A Trainer's Manual for

Inclusion and Diversity in the Caribbean

KALEIDOSCOPE INTERNATIONAL TRUST

EQUALITY & JUSTICE ALLIANCE

ECADE

Equals

This work has been commissioned by the Equality and Justice Alliance and the Eastern Caribbean Alliance for Diversity.

Disclaimer

This work has been commissioned by Kaleidoscope Trust, a member of the Equality & Justice Alliance, but it has not been approved by nor does it necessarily represent the opinions of any other member of the Equality & Justice Alliance.

Equals Inc.

Equals is a non-profit civil society organisation located in Barbados that focuses on ensuring the LGBTQ+ community has access to services that they have rights to access as human beings. This includes providing some services themselves, as well as sensitising service providers to the LGBTQ+ community's needed, the barriers they face in accessing services and how stigma and discrimination affect these populations. Most of the work to date that Equals has done in sensitisation has focused on health care providers in the public settings but as more needs of the community have been identified over the years, Equals wanted to focus on sensitising other sectors such as the police and media.

About the Equality & Justice Alliance

The Equality & Justice Alliance is a consortium of international organisations with expertise in advancing equality, addressing the structural causes of discrimination and violence, and increasing protection to enable strong and fair societies for all Commonwealth citizens, regardless of gender, sex, sexual orientation, or gender identity and expression. The members of the Alliance are the Human Dignity Trust, Kaleidoscope Trust, Sisters for Change, and the Royal Commonwealth Society.
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About the Eastern Caribbean Alliance for Diversity and Equality (ECADE)

ECADE is an independent umbrella organisation working with LGBTQ human rights groups to strengthen institutional capacity and provide a platform to strategise and work towards equality with membership spanning twenty-two islands in the Eastern Caribbean.
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About the Kaleidoscope Trust

Established in 2011, Kaleidoscope Trust works to uphold the human rights of lesbian, gay, bisexual and transgender (LGBT+) people in countries around the world where they are discriminated against or marginalised due to their sexual orientation, gender identity and/or gender expression. Since 2013, our organisation has hosted the Secretariat of the Commonwealth Equality Network (TCEN), which provides a unique space for LGBT+ advocates to challenge inequality in the Commonwealth, including by advocating for better national and regional policies, laws, and priorities of Commonwealth governments. To date, TCEN consists of 56 member organisations from all five regions of the Commonwealth. Kaleidoscope Trust is also civil society Co-Chair of the Equal Rights Coalition, which works to advance the human rights of LGBT+ people and promote inclusive development of LGBT+ persons globally.
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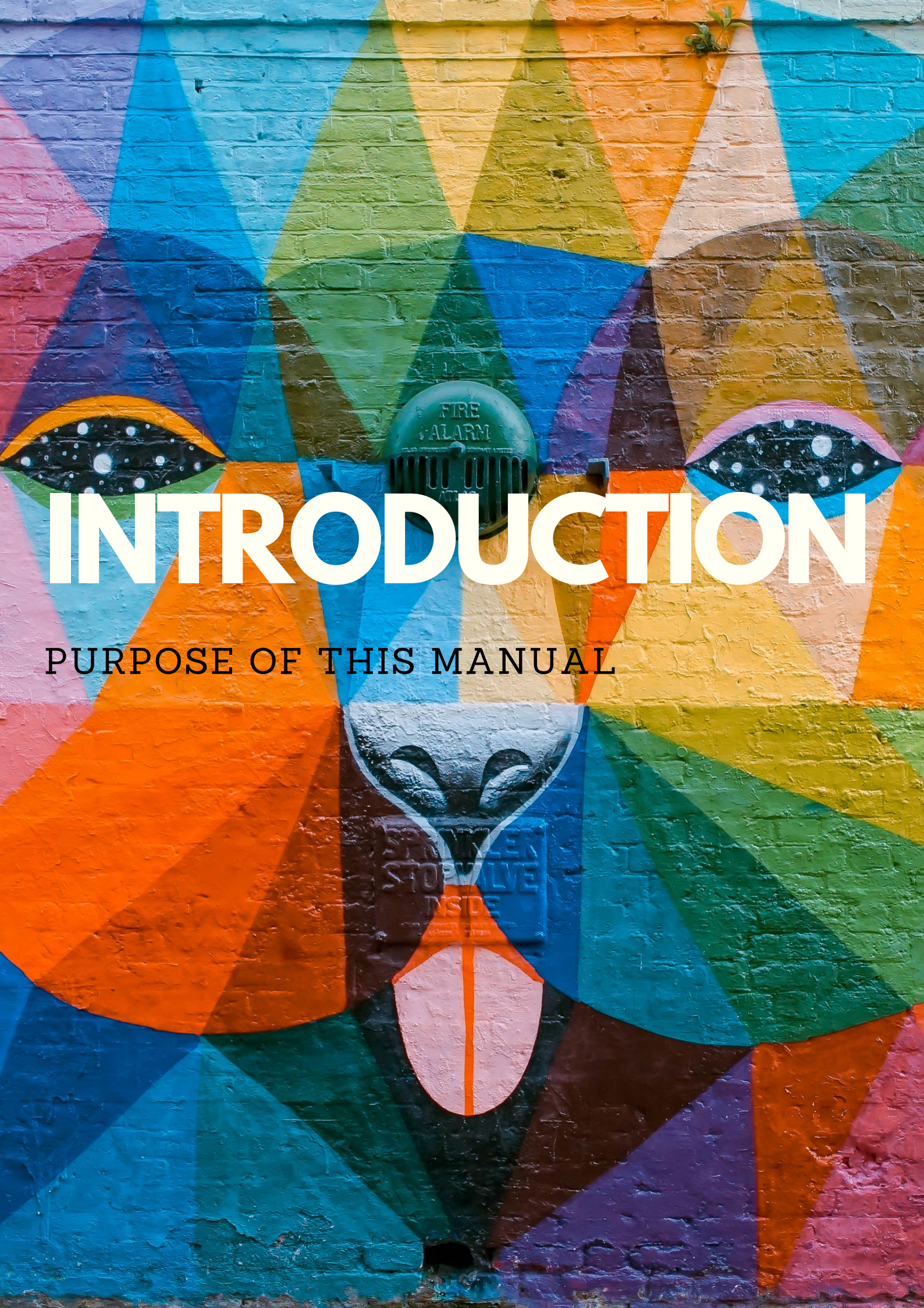
TABLE OF CONTENTS



INTRODUCTION

PURPOSE OF THIS MANUAL

OVERVIEW

This diversity training manual was designed as a tool for organisations working with lesbian, gay, bisexual, transgender, queer plus (LGBTQ+) persons, persons with disabilities (PWDs) and persons living with HIV (PLHIV) to educate and attempt to change beliefs and attitudes towards these communities by persons from the general population. This training manual is intended to be a flexible tool for facilitators to be able to design a training program not only based on the target audience and the sector that they are working with, but the length of time they have available to them when executing the program. The manual has also been designed so that modules and sections could be printed separately to cater for specialised trainings that only focus on specific populations.

This manual was commissioned under the Equality and Justice Alliance (EJA) through Eastern Caribbean Alliance for Diversity and Equality Inc. (ECADE) to help push the efforts to fight discrimination against marginalised groups. It is a tool that organisations throughout the region can use to battle stigma and discrimination and improve the standard of living of persons from these marginalised groups by sensitising healthcare providers, corporate employers, customer service institutions, educational institutions, media, law enforcement as well as the general public. There is also a module on creating code of conducts and policies within the institutions to reflect the impact made within the sensitisation trainings and protect the marginalised populations from further discrimination.

Many countries in the region are battling discriminatory laws for the marginalised groups that this training manual was developed for, and can be used as a tool in the efforts to address those laws. We hope that it can be used to address the many situations that marginalised groups face, such as being denied access to services (healthcare, social, and customer services), lack of employment or poor working conditions not being taken seriously or even being abused by the police force, suffering abuse and being kicked out of home, communities or even the church because of who they are, as well as improve the media's ability to report on matters relating to this community by educating them on language to use.

The activities in this manual have been pulled from a variety of tried and tested trainings from around the world, and those with the largest impact have been selected. Many of the activities are largely derived from ***USAID/PEPFAR's Facilitator's training guide for a stigma-free health facility: Training Menus, Facilitation Tips, and Participatory Training Modules***, and the developers of this manual extend their gratitude for this resource. Even though this manual has clearly defined activities and points that should be made, we encourage facilitators to modify the content, ex. language or scenarios, that best reflect the culture of the community as well as the realities that occur, as every country, island or providence may face different issues. We hope that you are able to utilise this tool as intended and wish you all the best in your advocacy endeavours.

SECTION 1

STRUCTURING YOUR TRAINING PROGRAM & FACILITATION TECHNIQUES

In this Section we will explain how to structure your programs based on your target audience, as well as explain how to prepare for the sessions, use ice breakers and energisers to re-engage your participants after a break, utilise facilitation techniques, control the participants, and evaluate the impact that the training program has had. This section is mainly adapted from Health Policy Project's Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide, which you can refer to for more in-depth information.

Knowing Your Audience

Knowing your audience is the first step in preparing your training program, as some of the activities are better suited than others depending on who you are training. At the end of each activity there will be a further explanation on how to cater the activity to your target audience, should there be a need. At the beginning of each module the activities will be listed with an indication on which audience the activity is best suited for. The different sectors (or audiences) that this training manual will cater these training activities to are listed below:


Healthcare


Mental health


Service Industry (e.g.sales or hospitality)


Corporate/Businesses


Educational Institutions


Law enforcement


Media (print, radio, televised)


General (can include religious institutions)

Arranging Times for the Program

In addition to choosing the modules that best suit the audience you are preparing the training program for, you also need to consider the timeframe that you are working with. Sometimes you will only get a few hours of the participant's time, for example 3 hours in the evening after work, or you will be able to get a few full days of the participant's time. You will have to work with the organisation you are preparing the program for to determine how it will be structured, e.g. during a single time period (one to four days, depending on the time available) or spread out over several weeks. This will depend on the availability of participants and what schedules can be agreed on by the Human Resource (HR) departments.

One day has been determined is too short to cover the key topics, bring about a real change in attitudes and behaviour, and have enough time to agree on a Code of Conduct for creating a stigma-free organisation. It is recommended that the basic course on stigma for medical and nonmedical health workers be at least two days long. It is recommended that the activities be roughly one hour in length each to ensure the participants get the most out of the activity, but the time for doing each activity may vary, depending on factors such as the number of participants, number of groups small groups or time available. Be aware that taking too long for one activity will affect the amount of time you have for other activities. Given tight timeframes, you may need to condense some of the activities or place greater or lesser emphasis others, depending on your observation of the needs of the participants. Feel free to make the necessary adjustments to save time.

Differences within your Audience

There will be different levels of understanding or acceptance of the communities you are sensitising your participants about. There may also be different cadres or levels of authority available for the training, such as within the medical sector with doctors vs frontline staff, or corporate entities with managers vs frontline workers. While a mixed approach could help to build better relations among participants, it requires good facilitation skills to make sure that the more educated or powerful groups (e.g.doctors or supervisors) do not dominate, and that other staff members develop the courage to talk. A good technique would be to start off with activities that get everyone talking and interacting as peers—to help nurses and auxiliary staff talk as equals with doctors, or frontline workers talk as equals with managers.

In some settings, the integration of different cadres and levels of staff within the training may be regarded as too radical a step. In such cases, an alternative might be to run the training for single groups (e.g., all of the doctors in one session) and then run an additional session near the end of the process, bringing all of the groups together, perhaps in developing the Code of Conduct. It would be best to investigate with the entity you are providing the program for, for example the HR department, to determine the best approach. Regardless of the approach, all members of staff of all levels should take part in the program to ensure the maximum impact of the program to the institution and individuals.In planning your program, you should assume that some participants or trainers may be PLHIV, a PWD (as some disabilities can be invisible such as chronic pain or mental health illnesses),or LGBTQ+.

Participants may or may not have disclosed this information to other participants or choose to share it during the training. For this reason, it is important to treat everyone the same and not make assumptions about individuals. Using the phrase “we” (rather than “us” and “them”) when talking about stigmatized groups is one way to avoid further stigmatizing people when conducting the training.

- Markers
- Name tags (or paper and safety pins)
- Attendance sheets
- Pens (for filling out evaluation forms)
- Masking tape (to hang up flipchart paper on the wall)
- Card
- Printouts for Activities (you can break this down further by activity)
- Handouts (for participants to keep)
- Evaluation forms (pre/post-test, daily evaluations)

***Note:** A flipchart easel may help but is not necessary. However, you do need to be able to hang up the flipchart paper. This is usually done on the walls of the facilitation room. If the walls arenot usable, you may need to get an easel, but if there is concern about marking the wall by the markers being pressed on the flipchart paper, you can double up the flipchart paper to prevent leaking.

Once you have made these preparations, you are almost ready. The last bit of preparations comes on the day. Depending on the location, the facility will either be able to set out the room for you, or you may have set it out yourself. For this program, as it is interactive, either remove all the tables from the room, keeping one or two for your materials for the activities, or you can put them one side around the room, using them for participant to press on, or to place the refreshments on (such and coffee/tea/break). Afterwards, set all the chairs in a semi-circle or circle, and finally, arrange the materials necessary for the activities (e.g. put up the flipchart papers, images, or cards for activities).

FACILITATING ACTIVITIES

Within the activities you will be guided on how to facilitate each one and the ways to probe for the answers you want as well as describe the intended outcomes of the activity. However, in the section we will go through general facilitation methods and techniques that will be applicable for all activities.

Give Clear Instructions

- Preface exercises by telling participants what the exercise is called and what it involves.
- Explain the steps one at a time and have participants do the steps as you explain them, ex. “Divide into pairs” – and have them do it. Then explain the next step, and have them do that. Stating the steps without having them do it can be confusing and wastes time.
- Give simple and clear instructions and use examples to help with understanding.
- If you get blank looks, double check that persons understand by asking them what it is they were supposed to be doing.
- Write instructions or questions on a flipchart using the same words you used when explaining or questioning.
- After group formation, check that each group understands their task(s) and ask them to explain it to you.

Divide into Groups Quickly and Efficiently

- The aim of groups is to mix participants up, so they work with different people. Keep changing group members for each exercise.
- You can select groups randomly or use an energizer if you need to get people moving. Some suggestions are below in the section "Energisers and When to Use Them."
- In deciding on the group size, think about the following:
  - **Large groups (e.g., 5–9)**—less participation, but the report back takes less time.
  - **Small groups (e.g., 2–4)**—more participation, but more groups to report, so it takes longer.
- Some group work can be done in pairs so everyone gets a chance to talk.

Organise Report Backs

Reports are necessary after group work is completed. There are several ways to do this which may be dictated by time constraints.

- **Round robin reporting:** Each group presents one new point at a time, until points are exhausted. This means each group contributes and avoids repetition.
- **One group—one topic:** Each group reports on different topic or question.
- **Only one question:** Groups report on only one of the questions discussed—the key question.
- **Creative report:** Groups give their report in the form of a picture or role play.
- **Report back in paired groups:** Two small groups meet and share so they can have more intensive discussions.

Record Discussions on Flipchart

One facilitator should take notes on the flipchart, helping to record discussions, highlighting gaps, and stimulating new ideas and the basis for discussion. When recording:

- Write only **the main points or key words**, not everything said.
- Use **participants' own words** so they recognise their contributions.
- Write **big and clear** (ideally capital letters) so everyone can see.
- Use **different colours**.

Give Effective Summaries

After participants have completed discussions, you should briefly summarize what was said to be learnt. This summary is essential as it allows participants to consolidate what they have learnt, so ensure there's time to do this.

Manage Energy

Check on energy levels regularly, and respond if they are low.

- Observe body language: Yawning? Looking bored? Tired?
- Ask—"How are you feeling? Is it time for an energiser or a break?"
- When participants are tired do any activity that requires more participation (e.g., break into pairs or do an activity standing up), do an energiser, or take a break.

- Use your own energy as a facilitator—communicated through a strong voice and active body language—to energise the group.

Manage Space

Change the space the training is being held in to suit activities and provide variety:

- Start off with a circle or semi-circle so that everyone can see each other.
- For some activities, e.g., report backs, use a formation with participants sitting in rows close together—this adds energy and helps everyone hear better.
- Periodically switch up the front of the room to suit the activity and do some activities outside if possible.

Manage Time

- With short trainings, it's not possible to go in-depth with all issues, so manage time carefully or the overall objective will be lost.
- We have provided guides for how long a session should take; try to work within these limits. Don't allow sessions to drag on too long! Tell participants in up front how long a session is expected to be and explain if you decide to subsequently change its length.
- In establishing the ground rules, get the group to take co-responsibility for time management and the successful meeting of training aims.
- Small group work takes more time than you may expect, so remember to factor in times for report backs. Don't rush small groups.
- Do small group work in the afternoon, when the energy levels drop.
- Don't go too fast. Let the group help you set an appropriate pace.
- Close on time! Don't drag things on at the end of the day.

FACILITATING DISCUSSION

In the section, we are going to go through some techniques to help you enable the discussion and be a great facilitator.

Open Questions and Probing

- Ask effective questions. Ask participants what they have heard about the area in discussion or if they have witnessed or experienced anything themselves, ex. discrimination faced by minority groups, or barriers to access that persons with disabilities may face.
- Use open questions. This will encourage different opinions and help get all participants talking and contributing.
- Probing is asking a few more questions to encourage participants to give more information, find out the views of others, or brainstorm solutions (Ex. Can you expand on that? What do you think was the effect of that?)

Active Listening

- After asking each question, listen carefully to the response with your full concentration.
- If you listen actively, participants will know they are being heard and understood, encouraging future sharing.

- Active listening involves
  - Eye contact – Looking at the person shows interest and understanding
  - Encouraging - Signals to the other person that you are listening, ex. nodding your head, saying "Yes. Okay. I see. That's Interesting. Tell me more."
  - Rephrasing to check that you have understood what the person is saying

Rephrasing

- Rephrasing is summarising what someone has said, in your own words. You could start with: "What I heard you say is that you want to..."
- The aim is to show you value what was said, help clarify and help others to add their own input.
- Rephrasing also helps to ensure that you and the group have correctly heard what was said and helps the recorder summarize.

Encouraging Participation

In some trainings, some participants dominate the activities. Try to get others involved and the talkers to talk less.

- Use the ground rules as the basis for encouraging everyone to contribute.
- Thank the big talker(s) for their contribution and say "We would like to hear from everyone"
- Specifically question silent persons and praise their responses. This will encourage them to talk.
- Divide into pairs to get everyone talking.
- Go around the circle, getting one point from each person.

Hold a Daily Review and Planning Meeting

- Hold a meeting of the facilitators at the end of each day to review the day's activities and plan for the next day.
- Start off with a quick go-around to get each person's views about the day. Then go through each of the activities and participants' evaluation forms, and ask for comments.
- This can help you tweak your facilitation techniques or help you to know which areas to focus your efforts on in the following sessions.

Handling Sensitive Issues

You have to be prepared to manage sensitive issues, e.g. talking about sex.

- Try to figure out, based on chosen activities, what the potentially sensitive areas will be, so you can work out strategies to bring them out and handle them.
- Start with yourself. Prepare yourself for discussing issues comfortably.
- Build an open atmosphere in which participants feel comfortable talking about these issues. The body mapping exercise helps to get people talking about body parts and sex.
- Challenge stereotypes and general statements, but at the same time allow people to use words they feel comfortable with, even if they are not politically correct. The aim is to get people to talk openly, rather than shutting them up.

- Usually participants will have more questions than you can answer. Be prepared for this and don't be afraid to admit you don't know the answer; offer to find out the answer or refer to sources of information.

Managing Conflict

Participants may disagree, leading to conflict. This can be explosive, or you can turn it into an advantage – using the passion around the issue(s) to understand them better. As a facilitator you want to 'stop the fighting' and get participants to explore the issues.

- Restate the ground rules to create the right spirit.
- Ask the speakers to state their concerns and their reasons so everyone fully understands and avoids making assumptions.
- Ask everyone to listen to the speakers, and rephrase what each has said to make **s**ure everyone has heard the views clearly.
- Help participants identify common ground, things they agree on, and points of difference that need further discussion. Or just agree to disagree.

Some participants may hold negative attitudes about marginalised populations, so it is important that facilitators can handle these sensitively so that the beliefs are challenged but participants do not get upset or defensive. Facilitators also need to be able to challenge the (hopefully rare) situation where anyone participating or facilitating the training, is harassed or insulted. Ensure that facilitators who are members of marginalised communities do not feel that they are being interrogated or personally attacked in the process of answering the group's queries.

Tips on handling harsh or negative responses to issues or opinions raised

- Don't silence them. This will only re-confirm prejudice. Let them come out.
- Even the best exercises are unlikely to completely change people's attitudes in a short period. However, you can offer alternative perspectives about these issues that will encourage people to think and question their own attitudes. You are only here to share knowledge, not purposely change beliefs. Let them know that it is up to them how they use the knowledge gained from this program.
- Don't let discussions get out of hand. Allow people to speak their minds, but do not allow them to reinforce themselves and each other negatively.
- Keep participants focused on every person's right to be treated with respect.

BEGINNING THE PROGRAM: INTRODUCTIONS AND GROUND RULES

As participants arrive, have them sign in, write their names on their name tags, and complete the pre-test evaluation forms. When you are beginning the session there are a few things you should be mindful of to lay the foundation of the program. Introduce yourself and where you are from, if you are representing an organisation, and what the organisation does. Participants do like to know what work is being done for the communities that they are learning about.You can then go around the room and have the participants introduce themselves and where they are from or what department they are from.

You can add other things for them to say about themselves. It could just be stating an interesting fact about them, or have them chose an adjective that begins with the same letter as their first name and why they chose it, or you can play the "2 truths and a lie" game, where everyone comes up with 3 facts about themselves and the group has to guess which one is they lie. Afterwards, have them come up with some hopes and fears about the training program. Hopes include what they wish to get out of the program, and fears being and concerns they may have coming into the training. Afterwards, assure them that their hopes and fears/concerns will be addressed during the program. If they have any that you know will not be covered in the program you develop, you can try and assist them to where they can get more information.

Ground Rules

To start participants interacting with each other it is a good idea to let them come up with the ground rules themselves, with a little probing if necessary. You can ask for volunteers to make suggestions, or go around the group and have each person come up with a different rule each. Below are some examples of group rules for you to assist if necessary:

- We respect one another's ideas.
- We treat one another in a positive way and are considerate of one another's feelings.
- "What happens in de party, stays in de party!" We keep personal matters confidential.
- We do not interrupt one another.
- We do not put down or criticise each other.
- Put cell phones on silent.
- Be open to learning.
- We have a right to pass if we do not want to answer a question.
- We can choose not to do an activity if we are uncomfortable with it.

Energisers and When to Use Them

There are many energisers one can use to loosen up your participants and re-engage them. We are going to list some suggestions that can be used to tie into the activities in the program, such as re-enforcing what has been learnt, or pairing them up for the next exercise that may involve working in pairs or groups. In the description for each activity, we will suggest which energises could be useful to the exercise.

1: Fruit Salad

Source: "100 Ways to Energise groups: Games to use in workshops"

Normally for this energiser, a set of fruit are chosen (depending on the group size, or in our case, depending on how many groups you wish to separate the participants into) and participants are given a name of a fruit. You will go around the group giving persons different names of fruits, starting over when you have ended your list (for example; Apple, Banana, Kiwi, Grape, Apple Banana.... etc). Ask for a volunteer to start the activity.

This person stands in the middle and calls a fruit. All those with the name of the fruit

must get up and swap chair with each other, and the person in the middle must also find a chair. There will be a person without a chair and they have to stand in the middle and call another fruit. All those with the name of the fruit must get up and swap chair with each other, and the person in the middle must also find a chair. There will be a person without a chair and they have to stand in the middle and call another fruit. Additionally, they can shout out "Fruit Salad" and everyone must swap chairs. Do this a couple times to loosen up the group. Alternatively, to names of fruit, you can use names of the diverse groups you are discussing during the program, such as; gay, lesbian, bisexual, MSM, PLHIV, Deaf, wheel chair user etc. In addition, you can replace "Fruit Salad" with "Revolution".

2. Who Am I

Source: "100 Ways to Energise groups: Games to use in workshops"

Write names of famous persons on pieces of paper, which are stuck on the foreheads of the participants. They much then go around and ask questions to other participants about who their character might be (e.g. Am I a Singer? Am I a man?). These questions cannot be open ended questions and can only be answered by the other person with Yes or No. They can only ask one other participant one question. The participant guessing who their character is can guess at any time, and the other participant can confirm their guess.

You can tie this energiser into the program in two ways. One way is to choose famous persons who have identified themselves are part of the diversity groups being discussed. The other way is to choose labels instead of names of persons. If you chose the second method, you will have to restrict your questions, or let them know about specific questions they can ask. (E.g. for someone who is Blind; Am I a sexual Minority? No. Do I have a disability? Yes. Is it a physical disability? Yes. Does my disability have to do with my ears? No. Does my disability have to do with my eyes? Yes.)

3. Sit Down Targeted Game

Source: "Reproductive Justice in the Americas- Stand Up/Sit Down Game"

https://mas365.class.arizona.edu/sites/mas365.class.arizona.edu/file/Present%20Day%20Sexualities%20-%20Stand%20up%20Sit%20down%20game.pdf

This is a very quick game just to get participants up on their feet briefly. Ask everyone to stand. When a statement is read that refers to them, ask them to sit and remain seated for the rest of the activity. Ask them to be honest. All items do not have to be read or read in this order. You can pick and choose statements to read based on the type of audience you are speaking to.

- You are a man and sit with your legs crossed.
- You are a woman and you play sports aggressively.
- You are a man and you wear jewellery (rings, bracelets, necklaces, anklets...)
- You are a man and you have your ears pierced.
- You identify as a feminist.
- You are a woman and you do not shave your legs or under your arms.
- You are a man and you enjoy musicals.

- You are a woman and you are not wearing any makeup today.
- You are a man and you do not play sports.
- You are a woman with short hair (chin length or shorter).
- You are a man with long hair (chin length or longer).
- You have not dated anyone of the opposite sex in the past six months.
- You are friends with someone who is LGBT.
- You have a family member who is LGBT.
- You are a man and you have been told that you are sensitive.
- You are a woman with a low voice.
- Majority of your friends are the same gender as you.
- You are a romantic man.
- You are a man and you polish your toenails or fingernails.
- You are a man and you have received professional massages.
- You verbally support LGBT issues.
- You are a woman and you shop in the men's section in stores.
- You are a man and you colour your hair.
- You are a man and you have often been complemented on your sense of style.
- You are a man and enjoy female music groups.
- You have another visible part of your body pierced besides your ears.
- You are a man and you have spoken out against sexist jokes and comments.

Everyone who is now sitting down could be a target for LGBTQ+ hate crimes. All the statements we have read off were actual items perpetrators used to target LGBT people. This exercise shows that hate crimes do not have rationales behind them. The reasons people have given to discriminate against the LGBTQ+ population are often very arbitrary. For those of you still standing, we have only named a few things people have given to target the LGBTQ+ population. It is possible that you may be sitting down if we read additional statements. It is also possible that you have recognized these as reasons people target the LGBTQ+ population and have either intentionally or unintentionally avoided behaving according to these statements. This is just some food for thought for you to consider.

