constant state of figuring out who we are.

Individual people are all unique and do not always fit into these comfortable little categories. Bisexual people engage in a wide variety of relationships, just like everyone else. They simply have more options.

How many gay men and lesbians are there?

While this number is difficult to measure, the Kinsey Institute suggested that approximately 10 percent of the population is lesbian or gay. Other research studies have suggested that anywhere between 2 percent and 10 percent of the human population has a sexual orientation that is not heterosexual. LGBTI people are found in many walks of life, among all racial groups, at all socioeconomic levels, and in every country around the world.

Do lesbians or gay men hate the opposite sex?

No. Lesbians are lesbians because they desire loving relationships with women, and gay men are gay because they desire loving relationships with men. Neither forms relationships because they hate the opposite sex.

Do lesbians and gay men want to be the opposite sex?

No. Within the LGBTI community, there are many people who have challenged and discarded stereotypical gender roles, but this does not mean they are trying to be the other sex. Being gay, lesbian, or bisexual involves celebration and affirmation of one's identity, not a rejection of it.

Aren't transgender people sick and in need of counseling?

A person's gender identity is not causing any harm to themselves or others. For a transgender person wanting to undergo a transition from their biological sex to their desired sex by taking hormones and/or an operation, counseling is highly recommended to guide them through the difficult transition process. Transgender people are healthy, productive members of society. They simply identify much more with the gender that does not match their biological sex and strive in many ways to cope with that cognitive dissonance.

It's important that the appearance of an individual's genital's, how that individual expresses oneself or who the individual is attracted to causes no harm to anyone. We just need to respect each other's identities.

Do gay men and lesbians have long-lasting relationships?

Longstanding relationships are common and both exist and break up for the same reasons that heterosexual relationships do. However, because of the social stigma expressed against lesbians and gay men, these partnerships are frequently invisible.. When same-sex marriages are not recognized, it sends a message to gay people that they aren't meant to have long-lasting relationships, and that simply isn't true.

Should LGBTI people be banned from certain jobs?

Sexual orientation and gender identity do not affect one's job qualifications or performance. Unfortunately, some people believe that LGBTI people should not be allowed to hold certain positions, such as teacher or health care provider. For example, they feel that LGBTI people are sexually irresponsible, less trustworthy than others, and bad role models, particularly with children. In fact, it is well documented that the overwhelming majority of those who molest or abuse children are heterosexual men. There is no correlation between homosexuality or gender identity and illegal activity or poor job performance. Anything stating otherwise is a homophobic myth.

How can a same-sex couple raise children when kids need both a mother and a father?

Studies from several different countries show that children of same-sex parents grow up no differently from people with opposite-sex parents. The same is true for single parents. Many children are not raised by a mother and father. Many are raised by adoptive parents, extended relatives, grandparents, single mothers, or single fathers. If children can be raised by people who will love and care for them, that's all that matters. Being raised by male or female "role models" makes no difference in a child's development. Good role models are important, and the gender of the person providing those role models is not.

Won't gay parents make their children gay?

Research has shown that children of lesbian or gay parents are no more likely to become gay or lesbian than children of heterosexual parents. Most LGBTI people have heterosexual parents, and that didn't make them straight. LGBTI people are just as likely to be good parents as anybody else. Of course, children growing up in non-traditional families may face a certain amount of societal prejudice. Fewer and fewer children are growing up in two-parent, heterosexual, nuclear families. LGBTI families are one of the many diverse families that exist.

Why do gay people have to flaunt their homosexuality?

Gay men and lesbians are often accused of "flaunting it" (wearing buttons, talking and writing about homosexuality, showing affection in public, etc.). Caribbean culture teaches that it is more acceptable to be silent or invisible ("in the closet"). Openness about LGBTI identity is labeled "blatant" or as "flaunting." However, "blatant" heterosexuality is rarely questioned. In society, the assumption of heterosexuality is so strong that unless one proclaims a gay identity, then heterosexuality is assumed. LGBTI people just want to be themselves, to be accepted for who they are, and to be treated fairly without fear.

Why do gay people want special rights?

LGBTI people want equal rights, not special rights. LGBTI people are not seeking anything special or different from the rest of the population. They want to be treated equally, just like everyone else. They want the right to safety, security, privacy, the right to work, the right to have an education, and the right to have consensual relationships.

Why should people be informed about LGBTI issues?

Becoming informed about lesbian, gay, bisexual, transgender and intersex issues helps reduce heterosexism, homophobia, and transphobia. This makes it easier for everyone to live more open and productive lives in their work and home communities. The culture as a whole is therefore enriched. For LGBTI youth, who are more likely to experience depression and rejection by friends and/or family, acceptance and understanding could be a matter of life or death. The risk of suicide in gay adolescents is two to three times greater than among their straight counterparts.

Why should I support LGBTI equality and acceptance?

You should support LGBTI rights because:

- Our LGBTI friends and family members deserve the same rights as everybody else.
- LGBTI people exist in every country, culture, and profession. LGBTI are our police, social workers, nurses, teachers, construction workers, shop clerks, janitors, and lawyers.
- LGBTI youth face constant harassment and abuse in schools due to being different in this way, and some commit suicide due to the lack of acceptance.
- Your loved ones need you to take a stand for fairness. By being open about yourself and your family, you are already helping to dispel misinformation and fear.
- The most productive society is one that treats all of its members equally, regardless of who they are. Freedom and equality are pillars of a flourishing and healthy community.

Annex 6: Handout — What is Sex? What is Gender?

- **Sex** describes the biological and physiological characteristics that define men and women. Men have a penis and testicles and produce sperm to make babies. Women have a vulva, vagina, and ovaries, and produce eggs to make babies.
- **Gender** refers to the socially constructed roles, behaviours, 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 bread-winner, and marry/have sex with women. Women are expected to be gentle, hard-working, and marry/have sex with men.
- **Sex** is physical, whereas **gender** is social or cultural, e.g., a woman can give birth to children but a man cannot (sex); women can raise children and so can men (gender). Sex is fixed or inborn, but gender can change, as it is socially constructed.
- Boys and girls are taught how they should behave to become ideal men and women according to the culture. From an early age, children are taught that boys and girls have **different roles** and should behave differently, e.g., girls work in the home, cooking, washing, and cleaning, and boys do physical work outside the house. Girls are discouraged from playing rough games like football, and boys are discouraged from playing with dolls or dressing in girls' clothes. Girls and boys are expected to respond differently to the same experience. For example, while it is acceptable for girls to cry, crying is seen as a weakness in boys.
- These different expectations of boys and girls, men and women, are expressed in slogans such as, "Act like a real man," "Boys should never cry," and "Girls should behave properly" (e.g., girls should never initiate sex or talk about sex).
- Sexual minorities who behave differently from these expectations are often stigmatised and harassed. For example, gay boys are often forced by their parents to change the way they dress or act, or the roles they play in the family—to become a "real man."
- Perceptions of gender roles strongly influence how society views sexual minorities. For example, gay men or men who have sex with men (MSM) have no biological differences (sex) from men who are not gay/MSM. However, they often challenge traditional perceptions of gender roles and stereotypes. They may refuse, for example, to get married or to conform to traditional stereotypes of what is considered to be masculine (e.g., not expressing emotion, not doing household tasks, etc.).
- Men who have sex with men also challenge heterosexual norms of sexual practice (penis-anus instead of penis-vagina), and because of this, they are also stigmatised.In some countries, sex between men is considered illegal and men found having sex with other men can be severely punished. [1]

1 Ottosson D. 2009. "State Sponsored Homophobia: A World Survey of Laws Prohibiting Same-Sex Activity Between Consenting Adults." Available at: https://studyabroad.ucsd.edu/_files/diversity-abroad/ilga-state-sponsored-homophobia2009.pdf. Accessed on March 4, 2016. The report points out that no less than 80 countries consider homosexuality illegal. In five of them—Iran, Mauritania, Saudi Arabia, Sudan, and Yeman, and in parts of Nigeria and Somalia—homosexual acts are punishable by death.

- Transgender people who do not accept the gender ascribed to them and/or consider themselves to be a member of the opposite gender are often severely stigmatised. In the eyes of other people, they do not behave appropriately to their gender characteristics and roles. Transwomen, for example, who have a man's body but do not consider themselves as men but rather as women, dress and behave like women and want people to treat and view them as women. Because their behaviours are seen as inappropriate and not masculine, they are often mocked, humiliated, and in some cases subjected to violence.
- Transgender persons in the past were categorized as MSM. However, transwomen (people whose biological sex is male, but whose gender identity is female) do not identify themselves as male and should not be included in this category.
- Growing up in the same society, sexual minorities have internalised the same set of gender roles and stereotypes—Be a real man, don't cry, etc. When sexual minorities are shamed by their families for not following these gender roles and expectations, it may make them feel abnormal, begin to stigmatise themselves, or become confused about their own identity and behaviour.

Annex 7: Handout–Value Clarification Questionnaire

Take a few minutes to sit on your own and read through the questions. Tick the box that describes your answer.

	Agree	Disagree	Not Sure
I think that using condoms spoil sex.			
I can understand why some people choose not to know their HIV status.			
If my partner was HIV positive I would keep it a secret.			
Men who have sex with men have the same rights as everyone else.			
I feel uncomfortable discussing sex with people I don't know.			
I can freely interact with sex workers.			
If I found out that my son or a male relative had slept with a man, it would negatively affect how I interact with him.			
I think it is important to have clear, fixed gender roles in a society.			
I think we should talk openly about sex to young people so that they can ask questions.			
I think young people should delay starting to have sex for as long as possible.			
Using or promoting HIV protection is against my religion.			
I know my HIV status.			
I am open about my HIV status.			
Gay couples have a right to access information about HIV.			

	Agree	Disagree	Not Sure
I think it is strange to see a man dressed as a woman.			
I think it is strange to see a woman dressed as a man.			
It is difficult for persons who subscribe to Christian principles to have open hearts and minds and to accept diversity.			
It is an employer's right to deny transgender people employment regardless of qualifications.			
Gay people are good parents too.			
Men should learn to control their sexual urges.			
Most sex workers sell sex because they are poor.			

Annex 8: Naming Stigma and Discrimination through Pictures (from Activity C, pg. 6)


Is this how we raised you? Why don't you act like a real man?


Sinners!

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