4. Find Your Pair
Source: "100 Ways to Energise groups: Games to use in workshops"
This is a good exercise to pair up participants and can be carried out in one of two ways. The first way is a simple paring up game where you write the random words on pairs of paper, and the participants have to find the other person with the same word (in this case could be key words). Alternatively, you can write a terminology on one paper, and the definition on another. This is a great exercise for refreshing participants' memory on definitions, and get them interacting with each other.

A great source for additional energisers can be found in the International HIV/AIDS Alliance's "100 Ways to Energise groups: Games to use in workshops"
https://www.ndi.org/sites/default/files/Energisers.pdf

EVALUATION

Evaluation of the training is a necessary step and should be carried out regardless of

duration or number of participants. The main benefits of evaluation are:

- Improving future trainings for maximal impact. A training may be the only chance to influence the knowledge, attitudes and skills of participants, so they should be strengthened as much as possible.
- Showing that the objectives of the training were accomplished and its individual impact.

There are various levels of evaluation that could be used: for basic trainings, we recommend evaluating, at the very least, the participants' reaction (to the training) and their learning.

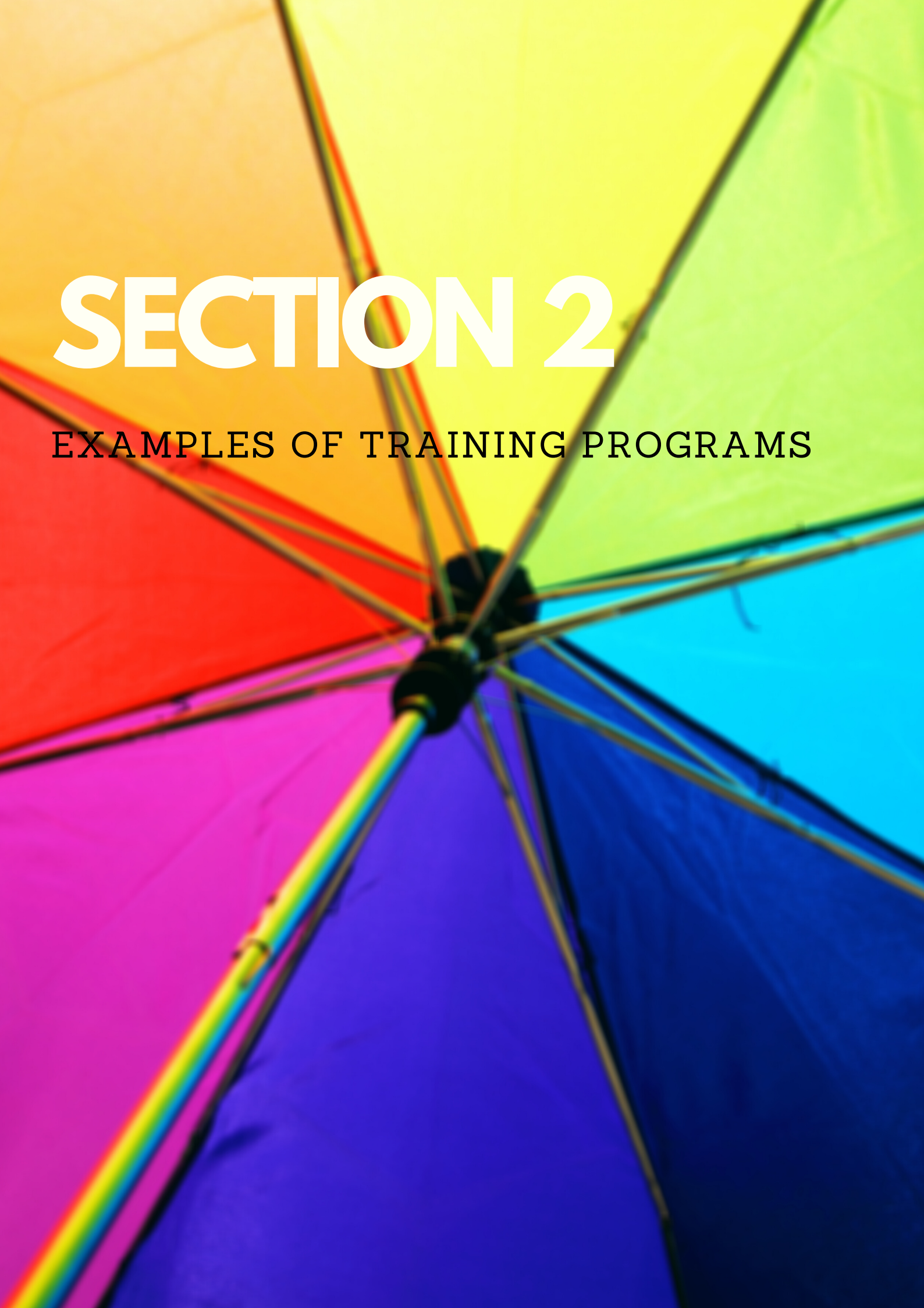
Evaluation of Reaction
This involves a simple post training survey for participants. A combination of closed and open-ended questions can be used. Please see **appendix A** for an example of a post training survey. This evaluation is handed out at the end of each day, but a modified survey can be used on the last day of the program to ask additional questions about the training on a whole.

Evaluation of Learning
This measures knowledge gained by looking at what the knowledge, attitudes or skills were before (pre) training and compares it to after (post) training. By conducting this pre- and post-evaluation within such a short time period, it can be safely assumed that any significant changes that are observed are a result of the diversity training itself. Please see **appendix B** for an example of pre and post-test.

Evaluation of Behaviour
Even though participants may say they enjoyed the training or show they have gained knowledge or changed attitudes, will they actually apply what they learnt when encountering a person from a marginalized population? Evaluating this change in behaviour needs buy-in from the participants' organizations, as these organizations will be required to evaluate clients/ customers / staff/ etc. on long-term behaviour change. To get the best responses from marginalised persons, it is best that they complete a survey anonymously, and possibly online.

This type of evaluation is also good at keeping organizations accountable, especially if they devised or implemented a code of conduct. You can review the evaluations after 1 month, then 3 months, and finally 6 months. You can also review it after a year as well. You can perform a 6-month evaluation and tie it into some of the more advanced activities, either congratulating them on the positive responses, or highlighting the areas that need improvement based on the surveys. This will also help you as a facilitator, understand how to design your advanced program. These surveys can be very short (3 – 5 minutes) and an example can be found in **appendix C**.

Source: Cultural Competency Coordination. 2017. Best Practices in Creating and Developing LGBTQ Cultural Competency Trainings For Health and Social Service Agencies. Available from: **https://cancer-network.org/wp-content/uploads/2017/02/best_practices.pdf**



SECTION 2

EXAMPLES OF TRAINING PROGRAMS

This section will give examples of training programs that you can use as guidance when structuring your program. These are just suggestions and do not have to be followed exactly. Remember while facilitating or going through an energiser to help get participants interacting, to pair them up in a fun way or to get them thinking further. Remember that within each activity, there are guidelines on how to further cater the program to your audience. At the end of this section we offer an example of how to budget for your training. Local costs will vary, so adjust accordingly.

Basic introduction of Stigma and Discrimination and Marginalised groups

This is an example of 2 half day (4 Hours) introductory session to identifying stigma and discrimination and understanding the marginalised groups. Day 1 Focuses on Modules 1 and 2 and Day 2 focuses on Modules 3 - 5.

DAY 1

ACTIVITY	TITLE	TIME
	Introductions & Ground Rules	15 Minutes
IA	What is the meaning of 'Stigma' and 'Discrimination'?	30 Minutes
1B	Naming Stigma and Discrimination through Pictures	45 Minutes
	BREAK	15 Minutes
1E	Our Own Experience of Being Stigmatised (Reflection Exercise)	30 Minutes
1F	Forms, Effects, & Causes of Stigma	30 Minutes
2C	The Power Flower	30 Minutes
2G	Challenge the Stigma in your organization	45 Minutes
	EVAULATION	10 Minutes

DAY 2

ACTIVITY	TITLE	TIME
	Review evaluations and recap of Day 1	15 Minutes
3B II 3B III	The LGBTQ+ Umbrella The Gender and Sexuality Continuum (parts 1&2)	20 Minutes 60 Minutes
	BREAK	15 Minutes
4A	Exploring Beliefs and Attitudes About People Living with HIV and other key populations	45 Minutes
5A I	BasicConcepts and Issues: Brainstorming	40 Minutes
5C	Barriers for Persons Living With Disabilities	40 Minutes
	SUMMARISE & EVALUATIONS	15 Minutes

Basic introduction to Stigma and Discrimination towards LGBTQ+ Populations

This is an example of 2 half day (4 Hours) introductory session to identifying stigma and discrimination and understanding LGBTQ+ Populations. Day 1 Focuses on Modules 1 and 2 and Day 2 focuses on Module 3.

DAY 1

ACTIVITY	TITLE	TIME
	Introductions & Ground Rules	15 Minutes
IA	What is the meaning of 'Stigma' and 'Discrimination'?	30 Minutes
1B	Naming Stigma and Discrimination through Pictures	45 Minutes
	BREAK	15 Minutes
1E	Our Own Experience of Being Stigmatised (Reflection Exercise)	30 Minutes
1F	Forms, Effects, & Causes of Stigma	30 Minutes
2C	The Power Flower	30 Minutes
2G	Challenge the Stigma in your organization	45 Minutes
	EVAULATION	10 Minutes

DAY 1

ACTIVITY	TITLE	TIME
	Introductions & Ground Rules	15 Minutes
IA	What is the meaning of 'Stigma' and 'Discrimination'?	30 Minutes
1B	Naming Stigma and Discrimination through Pictures	45 Minutes
	BREAK	15 Minutes
1E	Our Own Experience of Being Stigmatised (Reflection Exercise)	30 Minutes
1F	Forms, Effects, & Causes of Stigma	30 Minutes
2C	The Power Flower	30 Minutes
2G	Challenge the Stigma in your organization	45 Minutes
	EVAULATION	10 Minutes

DAY 2

ACTIVITY	TITLE	TIME
	Review evaluations and recap of Day 1	15 Minutes
3B II 3B III	The LGBTQ+ Umbrella The Gender and Sexuality Continuum (parts 1&2)	20 Minutes 60 Minutes
	BREAK	15 Minutes
3C I	Understanding Gender and How it is Different from Sex	20 Minutes
3C II	Gender Division of Articles, Activities and Roles	20 Minutes
3C IV 3D I	Pronouns Coming Out Stars	30 Minutes 45 Minutes
	SUMMARISE & EVALUATIONS	15 Minutes

Full workshop for Stigma and Discrimination towards LGBTQ+ Populations
This is an example of 2 full day (8 Hours) sessions for identifying stigma and discrimination and understanding LGBTQ+ Populations. Day 1 Focuses on Modules 1 and 2 and Day 2 focuses on Module 3. Alternatively, all this content could be provided in 4 half day sessions as well.

DAY 2

ACTIVITY	TITLE	TIME
	Review evaluations and recap of Day 1	15 Minutes
3B II	The LGBTQ+ Umbrella	20 Minutes
3B III	The Gender and Sexuality Continuum (parts 1&2)	60 Minutes
	BREAK	15 Minutes
3C I	Understanding Gender and How it is Different from Sex	20 Minutes
3C II	Gender Division of Articles, Activities and Roles	20 Minutes
3C IV	Pronouns	30 Minutes
3D I	Coming Out Stars	45 Minutes
	SUMMARISE & EVALUATIONS	15 Minutes

Full workshop for Stigma and Discrimination towards LGBTQ+ Populations
This is an example of 2 full day (8 Hours) sessions for identifying stigma and discrimination and understanding LGBTQ+ Populations. Day 1 Focuses on Modules 1 and 2 and Day 2 focuses on Module 3. Alternatively, all this content could be provided in 4 half day sessions as well.

DAY 1

ACTIVITY	TITLE	TIME
	Introductions & Ground Rules	15 Minutes
IA	What is the meaning of 'Stigma' and 'Discrimination'?	30 Minutes
1B	Naming Stigma and Discrimination through Pictures	45 Minutes
	BREAK	15 Minutes
1C	Naming Stigma and Discrimination in Different Contexts	30 Minutes
1E	Our Own Experience of Being Stigmatised (Reflection Exercise)	30 Minutes
1F	Forms, Effects, & Causes of Stigma	30 Minutes
	LUNCH	40 Minutes
2A	Reflection Quiz	30 Minutes
2B	Panel Discussion	30 Minutes
2C	The Power Flower	30 Minutes
2G	Challenge the Stigma in your organization	45 Minutes
	EVALUATION	10 Minutes

DAY 2

ACTIVITY	TITLE	TIME
I	Review evaluations and recap of Day 1	15 Minutes
3A	History of LGBTQ+ Populations	15 Minutes
3B I	First Impressions of LGBTQ People	20 Minutes
3B II	The LGBTQ+ Umbrella	20 Minutes
	BREAK	15 Minutes
3B III	The Gender and Sexuality Continuum (parts 1&2)	60 Minutes
3B IV	Terminologies and Definitions	30 Minutes
	LUNCH	40 Minutes
3C I	Understanding Gender and How it is Different from Sex	20 Minutes
3C II	Gender Division of Articles, Activities and Roles	20 Minutes
3C III	First Impressions of Trans People	20 Minutes
3C IV	Pronouns	30 Minutes
3D I	Coming Out Stars	20 Minutes
3D II	What is Heterosexual Privilege	20 Minutes
3E	Including and Accommodating LGBTQ+ Populations	30 Minutes

DAY 2

ACTIVITY	TITLE	TIME
6	Developing a code of Conduct	20 Minutes
	SUMMARISE & EVALUATIONS	15 Minutes

Basic Introduction to Stigma and Discrimination towards Persons with Disabilities

This is an example of 2 half day (4 Hours) introductory session to identifying stigma and discrimination and understanding persons with disabilities (PWDs). Day 1 Focuses on Modules 1 and 2 and Day 2 focuses on Module 5.

DAY 1

ACTIVITY	TITLE	TIME
	Introductions & Ground Rules	15 Minutes
1A	What is the meaning of 'Stigma' and 'Discrimination'?	30 Minutes
1B	Naming Stigma and Discrimination through Pictures	45 Minutes
	BREAK	15 Minutes
1E	Our Own Experience of Being Stigmatised (Reflection Exercise)	30 Minutes
1F	Forms, Effects, & Causes of Stigma	30 Minutes
2C	The Power Flower	30 Minutes
2G	Challenge the Stigma in your organization	45 Minutes
	EVALUATIONS	10 Minutes

DAY 1

ACTIVITY	TITLE	TIME
	Introductions & Ground Rules	15 Minutes
1A	What is the meaning of 'Stigma' and 'Discrimination'?	30 Minutes
1B	Naming Stigma and Discrimination through Pictures	45 Minutes
	BREAK	15 Minutes
1C	Naming Stigma and Discrimination in Different Contexts	30 Minutes
1E	Our Own Experience of Being Stigmatised (Reflection Exercise)	30 Minutes
1F	Forms, Effects, & Causes of Stigma	30 Minutes
	LUNCH	40 Minutes
2A	Reflection Quiz	30 Minutes
2B	Panel Discussion	30 Minutes
2C	The Power Flower	30 Minutes
2G	Challenge the Stigma in your organization	45 Minutes
	EVALUATIONS	10 Minutes

DAY 2

ACTIVITY	TITLE	TIME
1	Review evaluations and recap of Day 1	15 Minutes
5A	Basic concepts and Issues	90 Minutes
	BREAK	15 Minutes
5B 1	Access and Accommodation problem solving	4O Minutes
5B 3	Manners charades	30 Minutes
5C	Barriers for Persons Living with Disabilities	40 Minutes
	SUMMARISE & EVALUATIONS	15 Minutes

Full workshop for Stigma and Discrimination towards Persons with Disabilities

This is an example of 2 full day (8 Hours) sessions for identifying stigma and discrimination and understanding persons with disabilities (PWDs). Day 1 Focuses on Modules 1 and 2 and Day 2 focuses on Module 5. Alternatively, all this **c**ontent could be provided in 4 half day sessions as well.

DAY 2

ACTIVITY	TITLE	TIME
1	Review evaluations and recap of Day 1	15 Minutes
5A	Basic concepts and Issues	90 Minutes
	BREAK	15 Minutes
5B 1	Access and Accommodation problem solving	40 Minutes
5B 2	The Impact of Language	30 Minutes
5B3/5B4	Manners charades/Disability Quiz	30 Minutes
	LUNCH	40 Minutes
5C	Barriers for Persons Living with Disabilities	40 Minutes
5D	Workplace discrimination as a barrier to diversity and inclusion	90 Minutes
6	Developing a code of Conduct	20 Minutes
	SUMMARISE & EVALUATIONS	15 Minutes

Basic Introduction to Stigma and Discrimination towards Persons Living with HIV (PLHIV)

This is an example of 2 half day (4 Hours) introductory session to identifying stigma and discrimination and understanding persons living with HIV (PLHIV). Day 1 Focuses on Modules 1 and 2 and Day 2 focuses on Module 4. For a more in-depth look at the stigma and discrimination aspect, the Day 1 activities from the full workshop for PWDs could be incorporated as a whole day training.

DAY 1

ACTIVITY	TITLE	TIME
	Introductions & Ground Rules	15 Minutes
1A	What is the meaning of 'Stigma' and 'Discrimination'?	30 Minutes
1B	Naming Stigma and Discrimination through Pictures	45 Minutes
	BREAK	15 Minutes
1E	Our Own Experience of Being Stigmatised (Reflection Exercise)	30 Minutes
1F	Forms, Effects, & Causes of Stigma	30 Minutes
2C	The Power Flower	30 Minutes
2G	Challenge the Stigma in your organization	45 Minutes
	EVALUATIONS	10 Minutes

DAY 2

ACTIVITY	TITLE	TIME
I	Review evaluations and recap of Day 1	15 Minutes
4A	Exploring Beliefs and Attitudes About People Living with HIV and other key populations	60 Minutes
	BREAK	15 Minutes
4B	The Blame Game—Things People Say About People Living with HIV and Other marginalized groups	40 Minutes
4C	Fears About Getting HIV Through Nonsexual Casual Contact	60 Minutes
4D	HIV Transmission and Men Who Have Sex with Men	40 Minutes
	SUMMARISE & EVALUATIONS	15 Minutes

Conducting a Training of Trainers

If conducting a trainer of trainers for your organization or area, you will need to go through and practice the activities in the module(s) you've selected for training. This will require approximately half day to one whole day per module and will allow the trainees to practice the facilitation techniques. At the beginning of the training of trainers, dedicate a half day to learn the facilitation techniques (can use the Health Policy Project's Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide for more in-depth information) as well as go through all the terminologies listed at the end of this manual that will be applicable to the modules being trained on. This will be the appropriate time to ensure that trainers improve and update their knowledge as well as have their questions answered.

SAMPLE BUDGET FOR TRAINING

ITEM	DESCRIPTION	COST(USD)/DAY
Venue	1 Day	100
Facilitators	2 Facilitators	400
Community Member Stipend	Community member supporting the facilitation of training	100
Refreshments	Lunch and snacks for 10 -15 people	300
Travel stipends*	For 10 participants	100
Panellist stipend*	1 Panellist	25
Projector*	1 Projector	50
Rewards/treats*	1 Day	20
Flipchart	1 Flipchart Roll	50
Writing materials– pens, pencils, markers	For 10 persons	25
Printing/photocopying	Paper, Card, Ink, etc.	25
Report writing*	1 Report on activities	200
Long-term monitoring and evaluation*	For 1 training	200
TOTAL		**1,595**
TOTAL minus optional items		**1,000**

Note:
Some items might be covered by the entity that you are conducting the training program with/for, such as refreshments or printing and projector. Alternatively, these costs may be different depending on the venue that you are hosting the workshop at (e.g. hotel conference rooms have packages that include venue, refreshments, printing and projector.) *This sample budget is an example of the items to consider while budgeting for your training program and will vary from place to place and over time.

SECTION 3

MODULES & ACTIVITIES

MODULE 1

NAMING STIGMA & DISCRIMINATION

MODULE 1:
NAMING STIGMA AND DISCRIMINATION

Stigma is often a result of fear and lack of understanding of persons who have different lifestyles or ways of living that are different to our own. When someone stigmatises another, they will usually perform discriminatory actions towards them. These discriminatory actions are usually negative (such as name calling, or avoidance) and many people do not understand the power that words or actions have on an individual's wellbeing. In this module, participants will learn and understand the difference between stigma and discrimination, and the effects it has on persons. As a trainer, you need to help the participants understand that discrimination in all forms, no matter how small, have many effects that don't just affect the individual being discriminated against, but thosearound them as well as the wider community.

The activities in the modules are important to this training program and should always be used at the beginning of the program as they set the foundation of understanding why they should not stigmatise or discriminate against anyone and can result in participants beginning to empathise with the communities they are learning about. The activities can cover stigma and discrimination in a broad sense, or you can focus the activities towards the community or communities you are covering inthe program.

ACTIVITIES

Activity A: What is the meaning of 'Stigma' and 'Discrimination'?	Suitable for all participants	30 minutes
Activity B: Naming Stigma and Discrimination through Pictures	Suitable for all participants	45 minutes
Activity C: Naming Stigma and Discrimination in Different Contexts	Suitable for all participants	30 minutes
Activity D: Naming Stigma and Discrimination through Case Studies	Suitable for all participants	30 minutes
Activity E: The Blame Game—Things People Say About People Living with HIV and Other marginalized groups	Suitable for all participants	40 minutes
Activity F: Our Own Experience of Being Stigmatised (Reflection Exercise)	Suitable for all participants	30 minutes
Activity G: Forms, Effect & Causes of Stigma	Suitable for all participants	30 minutes

ACTIVITY A: WHAT IS THE MEANING OF 'STIGMA' AND 'DISCRIMINATION'?

Facilitator's Note: This activity introduces the participants to the difference between stigma and discrimination and how stigma leads to discrimination.

Objectives: By the end of this session, participants will be able to define stigma and discrimination and give examples.

Target group: All groups

Time: 30 minutes

Materials: Flipchart paper, markers,
card.

Adapted from: Health Policy Project. 2013. Understanding and Challenging HIV and Key Population

Preparation: You can use two separate flipcharts, or divide one flipchart into two sections horizontally. Label each flipchart / section with the headings 'Stigma' and the other with 'Discrimination'. Draw a circle in the middle of each, giving enough room

to write the definitions of each within the circle and examples of each on the outside.

Steps:
Participants' Ideas about Stigma (Brainstorm):
Ask, "What do you think is the meaning of 'stigma'?" Record participants' responses in then middle of the circle under Stigma. Then ask them to work in pairs and write on card reasons why people may stigmatise other people. Record the responses around the circle. Repeat this exercise with 'discrimination', this time recording examples of discrimination. Preview **Handout 1** for an example of what this diagram might look like.

Examples of Responses:
Definition of Stigma: a set of negative and often unfair beliefs that a society or group of people have about someone or something.
Reasons we stigmatise

- Socialisation
- Ignorance
- Moral beliefs
- Cultural norms
- Fear
- Image

Definition of Discrimination: the unjust or prejudicial treatment of different categories of people based off of certain characteristics they may have.

Examples of discrimination

- Verbal Abuse / name calling
- Physical violence
- Denied Housing
- Not Hired, not promoted, or fired from job
- Kicked out of home
- Denied access to services
- Not being able to make a report
- Gossiped about

Presentation:

Next, explain and discuss the following:

- Stigma is a process where we create a 'spoiled identity' for an individual or a 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 (e.g., same-sex relationships), physical (e.g., physical disfiguration), or social difference (e.g., poor or a migrant) and then assign negative connotations to that difference, thereby marking it as something negative—as 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, and 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 they have done something wrong (sinful or immoral behaviour).

- To stigmatise is to believe that people are different from us in a negative way, to assume that they have done something bad or wrong. When we stigmatise, we judge people, saying they have broken social norms and should be shamed or condemned, or we isolate people, saying they are dangerous or a threat to us.
- Stigma is a powerful social process of devaluing a person or group that often ends in the action of discrimination—unfair and unjust treatment, e.g., PLHIV or LGBTQ+ persons not being hired, a sex worker kicked out of the house, gay men refused treatment at a clinic, or their HIV status or sexual behaviour being publicly revealed.
- Stigma and discrimination result in great suffering. People get hurt.
- Stigma takes two major forms: isolation or rejection, and shaming and blaming
- Stigma has three major causes:
  - Lack of awareness about stigma—what it looks like, what it does—and lack of awareness that we are stigmatising others.
  - Fear and ignorance.
  - Moral judgements: People may think anal sex is immoral or may blame a person with a disability for having such and they condemn people for immoral behaviour.
- Stigmatisation is a process:
  - We identify and name the differences in someone suspected to be a member of the LGBTQ+ community, be disabled, or have HIV.
  - We make negative judgements about the person (e.g., promiscuity).
  - We isolate or judge/ridicule the person, thereby separating 'her/him' from 'us.'
  - The person who is stigmatised (isolated and judged) loses status and faces discrimination.

- Stigma is often viewed as something right, as a tool to 'control' behaviour and people. People think that it is acceptable to isolate and shame people. People are not aware of how stigma affects the populations and can make things worse, such as the HIV epidemic.

Developing a Code of Conduct:
Ask participants, based on the discussion, to suggest two to three changes they could make in their organization to reduce stigma toward their clients. Keep a record of this list of changes.

ACTIVITY B: NAMING STIGMA AND DISCRIMINATION THROUGH PICTURES

Facilitator's Note: 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 personalised 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. The pictures can also be used by participants to discuss stigma with their colleagues, families, and friends—a form of follow-up, so make photocopies and hand them out to your participants.

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.

Target Group: All groups

Time: 45 Minutes

Materials: Stigma Pictures, displayed on the wall – **Handout 2**.

Adapted from: USAID/PEPFAR. 2015. Facilitator's training guide for a stigma-free health facility: Training Menus, Facilitation Tips, and Participatory Training Modules.

Steps:
Naming Stigma (Picture Discussion):
Have these photos [**Handout 2**] stuck up on the wall (or placed on a table) before the event. Divide participants 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 group to select one picture.

Steps:

Naming Stigma (Picture Discussion):

Have these photos [**Handout 2**] stuck up on the wall (or placed on a table) before the event. Divide participants 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 group to select one picture.

Ask them to discuss:
What do you think is happening in the
picture in relation to stigma?

- Ask them to briefly describe what is happening in the picture.
- Why do you think it is happening?
- Does this happen in your own community/work setting? If so, discuss some examples.

Report Back:

Ask each pair to hold up their picture for everyone to see (or tape it on the wall) and explain its contents. Record points on flipchart.

Presentation

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

- Sometimes we treat people badly. We isolate or reject them, e.g., refusing to sit beside someone who is assumed to have a mental disability or is gay; or we gossip about them and call them names. When we isolate or make fun of other people, this is called 'STIGMA.' Another word commonly used for stigma is 'prejudice.'
- When we stigmatise people, we isolate them, saying they are a danger/threat to us (because we think we can catch whatever disability they may have, or we might be negatively affected by their assumed behaviour, or they might infect us with HIV,), or we judge them, saying they have broken social norms and should be shamed or condemned.
- Stigma is a powerful social process of devaluing a person or group that often ends in the action of discrimination—unfair and unjust treatment, e.g., not hired, kicked out of the house, refused treatment at the clinic, or their 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 and, 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 or self-stigma.
- People who are stigmatised often encounter this stigma from their own families and the community. They often have to change their behaviour to be accepted, or they are forced to leave home. Many people living with HIV or LGBTQ+ are forced to lead a hidden, 'underground' existence and as a result they find it difficult to get work and housing, and access health services that could save their lives.

- There are different forms of stigma and discrimination:
  a) Isolation and Rejection—based on ignorance and fear about a person or their behavior. The person stigmatised is forced to sit alone, eat alone, and live alone.
  b) Shaming and Blaming—gossip, name calling, insulting, judging, shaming. Stigmatised people are "blamed and shamed" for assumed 'bad behaviour,' for breaking social norms.
  c) Unfair Treatment - such as refusing to provide services, firing someone who is found to have a disability or develops one, is LGBTQ+, or kicking someone out of housing.
  d) Self-Stigma—Marginalised persons sometimes stigmatise themselves in reaction to stigmatisation from society. They accept the blame and rejection of society, and withdraw from social contact or exclude themselves from accessing health and other services out of fear of having their status revealed.
  e) Stigma by Association—People associated with stigmatised groups often face stigma themselves. The family of a person with a disability or a person who is a member of the LGBTQ+ community may be stigmatised because of the stigma faced by their family member—the reputation of the family is affected. People who work with marginalised persons, such as health workers, are also often stigmatised by association.
  f) Layered Stigma—Marginalised groups (e.g., LGBTQ+, sex workers, PWD, migrants, etc.) are already stigmatised. When they get HIV they are doubly stigmatised—getting another layer of stigma.
- Some of the effects of stigma are:
  - Feelings of sadness, loneliness, rejection, hopelessness, self-doubt.
  - Shame and loss of confidence—feel they are no longer accepted by others
  - Discrimination—people kicked out of family, community, job, organisations, etc.
  - Denial—stops people disclosing status and seeking support.

Action Ideas:
Take the pictures home and discuss them with family members and friends. Help others see what stigma means in our lives—how it happens and how it hurts people.

Developing a Code of Conduct:
Ask participants, based on the discussion, to suggest two to three changes they could make in their organization to reduce stigma toward their clients. Keep a record of this list of changes.

ACTIVITY C: NAMING STIGMA AND DISCRIMINATION IN DIFFERENT CONTEXTS

Facilitator's Note: In this exercise, participants describe stigma and discrimination towards communities in specific contexts, e.g., home, community, faith-based setting, school, health facility, workplace, public spaces (e.g., bar, market, or bus).

Extra Tips for Facilitators:

- The number of flipchart stations/categories depends on the number of participants and the amount of time you have. With a large group, you will need need many stations/categories so that the groups are not too large. (For this activity, it is good to keep the group size to four or less.)
- In introducing this exercise, tell groups which direction to move—so there is no confusion when you blow the whistle to ask groups to move to the next station.
- The rotational brainstorm is fun, but the real learning comes in the debriefing—so make sure you allow enough time/energy for this.

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

- Identify stigma and discrimination faced by these communities in different contexts.
- Identify some of the effects of stigma

Target Group: All groups—works well in large community workshops.

Time: 30 Minutes

Materials: Flipchart, markers, tape, whistle (optional)

Adapted from: Health Policy Project. 2013. Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide; Illustrations by Petra Rohr-Rouendaal.

Preparation:

Set up flipchart stations, depending on the number of participants. Tape blank sheets of flipchart paper on the walls of the room, with a topic on each sheet – home, community, school, health facility, church/mosque, workplace, bar, and media. (Select the contexts best suited to your target group). If you are covering all the groups in this training manual, you can also label with the different communities (e.g. Persons with disabilities at home, LGBTQ+ persons in the media, PLHIV at work). However, focusing on one population allows participants to understand that they face stigma and discrimination everywhere they go.

Steps:

Setting Up Rotational Brainstorm:

Divide into groups of equal size and assign each group to one of the flipchart stations. Hand out markers and ask each group to write a list on the flipchart of specific forms of stigma or discrimination faced by these communities in their particular context. Provide a few examples—write one example at the top of each flipchart. Explain that, after a few minutes, groups will be asked to rotate in a clockwise direction—to move to the next flipchart, read the points, and add new points. Then ask groups to start—and, after two minutes, shout "CHANGE" and ask them to rotate. Continue until groups have contributed to all flipcharts.

Report Back and Processing:

Ask each group to present the points on one flipchart (the one they started with). Then discuss some of the following questions:

- What are some of the common features across the different contexts?
- What are the attitudes/feelings in all contexts towards these communities?
- What are the effects on those who have been stigmatised?

Example Responses:

Home

- Name calling, scolding,belittling, and shaming – "Why have you brought shame on the family?"
- Shunned, isolated, and neglected. Forced to stay alone. Not sharing utensils, food, or clothing.
- Kicked out of the home and forced to move to another place. Exclusion from family activities. Disowned—no longer can access family property.
- Parents try to hide the behaviour of their gay children or their disabilities, fearing what the neighbours will say.

Community

- Name calling, finger pointing, whispering, and gossip. Isolation and rejection.
- Angry looks. Dissing. Verbal and physical violence towards marginalised populations.
- Disclosure of status to others. Refusal to shop at a store where owner/family is LGBTQ+, or disabled.
- Non-acceptance in groups or clubs. Discrimination on public transport.
- The community says they will not attend a funeral of an LGBTQ+ person or person with disability.

Health Facility

- Patients are kept waiting, told to come another day, or treated last.
- Unfriendly treatment. Harsh/scolding language. Negative body language and facial expressions.
- Blaming and shaming—"You deserve to get this, because of your disgusting behaviour."
- Medication in paper bags. Extra mask and gloves. Mistreatment when being served.
- Cleaning with extra sanitary measures. Disposing of bed linens instead of washing them.
- Exposing records, using red ink to designate LGBTQ+ status. Breaking confidentiality. Informing partner or parents. Gossip and labelling.
- Invasive questioning about LGBTQ+ patients' behaviour, e.g., "What kind of sex are you doing?"
- Some patients go to other islands to avoid being seen by neighbours, or receiving treatment for other matters so they don't have to e seen by a local doctor, but this is expensive.

School

- Stigma towards children of LGBTQ+ or disabled parents. Placing child at back of classroom. Not allowing child to play or eat with other children. Refusing to teach them or sending them home.
- Calling children derogatory names. Writing insulting notes on chalkboard. Teasing and bullying.
- Disclosure of child's or parent's status. Low grades (harsh grading).
- Students make fun of and isolate other students. They insult them and imitate their body language.
- Some students accept the shame (self-stigma) and drop out of school because of stigma.

Workplace

- Fired from job.
- Anyone assumed to be LGBTQ+ or disabled is not hired.
- Mandatory HIV testing (that isn't actually mandatory).
- Denied promotion or educational opportunities.
- Breach of confidentiality.
- Harassment.
- Gossip and isolation towards anyone suspected to be LGBTQ+ or have a disability.
- Coworkers refuse to socialise, do not share utensils, washrooms, seats, or dining area.
- Supervisors don't allot time off for medical treatment/appointments.

Church

- Isolation and rejection—segregation in seating. Shaming, blaming, and gossip. Labelled "sinners."
- Preaching—sermons—Sodom and Gomorrah—"We don't want Sodom & Gomorrah here."
- Kicked out of the church membership for being a 'sinner' and refusing to'repent.'
- No home visits. Isolation on church bus. Refusal to greet someone.
- Stopped from accessing baptism.
- Treated as modern-day lepers (unclean).
- Family gets treated differently.
- Stigma related to the use of the communion cup. Pastors refuse to marry HIV-affected couples or disabled couples.

Presentation:

Summarise the main points made by participants. You might include some of the following points:

- Stigma and discrimination takes place everywhere—homes, schools, communities, clinics, workplaces, churches, public places, and in the media.
- Marginalised persons are often shamed and rejected by families and forced to leave home; isolated and made fun of by their peers at school and in the media; mistreated at health facilities; harassed by the police; and banned from religious and social gatherings.
- There are few places where these populations feel completely safe. They often feel watched and face stigma and hostility in many places they go.
- Stigma at home is particularly painful. This is the place of last resort for a safe space. If your own family stigmatises you, you may feel you have nowhere else to go. You are all alone.
- Stigma has a number of common features across these contexts:
  - People make fun of or gossip about LGBTQ+ who dress or act differently from other people. Even if someone is not openly gay, people will make assumptions on the basis of their clothing and body language and discriminate against him. The same is true for sex workers: people will abuse them if they dress 'inappropriately.'
  - People 'shame and blame'—condemning them for their sexual practices or believe they did something to deserve being disabled—practices viewed as breaking 'traditional' norms.
  - People may isolate or exclude persons from these populations, trying to keep them at a distance, e.g., not allowing them to attend social events.
  - Families and friends of persons from these communities may also be stigmatised.
  - Persons from these communities face different forms of discrimination, e.g., health workers treat them unfairly, police officers harass them, and they are turned down for jobs.

    - Persons from these communities may be attacked if people suspect they are LGBTQ+ and disabled persons may be attacked because they are deemed helpless.
- Stopping stigma will take a huge effort by everyone. The starting point is to change ourselves—the way we think, talk, and act towards these communities. We have to personalise the issue for ourselves, to see that we have to do something to change things. We first need to change our attitudes—the way we feel towards these communities.
- After we have changed ourselves, we can start to educate and challenge others. It takes courage to stand up and challenge others when they are stigmatising marginalised populations—but this is one of the ways to stop stigma. Breaking the silence and getting people talking openly is the first big step.
- Talk with your family and friends, and get community leaders to speak out against stigma and discrimination. Help everyone make these problems visible and unacceptable.
- Reach out to and support marginalised populations. Once these populations feel accepted, they will be more open to discussing their situation with others, seeking support, and accessing services.

Developing a Code of Conduct:
Ask participants, based on the discussion, to suggest two to three changes they could make in their organization to reduce stigma toward their clients. Keep a record of this list of changes.

ACTIVITY D: NAMING STIGMA AND DISCRIMINATION THROUGH CASE STUDIES

Facilitator's Note: These case studies are based on real experiences of PLHIV and key populations. They can be used to help participants develop a better understanding of the lives of PLHIV and marginalized populations. To prepare for the exercise, review the case studies and make changes necessary to adapt to the local context. If these case studies are not applicable, you should create new ones more relevant to the reality and experiences of participants.

Objectives: By the end of this session, participants will be able to:
- Understand stigma and discrimination towards these communities in more depth.
- Discuss real-life stories and look at ways of challenging stigma.

Target Group: All groups if the workshop has a component on HIV

Time: 30 Minutes

Materials: Copies of the case studies for participants – **Handout 3**

Adapted from: Health Policy Project. 2013. Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide; Illustrations by Petra Rohr-Rouendaal

Steps:
Case Study Analysis:
Divide into small groups of three to four people. Assign each group one of the case studies, but give each group the whole set of case studies so they can have a look at the others. Ask them to read the case study and discuss the following questions:
- What happened? Why?
- What do you think about the situation?
- What could help to change things for the main character?

Report Back:
Ask each group to report back on the things that they have learned from discussing the case study.

ACTIVITY E: THE BLAME GAME—THING PEOPLE SAY ABOUT PEOPLE LIVING WITH HIV AND OTHER MARGINALIZED GROUPS

Facilitator's Note: This exercise helps participants verbalize stigma toward 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 PLHIV and other marginalized groups. The title of this exercise, "Things people say about people living with HIV and other marginalized groups," allows participants to express their own stigmatizing labels for other groups under the cover of attributing them to "the people." So, whereas 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.

Extra Tips for Facilitators:

- The rotational brainstorm is fun, but the real learning comes in the debriefing—so make sure you allow enough time/ energy for this part.
- In debriefing this exercise, it is important to focus on "how participants feel about these names," rather than focusing on the words themselves. This approach helps to avoid the embarrassed laughter that can often occur. The whole point of this exercise is to help participants recognize how these words can hurt.
- Challenge the laughter. Often participants will laugh out of embarrassment, providing a good opportunity to ask, "How do you feel about the laughter?"

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

- Identify labels used to stigmatize PLHIV and other marginalized groups.
- Recognize that these words hurt.

Target group: All groups

Time: 40 minutes

Materials: Flipchart, markers

Adapted from: USAID/PEPFAR. 2015. Facilitator's training guide for a stigma-free health facility: Training Menus, Facilitation Tips, and Participatory Training Modules.

Preparation:

Make a list of groups that experience stigma in your context e.g., PLHIV, MSM, transgender people, sex workers and health workers living with HIV. Then, using this list, prepare the flipchart stations—blank sheets of flipchart paper on different walls of the room, with the name of one of the groups written at the top of each sheet.

Steps:

Warm-up—Switching Chairs Game

Set up the chairs in a circle beforehand. Allocate roles to each person, going around the circle; base the roles on the groups listed on the flipcharts: a person living with HIV, a man who has sex with other men, a transgender person, a sex worker. Continue until everyone has been assigned a role. Then explain how the game works:

I am the caller and I do not have a chair. When I call out two roles, e.g., "PLHIV" and "MSM," all the "PHHIV" 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"—and when this happens, everyone has to stand up and run to find a new chair.

Then shout—"PLHIV and MSM"—and get people having those roles to run to a new chair. The game starts at this point.

Debriefing

Ask, "How did it feel to be called a PLHIV, an MSM, a sex worker, or a transgender person?"

Things People Say About... (Rotational Brainstorm)

Note that this activity can be triggering for persons who identify as some of these populations in the room. Do not attempt if not experienced in facilitation or unable to deal with possible consequences. You can also instruct participants to ONLY WRITE 2 things on each sheet in order to limit the number of triggering responses.

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 its flipchart station. Hand out markers and ask each group to write on the flipchart all of the things people say about the people in their group. After two minutes, shout "CHANGE" and ask groups to rotate in a clockwise direction and add points to the next sheet. Continue until the groups have contributed to all of the flipcharts and end up back at their original list.

Report Back

Bring everyone back together into a large circle. Ask one person from each group to read out the names on their flipchart, starting with "I am a (e.g., sex worker) and this is what you say about me ...."

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

- What do you think about these names?
- Why do we use such hurtful language?

Summarise:

<u>The summary in this case is very important, so allow enough time for it.</u>

- We are socialized or conditioned to judge other people. We judge people based on assumptions about their sexual and other behavior.
- Sex is a taboo—it is regarded as something shameful · that we should not talk about, so we often shame and blame people whose sexual behavior is different from ours.

- Key populations are already stigmatized even if they are not HIV positive. They are stigmatized because they are seen as being different, and it can be difficult for them to challenge the stigma.
- All of these labels show that when we stigmatize, we stop dealing with people as human beings. Using mocking or belittling words gives us a feeling of power and superiority over them, and we forget people's humanity.
- Stigmatizing words are very strong and insulting—they have tremendous power to hurt, humiliate, and destroy people's self-esteem. When we "shame and blame" people for their characteristics or behavior, it is like stabbing them with a knife—it hurts!
- So how should we treat PLHIV and other key populations? We should give them (a) respect and affection; (b) support and encouragement; and (c) space, place, and recognition. If we treat them well, they will keep their self-esteem, feel empowered, and take charge of their lives, accessing services and taking care of their sexual health.

Developing a Code of Conduct:
Ask participants, based on the discussion, to suggest two to three changes they could make in their facility to reduce stigma toward their clients. Keep a record of this list of changes.

ACTIVITY F: OUR OWN EXPERIENCE OF BEING STIGMATISED (REFLECTION EXERCISE)

Facilitator's Note: 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 empathise 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, 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. Emphasise that the sharing is voluntary—no one is forced to give their story—and emphasise the importance of confidentiality. Remind participants about the ground rules—"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. (See the introductory chapter for suggestions on how to do this.)

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.

Target Groups: All groups

Time: 30 Minutes

Adapted from: USAID/PEPFAR. 2015. Facilitator's training guide for a stigma-free health facility: Training Menus, Facilitation Tips, and Participatory Training Modules.

Steps:

Individual Reflection:

Ask participants to sit on their own. Then say: "Think about a time in your life when you felt lonely or rejected for being seen to be different from others." Explain that these do not need to be examples of stigma towards LGBTQ+ persons or persons with disabilities, it could be any form of stigmatisation for being seen to be different, e.g. the race, religion, weight, nationality, et . Ask them to think about what happened, and how it felt.

Sharing:

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?"

Then ask— "What did you learn from this exercise?"

Example Responses

How did you feel when you were stigmatised?

Angry. Ashamed. Misunderstood. Depressed. Rejected. Pitying myself—feeling miserable. Resentful. Doubting myself. Useless. Failure. Hated. Despised.

Example Responses

How did you feel when you were stigmatised?

Angry. Ashamed. Misunderstood. Depressed. Rejected. Pitying myself—feeling miserable. Resentful. Doubting myself. Useless. Failure. Hated. Despised.

What did you learn from this exercise?

- We stigmatise for many reasons—nationality, gender, ethnicity, language, religion, physical or mental abilities or challenges, etc.
- We all stigmatise—it is a part of life. Some people stigmatise without realising it.
- When we stigmatise, we create separation—'us' and 'them.'
- We need to recognise the damage we can do to others by stigmatising and judging them.
- The experience of being stigmatised is very painful. It really hurts. It can last for a lifetime.
- Once we have been stigmatised, we know how it feels for marginalised populations to be stigmatised.
- Facing stigma has taught me to empathise and embrace people from different churches.

Summarise:
Summarise the main points which
participants have made during the exercise. In giving your summary, you may use some of the following points if they have not already been mentioned by participants.

- This exercise helps us get an inside understanding of how it feels to be stigmatised —shamed or rejected. It helps put us into the shoes of marginalised people. 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 ostracised or been treated like a minority at different times in their lives. And it is okay to feel like that, because you are not alone. We have all experienced this sense of social exclusion.

ACTIVITY G: FORMS, EFFECTS, & CAUSES OF STIGMA

Facilitator's Note: In this exercise, participants divide into groups, and each group analyses the stigma facing a different category, using the problem tree methodology (effects, forms, and causes), and then looks at what they can do to solve these problems. This exercise helps to reiterate what the participants have learnt in the other activities in the module and have them start thinking about how they can challenge their own stigma.

Objectives: By the end of this session, participants will be able to identify:
- Different aspects of stigma and how it affects different people.
- Some of the root causes of stigma.
- Practical things they can do to stop or reduce stigma.

Target Group: All groups

Time: 30 Minutes

Materials: Flipchart, markers, cards, tape

Adapted from: Health Policy Project. 2013. Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide; Illustrations by Petra Rohr-Rouendaal.

Steps:
Analysing Different Forms of Stigma (Task Groups):
Write the different types of stigma which may occur in your context on cards. (EXAMPLES BELOW)

A. STIGMA TOWARDS HIV-POSITIVE CLIENTS BY HEALTH WORKERS

B. STIGMA TOWARDS PERSONS LIVING WITH DISABILITIES BY THE COMMUNITY

C. STIGMA TOWARDS GAY MEN BY HEALTH WORKERS

D. STIGMA TOWARDS TRANSGENDER PERSONS BY THE POLICE

E. STIGMA TOWARDS LESBIANS BY THE CHURCH

F. BREAKING THE CONFIDENTIALITY OF CLIENTS

Then divide into groups and assign one topic to each group. Ask each group to do a PROBLEM TREE analysis of their problem, using the following steps:

- Draw a picture of a tree on a flipchart paper.
- On the trunk, write the problem—e.g., 'STIGMA TOWARDS HIV-POSITIVE CLIENTS BY HEALTH WORKERS.'
- Then, on the trunk, using cards, add more details on forms of discrimination, e.g., 'shouting and scolding the client, making the client wait, using gloves to do non-invasive tasks, etc.'

If you want, you can take examples from activity 3 if you have diversified the contexts. This helps to tie everything together.

- Then, at the roots at the bottom of the picture, write causes of stigma on cards, e.g., 'fear of getting HIV through casual contact, judgemental attitudes, heavy workloads and stress, etc.' Ask participants to 'dig deeper'—to look for the causes of some of the causes they list.
- Then, on the branches of the tree, write the effects on cards, e.g., 'feeling isolated and ashamed, feeling angry and depressed, self-blame, wanting to leave the health facility, etc.'
- Then, underneath the flipchart paper, write POSSIBLE SOLUTIONS on cards, e.g., 'remind health workers of their code of conduct, improve health workers' knowledge about HIV transmission so they no longer fear getting HIV through contact with HIV-positive clients.'

Hand out flipchart paper, cards, markers, and tape to each group and ask them to prepare their analysis as a problem tree on the wall.

Report Back (Gallery Walk):
Organise a gallery walk, moving around the room and having each group present its report. Other groups can make additions.

Developing a Code of Conduct:
Ask participants, based on the discussion, to suggest two to three changes they could make in their organization to reduce stigma toward their clients. Keep a record of this list of changes.

MODULE 2

BREAKING DOWN STIGMA

MODULE 2:
BREAKING DOWN STIGMA

Our values and beliefs, especially around sex and morality, influence how we relate to, and stigmatize others. What we see as "normal" can lead us to judge those deviating from this "normal". Many countries also criminalize behaviours or reinforce prejudice making it difficult for persons to exercise their human rights and gain full access to services. Our culture and society is continuously changing, which means our values and beliefs can also change. Many times, we think that we have not met anyone who is "different", and thus have not had a chance to talk to them, listen to them, or tried to understand them.

As a trainer, you need to help persons understand why it's important to explore their own attitudes and beliefs in order to help change the stigma it manifests as. This module will help teach explore some of the basics so that participants have the right information and greater understanding needed to overcome fears and misconceptions about LGBTQ+ persons and PWDs. It will also help them learn the best practices used to support marginalised populations in overcoming stigma and accessing high-quality services.

ACTIVITIES

Activity A: Refection Quiz	Suitable for all participants	30 minutes
Activity B: Panel Discussion	Suitable for all participants	30 minutes
Activity C: The Power Flower	Suitable for all participants	30 minutes
Activity D: The Privilege Walk	Suitable for all participants	30 minutes
Activity E: Talking about sex-breaking the sex ice	Suitable for all participants	75 minutes
Activity F: Counselling Skills and Value Judgements	Only for health care participants	45 minutes
Activity G: Challenge the Stigma in your organization	Suitable for all participants	45 minutes
Activity H: Bystander Intervention in Public	Suitable for all participants	60 minutes

ACTIVITY A: REFLECTION QUIZ

Facilitator's Note: This exercise consists of an individual reflection quiz about beliefs, knowledge, and feelings toward LGBTQ+ and/or PWDs. Then participants discuss their thoughts with a partner and share them in the large group. The quiz may also be done individually as a form of homework. Ideally, this exercise should be done in conjunction with exercise 2 (Panel Discussion). Participants complete the reflection quiz individually before the discussion.

Then they listen to a panel of resource persons drawn from the different populations. However, if it is not possible to organize members of population groups to participate, the Reflection Quiz is a good introduction to the topic. The quiz consists of questions on each of the different populations. It helps persons assess what they know, believe, and feel about marginalized populations, and trigger other questions. Select the quiz questions suited to your context. You might, for example, ask the group, "Which one of the populations under the LGBTQ+ umbrella would you like to know more about?" and then hand out the quiz about that population.

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

- State their own values and beliefs, and identify gaps in their knowledge about marginalised populations.
- Explain some of the basic facts and issues affecting LGBTQ+ and PWDs

Target group: All groups

Time: 30 minutes

Materials: Reflection Quiz + Answer Sheets [Found in Handout 4]

Adapted from: USAID/PEPFAR. 2015. Facilitator's training guide for a stigma-free health facility: Training Menus, Facilitation Tips, and Participatory Training Modules.

Steps:
Hand out the quiz (choose sections suited to your context and group) and ask participants to spend time alone thinking about the questions and writing any notes if they wish. Allow at least 15 minutes for this process.

Sharing Thoughts:
Ask participants to pair up and share their thoughts about the reflection. If you are NOT doing the panel discussion, hand out the answer sheet and ask pairs to read it through together.

Group Discussion:
Ask if anyone wants to discuss their thoughts or has any other questions about marginalized populations. Ask “What did you learn from this exercise?”

Developing a Code of Conduct:
Ask participants, based on the discussion, to suggest two to three changes they could make in their organization to reduce stigma towards these populations. Keep a record of this list of changes.

Reflection Quiz Questions: **GAY MEN AND LESBIANS**

1. Becoming gay does not just happen. Rather, people decide or learn that they want to be gay or lesbian.
2. Gay men and lesbians are mentally ill but they can be cured.
3. Sex between two men or between two women is against religion.
4. Gay men and lesbians have been too influenced by Western values.
5. Gay men and lesbians are all the same. You can identify them by the way they dress and behave.
6. In many countries, it is illegal for men to have sex with men.
7. Gay men and lesbians engage in the same sexual practices as other couples.
8. Gay men do not want long-term partners; they want only casual sex.
9. Children with gay or lesbian parents become homosexuals.
10. I feel able to offer welcoming and safe services to a client who is gay or lesbian.

Reflection Quiz Questions: **BISEXUALS**

1. Bisexuals are just confused about their sexuality
2. Sexual identity never changes. If you're gay, you're always gay, if you're straight, you're always straight.
3. To be a bisexual, you have to have had sex with people of both sexes.
4. Bisexuals are equally attracted to both men and women.
5. Bisexuals are just opportunists. They just want to have sex, they don't even care who it's with.
6. Most people who are bisexual are really gay or lesbian. They just say they're bi because it's easier when you can "pass" as straight.
7. If you're bisexual, you have to have a male and a female partner to feel fulfilled
8. Bisexual people spread HIV to straight people.
9. If you've never had sex, you can't know whether you're bisexual or not.
10. I feel able to offer welcoming and safe services to a client who is bisexual.

Reflection Quiz Questions: **TRANSGENDER PERSONS**

1. Being transgender is just a recent thing.
2. Transgender people are unnatural and what we are assigned at birth is our real and correct gender.
3. Transgender people are not confused or mistaken about what gender identity they identify as.

4. A person assigned female at birth but who identifies as male is a trans woman.
5. Being transgender is just a fetish or kink.
6. There are both trans men and trans women.
7. A person can not know their gender identity a child.
8. Being transgender is a mental illness.
9. Trans people always want to or are going to get surgery.
10. I feel able to offer welcoming and safe services to a client who is transgender.

Reflection Quiz Questions: **Q PLUS**

1. Asexuals have taken a conscious decision to not take part in sexual activity despite experiencing sexual attraction.
2. Pansexuals are attracted to people regardless of their sex or gender identity.
3. Queer is a derogatory term that should never be used.
4. Intersex is the same as transgender.
5. Intersex children should have surgery as soon as possible.
6. Hermaphrodite is an acceptable term for intersex people.
7. Pansexuals are just opportunists. They just want to have sex, they don't even care who it's with.

Reflection Quiz Questions: **PERSONS WITH DISABILITIES**

1. Everyone is likely to experience disability at some point in his/her life.
2. Accessibility means equal access to only the physical environment.
3. Words such as wheelchair bound, handicapped or special needs child are acceptable to use.
4. The words ‘disability’ and ‘impairment’ mean more or less the same thing.
5. It is better to talk to the person supporting someone who is visually impaired, rather than the person themselves.
6. Persons with disabilities always need assistance.
7. It is always obvious if someone has a disability.
8. Shouting at a person who is deaf will enable them to hear you better.
9. Mental health disorders and intellectual disabilities are the same thing.
10. I feel able to offer welcoming and safe services to a client who has a disability.

ACTIVITY B: PANEL DISCUSSION

Facilitator's Note: This exercise can have a big impact on changing participants' understanding and attitudes toward marginalised populations. The personal stories from resource persons have a powerful impact—it is often the first time that service providers have listened to marginalised populations talk about their lives and their experiences of being stigmatized. If possible, do the Reflection Quiz before a break and organize the Panel Discussion after the break to allow time to organize the discussion, and give the participants a chance to absorb the topic.

Your job as facilitator is to guide this panel discussion, asking questions and ensuring that everyone on the panel gets a chance to talk. Make sure that the resource persons are well prepared. Give them copies of the reflection quiz and an outline of any questions that the participants want to ask before the discussion starts. Ask them also to talk about their own experiences in using the services offered by participants in the workshop and how they were treated.

Objectives: By the end of this session, participants workers will be able to do the following:

- State their own values and beliefs, and identify gaps in their knowledge about marginalized populations.
- Understand some of the main challenges facing members of these populations.
- Explain some of the basic facts and issues affecting the marginalized populations.

Target group: All groups

Time: 30 minutes

Materials: Answer Sheet to the Quiz Questions [Found in Handout 4]

Adapted from: USAID/PEPFAR. 2015. Facilitator's training guide for a stigma-free health facility: Training Menus, Facilitation Tips, and Participatory Training Modules.

Preparation:
Approach support groups or organizations for LGBTQ+ and PWDs in your area to identify people who are willing to talk about their lives. Find out in advance the needs of the resource persons and make sure that these can be met in the training environment. You may need to provide financial support for travel and other costs. Give the resource persons the following briefing on how to present their stories and information:

Respond to participants' questions and give examples drawn from your own life. Talk about how you have been treated in the facilities the participants are coming from—and how it made you feel. Tell your stories in a factual way, without blaming or criticizing service providers. This approach will ensure that participants don't become defensive.

Steps: Do the Reflection Quiz before the panel discussion.
Preparation for Panel Discussion. Ask participants:

- Which of the questions would you like to know more about?
- What other questions would you like to ask the resource persons?

Write down the questions. You should rephrase any questions that could be offensive or judgmental. Use this set of questions to guide the panel discussion.

Panel Discussion: Go through each of the questions and invite the resource persons to respond. Make sure to allow time for the resource persons to talk about their experiences in using the relevant facilities and any stigma they have faced. At the end of the session, hand out the Answer Sheet to the Quiz Questions.

Summarise:

- Some people know little about LGBTQ+/PWDs, so out of ignorance they judge them unfairly or isolate/reject them out of fear.
- When we know little about others, we often make assumptions or accept stereotypes about them. We attribute characteristics to a group and everyone belonging to that group. We assume that all members of the group have the same characteristics, e.g., that all gay men are promiscuous, all PWDs are helpless, etc.
- These assumptions are stereotypes—things we say about other people about whom we know little. Often, we believe these assumptions are facts about other people, when in fact they are false. This belief leads to prejudice, which can result in stigma and discrimination.
- Each of these groups is unique and includes people with diverse knowledge, attitudes, and practices. We often think we know more about these groups than we actually do, or generalize when we should not. We still have a lot to learn!
- By learning more about LGBTQ+/PWDs, we will begin to overcome some of our doubts or prejudice about them and be less fearful or condemning toward them.
- We need to understand and respect LGBTQ+/PWDs as human beings. They are as fully human as anyone else, and are entitled to be treated in the same way.

Developing a Code of Conduct:
Ask participants, based on the discussion, to suggest two to three changes they could make in their facility to reduce stigma towards LGBTQ+ persons or PWDs. Keep a record of this list of changes.

ACTIVITY C: THE POWER FLOWER OUR MULTIPLE SOCIAL IDENTITIES

Facilitator's Note: This exercise helps participants recognise that we all have many identities, e.g., nationality, race, ethnicity, gender, etc.—and often these identities are used as a focus for stigma.

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

- Recognise that humans have many social identities.
- See that stigma and discrimination are part of a process of imposing dominant identities.

Target group: All groups

Time: 30 minutes

Materials: Flipchart, tape, markers, **Handout 5**

Adapted from: Health Policy Project. 2013. Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide.

Preparation

- Draw the Power Flower on a flipchart sheet and tape it on the wall.
- Hand out copies of the Power Flower

Steps:
Introduction: 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 Example and print out in **Handout 5**).

Examples of identities: Nationality. Male/female. Gender identity. Age. Race. Class. Ethnicity. Marital status. Religion. Occupation. Employed or unemployed. Education. Language. Birth position. Socioeconomic status. Income (rich or poor). Non-disability/disability. Physical features. Having children (or not). Political affiliation. Health status. HIV status. Sexual orientation. Sexual experience. Rural/urban.

What is our own social identity? (Individual Work):
Ask each person to record his/her identities in relation to each factor in the flower. This is an individual task—no one is forced to share this product.

Who do we stigmatize? (Cardstorm):
Then divide into pairs, hand out markers, and ask –"Who do we stigmatise?" Ask participants to write single points on cards and tape them on the wall. Then ask a few pairs to eliminate any repetition.

Example responses: PLHIV. MSM. Sex workers. Persons who use drugs. Persons with disabilities. Migrants. Prisoners. Indigenous people. Street children. Homeless people. Poor people. Illiterate people. People of different colour. People with disabilities. Young people. Old people. Pregnant teenagers. Women who have children from different fathers. Women without children. HIV+ pregnant women.

Processing:
- Why do we stigmatise these groups?
- What is the effect of a person having more than one stigmatised identity?

Why do we stigmatise?
- Tradition/culture/religion—we have been socialised 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 stay in power over others.
- Superiority complex—we like to feel we are superior.
- Judging others for immorality—people who break the social norms.

What is the effect of a person having more than one stigmatised identity, e.g., MSM who is a sex worker AND HIV positive?
- Increases the level of stigma
- Forces the person to hide all of their stigmatised identities or selectively hide identities.

Summarise:
Include some of the following points in your summary: (also stated in **Handout 5**)
- All of us have many social identities—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.
- Some populations are marginalised and stigmatised 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 marginalised 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 don't treat them as whole people, with 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 marginalised 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 we become blinded and rob ourselves of the entire rich package of a human being.
- So we need to change our ways of thinking about marginalised 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 a gay man or person with a disability or sex workers. We need to respect members of marginalised populations by treating them like anyone else.
- There are also layers of stigma. For example, a woman could be stigmatised as a woman, a sex worker, a PWD, a person living with HIV, 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.

ACTIVITY D: PRIVILEGE WALK

Facilitator's Note: This exercise will help persons understand the different levels of privilege an individual has based on characteristics they were born with or circumstanced they were born into, things they have no control over. This activity is usually done with persons own experiences and characteristics. However, in our activity, we have created character cards for participants to have so that no one is ashamed of their level of privilege compared to others. Participants will be able to identify with certain characteristics of the character cards and determine for themselves where they may lie.

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

- Understand the levels of privilege certain characteristics give you, such as being cisgender, heterosexual, and abled.

Target group: All groups

Time: 30 minutes

Materials: Character Cards **Handout 6**

Steps:

Hand out the character cards to the participants. Have participants line up on one side of the room in a straight line facing the same direction, shoulder to shoulder. This is also an opportunity to break out the session and head outside. This may also be an option is the room is not large enough. Read the following out loud, and ask persons to follow the instructions based on the character traits they hold in their hands:

1. Take a step forward if you are White
2. Take 2 steps forward if you are a Man
3. Take a step forward if you are a Woman
4. Take a step forward if your gender and sex match
5. Take 2 steps forward if you are Fully Abled
6. Take a step forward if you have a mental disorder (e.g. Depression/ Anxiety)
7. Take 3 steps forward if you have a degree above undergraduate
8. Take 2 steps forward if you have an undergraduate degree
9. Take a step forward if you have a college degree
10. Take 2 steps forward if you are a citizen fromthe global north (e.g. UK, US, Canadian)
11. Take a step forward if you have a dual citizenship from the global north.
12. Take 2 steps forward if you earn over 100K
13. Take a step forward if you earn of 50K

Reflection:
Ask the participant in the lead why they think they are where they are. Then ask the participant at the back why they think they are where they are. Then ask the participants in the middle if they can identify any reasons that prevented them from moving farther up

Summarise:

- We can see the instant effects some characteristics have on a person's ability to earn a living. Characteristics like being trans or having a disability can prevent persons from having a proper education and therefore limit their possible career prospects.
- Persons with some mental disorders are able to hide them unlike those with physical disorders, and therefore they can integrate themselves into the general population easier.
- Your level of education can also affect your career prospects, even though in reality it isn't always the case.
- Citizenship also affect privilege because it determines your ease of movement. Those with global northern citizenships and dual citizenships do not need to apply for visas or other such documentation to travel.

ACTIVITY E: TALKING ABOUT SEX—BREAKING THE SEX ICE

Facilitator's Note: We often find it difficult to talk about sex even if it plays a role in the advice we offer to clients. Talking about sex that is considered "immoral" or "abnormal" may increase our discomfort. Our views about what is "appropriate" sex may lead to a lack of acceptance of people who do not conform to our own or society's views about what is proper sexual behavior. These views about sex fuel stigma against the LGBTQ+ community. Because our attitudes and beliefs about sex can lead to stigma, we need to help participants talk more openly about sex. These exercises can help to achieve this objective.

The exercises below are optional. Choose the exercise or exercises suited to your group.

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

- Talk more openly about sex and their feelings about different types of sex.
- Recognize that beliefs about what is "acceptable" or "proper" sex is one of the root causes of stigma toward LGBTQ+ persons.

Target group: All groups

Total Time: 30 minutes

Materials: Character Cards **Handout 6**

Adapted from: USAID/PEPFAR. 2015. Facilitator's training guide for a stigma-free health facility: Training Menus, Facilitation Tips, and Participatory Training Modules.

EXERCISE I: First thoughts about sex

Time: 15 minutes

Materials: Cards, markers, tape

Steps:

Cardstorm

Write the word "sex" on a title card and tape the card on the front wall. Divide into pairs, hand out cards and markers, and ask, "What are your first thoughts when you hear the word 'sex'?" Ask the pairs to write down the first things they think about on the cards—and then tape them on the wall around the title card "sex." Then divide into four groups and give each group one of the following questions to discuss:

1. Why is it difficult to talk about sex?
2. What are the social norms around sex?
3. What is the link between sex and stigma?
4. Why is it important to be able to talk about sex?

EXERCISE II: Secret Vote - Anonymous Participatory Sex Survey

Time: 20 minutes

Materials: Papers, pens, flipchart, marker

Steps:

1. At least two facilitators are needed to run this exercise: one facilitator at the front of the room to read the questions, 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 10 slips of paper to each participant.
4. Ask each question and tell participants to record their answers on a slip of paper and fold it up. Collect the slips after each question and record the results on a flipchart. Do not present these results until all of the questions have been asked.
5. Present and discuss the results. You can draw up 4 columns each with the headings of Question, Yes, No, Total. Then ask, "How did you feel answering the questions? What did you learn from the exercise?"

Example Questions:

1. **C**an 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?
11. Have you ever been paid for sex?
12. Have you ever been attracted to someone of the same sex?

EXERCISE III: Why do people have sex?

Time: 20 minutes

Materials: Flipchart, markers

Steps

Split into gender groups. Give the women a flipchart with the question: "WHY DO WOMEN HAVE SEX?" Give the men a flipchart with the question, "WHY DO MEN HAVE SEX?" Bring the groups together and share the answers. Once participants have finished, discuss, "What did we learn from this exercise?" "Why do gay men, lesbians, bisexuals, and transgender persons have sex?"

EXERCISE IV: What have you always wanted to ask men/women about sex?

Time: 20 minutes

Materials: flipchart, marker

Steps:
Divide into two groups—a men's group and a women's group. Ask each group to make a list of questions about sex to be asked to the other group. Then swap the lists and ask the men and women to discuss the questions in their groups. Ask the men's group and then the women's group to present their answers. Then ask, "What did we learn from this exercise?"

NB: *There is no guidance for handling the multitude of questions that could arise from this exercise, so it should only be attempted by facilitator(s) with significant experience, comfort and knowledge about sexual issues.*

Example responses:
Questions asked by WOMEN to MEN

- How can you tell that a woman has reached orgasm? How can men help women reach orgasm? Why are men selfish in sex (i.e., thinking only of their own pleasure)?

- Why do men feel the need to sleep with different women at the same time?
  Questions asked by MEN to WOMEN
- Why do women fake orgasm sometimes? Why don't women like sex sometimes?
- How can a man help a woman get aroused for sex? What is your favorite sexual position?

Summarise:
Summarise the main points that participants have made during the exercise. In giving your summary, you may use some of the following points if participants have not already mentioned them.

1. Discussing sex is taboo in many cultures. We have been socialized not to talk about sex. Parents find it hard to talk about sex with their children, teachers with their students, and health workers with their clients. Sexual partners often don't talk about sex.
2. We learn about sex at an early age from parents, siblings, friends, etc. Often we don't question these messages, and they become internalized and shape how we think about sex (e.g., shame, embarrassment). es, and they become internalized and shape how we think about sex (e.g., shame, embarrassment).
3. It is important to challenge and change these messages. Sex is not something dirty or secret—it is something beautiful. If we are going to learn more about sexuality, we need to get over this idea that sex is taboo and not to be discussed.
4. HIV can be transmitted sexually, so if we are to control the epidemic, we have to become better at talking about sex and learn to talk about it in a non-judgmental way.
5. The more we talk about sex, the more comfortable we are talking about it.
6. Our views about the sexual practices of marginalized groups, such as the LGBTQ+ community are a major factor in stigma. We might judge or stigmatize some groups for having "immoral" or "abnormal" sex (male-to-male sex, oral sex, anal sex, sex for money). However, we have seen that they have the same reasons for having sex as heterosexuals—to experience pleasure, express love, and give others pleasure. Any sexual activity aimed at obtaining happiness and expressing love on the basis of mutual consent that causes no harm to one's health, economic condition, and dignity, should be respected—be it heterosexual, homosexual, or bisexual.

ACTIVITY F: COUNSELLING SKILLS AND VALUE JUDGMENTS

Facilitator's Note: This exercise helps health workers explore how their value judgments about certain types of behaviour or groups of people could affect the quality of their counselling in an HIV clinic. Sometimes these judgments lead to stigma: e.g., clients may be "rushed through" a session given inappropriate advice, avoided, or referred to other counsellors because a health worker refuses to see them. In countries where the HIV epidemic is concentrated and particularly affects key populations, such as sex workers, transgender persons and men who have sex with men, it is important that health workers have the skills to counsel these groups and are willing to ensure equal access to services for all clients.

The exercise provides counselling skills practice. The main focus of the practice sessions is to make health workers aware of the ways in which they may judge clients, and how their judgments affect the quality of the counselling. Explain that pairs will practice the first part of the counselling session, in which the counsellor is trying to establish rapport and find out about the client's concerns.

Objectives: By the end of this session, health workers will be able to do the following:
- Describe counselling situations that challenge their value judgments.
- Demonstrate how to use counselling skills to counsel clients from different backgrounds.
- Explain how their own value judgments could affect their counselling sessions

Time: 45 minutes

Materials: Flipchart, scenarios listed at end of exercise—give one to each group

Adapted from: USAID/PEPFAR. 2015. Facilitator's training guide for a stigma-free health facility: Training Menus, Facilitation Tips, and Participatory Training Modules.

Steps

Buzz and Brainstorm (5 *minutes*)
Divide into pairs and ask, "What situations might make us feel less comfortable in dealing with them as counsellors?" Give an example if needed; e.g., a man talking about his male partner or a sex worker who has been beaten by a client. Record responses on the flipchart—then select a few scenarios for the practice described below.

Counselling Practice (15 *minutes*)
Divide participants into groups of three. Explain that in each group, one person will play the counsellor, one person the client, and one person the observer. You are going to give the client in each group a role to play (without letting the counsellor know what that role is).

Explain that all of the role-plays will focus on the start of the counselling session. The role of the counsellor is to build rapport with the client, ensure confidentiality, and identify the client's concerns.
The role of the observer is to note whenever questions or statements from the counsellor contain a value judgment. Then hand out the scenarios (one to each group) and ask the groups to role-play the counselling session.

Large Group Discussion (10 minutes)
Bring the group back together and ask:
- Clients—How were you treated? Do you feel you were being heard?
- Counsellors— How did the session go?
- Observers—What happened? Did the counsellor make any value judgments?

Emphasize that the aim of the session is **not to assess counselling skills** but to help everyone become more aware of the ways in which we might make judgments about clients when we are counselling.

Stop-Start Counselling Practice (10 minutes)
Invite one pair to show the group a few minutes of their session in the centre of the circle. After a few minutes, shout "stop!" and ask—"How did it go? Did the counsellor make any value judgments?" Then invite other participants to take over the counsellor's role and continue the role-play. Explain that you or other participants will shout "STOP" when the counsellor makes a value judgment.

Processing: Ask
- What have we learned from this?
- How might our own value judgments interfere with the counselling process?
- What can we do if we find that our own judgments or inexperience are affecting the service we offer to a particular client?

Summarise: Draw out the main points from the discussion. Make some of the points below to add key things that may be missing:
- We need to be aware of how our values and judgments can affect our counselling practice.
- We need to accept and respect clients as they are, since this is one of th cornerstones of counselling.
- We should treat each client as an individual and be open to what they need to discuss.
- We need to respect each client's issues and explore the context in which they live to help frame good decisions.
- All clients have a right to access our counselling service and receive the same quality.
- Remember the key counselling principles—we need to accept everyone and be non-judgmental.

Developing a Code of Conduct:
Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

ROLES FOR CLIENTS—Counselling Role-plays
Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their patients. Keep a record of this list of changes.

- You are a man and have been with your male partner for two years. Two days ago, he told you that he had fallen in love with someone else and was leaving you. He also said that you should get checked for HIV. You are feeling very sad and start crying in the counselling session.
- You sell sex as a way of surviving but you hate what you do and worry all the time about HIV. You are scared to tell the counsellor what you do, but you want to find out if they can help you find a way to get out of sex work.
- You are a sex worker and really enjoy meeting different people and earning money. There are some sexual practices, e.g., anal sex, that you want to ask the counselor about, to see if there is a risk of HIV and get some advice—but you are not sure how the counselor will react.
- You have been given a positive result for HIV and are feeling very angry. All you can talk about to the counselor is how it is all your wife's fault, and that you will make sure she is "punished" when you get home.

- You are a woman and have come to find out information about HIV risks. Your husband has started insisting on anal sex and you are feeling embarrassed to ask, but you need to know how to protect yourself.
- You are a young woman and have realized that you are pregnant. You are not ready to have a baby, and your relationship with your boyfriend is not going well. You want to find out how to have an abortion.
- You are a prisoner and have been brought to the health facility because you are sick. You want to tell the counselor that you have been forced to have anal sex with other prisoners and find out what to do.
- You are a young man and have realized that you are more attracted to other men than to women. You want to talk to the counselor about how you are feeling, and where to meet other gay men.
- You have returned to the clinic after telling your husband about testing HIV positive last week. Your husband has left you and the children, and is threatening to tell the whole family.

ACTIVITY G: CHALLENGE THE STIGMA IN YOUR ORGANIZATION

Facilitator's Note: This exercise looks at how to challenge stigma toward marginalized groups in your day-to-day work. Participants learn how to be assertive and then practice this skill in a series of paired role-plays. The aim is to help people see that acting against stigma can be done whenever it happens.

Objectives: By the end of the session, participants will have the skills to challenge stigma and change the situation using an assertive approach.

Target group: All groups

Time: 45 minutes

Materials: Flipchart, markers

Adapted from: USAID/PEPFAR. 2015. Facilitator's training guide for a stigma-free health facility: Training Menus, Facilitation Tips, and Participatory Training Modules.

Steps:
Introduction

Explain that the session is aimed at practicing how to challenge stigma in an assertive way, i.e., looking the stigmatizer in the eye and saying what we think, feel, and want in a clear, forceful, and confident way, but without being aggressive or showing anger.

Paired Role-playing
Explain that we will now practice how to challenge stigma and discrimination in different common work situations by taking one issue at a time. Then give the following instructions:

EXAMPLE ROLE-PLAY for LGBTQ+ persons
Everyone stand up, find a partner, and face that partner. You are both employees. Make a role-play about the following situation: A complains to B about a client/patient/parent (for workshops with participants from the education sector), saying that the client/patient/parent (who is assumed to be a gay man) is disgusting and immoral. Employee B should respond in a strong and confident way. Play!
A. I don't know why we are dealing with this gay man. He is mentally sick and a danger to everyone.
B. He is no different from anyone else. He just happens to love men, not women.
A. But he is having sex with men, which is against our culture and religion.
B. We can't use our religion to not offer services to people, and he is a part of our culture too.

A. Okay, but I don't know why we have to deal with him. He should go somewhere else.
B. As professionals we have a Code of Conduct. We need to treat all of our clients equally. We cannot stop serving/talking to a person because we don't like him. It is part of our responsibility as professionals to provide services to everyone in the community.

After two minutes, ask a few pairs to show their role-plays (one at a time) in the center of the circle. After each role-play, ask, "How did the 'challenger' do? What approach was used by the challenger? Did it work? What other approaches might be used?"

COMMENTS ON ROLE-PLAYS

- Good eye contact—looked employee A in the face. Strong voice. Spoke with confidence.
- Didn't criticize the stigmatizer; simply explained her responsibility as a professional.
- Good arguments: "He is no different from anyone else."
- She was not afraid to disagree with her colleague. Did not back down, apologize, or allow the first employee to dominate her. She quietly insisted that the other employee do her job.
- After each performance, ask other participants if they have a better way of challenging the stigmatizer and let them take over the challenger's role in the play and show their approach. After each new attempt, ask, "What made a difference?"(Examples: good arguments, strong voice level, body language, confidence, etc.)
- Repeat the paired role-playing for other scenarios. For each new scenario, the partners should take turns playing the "stigmatizer" and "challenger" roles.

OTHER SCENARIOS

Health care and mental health participants:

- The manager of the health facility is enforcing a stigmatizing policy (e.g.,forcing key populations to get HIV testing without their consent). The health worker approaches the manager to explain the effect of the policy on client and discuss changing it.
- One health worker refuses to treat a male sex worker who is waiting in line. Try to challenge the stigmatizer.
- Two men enter the clinic and say they are a couple and have come for an HIV test. The counselor says they should go to another clinic. Try to challenge the stigmatizer.

Corporate/General population participants:

- The manager of the company is enforcing a stigmatizing policy (e.g., persons must disclose their sexual orientation when being hired). The employee approaches the manager to explain the effect of the policy on employees and discuss changing it.
- One cashier refuses to deal with a trans woman who is waiting in line. Try to challenge the stigmatizer.
- Two men enter the business and say they are a couple and have come for to sign up for your company's services. The receptionist says they should go to another company. Try to challenge the stigmatizer.

Education participants:

- The principal of the school is enforcing a stigmatizing policy (e.g., only heterosexual teachers will be hired). The teacher approaches the principal to explain the effect of the policy and discuss changing it.

Law enforcement participants:

- The police sergeant is enforcing a stigmatizing policy (e.g., persons have to declare thei sexual orientation before hiring). The officer approaches the sargeant to explain the effect of the policy and discuss changing it.
- One police officer refuses to take the report of trans man. Try to challenge the stigmatizer.
- Two women enter the police station and say they are a couple who have been harassed for their identity. The officer says they should go to another station, even though that is the correct station for lodging such a report. Try to challenge the stigmatizer.

Service Industry participants:

- The manager of the hotel is enforcing a stigmatizing policy (e.g., forcing gay employees to get HIV testing). The employee approaches the manager to explain the effect of the policy and discuss changing it.
- One bartender refuses to serve a trans woman. Try to challenge the stigmatizer.
- Two men book into the hotel as a couple with a shared room. The receptionist says they should go to another hotel. Try to challenge the stigmatizer.

Media participants:

- The manager of the TV station is enforcing a stigmatizing policy (e.g., forcing all gay employees to get HIV testing). The employee approaches the manager to explain the effect of the policy and discuss changing it.
- One reporter refuses to interview a trans woman. Try to challenge the stigmatizer.
- Two women want to submit their entry for a couples contest but the receptionist says they aren't eligible, even though the rules say nothing about the sex or gender of contestants. Try to challenge the stigmatizer.

EXAMPLE ROLE-PLAY for Persons with disabilities

Everyone stand up, find a partner, and face that partner. You are both employees. Make a role-play about the following situation: A complains to B about a client/patient/student (for workshops with participants from the education sector), saying that the client/patient/student (who has a mental illness) is "retarded" and "crazy". Employee B should respond in a strong and confident way. Play!

A. I don't know why we are dealing with this psycho. He is mentally sick and a danger to everyone.

B. He is no different from anyone else. He just happens to have a mental health disorder

A. But he should be locked away in the mad house.

B. The vast majority of persons with mental illnesses are not violent and he doesn't seem to be either. Actually with medication he can lead a regular productive life.

A. Okay, but I don't know why we have to deal with him. He should go somewhere else.

B. As professionals we have a Code of Conduct. We need to treat all of our clients equally. We cannot stop serving/talking to a person because we don't like him. It is part of our responsibility as professionals to provide services to everyone in the community.

After two minutes, ask a few pairs to show their role-plays (one at a time) in the center of the circle. After each role-play, ask, "How did the 'challenger' do? What approach was used by the challenger? Did it work? What other approaches might be used?"

COMMENTS ON ROLE-PLAYS

- Good eye contact—looked employee A in the face. Strong voice. Spoke with confidence.
- Didn't criticize the stigmatizer; simply explained her responsibility as a professional.
- Good arguments: "He is no different from anyone else."
- She was not afraid to disagree with her colleague. Did not back down, apologize, or allow the first employee to dominate her. She quietly insisted that the other employee do her job.

- After each performance, ask other participants if they have a better way of challenging the stigmatizer and let them take over the challenger's role in the play and show their approach. After each new attempt ask, "What made a difference?" (Examples: good arguments, strong voice level, body language, confidence, etc.)
- Repeat the paired role-playing for other scenarios. For each new scenario, the partners should take turns playing the "stigmatizer" and "challenger" roles.

OTHER SCENARIOS

Health care and mental health participants:

- An employee with a diagnosis of bipolar disorder has had frequent short-term disability leaves. The workplace's policy is to welcome back employees away from work for more than six weeks with a gift basket at their workstation but the manager doesn't want to give them the gift basket. The employee approaches the manager to explain the effect of this decision and discuss changing it.
- A porter is heard making fun of a young woman with cerebral palsy. Try to challenge the stigmatizer.
- The nurse tells a person using a wheelchair that they're taking up too much space in the crowded clinic and should find another clinic. Try to challenge the stigmatizer.

Corporate/general population/service industry/media participants:

- An employee with a diagnosis of bipolar disorder has had frequent short-term disability leaves. The workplace's policy is to welcome back employees away from work for more than six weeks with a gift basket at their workstation but the manager doesn't want to give them the gift basket. The employee approaches the manager to explain the effect of this decision and discuss changing it.

- A guard is heard making fun of a young woman with cerebral palsy. Try to challenge the stigmatizer.
- The receptionist tells a person using a wheelchair that they're taking up too much space in the waiting area and can't be served now. Try to challenge the stigmatizer.

Education participants:

- A teacher with a diagnosis of depression has had frequent short-term disability leaves. The workplace's policy is to welcome back employees away from work for more than six weeks with a gift basket at their workstation but the principal doesn't want to give them the gift basket. The employee approaches the principal to explain the effect of this decision and discuss changing it.

- A student is heard making fun of a young woman with cerebral palsy. Try to challenge the stigmatizer.
- The canteen attendant tells a person using a wheelchair that they're taking up too much space in the crowded canteen and can't be served. Try to challenge the stigmatizer.

Law enforcement participants:

- An employee with a diagnosis of bipolar disorder has had frequent short-term disability leaves. The workplace's policy is to welcome back employees away from work for more than six weeks with a gift basket at their workstation but the head officer doesn't want to give them the gift basket. The employee approaches the head officer to explain the effect of this decision and discuss changing it.
- An officer is heard making fun of a young woman with cerebral palsy. Try to challenge the stigmatizer.
- The receptionist tells a person using a wheelchair that they're taking up too much space in the waiting area and can't be served now. Try to challenge the stigmatizer.

Processing: Ask, "What have you learned about the best ways to challenge stigma?"

Example responses:

- Avoid getting upset—stay calm. Don't raise your voice.
- The best approach isto say it honestly, clearly, and simply: "This is wrong."
- When I challenged her politely but firmly, she denied that she was stigmatizing. Avoid condemning this person and telling him/her he is wrong.
- Ask questions to help clarify why this person is stigmatizing the client.
- Help the person think about her behavior and how it affects the client.
- Urge the stigmatizer to think about her own experience of being stigmatized—and how it felt.
- Help the person deal with her fears toward the client.
- Explain your argument for treating the client in the same way as other clients.
- Encourage the person to take responsibility for caring for the client.

Summarise:

We can all challenge stigma on an individual level, using an assertive approach. When stigma leads to discrimination, you may need to develop policies or a Code of Conduct to protect clients. Involve senior managers in this process. The most powerful responses to people who are stigmatizing are those that make the stigmatizer stop and think, rather than attacking responses, which can make the stigmatizer defensive. These are examples of strong responses:

- You are probably not aware that you are stigmatizing.
- LGBTQ+ persons do not choose to be LGBTQ+. This just happens; it is natural.
- We have a Code of Conduct as professionals to serve everyone.

Explain and discuss the following list of assertiveness techniques:

- Tell people what you think, feel, and want—clearly and forcefully.
- Say "I" feel, think, or would like.
- Don't apologize for saying what you think, or put yourself down.
- Stand or sit straight in a relaxed way.
- Hold your head up and look the other person in the eye.
- Speak so that people can hear you clearly.
- Stick with your own ideas and stand up for yourself.
- Don't be afraid to disagree with people.
- Accept other people's right to say "no" and learn how to say "no" yourself.

Developing a Code of Conduct:
Ask participants, based on the discussion, to suggest two to three changes they could make in their organization to reduce stigma towards LGBTQ+/PWDs. Keep a record of this list of changes.

ACTIVITY H: BYSTANDER INTERVENTION IN PUBLIC

Facilitator's Note: This training will focus on ways to intervene in public instances of racist, anti-Black, anti-Muslim, anti-LGBTQ+, anti-PWD and other forms of oppressive interpersonal violence and harassment while considering the safety of all parties. We do not believe anyone is an expert on bystander intervention as different situations and one's own risk factors will influence how they intervene; however, we seek to hold space for people to share skills and experiences in a safer and affirming environment.

Objectives: Persons would have built confidence for situations where they're intervening as a third party or stranger(s), sharing tips and collective knowledge to gain confidence and to get used to the messiness when trying to respond - because harassment and interpersonal violence are messy.

Target group: All groups

Total time: 1 hour

Materials: Projector, flip chart, markers, **Handout 7**

Adapted from: The people's response team. Bystander Intervention 101: Training Guide.

Steps:
Start with Intervention Basics (10 minutes)
Getting ready to intervene...
Ask: What are the biggest barriers to intervening and remaining a bystander?
After hearing some ideas, share that these are the most common two: Not having the confidence that you know what to do AND Fear of making it worse.

Bystander intervention training has two main goals in mind:
- Reduce harm in the moment - make our presence known to the targeted person.
- If it's a verbal/argumentative attack - the goal isn't to convince the perpetrator they are wrong, it's to show observers an alternative.

Say:
If we approach bystander intervention with those two goals in mind, it helps to remind us that it is hard to actually make a situation worse, and that there doesn't need to be a "right answer" in order to show support to someone being targeted for harassment.

How do you know if/when a situation needs intervention?

- BE ALERT, SCAN YOUR ENVIRONMENT *A note on headphones - many of us wear headphones as a preventative measure. It's a universal language for 'don't talk to me.' At the same time, having the music up loud can mean that we miss important audio clues that a situation is escalating. That's just something to keep in mind.
- Notice how your body is responding. Do you have that sinking pit feeling in your stomach? Is your heart racing? What is your baseline for intervention?
- Remember to breathe.

Instruct the group to square their feet with their shoulders, sit up-right in the chairs, take a deep breath (so they feel it in their belly), and practice saying "no" assertively.

Try to resist the urge to count to 3 or say it at the same time, the goal is for people to work through the discomfort of hearing their own voice, so it's important to have it be free-flowing.

- Go into a situation with a buddy whenever possible. It can help keep everyone safer. If you are with friends, make sure they are aware of the situation you are intervening in, so that they can have your back.
- If you are alone, but you notice other people observing a situation, try to make eye contact with someone before taking action.

EXERCISE I: Speak up! (10 minutes)

In this exercise you learn how to attract the attention of bystanders just with the help of your voice. Often people are unaware of the actual power their voice can have. Addressing people around you in a clearly audible and distinct way will give you the confidence to demand attention when getting caught up in a difficult situation.

Preparation:

Think about a situation in which it is important to gain the attention of others. Here are some examples: You notice a fire; you note somebody stealing a woman's handbag; you see somebody being harassed. Think about what you could say or do to point to the problem and how you can make yourself heard. Perhaps even make a short one-line script for yourself.

Scene:

Now all participants of the exercise stroll around the room and start speaking all at once. At some point the facilitator randomly taps a person on the shoulder. They then try to draw everybody's attention to the imagined problem just by means of their voice.

Debrief:

Did you manage to attract attention? If yes, what do you think was the reason? If not, what was the problem? How did your intervention affect the others? Did they understand the message you were trying to get across? Discuss your opinions and observations with other members of the group. Repeat the exercise until everybody has given it a try.

This easy exercise strengthens confidence and ability to point to an emergency situation loudly and distinctly. We do this exercise NOT to imply that being loud and drawing attention to an incident is always what's needed. Remember we are building confidence, which is needed no matter the strategy you employ to intervene.

EXERCISE II: Overview of DO'S and DON'T'S (10 minutes)

- Distribute the Do's &Don'ts handout that can be found in **Handout 7**
- Have volunteers read each segment of text out loud, including the explanation of the handout at the top. Ask if there are any questions as you go along.

Important Note: *"Don't Call The Police" is one of the strategies, because some see this as an important intervention in the vast majority of resources that exist for Bystander Intervention. Many guides encourage people to delegate conflict resolution to the police as an immediate/first step. However, there are risks in calling the police, especially in situations that have not yet escalated to physical violence. It's also included because we want to encourage individuals and communities to build capacities to resolve situations without relying on harmful institutions such as the police. However, if the police in your community are sensitized and deals well with conflicts involving bigotry, racism or sexism, you could call them as a first resort.*

There are of course going to be situations in which the person being harassed or targeted may ask you to call the police, an ambulance, or 911 on their behalf, and we would encourage people to recognize that if authorities are reached out to we would hope it would be with the consent of the person experiencing the harm/risk.

- Ask if there are any questions about the other suggestions on the Do's & Don'ts handout, and make clear that during the next portion of the training, there will be time to practice these strategies and see them in action.

EXERCISE III: Role play (30 minutes)

There are many ways to structure this section. If you have a relatively small group, we suggest keeping the group together. If you have a large group, we suggest breaking into smaller groups, and allowing each small group to experiment with the different role-plays. It is important to debrief altogether to share in the learning.

1. Read/share the scenario with everyone. Be sure to have one of the facilitators moderate each scenario, to direct the actors as needed and facilitate the debriefs.
2. Have the volunteers role-play how they would respond, without any guidance from the facilitators (3-4 people per scenario)
3. Briefly debrief with the actors and audience - what did you notice?
4. Role-play it again (with new people, or with the same people but using suggestions from the debrief)
5. Debrief the role-play again.
6. Take notes on a flip chart paper to track "STRATEGIES" for bystander intervention.
7. Be sure to chart the D's of De-escalation Strategies in the debriefs, on flipchart paper. It is a helpful way to remember these strategies later.

Things to keep in mind before role-plays: *Share visual reminder about "Growth Zone" (drawing three concentric circles on flipchart paper is a simple way to demonstrate this). Comfort zone is the first circle, growth zone is circle surrounding that and panic zone is the third circle surrounding previous two circles.*
Say: If we stay in our comfort zone, it is harder to learn. We also don't want people to take such intense risks that they feel panic or undo stress. We encourage participants to challenge themselves to enter their "growth zone" while participating in this workshop.

We DO NOT advise using actual slurs or using real physical force during role-plays.

SCENARIO 1: Verbal harassment on the bus, where the person being targeted appears uncomfortable and unsure of how to respond.
Description: You are riding on the bus, it's crowded, and notice a man muttering slurs and threats under his breath towards a younger person near him (assumed to be gay/or has a wheelchair). You are nearby and notice there is more room on the other end of the bus. What do you do?
3 Volunteers needed:

- Actor (aggressor) – should be a facilitator
- Actor (targeted person)
- Actor (intervener)

NOTES FOR BIG GROUP DEBRIEF:
DE-ESCALATE: In this kind of a scenario, it can be highly effective to act as though you know the person. Saying something like "Hey I haven't seen you in so long, wanna go catch up over here?" can open up opportunities for the person experiencing harassment to accept your support and leave the situation, or reject your support by saying they don't in fact no you. Though it may feel silly/vulnerable it can be highly effective, and the worst that happens is you apologize for mistaking them for someone else.

SCENARIO 2: Public, Verbal Abuse where the person being targeted is responding assertively.
Description: You and your friend are walking in a crowded shopping area, and you overhear yelling. You stop and notice that a man is shouting aggressively at an older woman with a cane including telling her to "get a job." She is yelling back and pointing her cane at him, telling him to leave her alone. What do you do?
4 Volunteers needed:

- Actor (aggressor)
- Actor (targeted person)
- Bystander who intervenes and their friend

NOTES FOR BIG GROUP DEBRIEF:
BE DIRECT: Here we think it's important to respect the tone of the person being harassed, and consider supporting them rather than acting as a neutral bystander. Especially if there are clear power dynamics of race, class or gender at play. The bystander could join with the woman to tell the man to leave her alone. Then check in with the woman and offer further assistance as needed such as walking to next destination. This is not de-escalating the situation, but simply expressing support for the person being harassed and affirming her agency in shutting down the attack.

SCENARIO 3: Verbal altercation that's escalating, between two people who appear to know each other.
Description: You are leaving a store at the mall and overhear what appears to be a couple arguing about money, with one party accusing the other of over-spending and raising their voice at them. At a certain point they get physical and grab the other person's wrist and shake them, while still yelling about their money. What do you do?

Alternate Scenario: You are in a store and notice a manager aggressively shaming an employee, who appears uncomfortable and embarrassed. What do you do?
3 Volunteers needed:

- Actor (aggressor) – should be a facilitator
- Actor (targeted person)
- Bystander who intervenes

NOTES FOR BIG GROUP DEBRIEF:
DISTRACT: The strategy we have most consistently heard advocated and experienced as being effective is to approach the situation with the intention to DISTRACT. In situations where intimate partner violence may be occurring, it can endanger the person later to argue on their side, or point out that you think it is harassment or violent. Simply asking a question like, "is everything okay here?" or "I live close by - just wondering if either of you need anything?" or being even more subtle like asking for directions can de-escalate without bringing extra attention to the person being harmed.

In institutional settings, reminding people that they have responsibilities to attend to can be helpful. For example, if you noticed the alternative scenario happening, walking up and asking 'where can I find a certain item?' can de-escalate and allow the employee some immediate relief.

SCENARIO 4: Physical Attack
Description: You're leaving a party, and you notice that several people who appear drunk are shoving another person who seems non-confrontational, but also unable to get away. What do you do?
6 Volunteers needed:

- Actors (3 aggressors)
- Actor (targeted person)
- Bystander who intervenes and their friend

NOTES FOR BIG GROUP DEBRIEF:
DELEGATE: Situations involving physical violence mean there is a greater risk of a bystander also experiencing violence by becoming involved, but it also raises the stakes and urgency of intervention. While there is no single answer for how to intervene, we suggest always finding another person to support you, and/or notifying a friend or loved one (via text or a phone call) if you are intervening in a situation of physical violence.While many believe this is the moment to call the police, acting as a witness and threatening to call the police (or acting as though you are on the phone with them) can also be sufficient to scare off an attacker. Trust your instincts, assume the level of risk you are willing to, and proceed with caution. If you decide to intervene physically consider whether it is more strategic for you to try to shield the person being attacked, help them move to a different location, or directly confront the attacker. There is a huge range of possible responses, and they could have a variety of outcomes, always depending on a number of circumstances.

SCENARIO 5: A situation involving the police harassing a stranger.
Description: You and a friend are walking home past a shop and notice two police officers harassing someone you appear to be homeless and telling them they cannot sit on the sidewalk. You also observe that the manager/employee of the store is watching the situation. What do you do?
6 Volunteers needed:

- 2 Police Officers
- Actor (targeted person)
- Bystander who intervenes and friend
- Store Manager

NOTES FOR DEBRIEFING THIS SCENARIO:
In this particular scenario, we would hope that the bystanders would engage the store manager to encourage them to assure police that the person was welcome and/or not causing problems. People with institutional power in a situation involving police can have far more influence that bystanders/passersby without an apparent relationship or connection to the situation. We would also hope that one of the bystanders would ask

the person who appears to be homeless whether they are okay, if they need anything, or if they would like us to wait with them until the police leave. One of the biggest myths about cop-watching is that it means antagonizing/engaging with cops themselves. While any engagement during a situation involving police will likely be bothersome to officers, we have seen it be very effective to try to communicate directly with the person they are questioning and/or arresting instead of the officer. This also shows the officers that they are being watched.

Wrapping Up (10 minutes)
- What was one new tool you gained today?
- What did you find challenging?
- What was missing from the training?
- What would you do differently if you lead this training?
- Anything else?

Closing
Say: We are going to say "No" loudly and firmly at the same time. Imagine all that we are rejecting with this word - state violence, interpersonal harm, sexism, racism, transphobia, homophobia, intolerance etc. And remember that by saying "no" to these things we are opening up space for alternatives, and practicing living and building the world that we want to see.
1-2-3- "NO!"

MODULE 3

LGBTQ+ POPULATIONS

MODULE 3:
LGBTQ+ POPULATIONS

This module aims to introduce participants to concepts about sexuality and gender. It goes thought the history of LGBTQ+ populations to help participants understand that sexual and gender minorities are not a new modern western influence. The module then breaks down LGBTQ+ populations and helps the participants better understand them while slowly progressing to more advanced concepts of LGBTQ+ populations. Depending on the time available and level of understanding of the concepts that that participants may have, you could stick to the basic activities, or you go straight into the advanced activities. What is advised is that you carry out all the activities on a basic level with the audience first and then have a shorter training using the advanced activities when following up.

The module then covers gender identities and using pronouns as cisgender persons do tend to have more difficulty understanding gender identity than sexuality (even cisgender LGB persons). The module then tries to help the participants understand the hardships the communities go through by helping them understand the process of coming out and the privileges they themselves have a cisgender heterosexual identifying persons and what it might be like to not have these privileges.

Lastly, the module goes through the importance of having an inclusive environment and the positive impacts it might have on service delivery, employee productivity and learning environments. There is a section at the end of the final exercise for employers and institutions on how to create a more inclusive environment and should be completed with the leaders on the organisations, e.g. Directors, management, HR Department, as they are the ones who have the influence to actually effect change.

ACTIVITIES

Activity A: History of LGBTQ+ Populations	Suitable for all participants	15 minutes
Activity B: Understanding LGBTQ+ Populations	Suitable for all participants	120 minutes
Activity C: Understanding Gender Identity + Using Pronouns	Suitable for all participants	90 minutes
Activity D: Putting yourself in LGBTQ+ Persons' Shoes	Suitable for all participants	40 minutes
Activity E: Reasons for Inclusion and Accommodation of LGBTQ+ Populations	Suitable for all participants	30 minutes

ACTIVITY A: HISTORY OF LGBTQ+POPULATIONS

Facilitator's Note: This activity is a very short lecture on the History of LGBTQ+ persons in history. It shows participants that being queer is not a "modern western influence" and that queer persons have existed since history began.

Objectives: By the end of this session, participants will be educated on the history of LGBTQ+ populations.

Target group: All groups

Total time: 10 – 15 minutes

Materials: Projector, **Handout 8**

Adapted from: Free and Equal United Nations. Sexual Orientation and Gender Identity Throughout History.

Steps:
Convert the points in **handout 8** into a Power Point presentation. Use a projector to project onto one of the walls, have participants arrange their chairs in a semi-circle or a lecture style, depending on how many participants there are.

If you don't have access to a projector you can distribute the handout before the activity so that participants can follow. If you do have a projector, distribute the handout at the end of the activity.

ACTIVITY B: UNDERSTANDING LGBTQ+ POPULATIONS

Facilitator's Note: This activity is divided into 4 exercises. Depending on timing 1 or more of the exercises can be done at one training.

Objectives:

- Participants will reflect upon their first impressions with LGBTQ people and identity,how this has evolved, and hear how diverse the group's experience with LGBTQ people and identity are.
- Understand the acronym that is LGBTQ, increase understanding of LGBTQ+ vocabulary and understand genders and sexualities are different.
- To emphasize how powerful language is and clear up any misconceptions or questions about terminology or common phrases.

Target group: All groups

Total time: 2 hours

Materials: Flipchart, markers, cards

Preparation: Hand out the participant Sheet [**Handout 9**] while explaining the activity.

Exercise I: First Impressions of LGBTQ People (Reflection Activity) (20 minutes)

Adapted from: The Safe Zone Project. First Impressions of LGBTQ People.

Facilitator's Notes: This activity helps participants ease into thinking about LGBTQ identity, people, and experiences from their own perspective. It can be effective at contextualizing the importance of the workshop or talking openly about these issues (and how often rare that open conversation can be). Participants sharing about their past (or present) views can expose a lot of prejudice. While some prejudice being named isn't inherently a bad thing, too much is unproductive to the learning outcomes. Try to invite shares from participants from a variety of views and perspectives. Keeping the debrief on the shorter side and moving through the questions quickly does not negatively impact the goals and will help you manage the feelings that may come up for folks.

Steps

1. Assure participants that this activity is primarily reflective and they won't be asked to share anything they don't want to. For example, "We are going to start with a reflective activity called First Impressions.

We're going to give you a few minutes to think on and write some answers to the list of questions on this sheet. These questions are for your reflection, we aren't going to collect your sheets or require you to share anything with the group that you don't want to. If there is any question you're struggling with skip it and come back at the end of the activity. We'll give you a few minutes here to answer the questions and then bring it back to the big group."
2. Give participants time to reflect (3-5 minutes).
3. Move into the debrief questions.
4. Wrap-up the activity.

Report Back

- What was it like to do that activity?
- Does anyone have something that came up for them while they were answering the questions that they would like to share?
- Does anyone have an experience that was significantly different that they'd be interested in sharing?
- What about question 5, would anyone share how their understanding of these issues have changed over time?

Summarise

- Highlight for participants that each of them have likely have shifted their understanding of LGBTQ people and identities over the course of their lifetimes and that this workshop may or may not also shift their understanding of LGBTQ people and identities.
- Often there is a mention of language or vocabulary that has shifted over the course of someone's.
- Exposure to the LGBTQ community and you can call back to this mention in order to create a seamless transition into vocabulary.

Make it your own

- These questions can be modified to focus more specifically on particular identitiesif you are doing a targeted training for example, "What was your first impression or initial conversations around LGBTQ identity within a medical environment?".
- They can also be modified in a way to focus on a particular subpopulation of the LGBTQ community, "What was your first impression of bisexual people?" or, "What is something that you are still unlearning about transgender identity?"
- Unlock the Magic: I you are not a member of the community, be an imperfect role model; this is an activity can be a space where you can share with participants your own development and journey. This can help assure participants that you identify with their stories or change and development and that they aren't alone in having unlearn and reconsider what they know about gender and sexuality.
- If you are of the community, you can share you journey of understanding your own sexuality by learning about the continuum that is sexuality and gender.

Exercise II: The LGBTQ+ Umbrella (20 minutes)

Adapted from: The Safe Zone Project. LGBTQ Umbrella

You can use this activity to gauge the participants' basic knowledge of LGBTQ+ Populations. However, you can also lead the discussion to speed up the process as other activities allow you to dive into the complexities of the LGBTQ+ community.

Preparation:
Draw an umbrella on a piece of flipchart paper. Make sure you have room to write the word "Queer" big and bold in the top of the umbrella, and that there is room to write "LBT" and Sexualities on the left of the umbrellas handle, and "T" and Genders. (Refer to **Handout 10** for ideal design)

Steps

- Start the activity by saying: "When we discuss 'LGBTQ' people, one thing we generally forget to make clear what, exactly, those letters mean. For example, there is no such thing as an 'LGBTQ' person. Lesbian, Gay, Bisexual, Transgender, and Queer are all different labels, representing different identities. Importantly, they are words that relate to folks' experiences of gender and sexual identities -- two things we often confuse for being one and the same. That is why this section is called 'LGBTQ+ Populations'."
- Draw the participants' attention to the umbrella handle. Tell them: "While these identities are all often grouped together under this umbrella, there are distinctly different aspects of our humanity and experience: sexuality and gender. The handle indicates that these are septate aspects."
- Now write the words "Sexualities" and "Genders" on each side of the handle, but under the umbrella.
- It's best to work your way backwards through the acronym, as Queer is the umbrella term. Ask participants if any of them understand the term Queer and where on the Umbrella do they think it should go.
- Q, generally meaning "Queer", is often used as an umbrella term, in an affirming and positive way, to lump all marginalized sexualities and genders together.
- This used to be a derogative term that the community has reclaimed, as some persons also use it to describe themselves if they either don't identify directly with a gender or sexual identity, or are still trying to figure out their gender and sexual identity.
- Write "Queer" in the top of the Umbrella while explaining the last two points.
- Ask them if they understand Transgender, and ask them if they think it should be under "genders" or "sexualities".

- While writing “T” under the umbrella on the right side say “Transgender refers to a gender description for anyone whose sex assigned at birth and gender identity do not correspond in the expected way (e.g., someone who was assigned male at birth, but does not identify as a man). It can also be an umbrella term in itself, as you have transmen and transwomen, but we will discuss transgender in more detail inlater activities”.
- Repeat the with “L”,”G” and ”B”, asking them which side of the umbrella they go under (in this case they all go under sexualities”), making the following points as you write the letters on the flipchart paper:
  - B– Bisexuals are persons who experience attraction to their own and other genders.
  - L– Lesbians are women who are primarily attracted romantically, erotically, and/or emotionally to other women.
  - G– Gay in the case of the acronym, is used to refer to men who are attracted to other men, However, it can also be used as an umbrella term for anyone who is attracted to the same gender as the one they identify as.
- Recap by saying “When we say sexual identities, sexualities, or sexual orientations, we are talking about are the ways we categorize and define who we are attracted to. When we say “gender identities” we are talking about the ways we categorize and define our genders.
- On one side we have queer sexualities (Lesbian, Gay, and Bisexual, to name a few), and on the other we have queer genders (Transgender, to name one), and we often group all of these under the umbrella term of “queer.”

Exercise III: The Gender and Sexuality Continuum (60 minutes)

Adapted from: Health Policy Project. 2013. Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator’s Guide; Illustrations by Petra Rohr-Rouendaal.

This exercise looks at the different identities within the LGBTQ+ community and how they are treated by the larger community. The first half of this activity will help to build understanding about different terminologies that are used in relation to sexuality, including biological sex, gender identity, gender roles/expression, sexual orientation, and sexual behaviour. It is important to recognise that these identities are held by everyone, not just sexual minorities. A heterosexual man, for example, may not be attracted to other heterosexual men but have female gender expression, acting in a feminine way.

You will need to provide accurate information to respond to all the questions which might come up in this exercise. So arrange for LGBTQ+ representatives to attend this session to help explain these issues if possible, and use the Fact Sheets as an extra resource. Make sure that the resource persons are fully briefed beforehand and aware of what is being asked of them.

Part I: Understanding the Continuum (30 minutes)

Steps

Explain that many people think that all persons from LGBTQ+ Populations can be identifiable, e.g. that all gay men, bisexuals, and transgender people all look, dress, and behave in a similar fashion. This is not true. Gay, bisexual and transgender people have many different identities, and we need to be able to understand the differences if we are to respond to their needs effectively. This exercise will help to explain the different identities.

Acknowledge that some participants might have very strong views about this topic. Explain that you will respect every person's right to his or her opinion, but emphasise that this topic is important to discuss because it is a human rights issue and an important part of every individual's sexuality. Remind them that you just providing them with the information, not trying to change their beliefs. They have the right interpret the information in their own way. Invite participants to ask questions as you explain and discuss the following information.

Use the **Handout 11** to explain these concepts.

- Write 'BIOLOGICAL SEX' at the top of a flipchart sheet and draw a line immediately below it. Label one side of the line 'Male,' the other side 'Female,' and place 'Intersex' in the middle. (**See handout 11**) Then explain: Most children are born male or female, but some people are born with full or partial genitalia of both sexes, underdeveloped genitalia, or unusual hormone combinations.

  We say these people are 'intersex.'
- Draw a second line and title it 'GENDER IDENTITY 1' . Lable one side "Cisgender" and the other "Transgender. Explain that a person's GENDER IDENTITY is not always the same as their biological sex. When a person feels that their personality, their inner self, is the same as their biological sex, we say that the person is 'cisgender.' When a person feels that their personality, their inner self, is different from their biological sex, we say that the person is 'transgender.' A transgender person may decide to wear clothing of another gender, decide to change thier biological sex (called 'gender affirming surgery'), or do nothing at all. Explain that a 'trans woman' is a person whose biological sex is male, but identifies as a woman; a 'trans man' is a person whose biological sex is female, but identifies as a man.
- In the midpoint, place 'Gender fluid'. Explain that gender fluid is a gender identity best described as a dynamic mix of boy and girl. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more man some days, and more woman other days.
- Draw a third line and title it 'GENDER IDENTITY 2'. Label one side 'Male' the other side 'Female'. The midpoint and be either 'Agender or 'Gender Fluid'. Explain that an agender person is a person with no (or very little) connection to the traditional system of gender, no personal alignment with the concepts of either man or woman, and/or someone who sees themselves as existing without gender. Sometimes called gender neutrois, gender neutral, or genderless.

Advanced: Add 'two-spirit' to the midpoint. Explain that two-spirit is an umbrella term traditionally within Native American communities to recognize individuals who possess qualities or fulfil roles of both genders.

- Draw a forth line and title it 'GENDER EXPRESSION/ ROLES.' Label one side 'Masculine' and the other 'Feminine.' Explain that gender roles are society's expectations of how men and women should act. Often, when a man acts in a feminine manner, he is assumed to be homosexual, but this may not be true, because gender roles and sexual orientation are different. Explain that a person's gender roles can also move across the continuum over time or can change in a given situation.
- Draw a fifth line and title it 'SEXUAL ORIENTATION.' Label one side 'Homosexual,' the other side 'Heterosexual,' and the mid-point 'Bisexual." Explain that sexual orientation can be seen as a continuum, from homosexuality to heterosexuality, and that most individuals' sexual orientation falls somewhere along this continuum. While individuals cannot change their sexual orientation at will, the expression of one's sexual orientation might change throughout a person's lifetime. So an individual's orientation can move along the continuum as time passes. Most people, however, do not change much during their life.
- Draw a sixth line and title it 'SEXUAL BEHAVIOUR.' Label one side 'Sexual', and the other side 'Asexual'. Explain that asexual persons experience little or no sexual attraction to others and/or a lack of interest in sexual relationships/behavior. Asexuality exists on a continuum from people who experience no sexual attraction or have any desire for sex, to those who experience low levels, or sexual attraction only under specific conditions. Many of these different places on the continuum have their own identity labels (see demisexual). Sometimes abbreviated to "ace."
- Draw a seventh line and title it 'SEXUAL BEHAVIOUR 2.' Label one side 'Sex with Men' and the other side 'Sex with Women.' Explain that a person's sexual behaviour does not always indicate his or her sexual orientation. Not all individuals whohave had sexual experiences with members of their own sex define themselves as homosexual. For example, some men who have sex with other men in isolated settings, e.g., prisons, do not consider themselves to be homosexual. In addition, individuals who engage in same-sex sexual activity might not be exclusively attracted to members of their own sex and might not wish to engage in sex only with members of their own sex. Some married persons, for example, engage in same-sex sexual activity outside of marriage and still consider themselves to be heterosexual. People who have sex with both men and women might consider themselves to be bisexual, homosexual, or heterosexual.

In summary, our human sexuality and gender identity include five elements:
a) Biological Sex: Based on our physical status of being either male or female.
b) Gender Identity: How we feel about being male or female.
c) Gender Roles: Society's expectations of us based on our sex.
d) Sexual Orientation: The sex to which we are attracted to sexually.
e) Sexual Behaviour: The sexual experiences we have.

Part 2: Practicing the Continuum (30 minutes)
This activity allows participants to practice what they have learnt in part 1 and help them identify the different sexual and gender qualities of an individual from their character descriptions.

Steps:
Divide into small groups and hand out the following character descriptions to each group [**Handout 12**]. Ask groups to think about and discuss each individual in relation to the diagram on the wall, and decide where that character falls on each one of the lines/continuums.

Case Profiles:

1. Makara is a young gay man who works as a computer expert. He first discovered that he was attracted to men in his teens, but didn't start having sex with men until he finished his studies and started work. One day at work, his colleagues teased him that he was holding a tea cup "like a gay man," but he kept quiet and no one bothered him. When he started work, he had lots of short-term relationships with other men until he met Issa, whom he has been seeing for two years. Issa is a gay man who works as a mechanic. He loves to play football and drink with the boys, and no one has ever suspected that he is gay or MSM.
2. Sam is a 25-year-old trans man. He was born in a woman's body, but from an early age began to think of himself as a male, and used to dress in boy's clothing. After trying to change Sam, his parents gave up and kicked him out of the house. Sam moved to the city where he met a 28- year old, gay man, Bob, a taxi driver. They fell in love, developed a strong sexual relationship, and moved in together.
3. Sean is a married businessman of 40 years. He has a few effeminate gestures, but everyone sees him as a happily married man. But he loves to have sex with men and arranges this with male sex workers. One of the sex workers is Peter, a poor, uneducated young man who makes his living as a sex worker. Peter only has sex with men for money. He is sexually attracted to women and, in the future, when his finances allow it, hopes to get married to his girlfriend.

4. Brook is an artist who was born a man but does not identify as a male, nor do they identify as a female. They dress however they feel on a day to day basis. They are currently dating Sally. Sally is female and identifies with the gender that corresponds to her sex, she is the manager of an art supply store and finds persons attractive not based on their gender identity, but how they express themselves, and enjoys anyway that Brook expresses themselves.
5. Tash is a female lawyer who has done very well for herself. She identifies as woman but and enjoys feminine attire, but is not afraid of suits. She has both men and women flirting with her daily, but shy's away from anyone who expresses intentions of getting sexual.
6. Mandy is a trans woman who has her own salon. Many times persons still get her gender wrong and use the wrong pronouns because she still likes to dress masculine and has a short haircut. She is married to Jessie, a woman who is attracted to masculine presenting women.

Character	Example Analysis
Makara	BIOLOGICAL SEX—MALE. GENDER IDENTITY—MALE. GENDER EXPRESSION—PRIMARILY MASCULINE, BUT SOME EFFEMINATE GESTURES. SEXUAL ORIENTATION—GAY (SEXUALLY ATTRACTED TO MEN).
Issa	BIOLOGICAL SEX—MALE. GENDER IDENTITY—MALE. GENDER EXPRESSION—TOTALLY MASCULINE. SEXUAL ORIENTATION—GAY (SEXUALLY ATTRACTED TO MEN).
Sam	BIOLOGICAL SEX—FEMALE. GENDER IDENTITY—MALE. GENDER EXPRESSION: MASCULINE. SEXUAL ORIENTATION: GAY (SEXUALLY ATTRACTED TO MEN).
Bob	BIOLOGICAL SEX—MALE. GENDER IDENTITY—MALE. GENDER EXPRESSION—MASCULINE; NO FEMININE CHARACTERISTICS. SEXUAL ORIENTATION—GAY (SEXUALLY ATTRACTED TO MEN).
Sean	BIOLOGICAL SEX—MALE. GENDER IDENTITY—MALE. GENDER EXPRESSION—SLIGHTLY FEMININE. SEXUAL ORIENTATION—BISEXUAL (SEX WITH HIS WIFE AND WITH MEN).
Peter	BIOLOGICAL SEX—MALE. GENDER IDENTITY—MALE. GENDER EXPRESSION—MASCULINE. SEXUAL ORIENTATION—HETEROSEXUAL (SEXUALLY ATTRACTED TO WOMEN). SEXUAL BEHAVIOUR—HE HAS SEX WITH WOMEN (LOVE) AND MEN (MONEY). HE IDENTIFIES AS HETEROSEXUAL.

Brook	BIOLOGICAL SEX—MALE. GENDER IDENTITY—GENDER FLUID. GENDER EXPRESSION—BOTH GENDERS. SEXUAL ORIENTATION—ATTRACTED TO WOMEN. SEXUAL BEHAVIOUR—THEY HAVE SEX WITH WOMEN.
Sally	BIOLOGICAL SEX—FEMALE. GENDER IDENTITY—FEMALE. GENDER EXPRESSION—FEMININE. SEXUAL ORIENTATION— PANSEXUAL
Tash	BIOLOGICAL SEX—FEMALE. GENDER IDENTITY—FEMALE. GENDER EXPRESSION—MORE FEMININE BUT CAN BE MASCULINE. SEXUAL ORIENTATION— ASEXUAL
Mandy	BIOLOGICAL SEX—MALE. GENDER IDENTITY—FEMALE. GENDER EXPRESSION—MASCULINE. SEXUAL ORIENTATION—HOMOSEXUAL (AS SHE IDENTIFIES AS A WOMAN)
Jessie	BIOLOGICAL SEX—FEMALE. GENDER IDENTITY—FEMALE. GENDER EXPRESSION—FEMININE. SEXUAL ORIENTATION— HOMOSEXUAL (ATTRACTED TO MANDY WHO IDENTIFIES AS A WOMAN BUT EXPRESSES HERSELF MASCULINE)

Advanced Exercise: Gender Unicorn (20 minutes)
Adapted from: Trans Student Educational Resources: Gender Unicorn

This activity looks at the different aspects of a person; Gender Identity, Gender Expression, Sex Assigned at Birth, Sexual Attraction and Emotional Attraction. This exercise can be included after part 2 if you find that you participants are grasping the concepts, or it can be used as a recap in an advanced program.

Material: Gender Unicorn [**Handout 13**], Case Profile [Handout 12], pens / markers

Steps:
Distribute handout 13, the Gender Unicorn, to the participants. Explain that while, yes, identity and sexuality can be looked at as a continuum, if can also be understood as having different levels of attraction to each aspect of sexuality and gender, and your level of attraction or internal identity determines how we refer to ourselves. This is why the term 'Queer' is sometimes used by individuals who do not think certain labels represents them.

Using the case studies from part 2 of this exercise, have participants determine where they think each individual lies on the spectrums. You can assign a case profiles to a pair, each selecting which individual they will map out on the gender unicorn diagram they are given. Or, you can go through each case study as a group. There are no absolute correct answers to this, just ensure that they line up with the identities in the example analysis.

Exercise IV: Terminologies and Definitions (30 minutes)

Adapted from: Substance Abuse and Mental Health Services Administration. LGBTQI2-S Resource Tool. Learning Activity: LGBTQ Words and Definitions "Match Game"

This activity goes though the many terminologies within LGBTQ+ Populations. The type of terminologies you discuss in this activity should depend on the level of knowledge and understanding that your participants might have. If they have shown to be struggling to grasp some of the concepts in the last 2 activities, you may have to go through the basic terminologies. It is advised that, as a facilitator, you fully understand the definitions yourself as the participants may ask some challenging questions.

Preparation

Take the facilitators **Handout 14** (which is formatted for the activity) and cut out the terminologies and definitions (they should be separate from each other). Alternatively, print them or write them out on card to be reused for later trainings. Place them in a box or bag. On a flipchart paper, draw two columns, one for "Definitions" and one for "Terminologies". This is optional as you can be creative on the method of reporting back.

Steps:

Go around the room, asking the participants to pick a piece of paper/card out at random, going around the room until all have been taken. The participants are then to work as a team to match the terminology with the correct definition. They can stick them on the flipchart paper or they can put them together in your preferred method for reporting back. Give participants no more than 10 minutes to complete. Inform them that any that they are unable to match can be done during the reporting back phase.

Reporting Back:

After the participants have finished matching up the terminologies and definitions, go through them one by one, answering any questions they may have regarding to the terminology. Do not be afraid to indicate that you are not certain about something if that is that case. Let them know you will do some research and get back to them.

ACTIVITY C: UNDERSTANDING GENDER IDENTITY + USING PRONOUNS

Facilitator's notes: This activity is divided into 4 exercises. Depending on timing 1 or more of the exercises can be done at one training.

Objectives:

- To enable participants to reflect on their understandings of sex and gender.
- Participants will reflect upon their first impressions with trans people and identity and how their understanding of trans people and identity has changed over their lifetime.
- Understand why using a person's preferred pronouns in important, how to ask for a person's preferred pronoun and that using preferred pronouns is a process, but they must take it seriously.

Target group: All groups

Total time: 90 minutes

Materials: Flipchart, markers, cards

Exercise I: Understanding Gender and How it is Different from Sex (20 minutes)

Adapted from: **CARE.** 2014. Gender, Equity, and Diversity Training Materials: Module 4: Gender Training

Facilitator's Note: This activity should be carried out with the second activity in this exercise so that participants can start to understand that gender identity is based on the social expectations we place on people based on their biological sex.

Preparation:

On a flipchart paper, draw two columns, one for "Sex" and one for "Gender". On card, have the following statements written or printed on them. These are examples and you can cater your statements based on the target audience.

- Women give birth to babies, men don't.
- Care of babies is the responsibility of women because they can breastfeed them.
- Men have moustaches.
- Women cannot carry heavy loads.
- Women are scared of working outside their homes at night.
- Men's voices break at puberty, women's don't.
- Women are emotional and men are rational.
- Most of the women have long hair and men have short hair.
- Most scientists are men.
- Cooking comes naturally to women.

Steps:
Ask the participants to give their understanding of the differences between sex and gender. Summarize the responses of the participants to include (but not limited to) the following significant differences between sex and gender.

Sex	Gender
Biologically Determined	Constructed by Society
Naturally Universal for all human beings	Multi-faceted: differs within and between cultures and across geography, climate, etc.
Naturally Unchanging	Dynamic, changes over time

Distribute the cards with the statements on men and women to some participants. Ask them to read these aloud, one by one.

Reporting Back:
Ask the participants to decide which statement denotes characteristics/behaviours based on sex and which are socially constructed. Request them to explain why they think so.

Summarise:
Explain to the group that these statements were meant only to generate a discussion around how society promotes images of men and women, which result in gender biases and images. Also explain why understanding the difference between sex and gender is critical in understanding how someone could have a gender identity different to what they are expected to have based on their biological sex.

Exercise II: Gender Division of Articles, Activities and Roles (20 minutes)
Adapted from: CARE. 2014. Gender, Equity, and Diversity Training Materials: Module 4: Gender Training

Facilitator's Note: This activity should be carried out with the first activity in this exercise so that participants can start to understand that gender identity is based on the social expectations we place on people based on their biological sex.

Preparation:
On two flipchart paper, draw the face of the man (or another indicator of a man) on one and the face of the woman (or another indicator of a woman) on the other.
Make a list of items, activities and roles. Examples below:

Item	Activity	Roles
Broom	Sewing	Chef
Hammer	Cooking	Farmer
Tie	Washing Clothes	Nurse
Lipstick	Cleaning	Barber
Briefcase	Fixing electronics	Tailor
Stove	Mowing the Lawn	Lawyer
The Colour Pink	Reading the Newspaper	Photographer

Steps:

1. Put up the face of a man at one end of the room and a face of a woman at the other end.
2. Ask everyone to move their chairs to the side of the room.
3. Call out the name of each article, role or activity from the list and ask participants to take their position whether it belongs to a man or a woman.

Reporting Back:

Discuss the responses of the participants:

- Why do we associate certain articles/activities/roles with women, and some with men?
- Which of the activities above have any biological basis? [*Note: none of the activities or roles in the examples above have a biological basis*]
- Which activities do not have any biological basis and yet are performed by either men or women only?

Summarise

It should start to register with participants that gender roles are constructed by society and that these roles change over time. You may notice in the activity that there are differences in opinions on what items, activities, and roles should be associated by which sex. Explain to them that there have been changes over time in association of items such as high heels originally being worn by men of high prestige in the Victorian times, or that blue used to be a colour associate with baby girls and pink was associated with baby boys.

Exercise III: First Impressions of Trans People (Reflection Activity) (20 minutes)

Adapted from: The Safe Zone Project. First Impressions of Trans People.

The activity can be effective at contextualizing the importance of the workshop or talking openly about these issues (and how often rare that open conversation can be). As well as how change and growth has already happened for your participants around trans issues and identity.

Preparation: Hand out the participant sheet [**Handout 15**] while explaining the activity.

Steps:
1. Assure participants that this activity primarily reflective and they won't be asked to share anything they don't want to. For example, "We are going to do another reflective activity that you all might remember called First Impressions. This time we are asking specific questions about trans people. We're going to give you a few minutes to think on and write some answers to the list of questions on this sheet. These questions are for your reflection, we aren't going to collect your sheets or require you to share anything with the group that you don't want to. If there is any question you're struggling with skip it and come back at the end of the activity. We'll give you a few minutes here to answer the questions and then bring it back to the big group."
2. Give participants time to reflect (3-5 minutes).
3. Move into the debrief questions.
4. Wrap-up the activity.

Report Back
- What was it like to do that activity?
- Does anyone have an experience that was significantly different that they'd be interested in sharing?
- What about question 5, would anyone share how their understanding of trans* issues and identity have changed over time?

Summarise
- Highlight for participants that each of them have likely have shifted their understanding of trans people and identities over the course of their lifetimes and that this workshop may or may not also shift their understanding of trans people and identities.
- Often there is a mention of language and/or public conversation that has shifted over the course of someone's lifetime and you can call back to this mention in order to create a seamless transition into vocabulary.
- There may be a mention of the previous exercises helping them understand gender better.

Make it your own
- These questions can be modified to focus more specifically on particular identities if you are doing a targeted training for example, "What was your first impression or initial conversations around trans identity within a medical environment?"

- Unlock the Magic: If you are not a member of the community, be an imperfect role model; this is an activity can be a space where you can share with participants your own development and journey. This can help assure participants that you identify with their stories or change and development and that they aren't alone in having unlearn and reconsider what they know about gender and sexuality.
- If you are of the community, you can share you journey of understanding your own sexuality by learning about the continuum that is sexuality and gender.

Exercise IV: Pronouns (30 minutes)
Adapted from: Human Rights Campaign Foundation. Talking About Pronouns in the Workplace

Preparation: Have Handout 16 ready for distribution

Steps:
1. First you will explain to the participants what preferred pronouns are, and why they are important. Read the following out loud to the participants:

- Pronouns-- we all use them as part of everyday conversation. A pronoun is a word that refers to either the people talking (like "I" or "you") or someone or something that is being talked about (like "she," "it," "them," and "this").
- Gender pronouns (such as "he/him/his" and "she/her/hers") refer to people that you are talking about.
- Gender pronouns are the way that we constantly refer to each other's gender identity - except we often don't think a whole lot about them. Usually we interpret or "read" a person's gender based on their outward appearance and expression, and "assign" a pronoun. But our reading of them may not be a correct interpretation of the person's gender identity.
- Because gender identity is internal -- an internal sense of one's own gender -- we don't necessarily know a person's correct gender pronoun by looking at them. Additionally, a person may identify as genderfluid or genderqueer and may not identify along the binary of either male or female (e.g. "him" or "her").
- Some people identify as both masculine and feminine, or neither. A genderqueer or non-binary identified person may prefer a gender-neutral pronoun such as the "they" (e.g. "I know Sam. They work in the Accounting Department").
- Other options include; Ze is pronounced like "zee" can also be spelled zie or xe, and replaces she/he/they. Hir is pronounced like "here" and replaces her/hers/him/his/they/theirs.
- Some people prefer not to use pronouns at all, using their name as a pronoun instead.
- Never, ever refer to a person as "it" or "he-she" (unless they specifically ask you to.) These are offensive slurs used against trans and gender non-conforming individuals.

- Transgender and gender nonconforming people are subject to others consistently try to “read” or “figure out” their gender. If their gender presentation is not either male or female “enough,” they may be subject to misunderstanding, bias and discrimination.
- Nothing may be more personal than the way in which people refer to us through our name and pronouns. Using a person’s chosen name and desired pronouns is a form of mutual respect and basic courtesy. The experience of being misgendered · can be hurtful, angering, and even distracting. The experience of accidentally misgendering someone can be embarrassing for both parties, creating tension and leading to communication breakdowns across teams, with customers, or with clients.
- It is a privilege to not have to worry about which pronoun someone is going to use for you based on how they perceive your gender. If you have this privilege, yet fail to respect someone else's gender identity, it is not only disrespectful and hurtful, but lso oppressive.

2. How can you ask someone for their preferred pronoun?
- Try asking: "What are your preferred pronouns?" or "Which pronouns do you like to hear?" or "Can you remind me which pronouns you like for yourself?" It can feel awkward at first, but it is not half as awkward as getting it wrong or making a hurtful assumption.

3. What if you make a mistake?
- It's okay! Everyone slips up from time to time. The best thing to do if you use the wrong pronoun for someone is to say something right away, like "Sorry, I meant she." If you realize your mistake after the fact, apologize in private and move on.
- A lot of the time it can be tempting to go on and on about how bad you feel that you messed up or how hard it is for you to get it right. But please, don't! It is inappropriate and makes the person who was mis-gendered feel awkward and responsible for comforting you, which is absolutely not their job. It is your job to remember people's preferred gender pronouns.

4. Ask Participants (should be no more than 10 minutes):
- How would you react or feel if someone referred to you by the wrong pronouns?
- Do you think you would have any challenges addressing someone by their correct pronouns? (refer to discussion points below)

5. After the discussion, pair up participants and hand out the scenarios in Handout 16 to the pairs, one per pair. Give them 5 minutes to read the scenario, and answer the questions under the scenario.

ACTIVITY D: PUTTING YOURSELF IN LGBTQ+ PERSONS SHOES

Objectives:

- Participants will be introduced to and become familiar with the typical stages of coming out, and consequences of coming out.
- To build empathy and respect for LGBTQ+ people by asking participants to experience the coming out process while hearing statistics regarding the real-world challenges that LGBTQ+ people have faced when coming out.
- To provide some best practices (do's and don'ts) when supporting someone's coming out process.

Target group: All groups

Total time: 40 minutes

Materials: Construction paper for stars, pens, pencils, **Handout 17**

Exercise I: Coming Out Stars (20 minutes)
Adapted from: California Faculty Association. 2014. Safe Zone Ally Training Manual

Preparation:
Prepare construction paper stars for each participant. Each card should be of one of four colours, with each colour equally represented among the participants (the sample exercise below uses Blue, Green, Purple and Yellow stars.) As the participants are told the stages of coming out and some of the statistics regarding the hardships of coming out, they will be asked to consider these hardships first-hand, tearing off some or all of the points of their stars and dropping them to the ground. The colours and specific points torn off roughly match the statistics presented throughout this exercise.

In this exercise, some participants have positive and supportive coming out experiences, while others' experiences are negative, discouraging, and dehumanizing. At the end of the exercise, many "lives" (i.e., stars) are in pieces.

Part 1
Steps
Distribute the stars to each person. Be sure to have a relatively equal number of participants for each colour. Individuals participating in this exercise may react with strong emotions. If you are familiar with your participants, you may want to choose who receives the Green star, as this is the most challenging of the coming out experiences. Otherwise, you can randomly deal the stars to participants.

The rest of the exercise will be read to the participants. "Imagine that this star represents your world, with you in the center and each point represents someone or something important to you."

1. Write your name in the center of the star.
2. Pick any point on the star and write the name of your best friend or a very close friend (not your partner, girl/boyfriend, or spouse).
3. On another point, write the name of a group, team, or club to which you belong (not LGBTQ+ related). It can be a meetup, church, community organization, bowling team, poker game buddies, or political group to which you belong (again, not LGBTQ+ related).
4. On another point, write the family member (i.e., girl/boyfriend; spouse) to whom you confide and turn for advice, and who listens and supports your decisions (e.g., your mother, father, aunt, uncle, grandparent). This could be any family member who has made a large impact on your life. Please write their name on another point of your star.
5. On another point of the star, write your profession or the profession you would most like to have.
6. Finally, list 2-3 dreams that you have – owning a car, buying a home, traveling, having children, retiring – on the remaining point.

Say: "So, your star represents you and all of the important people/things in your life. For this exercise, I will be asking you to come out as an LGBTQ+ person to them. Each colour star represents a different coming out experience. But, before you come out to them (before we use your star), I will first describe some of the stages you went through that got you to this point. You have been going through the coming out process - the life-long process of developing a positive LGBTQ+ identity. Some of you have struggled with your own negative stereotypes and feelings of homophobia that you learned when you were growing up. Some of you felt repulsion and pity.

You had to challenge your own attitudes. You have struggled with your identity – going through your own internal coming out process – to get to this point. You have been wondering who you were, considering your behaviour as mere experimentations. You would tell yourself that you were, "just drunk." Those of you who had this experience probably went through the identity confusion stage. Some of you always thought that you were gay, while others thought that these feelings or your love for that man or woman were just temporary. Those who felt like that probably began to isolate. You probably went through the identity comparison stage.

All of you eventually broke through that self-denial and accepted the fact that you are LGBTQ+. You are in the identity tolerance stage. You have begun to legitimize your sexual identity and are comfortable being seen with other LGBTQ+ people. You think, "I am Gay; I am okay; I can come out to some people." Experts consider this the identity acceptance stage. For some, it has taken you years to get to the point where you are now– ready to come out. Now, it is important to know that not everyone goes through these stages, and for most, it is not very stage like.

The process is different for everyone. Most of you will fluidly move back and forth through these stages because you will always have to come out. Since we live in a hetero- and cisgender- normative society, many people assume that everyone is heterosexual. You can hear it in everyday speech and when adults talk to young boys and girls. So, you will always have to decide whom to tell and when—especially at new job, with a new co-worker, in a new city, meeting new friends, going to a new school, in new class, or with a new professor. Most will always fear rejection, abuse, harassment, bullying, discrimination, backlash from students, or backlash from colleagues when coming out.

Still, the process of coming out is very freeing. You are alleviated of the stress and fear of hiding one's identity and being "found out." Most importantly, you are able to live more honest lives and develop more genuine relationships with others. And, each of you is now eager to take that step. So, whatever has been your process, you are all at the point in which have come to terms with the fact that you are gay, lesbian, bisexual, or transgender. You are now a part of the 1 in 25 people who identify as LGBT. You are ready to begin coming-out to others.

Get your star ready. Throughout this exercise, we ask that you try not talk. Please listen carefully. I will be giving you specific instructions regarding your coming out experience based on the colour of your star. You will be asked to either fold-back, tear off, or leave intact different points of your star. Let's begin. This is your life. These are the most important people in your life. And, you are now going to come out to them.

A. *You decide to tell your closest friend first, since they have always been there for you—you can't imagine keeping this a secret.*

- If you have a **Blue** star, your friend suspected all along and is grateful you have finally said something. Your friendship grows stronger. If you have a **Yellow** or **Purple** star, your friend is hesitant. They are a little irritated that you have waited so long to tell, but you are confident that one day they will understand and support you. Eventually, the relationship will be okay. If you have a **Yellow** or **Purple** star please fold back this point.
- If you have a **Green** star, you are met with anger and disgust. This friend who has been by your side in the past tells you that being gay, lesbian, bisexual or transgender is wrong and they can't associate with anyone like that. If you have a **Green** star, please tear off this point and drop it on the floor. This person is no longer part of your life.

B. *With most of you having such good luck with your friends, you decide to tell your family. You turn to your closest family member first, so that it will be a little easier.*

- If you have a **Blue** star, you are embraced by this family member. They are proud that you have decided to come out and let you know that they will always be there to support you.

- If you have a **Yellow** star, the conversation does not go exactly how you planned. Several questions are asked as to how this could have happened, but after some lengthy discussion, this relative seems a little more at ease. Fold back this point of your **Yellow** star, as they will be an ally, but only with time.
- If you have a **Green** or **Purple** star, your family member rejects the thought of being related to a person like you (you join the other 26% of LGBTQ+ people who experience this reaction from their family). They are disgusted and some of you are thrown out of your house or even disowned. You are now a homeless youth who identify as gay, lesbian, bisexual, or transgender. If you have a **Green** or **Purple** star, please tear off this point and drop it on the floor.

C. *Having told your friends and family, the wheels have started to turn, the word gets out, soon members of your community begin to question your sexual orientation and gender identity, and some of you are just less willing to pass as straight or gender-normative. You have deep rage towards the majority community and have pride in your identity. This is the identity pride stage. So, you come out to members of your non-LGBTQ+ community.*

- If you have a **Purple** or **Blue** star, your sexual orientation or gender identity is accepted by your community. They continue to embrace you like anyone else, and together you celebrate the growing diversity in your community.
- If you have a **Yellow** star, you are met with mixed responses. Some members accept you and some don't know how they feel about you now. You remain a part of the community, but some jokes are made at your expense, and it will take time for all to embrace you as they had before. If you have a **Yellow** star, please fold back this point.
- If you have a **Green** star, your community reacts with hatred. They tell you that someone like you doesn't belong in their community. Suddenly, they look at you like a stranger. Those who once supported you either put you down or don't acknowledge you at all. (27% of LGBTQ+ youth say they experience intolerance in their communities). If you are a trans woman of colour, you are likely to experience the most intolerance; 44% of LGBTQ+ murder victims were trans women of colour. If you have a **Green** star, tear this point off and drop it on the floor.

D. *Work is now the only place where you have not come out officially, but rumours are spreading rapidly about your sexual orientation or gender identity. In the past, you've done your best to keep your life private and ignore gossip. But now, you're feeling claustrophobic—like all the whispers are about you, all looks received are menacing, and you're not sure if you're paranoid or cautious. Besides, you already have synthesized your sexual identity into your self-identity. You now realize that you are an ordinary person, who just happens to be gay. So, some of you selectively come out to those co-workers you trust, while others, feeling worried about the repercussions, decide not to come out. Eventually, you all find out the consensus of the rumours...*

- If you have a **Blue** star, your co-workers begin to approach you, or those you told let you know they have heard the rumours and they don't care. They support you and share stories about people in their own lives who are gay, lesbian, bisexual or transgender. Your supervisors react the same way letting you know that you're a hard worker and that's all that matters.
- If you have a **Purple** star, your workplace has become quite interesting. Some colleagues (the ones you trusted to tell) show support with hugs, others do so in subtle ways: a random thumbs-up or a nudge in the lunch or break room or at the water cooler. However, some colleagues speak to you less, and the environment is quite awkward. But, in less than a month, things will return to normal. If you have a **Purple** star, please fold back this point.
- If you have a **Green** or **Yellow** star, you ignore the rumours; you think to yourself that your sexual orientation or gender identity has no bearing on your work life. You continue to work as though nothing is happening. One day, you come in to find that your office has been packed up. You are called into your supervisor's office and she explains that you are being fired. When you ask why, she tells you that lately your work has been less than satisfactory and that she had to make some cutbacks in your area. You are now, depending on where you live, part of the 15-30% LGB who are harassed, passed for promotions, or fired from their job. If you are transgender, you now join the other 90% of transgendered individuals who are harassed, passed for promotions, or fired from their job. Even in the US, in 29 states, it is not prohibited to fire someone because they are lesbian, gay, or bisexual; in 34 states it is notprohibited to fire someone solely for being transgender. If you have a **Green** or **Yellow** star, please tear off this point and drop it on the floor

A. *Now...your future lies ahead of you as a member of the gay, lesbian, bisexual, and transgender community. Your hopes and dreams, your wishes for the perfect life...for some of you, these are all that remain.*

- If you have a **Green** star, you fall into despair. You have been met with rejection after rejection, and you find it impossible to accomplish your lifelong goals without support and love from your friends and family. You become depressed. LGBTQ+ populations have higher rates of depression than non-LGBTQ+ populations. With nowhere else to turn, many of you begin to abuse drugs and alcohol; about 20-25% of lesbians and gays are heavy alcohol users. Eventually, you feel that your life is no longer worth living. If you have a **Green** star, please tear it up and drop the pieces to the ground. You are now part of the 40% of suicide victims who are part of the LGBTQ+ community.
- If you have a **Purple**, **Blue**, or **Yellow** star, these hopes and dreams are what keep you going. Most of you have been met with some sort of rejection since beginning your coming out process, but you have managed to continue to live a happy and healthy life because of the support and love you have received. Love and support from friends, family members, co-workers, and in particular, allies. You are now allowed to live more honest lives, develop more genuine relationships with others, connect with others who identify as LGBTQ+, and be part of a community and culture with others. Your personal hopes and dreams become a reality.

Report Back
The trainer now can take a minute to ask the participants to look around and see how, for many, their life is in pieces. Ask the group to respond to the following:

- Does anyone want to discuss how they feel?
- Would anyone like to provide some thoughts or comments?

Summarise (and close out activity)
After the discussion, the trainer will continue reading the exercise; "Now, those who have full stars find someone else and help them pick up the pieces. As you pick up these pieces think about what it is like to be alone and the importance of being their ally to ease the suffering. We/they may need your help. We need your acceptance, support, understanding, comfort, reassurance, acknowledgement, validation, and love."

Part 2
Steps
Read **Handout 17** or have the participants read the different sections of the handout clearly designated by different colours.

Report back
Ask the following: How might this information be relevant to you in your role as a (insert professional/personal role here)?

Summarise
Summarise the major points of the discussion and/or highlight major outcomes you want to mention that have not been hit. May include:

- It is never okay to out someone (to reveal that they are LGBTQ without their permission)
- If you are supporting someone in their coming out process it is important for youto find out what they want you to do with the information they've shared—do they want you to share with others, keep it to yourself, check in with them regularly about it, etc.
- Everyone is going to want/need different things during their coming out process. Asking explicitly, "Hey, I'm so glad you shared this with me, how can I best support you in this process?" is a great question to ask.

Exercise II: What is Heterosexual Privilege? (20 minutes)
Adapted from: Herriott, T. K. & Halcro, C. M. 2014. Safe Zone: 101 Training Manual. Office of Diversity and Equity. Scholarship.

This activity will help participants better understand the privilege they may have if they identify as a cisgender, heterosexual person. It identifies things they take for granted and inform them that sexual and gender minorities may not have those options awarded to them. The activity asked them to think about what life would be like if the tables were turned and hopefully have them understand what the "Gay Agenda" is all about.

Steps:
Read: Heterosexual privilege is the basic civil rights and social privileges that a heterosexual individual automatically receives, which are systematically denied to gay, lesbian, bisexual or transgender persons on the sole basis of their sexual orientation or gender identity. The problem with privilege is being unaware that you have it and believing that everyone has equal opportunities and advantages. Many don't realize the ways in which people, systems, and institutions are set up to advantage some and disadvantage others.

Heterosexual Privilege is...[as you read these out list them on the flipchart]

A. Living without ever having to think twice about, facing, confronting, engaging, or coping with anything on this page. Heterosexuals can address these phenomena but social/political forces do not require them to do so.

B. Marrying...which includes the following privileges:

- Public recognition and support for an intimate relationship (e.g., receiving cards or phone calls celebrating a commitment to another person), supporting activities, and social expectations of longevity and stability for the committed relationship.
- Paid leave from employment and condolences when grieving the death of the partner/lover (i.e., legal matters defined by marriage and descendants from marriage).
- Inheriting from the partner automatically under probate laws.
- Sharing health, auto and homeowner insurance at reduced rates.
- Immediate access to the loved one in cases of accident or emergency.
- Family of origin support for a life partner/lover/companion.

C. Increased possibilities for getting a job, receiving on-the-job training and promotion.

D. Talking about the relationship or what projects, vacations, and family planning.

E. Not questioning your own normalcy, either sexually or culturally.

F. Expressing pain when a relationship ends and having other people notice and attend to that pain.

G. Adopting children or foster-parenting children.

H. Being employed as a teacher in pre-school through high school without fear of being fired any day because it is assumed the person would corrupt children.

I. Raising children without threats of state intervention and without the children having to be worried which of their friends might reject them because of their parents' sexuality and culture.

J. Dating the person one is attracted to in your teen years.

K. Living with the partner and doing so openly.

L. Receiving validation from the religious community.

M. Not having to hide and lie about LGBTQ+ social events.

N. Working without always being identified by one's sexuality/culture (e.g., a straight person gets to be a teacher, artist, athlete, etc., without being labelled the heterosexual teacher, the heterosexual lawyer, etc.).

Questions for Discussion:

- How do these privileges manifest at work?
- What other types of privilege exist in our society?
- How would you feel if you did not have access to these privileges?

Discussion Points:

- As heterosexuals, these privileges are often not considered as privileges, but everyday life.
- For LGBTQ+ persons, because they cannot experience these privileges, they often get treated, and feel like, second class citizens. That is why equals rights are important.

Heterosexual privilege lets heterosexuals live their lives without ever having to think about some of this issues that affect LGBTQ+ individuals on a daily basis. Take a moment to consider what it would be like if the tables were turned.

A. Discovering Your Heterosexuality

Being heterosexual means, you are emotionally and sexually attracted to and fall in love with the opposite gender. These feelings are normal and natural and most likely arise during childhood. Research has not shown whether the cause of heterosexuality is genetic, environmental or a combination of the two.

B. Family & Friends

If you choose to come out as heterosexual to your family, be prepared for their reaction. Your family may encourage you to get counselling or attempt to persuade you to change your mind. Deciding whether to tell your family and friends is a big decision. If you have doubts or questions, consult a counsellor. Once your family and friends are comfortable with your decision, they can acknowledge knowing and loving a straight person. Parents may decide to "come out" when someone asks them when their son is "finally going to find a nice partner" or by responding to an anti-straight joke at the family reunion. If you are the parent of a straight child, you can find advice on various supportive web sites.

C. Coming Out to Yourself

Being openly heterosexual can be a challenge, but the most important thing is being honest with oneself. It can be difficult to discover you are straight; you can find valuable information by reading. You don't need to rush to label yourself as straight. For some, heterosexuality may just be something new and exciting to try, but the majority of straight people discover that the heterosexual lifestyle suits them best. They realize that a happy and productive heterosexual lifestyle is possible.

D. Coming Out to Others

There are many reasons to come out. Some people come out because they are proud to be heterosexual, while others enjoy the opportunity of meeting other straight people. It's most important for you to come out because it's an expression of who you are. You probably want to meet other straight people for friendships or intimate relationships.

Be prepared for a wide range of reactions if you choose to come out. Your confidant may be shocked, angry or not surprised at all. He or she might even come out to you! Get a sense of how the person you wish to come out to might react beforehand. For example, you might watch a TV show or movie that has straight characters and then discuss it. You may want to refer your confidant to a straight-gay alliance for more resources and support.

E. Being Yourself

Straight people are often accused of flaunting their sexuality. In a world of fixed and rigid gender identities, coming out may be the only way straight people can make their sexual orientation known. Yet there is a difference between being forthright and flaunting. Most straight people are not out to make a statement. They simply want to be able to incorporate the many aspects of their lives the way homosexuals do – by talking about their partners, wearing a wedding ring or putting a photo of a spouse in the office.

Questions for Discussion:

- How did these statements make you feel?
- Would you be able to "choose to be gay" if it meant living a "normal" life?
- How do you think that would affect you?

Discussion Points

- These are things the LBGQ+ persons come across when trying to come to terms with their identity.
- They often do not feel as if they are normal and struggle because, no matter how hard they try, they cannot change their sexuality or gender identity.
- For those who are bisexual or pansexual, they may be able to live heteronormative lives as they may be able to find a cisgender partner of the opposite sex to build a relationship with. However, this might not necessarily mean that they wouldn't happier with a partner of the opposite sex or different gender identity.

ACTIVITY E: INCLUDING AND ACCOMMODATING LGBTQ+ POPULATIONS

Facilitator's Notes: This activity will run through a few scenarios that are based on the type of audience you have. There are a selection of examples of scenarios in handout 16, but you are free to create your own scenarios based on situations that you know may occur in your country.

Objectives:

- To provide real world situations that participants may encounter in the future and for participants to think through and game plan the different ways to handle the situation.
- To empower participants to feel more comfortable applying the knowledge that they have gained during the program of the training in real-world situations.

Target group: All groups

Time: 30 minutes

Materials: **Handout 18**, Flip charts, markers,

Adapted from: The Safe Zone Project. Scenarios.

Steps

1. Introduce the activity to the participants. For example, "Now that we're nearing the end of our training on LGBTQ+ populations, we are going to focus on some scenarios related to these concepts that you may encounter in your daily lives."
2. Split your participants up into small groups of 3 - 4.
3. Provide each group with a scenario from **Handout 18** to work through. Let the groups know they're going to have a 5 - 10 minutes to discuss solutions before sharing their t thoughts with the larger group.
4. Have them think about what they could do in the following times:
   a. During the scenario: "in the moment" that the scenario is taking place.
   b. After: immediately after
   c. Follow-up: maybe later in the day or a week or two later.
   d. Before: is focusing in on how to prevent that moment from happening again.
5. Bring the groups back together and review the scenarios.
6. Ask an individual from each group to read out their scenario and then ask the whole group to discuss what they thought the best way to handle the scenario would be. Ask for feedback from the larger group, add your own, and then move onto the next group repeating the process.
7. If the group is struggling to work through a scenario, particularly if they don't understand the concern, guide them through these steps:

Group Work Stages:

A. **Clarify the problem:** At this stage you really want to identify what the problem is and make sure everyone in the group agrees on what the issue is before moving to the next step.
B. **Identify options:** Have the group brainstorm a number of different options that are available to address the problem at hand. These options may be more or less feasible but you don't need to address that at this stage, just get the options out there.
C. **Weigh outcomes:** Now that you've identified options, talk through some of the options presented and what the possible outcomes of going that direction could be. Weigh pros and cons.
D. **Do it. Listen. Reassess:** Talk through implementing the decided upon direction with the group. If it would be helpful talk about some possible future barriers/ complications after taking that path and talk through those as well as possible scenarios.

Example Responses

1. You've noticed someone you know making comments that are subtly homophobic and/or transphobic, which are making you and others uncomfortable. You're unsure if this person realizes what they are saying is problematic or not. What might you do?
    a. Ask to chat with this person and then let them know what you've noticed and give an example of what they may have said.
    b. When giving feedback, relate-in to this person: "I used to mess this up all the time and while it took some practice at getting better, I've noticed people feel more at ease around me now."
    c. Educate them to the best of your ability and direct them to educational outlets.
    d. Talk with another person who feels the same way as you about how to respond in the moment to the negative comments. Come up with a response that feels appropriate and try it out the next time this person makes a comment.
    e. Perhaps you know that you're not willing to connect with this person directly. Find someone who would be and support them approaching this person.

Additional points:

    f. Give them the benefit of the doubt that they likely didn't mean to make anyone uncomfortable and don't realize it's having that effect.
    g. Highlight this is about their actions not their identity. A lot of times people take things as a personal attack, be sure to speak to and focus on the behaviour not on the person's beliefs/identity or whether they are a good/bad person.

2. You're interacting with someone new, and they introduce themselves as Alex and they look very androgynous. You're not really sure what pronouns to use - what should you do?
    a. Share your pronouns & ask theirs. "Hey my name is Marla and my pronouns are she/her/hers. What are your pronouns?" This is particularly important if you're going to be introducing them to other people.

b. Use their name. If you haven't asked their pronouns yet, use their name every time. "Alex is here to check out the office. Alex have you been anywhere else today?"If you mess up, apologize, correct, and move on. "He was -- oh, I'm sorry, Alex. She. She was saying the pizza place would be great for lunch."

3. There is a very flamboyant young man who has come into the shop where you work. You notice your co-workers pointing and making fun at the potential customer, and it is clearly making him feel comfortable. What can you do to make him feel more conformable?
    a. Go over and talk to your co-workers about their behaviour. Explain to them that he is just like every other customer and deserves to be treated with respect as he is here to potentially spend his money and would the treat another paying customer that way?
    b. Go over the customer and ask them if they need any assistance and that you are willing to help them and they can try on anything they like. No need to be overly friendly, just keep a relax energy and the customer should feel comfortable around you.
    c. If the situation escalates, you see the customer leave in distress, or your co-workers do not listen to you, you can bring it up with your manager.

Additional Notes:

    d. You may try and be friendly to the customer but the damage may already be done by your co-workers as the customer may assume you may be coming to 'get a better look" or invade their privacy. Remember the LGBTQ+ persons have a higher sensitivity to discrimination as they encounter it everywhere they go.

4. You see someone being harassed on the street as they pass by a group of men, you cannot tell if it is a girl or a boy, and clearly neither can the men as they shout slurs and make statements such as "wait, dat is a boy or a girl?". How could you possibly help this situation?
    a. You can go over to the person being harassed and act as if they are your friend. Walking with them until you are a good distance from the men. Let them know that you are sorry that they are being treated that way and that you wanted to make sure that they get where they are going safely.
    b. If you are feeling bold, you can approach the group and ask them if it is any of their business if they are a boy or girl, have they done something o any of the people in the group?
    c. Call the police and report the harassment. If the police do not want to take you seriously, call a local LGBTQ+ or human rights NGO and report it to them.
    d. If you approach the person and they are willing to engage you, ask them if they want to make a report and that you will be their witness, or ask if you can make a report on their behalf.

Additional Notes:

    e. Sometime the person being abused may not be very welcoming to your assistance or what to engage with you. Remember that LGBTQ+ persons are always on guard about people's intentions as they are constantly discriminated against. Do not take it personally if they do not want to make a report or let you get involved.

f. Avoid conflict. If the group appear to be hostile, move away from the situation and report them to the police. NEVER STRIKE FIRST, the person who lands the first blow is always in the wrong.

Summarise:
One of the key things that we want you to get out of these exercises relates to the "Platinum rule". The idea behind the platinum rule is that while the golden rule (treat others as you would want to be treated) is a good start, it leads us to believe (and treat) people as we wanted to be treated and not necessarily how they want to be treated. The platinum rule is "Do unto others as they would have done unto them". In discussing these scenarios hopefully we've teased out a bit that there are often different ways to address an issue or a sticking point and that the most important thing in order to support someone is to find out how they want to be supported.

Remember, in your sector, inclusion is important because: [*read out the section that pertains to the type of audience participating in the training*]

Healthcare: Creating an inclusive environment is important for your clients and patients. If your client / patient is comfortable with you, they will disclose important information required for you to properly serve them, such as history of STIs or type of hormones they are on. It's also important to ensure you keep a neutral demeanour when they disclose their identity to you, as you may be the first person they have told, or they have had bad experiences telling people in the past.

Mental Health: Creating an inclusive environment is important for your clients and patients. If your client / patient is comfortable with you, they will disclose important information required for you to properly serve them. Knowing that your client is LGBTQ+ will help you understand the trauma they may have faced in their life, such as discrimination, societal pressures, and internal struggles. It's also important to ensure you keep a neutral demeanour when they disclose their identity to you, as you may be the first person they have told, or they have had bad experiences telling people in the past.

Service Industry: Every person who enters your establishment is a paying customer, and money has the same value no matter who's hand it comes from. If an LGBTQ+ person feels uncomfortable in your establishment, they are likely to leave without spending money, and they are also likely to not come back, as well as tell their peers, friends and family, and they may also no longer spend their money with you. If LGBTQ+ persons feel welcomed and treated with dignity and respect (i.e. the same as cisgender heterosexual individuals) they are likely to spend the same, or even more because they may have never received that level of service before. It is important to not focus on the customer's sexuality or gender identify when serving them, unless it applies to the type of service they need, (e.g. an outfit that accentuates a trans persons physical feminine or masculine features.)

Corporate: Having a diverse and inclusive workforce can increase the productivity of a company. Many times LGBTQ+ persons in a workforce are hidden for fear of discrimination, not being hired, or even being fired. An inclusive workforce allows those persons to have reduced stress about their identity, even if they still do not come out, which increases their ability to focus as well as be more actively involved. While the excuse of hiring LGBTQ+ persons would be that they would be distracting to other employees, sensitising the workforce to these populations will reduce that and employing these persons and having them occupy the space will reduce the distraction over time as persons grow comfortable around them. After all, remember, you probably also have LGBTQ+ employees without knowing it!

Educational Institutions: a major part of growing up is self-discovery. Students may show non-heteronormative traits or express that they may have a non-heteronormative identity. As an educator, you should encourage self discovery, but also respect their confidentiality. You can direct them to appropriate educational material, after all, in this age of technology they are probably going to do their own research. However, if you do not wish to get involved on this sensitive subject, the very least you can do is stand up against any bullying you may see.

Law enforcement: Everyone has the right to protection of the law. Members of the police force have sworn an oath to uphold the rights of ALL persons and to protect their property and protect them from harm. They also have an obligation to discover, arrest, prosecute or warn persons who have committed an offence against any person. Denying an LGBTQ+ person any of these rights is an offence.

Media: Using the correct language for LGBTQ+ persons is extremely important, not only out of respect and integrity, but also shows the level of research you have done. Ensure that you use a person's correct pronoun and use correct language such as "a trans woman" and not "a transgender".

General Population: Creating an inclusive culture helps improve the cohesiveness of a community. It reduces tensions between people and promotes respect. You never know when the only person you have to assist you with a problem is the LGBTQ+ person you continuously disrespect. An inclusive culture also help prevent "brain drain" an on economy as many persons seek asylum after being kicked out of the home and unable to find work. Many of these persons move to America, Canada or the UK and prosper because of their more inclusive environments, gaining persons with the skills and knowledge that would benefit a small Caribbean country.

MODULE 4

HIV & AIDS UPDATE

MODULE 4:
HIV AND AIDS UPDATE

This module provides an update on the basic facts around HIV transmission and how stigma affects persons living with HIV. Knowing this information is essential to overcoming fears about getting HIV through casual contact and understanding HIV transmission rates.

ACTIVITIES

Activity A: Exploring Beliefs and Attitudes About People Living with HIV and other key populations	Suitable for all participants but especially valuable for health care participants	60 minutes
Activity B: Fears About Getting HIV Through Nonsexual Casual Contact	Suitable for all participants	60 minutes
Activity C: HIV Transmission and Men Who Have Sex with Men	Suitable for all participants	40 minutes

ACTIVITY A: EXPLORING BELIEFS AND ATTITUDES ABOUT PEOPLE LIVING WITH HIV AND OTHER KEY POPULATIONS (VALUE CLARIFICATION EXERCISE)

Facilitator's Note: This is a value clarification exercise—participants review a number of statements about PLHIV and other key populations and 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. As the facilitator, you should do the following:

- Remain neutral throughout the exercise. You may, however, provide factual information to clarify matters, as needed.
- *If a participant expresses extreme views that reinforce stigma, allow other participants to challenge these statements or, if no one responds, do it yourself.*
- Emphasize that there are no "right" or "wrong" answers. The aim of the exercise is to explore different views when they exist.

Objectives: By the end of this session, participants will have accomplished the following:

- Explored their attitudes and values about PLHIV and other key populations.
- Recognized how their own attitudes regarding PLHIV and other key populations might affect their work as health workers.

Target Group: All groups but especially useful for health care participants

Time: 1 hour

Materials: Statements written on cards. Examples are given at the end of this exercise. Select those statements suited to your context or participants.

Adapted from: USAID/PEPFAR. 2015. Facilitator's training guide for a stigma-free health facility: Training Menus, Facilitation Tips, and Participatory Training Modules.

Steps:

Divide into groups, give each group three to four statements about each group, and ask them to discuss, "Do you agree or disagree, and why?" Explain to the groups that there are no "right" or "wrong" answers. We all respond to the statements based on our beliefs and values, and the purpose of this activity is to explore these differences when they exist.

Report Back

Then ask each group to report and ask other participants to comment.

Processing
Ask :

- Which statements were the most controversial, and why?
- How do our attitudes toward PLHIV and other key populations affect theway we behave toward these persons?
- How can we keep our own values from influencing our work in a negative way?

Summarise: Summarise the main points that participants have made during the exercise. In giving your summary, you may use some of the following points:

- Some of the statements involve stereotypes—negative things we say and believe about PLHIV and other key populations. Often we believe that these misconceptions are facts about other people, when actually they are false. This belief or assumption leads to S&D.
- We are socialized to judge other people based on assumptions about their behavior. PLHIV, MSM, transgender people, sex workers, people who use drugs, prisoners, and migrants are regarded as breaking social norms—so some people think they deserve to be condemned and punished.
- We are not saying that the moral values are wrong, we are saying that the "judging" is wrong. We have no right to judge others—and the judging ends up hurting people.
- We need to be aware that our opinions have effects on other people. Some of these opinions are very judgmental toward PLHIV and other key populations. As a result, they may feel hurt, humiliated, and depressed; this affects their access to services and how they protect their sexual health.
- **FOR HEALTH CARE WORKERS SPECIFICALLY:** As health workers, we have a professional obligation to remain objective and nonjudgmental with clients and avoid letting our personal beliefs and attitudes become barriers to providing compassionate and high-quality care to clients.

Developing a Code of Conduct: Ask participants, based on the discussion, to suggest two to three changes they could make in their health facility to reduce stigma toward their clients. Keep a record of this list of changes.

POSSIBLE STATEMENTS FOR EXERCISE
Select the statements suited to your context and training group.
Statements on PLHIV
1. Service providers have a right to know which of their clients are HIV positive.
2.Clients who are HIV positive should be treated the same as other clients.
3.HIV-positive clients should be treated at a separate facility, rather than in the same facility as other clients.
4.Health workers have a duty to inform the spouse and family of a person who is HIV positive.
5.Women living with HIV should not be allowed to have babies.
6. People who get HIV through sex deserve it because of their bad behavior.
7. People who get HIV through injecting drugs deserve it because of their bad behavior.

8. A person living with HIV should not be allowed to provide services to the public or treat persons
9. Clients have a right to know if a health worker has HIV.
10. PLHIV should be monitored closely by health workers.

Statements on Men Who Have Sex with Men

1. MSM can easily seduce or convert young men to become MSM.
2. MSM cause harm to society and to families, so they should all be locked up in prison.
3. MSM are victims of social stigma and discrimination, not criminals or deviants.
4. Preventing an HIV epidemic is more important than condemning MSM.
5. MSM deserve to get HIV because of their immoral behavior.
6. Men don't decide they want to love men. It just happens to them.
7. Being a man who has sex with men is a mental illness, so MSM should be given treatment.
8. MSM couples should be allowed to get married.
9. MSM do not want long-term partners, they only want casual sex.
10. A family with MSM is paying for the sins of its ancestors.

Statements on Sex Workers (male, female, and transgender)

1. Sex workers love money and are too lazy to work. They could easily get other jobs.
2. Sex workers have a right to say "no" to sex. No one can force them to have sex, even a client who has already paid them.
3. Sex workers deserve to get HIV because of their immoral behavior.
4. Sex workers are sex maniacs—they love to have sex with anyone.
5. Sex workers steal the partners of other women/men.
6. Sex workers are like other people—they have long-term, loving relationships with their regular partners.
7. All sex workers are HIV positive.
8. Sex workers should be allowed to get married and continue their work as sex workers.
9. Sex workers cause harm to society, so they should all be locked up in prison.
10. Sex workers show off and sell their bodies, so they deserve to be raped.

ACTIVITY B: FEARS ABOUT GETTING HIV THROUGH NONSEXUAL CASUAL CONTACT

Facilitator's Note: In this exercise, participants identify specific forms of contact with PLHIV that they fear might result in their becoming infected with HIV. Then they explain the reasons behind their fear, and the trainer provides information to counter these fears. Fear of HIV transmission is one of the main drivers of stigma; it is important to allow persons, especially those who have little training on HIV issue time to explore how HIV is—and is not— transmitted. Being able to provide clear information about HIV transmission is an important tool in eradicating stigma. The activity is divided into three parts. Part A explores common fears about HIV transmission. Part B gives participants a chance to try and explain transmission in a clear and simple way, so that they can help to challenge misinformation in their own settings.

Objectives: By the end of this session, participants will be able to do the following:
- Describe some of the fears they have about HIV transmission.
- Explain how HIV is, and is not, transmitted.
- Explain why HIV cannot be transmitted through nonsexual casual contact.

Target group: All groups

Time: 1 hour

Materials: **Handouts 19** and **Handout 20** – one copy for each participant.

Adapted from: USAID/PEPFAR. 2015. Facilitator's training guide for a stigma-free health facility: Training Menus, Facilitation Tips, and Participatory Training Modules.

Steps

Part 1: Naming and Analyzing Fears, and Providing Correct Information

Naming the Fears (Pictures) [**HANDOUT 19**][Print and cut out pictures]
Divide into pairs and hand out 4 pictures to each pair (randomly). Ask each pair to discuss the form of casual contact shown in the picture and the reasons why some people might fear that this form of contact could lead to getting HIV.

Analyzing the Fear
Go around the circle quickly, asking each pair to present their picture and explain why people think this form of contact will lead to HIV infection.

Providing Correct Information:
Explain Quantity, Quality, and Route of Transmission (QQR) [**HANDOUT 20**]. Then respond to two or three of the pictures, using information from the QQR Fact Sheet to show how transmission is not possible. Hand out the fact sheet.

EXAMPLE RESPONSES
Contact through food: A woman living with HIV cooks food in the canteen and cuts her finger. The blood gets into the food, then through the food into the mouths of her staff, who then get HIV.
Contact through food: HIV cannot survive outside the body, so even if the blood gets into the food, the HIV would die as soon as it is exposed to air. In addition, the heat of the cooking would kill the HIV.

Part 2: Practicing Giving Clear Information
Margolis Wheel
Arrange the Margolis Wheel—two concentric circles of chairs—an inner circle and an outer circle—with the two circles facing each other. Ask the more confident participants to sit in the inner circle. Give those in the outer circle the first four questions listed below (questions for the Margolis Wheel). Ask them to ask the first question to their partner seated in the inner circle. Those in the inner circle should try to give clear information and reasons to explain the transmission question. Ring a bell, and ask the outside row to rotate to the next seat, ask the second question to their new partners, and so on.

After the first four questions, ask the two circles to change places and continue with questions 5–8, so that both sets of participants have a chance to practice.
Questions for the Margolis Wheel
1. Can you tell me why you cannot get HIV from shaking hands?
2. Can you tell me why there is no risk of getting HIV from a mosquito bite?
3. Can you tell me why you cannot get HIV from a person living with HIV who is cooking?
4. Can you tell me why sharing utensils or blankets with someone who has HIV is not risky?
5. Can you tell me why you cannot get HIV from sharing a toilet?
6. Can you tell me why there is no risk of getting HIV from a barber's machine?
7. Can you tell me why there is no risk of getting HIV from changing a patient's bedding?
8. Can you tell me why there is no risk of getting HIV from a pedicure or manicure?

Plenary
Come back together and ask if anyone has any other questions about transmission. Ask participants to read through the QQR Fact Sheet and be ready to share the information with as many colleagues as possible.

QQR – Quantity, Quality, and Route of Transmission [**HANDOUT 20**]
There are three conditions, all of which need to be satisfied for HIV to be transmitted:

- There must be a large enough **Quantity** of the virus in body fluids. HIV is found in large quantities in blood, semen, vaginal fluids, and breast milk—so there is a risk of transmission from these fluids. HIV is found in small quantities in saliva, vomit, feces, and urine, and not at all in sweat or tears. In these cases, there is no risk. HIV is transmitted only through infected blood, sexual fluid, or breast milk entering the body.
- There must be sufficient **Quality**—the virus must be strong enough. HIV does not live on the surface of the skin; it lives inside the body. HIV is a fragile organism and does not survive for long outside of the body. It starts to die as soon as it is exposed to air.
- HIV must have a **Route of Transmission** or entry through the skin and into the bloodstream of the uninfected person; Through a vein; Through lining of the anus or vagina, or sores on the penis, anus, or vagina ; Through open cuts in the skin, although HIV cannot pass through these very easily; Mother-to-child transmission—HIV-positive mothers passing HIV to their babies before or during birth (through blood) or after birth through breast milk.

Additional notes on HIV transmission:

- Our bodies are closed systems. Healthy skin is an excellent barrier against HIV. HIV cannot pass through unbroken skin.
- To become infected with HIV, the virus has to get inside your body. When we have sex, sexual fluid can get into the bloodstream through small cuts on the penis, vagina, or anus. When we inject drugs, the infected blood on needles or syringes can go directly into the bloodstream.
- It is natural to fear HIV because there is no cure. This is a human reaction to a disease that can lead to people dying. Now that ARVs are available, however, HIV should be treated as a manageable disease, like hypertension or diabetes.
- Some fears are rooted in lack of knowledge about how HIV is transmitted— As a result of this fear, they try to protect themselves by minimizing contact with people who have, or are suspected to have, HIV. These practices are stigmatizing—they make the person feel unwanted, despised, and rejected.
- Sex without a condom and unsafe sexual practices carry a significantly higher risk of HIV transmission than accidental exposure to blood and body fluids in a facility.

ACTIVITY C: HIV TRANSMISSION AND MEN WHO HAVE SEX WITH MEN

Facilitator's Notes: This exercise is designed to deepen understanding of HIV transmission as it applies to MSM. Ideally, this exercise should be done with the involvement of an MSM resource person who is free to talk openly about his sexuality and skilled in explaining these basic facts. This exercise uses "BODY MAPPING." Using two body maps—a man and a woman—helps to make it easier to talk about all forms of sexual activity, and about sex between people of the same sex.

Participants may be shy at first about naming the sexual body parts. As the facilitator, you should let them do it, rather than doing it for them. Encourage them, even to the point of pointing a finger to a sexual body part and asking, "What do we have here?" Once people get past the initial embarrassment of naming the body parts, the process usually goes smoothly. Ask participants to use the words that they feel comfortable using. Out of embarrassment, some participants may not list the anus in naming sexual body parts. If so, remind them to add it to the list.

Objective: By the end of this session, participants will be able to identify the risks of getting HIV through different forms of sex involving MSM.

Target group: All groups

Time: 40 minutes

Materials: **Handout 21**, Flipchart, markers

Adapted from: USAID/PEPFAR. 2015. Facilitator's training guide for a stigma-free health facility: Training Menus, Facilitation Tips, and Participatory Training Modules.

Steps:

Divide into Single-sex Groups

Ask one group to draw the outline of a woman on the flipchart and the other to draw an outline of a man.

Sexual Body Parts

Ask participants to label the sexual body parts of the bodies. They can agree together on which language/words to use.

Male: penis, testicles, buttocks, anus, breasts, nipples, mouth, neck
Female: vagina, clitoris, breasts, nipples, belly, buttocks, anus, mouth, neck

Sexual Activities

Ask participants to write different sexual activities on cards—sexual activities between a man and a woman, between a man and a man, and between a woman and a woman—and stick these cards around the body map. Help the group if needed; ask probing

questions to make sure participants understand each sexual activity.

Vaginal sex. Oral sex. Anal sex. Kissing. Mutual masturbation. Fingering/fisting. Thigh sex. Vulvar rubbing.

Report Back
Ask the groups to look at each other's body maps and ask any questions to the group, if needed. If necessary, explain in more detail the sexual activities practiced by MSM, making some of the following points:

- Oral sex and anal sex are practiced by both heterosexuals and homosexuals.
- Not all MSM have anal sex.

Risks of Getting HIV (Brainstorm)
In the large group, ask, "Which of the sexual activities do you think are most risky in terms of HIV, and why?" Record points on a flipchart. Ask, "What advice can we give to persons to make these activities safer?"

- Ensure that all participants know about lubricant as well as condoms.
- Hand out the Fact Sheet [**HANDOUT 21**] for further reading.

Summarise
As a summary, present the following basic messages on HIV transmission in relation to sex between men:

- HIV has to penetrate your body for you to get infected. When we have anal sex without a condom, sexual fluid can get into the body through small cuts in the rectum or penis.
- Receptive anal sex is much riskier than insertive anal sex. The rectum has a large surface area and the skin in the rectum can easily get torn during anal sex, especially if the insertive partner is not using a water-based lubricant. Once the skin is broken, HIV in the semen, or in blood from cuts on the penis of the insertive partner, can easily get into the body and the bloodstream of the receptive partner if that person is not using a condom.
- Younger men, whose skin in the rectum is not fully mature, are more likely to develop cuts during anal sex and thus are at higher risk of getting HIV.
- Insertive anal intercourse is not as risky as receptive anal sex. Why? The skin of the penis is stronger than the skin of the anus. It is less prone to cuts, so it is less vulnerable to penetration by HIV. However, HIV contained in blood and rectal fluids can pass through the urethra of the penis or under the foreskin of someone who is uncircumcised.
- Water- or silicone-based lubrication is a must for anal sex. With a condom and lubricant, anal sex can be practiced and enjoyed safely.
- Oral sex is a low risk for HIV infection but a high risk for other STIs, such as gonorrhea.
- Some untreated STIs greatly increase one's risk of getting HIV. Many STIs cause sores, which make it easier for HIV to enter the body. MSM may not have symptoms of STIs or cannot see the sores because they are inside the anus or mouth, which puts them at greater risk of HIV infection or transmission.

MODULE 5

PERSONS LIVING WITH DISABILITIES

MODULE 5:
PERSONS WITH DISABILITIES

This module aims to introduce participants to basic concepts, language and etiquette for persons with disabilities. It also addresses barriers and how they can result in discrimination. The final activity is especially geared for corporate and business participants but will still be useful for any organization with employees.

ACTIVITIES

Activity A: Basic concepts and issues	Suitable for all participants	90 minutes
Activity B: Access, language, etiquette and culture	Suitable for all participants	120 minutes
Activity C: Barriers	Suitable for all participants	40 minutes
Activity D: Workplace discrimination as a barrier to diversity and inclusion	Suitable for all participants but especially useful for corporate and business participants	90 minutes

ACTIVITY A: BASIC CONCEPTS AND ISSUES

Facilitator's Notes: The following activities are heavily based on the American with Disabilities Act's definitions. If your country has a similar act with easily identifiable definitions you could use those instead.

Objectives:

- Participants will become familiar with different types of disabilities including hidden disabilities.
- Participants will learn to recognize different stereotypes of people with disabilities.
- Participants will learn to use appropriate language.
- Participants will learn about the basic types of reasonable accommodations used by persons with disabilities (personal assistance services, the removal of physical and communication barriers, and adaptive equipment)

Target group: All groups

Time: 90 minutes

Materials: Flipchart, markers, tape, prizes or small treats, **Handout 22** and **Handout 23**

Adapted from: Disability Awareness Workshop. Available from: https://worldinstituteondisabilityblog.files.wordpress.com/2016/01/disability-awareness-workshop.pdf

Exercise I: Brainstorming

All answers are recorded on a white board or flipchart. After each brainstorm, the answers listed are discussed by the group and a handout on the definitions of disability and reasonable accommodation [**Handout 22**] is shared out for this discussion. The facilitator says: In this brainstorming session, we want you to give as many answers as possible for us to put on the board. There is no right or wrong answer. Give us as many as you can, both positive and negative. We won't discuss your answers at this point, we will just list them. Since this workshop is focused on the topic of disability, let's start at the beginning and define our terms:

1. Many of us have some type of disability or know someone who does, but we may not always use the word `disability.' What images come to mind when you hear the word 'disability' ? The facilitator (or volunteer participant) writes all answers down. Allow the group 5 minutes or until the writing space is full.
2. The facilitator asks the group to look at the list of words and asks, "Which of these words do you perceive to be positive?" The facilitator lists those words identified as positive in a column on the left side of a new sheet.
3. The facilitator asks, "Which of these words do you perceive to be negative?" The facilitator lists those words identified as negative in a column on the right side of the sheet.

4.The facilitator asks, “What about the words not listed as positive or negative? Are they neutral terms?”
5.The facilitator asks, “Did we list more positive or negative words? Why do you think we came up with more (positive/negative) than (positive/negative) terms?”
6.The facilitator summarizes: Language is important, because it can be used to define a person. How a person is labelled by our society can sometimes be disempowering. Words and phrases like `epileptic' or `the disabled' reinforce objectification of people, because they describe people as if their disabilities were their definin characteristics. Better phrases are `person with a disability' or `woman who uses a wheelchair.' Here, the person comes before their disability or condition because persons with disabilities are people first. It is okay to sometimes use `disabled person' for stylistic reasons in writing.

Types of Disabilities

1.The facilitator asks, “What are some different types of disabilities? Again, answers given will not be discussed, just listed." The facilitator writes all answers. Allow the group 5 minutes or until the writing space is full.
2.The facilitator says, “This is the legal definition of `disability' in the United States: The term disability means, with respect to an individual:

- having a physical or mental impairment that substantially limits one or more major life activities;
- having a record of such an impairment, or
- being regarded as having such an impairment.

4.The facilitator asks, “Which disabilities are visible?” The facilitator reviews the list with the group, identifying those disabilities that are visible.
5.The facilitator then asks, “Which are invisible?” The facilitator and the group discuss those disabilities identified as invisible.
6.The facilitator asks, “Looking at the list of disabilities, how many people know someone with a disability?”

Exercise II: Quiz time!

In this activity, the facilitator asks questions about disability and disability issues, and participants search for the best answers provided from the list of answers cut out from[**Handout 23**]. The participants are divided into 2 (or 3 groups depending on numbers) and when a team gets an answer right they keep the cut-out answer. At the end of the quiz the team with the most correct answer wins a prize (treats for everyone on the team or pens etc). Most questions have more than one answer so ask each question until the answer options are exhausted. Alternatively, you can only print out one answer to each question for a quicker version of the quiz. The questions should be asked to one team at a time so that shouting over each other is avoided. If a team gets the answer wrong the other team can “steal” the point by answering correctly.

Quiz Questions and Answers

1. What is currently considered the proper way to refer to someone who has a disability?
   (*person with a disability*, *disabled*)
2. What is a negative term for disability?
   (*crippled*, *handicapped*, *physically challenged*, *special*, *invalid*)
3. Which one is an invisible disability.
   (*dyslexia*, *learning disability*, *epilepsy*, HIV/AIDS, *psychiatric disability*)
4. What is a disability that might result in a mobility impairment.
   (*spinal cord injury*, *cerebral palsy*, *muscular dystrophy*, *multiple sclerosis*, *arthritis*)
5. Find an accommodation for a person with a mobility impairment.
   (*wheelchair*, *lift*, *ramp*, *service animal*, *personal assistant*)
6. What is an accommodation for a person with a visual impairment.
   (*Braille*, *tactile surfaces*, *sound signal*, *personal assistant*)
7. What is an accommodation for a person who is hard of hearing.
   (*service animal*, *closed captioning*, ASL)
8. What is something that allows access for a person who uses a wheelchair.
   (*lift*, *ramp*)
9. What is a barrier for a person with a disability.
   (*ignorance*, *attitude*, *stairs*, *printed material*, *sound*)
10. What is something that might require adaptive equipment to allow access for persons with disabilities.
    (*bathroom*, *transportation*, *television*, *phone*, *book*, *printed material*, *computer*)
11. What is a communication barrier that someone might encounter at work?
    (*phone*, *printed material*, *computer*)

ACTIVITY B: ACCESS, LANGUAGE, ETIQUETTE AND CULTURE

Facilitator's Notes: These activities introduce participants to the concepts of access and accommodation as well as increase participants' sensitivity to stereotypes of persons with disabilities and understanding of why it is important to be aware of such stereotypes. It also increases participants' awareness of disability culture and issues and encourages participants to examine their attitudes towards disability. Depending on time, some or all of the exercise could be done.

Objectives:

- Participants will learn about the basic types of reasonable accommodations used by persons with disabilities (personal assistance services, removal of physical and communication barriers, adaptive equipment).
- Participants will become more aware of their environment, with regard to access for people with disabilities.
- Participants will learn to recognize different stereotypes of people with disabilities.
- Participants will learn to use appropriate language.
- Participants will discuss their attitudes toward disability.

Target group: All groups

Time: 2 hours

Materials: **Handout 21**, **Handouts 24 - 28**, Flip chart, markers, tape, bowl or hat

Steps:

Introduction

The facilitator explains and hands out **Handout 22**: "This handout includes the definitions of disability and reasonable accommodation and outlines the procedure for obtaining reasonable accommodations. As you proceed with this section of the workshop, keep in mind your agency, workplace, or school as a `test case' for access.
Are there programs and service sites accessible to people who have various types of disabilities?
If not, what reasonable accommodations could be made to make it accessible?
Are activities and events accessible?
If you are in charge of planning an event and have an individual with a disability, what could you do to make sure that the event (location, transportation, environment, information) is accessible to that individual?

Exercise II: Access and Accommodation Problem Solving (40 minutes)

Adapted from: Disability Awareness Workshop. Available from: https://worldinstituteondisabilityblog.files.wordpress.com/2016/01/disability-awareness-workshop.pdf

This activity is designed to increase participants' awareness of the physical environment and issues of access and accommodation for persons with disabilities. In this activity, participants determine the accommodations that allow a person with a given disability to fully participate in society. Participants break into small groups. Each group receives six questions and draws a disability from a hat. [**Handout 24**] The groups discuss each question as it applies to the disability selected and lists as many answers as possible on the sheets of paper provided. Then all groups post their answer sheets for each question on the wall. When all the answers are posted, the entire group discusses the answers for each question.

The facilitator says, "This activity is designed to help you become more conscious of the physical environment and those issues of access and accommodation for people with disabilities.

Directions

- Break into small groups of three to four people.
- Each group receives six questions.
- Each group draws a disability from the hat.
- Each group then discusses each question as it applies to the disability selected and lists answers on the sheets of paper provided.
- Each group posts their sheet of answers on the wall with the appropriate question when finished answering that question.
- Trainers are available for guidance.
- You have 20 minutes to list as many answers as possible for each question.

Questions

1. Name as many accessibility features as you can which allow people with your disability
   access to the physical environment in a downtown business district (buildings, streets,
   businesses, services, schools, etc.).
2. What are features that allow access for a person with your disability on ATMs, phones, computers, and other devices used for serving the public?
3. What are the communication barriers a person with your disability might encounter at work or at school, and what can be done to remove these barriers?
4. When might a person with your disability use a personal assistant work, home, school,
   extra-curricular activities, etc.)?
5. What proportion of parking spaces are reserved for persons with disabilities?
6. What are some transportation barriers that a person with your disability might encounter on their way to work (public, private or personal transportation, walking, etc.)?

Discussion Questions

- Which were the easiest reasonable accommodations to determine?
- Which were the most difficult?

What did you learn from this exercise?

Activity Closing:

The facilitator concludes,"Many places are not accessible. We designed this activity so that you will think about your surroundings and physical environment with regard to access and accommodation."

Exercise II: The impact of language (30 minutes)

Adapted from: Oxfam. 2013. Disability, Equality, and Human Rights: A Training Manual for Development and Humanitarian Organisations.

Preparation: Prepare sufficient copies of **Handout 25**

- Participants should work in pairs. Give each pair one copy of the photograph.
- Ask them to take ten minutes to think up two different captions to accompany the photo. One caption should be worded so as to make the image look negative. The other caption should be worded so as to give the viewer a positive impression from the photo. They can write their captions on flipchart paper if they want to.
- Bring the whole group together and ask each pair to share their captions. Tell them that the original caption was: 'Two English visitors to Calcutta photographing Mr Biswas, Director of the Fellowship of the Disabled'.

Facilitate discussion to bring out the learning points, which may be based on the following questions:

- Was it easy or hard to think up the captions? Why?
- What do they think most people would think about the photo if they saw it without the original caption?
- How would most people react when they then read the original caption?
- What can we conclude about using language, in this case with images?

Exercise III: Manners charades (30 minutes)

Adapted from: Field Band Foundation. Disability awareness and inclusive teaching: Facilitator's Guide.

1. Print out the scenarios in Handout 26 and cut each out
2. Fold the paper with the scenarios and drop them into the bowl/hat
3. Divide the groups into teams of three or four. Let each team pick a paper from the bowl. Give them three minutes to prepare a small play presenting the scenario on the paper.
4. Let the teams act out their scenario in turns.

5. Ask the opposing teams if the action is good or bad. Then ask them to explain what happened in the play and why it was good or bad.
6. Let the acting team explain their task to the others.
7. Have small discussions after each scenario.
8. Summarize at the end of the activity and handout **Handout 28** on rules and etiquette

Exercise IV: "Disability Etiquette Quiz" (30 minutes)
Adapted from: Field Band Foundation. Disability awareness and inclusive teaching: Facilitator's Guide.

People are often uncomfortable interacting with people who are living with disabilities. The discomfort often stems from limited experience, and can disappear with increased knowledge and familiarity. This activity is designed to provide learners with some basic dos and don'ts when encountering someone who has a disability.

1. Hand out the question sheet from **Handout 27**, and let the learners answer the questions either by themselves or in groups.
2. Go through the questions afterwards and have small discussions. If persons don't have already, hand Handout 28 on rule and etiquette distribute them now.

ACTIVITY C: BARRIERS

Facilitator's notes: Prepare 3 flip chart papers showing three forms of discrimination (attitudinal, environmental and institutional). Make sure that you are familiar with the different types of barriers beforehand.

Attitudinal barriers – prejudice, discrimination and stigma cause the biggest problems for people with disabilities, who are assumed to be incapable, need to be cured, dependent, and have low intelligence.
Environmental barriers – inaccessible public places and information/communication systems
Institutional barriers – legal, cultural and social organisational practices and systems

Target group: All groups

Time: 40 minutes

Materials: Cards, markers, print out of illustration in this activity

Adapted from: Disabled women in Africa. 2013. Gender and Disability Mainstreaming Training Manual.

Steps:
Divide participants into groups of four to six, and the group work should take about 15 minutes. Ask them to think of their daily life – social, work, home or school. They should try and imagine what obstacle or barriers that might exist if they were a disabled person. They should imagine that they have a specific impairment when doing this activity. The facilitator can divide the groups into impairment specific groups to make sure that all forms of barriers are covered.

Each barrier should be written on a piece of card, and they should discuss and agree whether it's attitudinal, environmental or institutional.

- Bring the whole group together. Ask one representative from each group to come up and place their stickers onto the wall under the subheadings – attitudinal, environmental and institutional (the prepared flip papers) and justify their choices. The facilitator should lead this process to ensure that barriers are being posted onto the right section. This is also a way of assisting participants to understand the reasons behind barriers and categories.
- Ask participants to discuss their experiences of identifying barriers and what they have learnt.

Points to consider - This is a very good exercise to use with groups who have not thought about different forms of barriers people with disabilities face on a daily basis. Sometimes it is helpful when we can break down issues into categories in order to make them more manageable. It is also useful to be able to name something rather than keeping it as just a feeling or sense. You can pre-prepare the wall statements with some of your ideas about what barriers exist but then compare them to the ones identified during group work; and this can quite an eye-opener.

The biggest barrier is often that of attitudinal, and this should be stressed during this session. Attitudinal barriers can be minimised by awareness-raising events, campaigns and training. Institutional barriers can form the basis for an advocacy strategy. Environmental barriers can be dealt with when designing programmes and make provisions for appropriate access needs.

- The facilitator should emphasise that attitudinal, environmental and institutional barriers limit persons with disabilities' participation in society more than impairments as illustrated in the picture below.

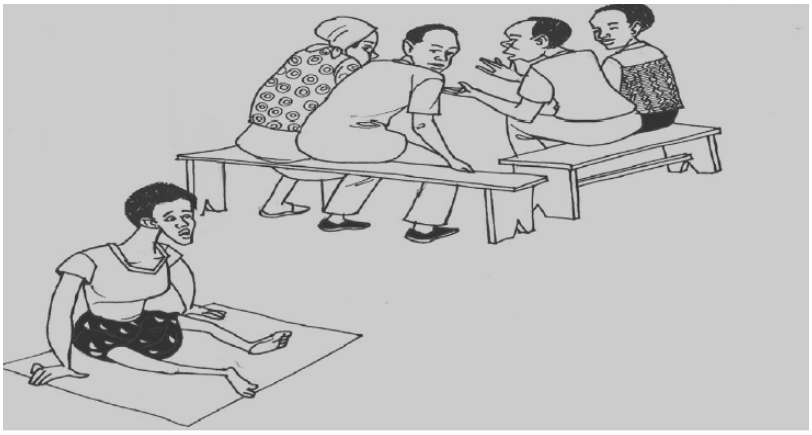


Figure 2: Barriers to Participation
Source: World Vision Uganda (2008)

Engage in a discussion of what is happening in the above picture. A description of the picture is important if there are participants with visual impairment.

Notes
The above picture is a classic example of discrimination on the basis of impairment. This means any distinction, exclusion or restriction on the basis of impairments which has the purpose or effect of restricting the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation. Effectively this means any behaviour or sets of rules/ policies which restricts or denies people with disabilities from participating in an activity. Discuss the excuses that could be given by various people and their organisations to avoid disability mainstreaming and write them on a flip chart.

ACTIVITY D: WORKPLACE DISCRIMINATION AS A BARRIER TO DIVERSITY AND INCLUSION

Facilitator's notes: It's easy to discriminate against a person - sometimes you are not aware when you are doing it. There is a natural process of identifying which people are more useful for you or who make you feel comfortable because they are similar to you. It is part of the way in which human beings socialise and we need to be able to differentiate.

However, we also need to be aware of how our own attitudes can inadvertently discriminate unfairly against certain people. If we understand our own bias we can make decisions based on fair criteria. We need to challenge unjustified discrimination that affects persons and understand how discrimination results in inequity, exclusion and ultimately can cause poverty and marginalisation. Exercise A and either Exercise B or C would complete this activity. If time permits, all exercises can be done.

Target group: All groups but especially useful for corporate and business participants

Time: 90 minutes

Materials: Projector, flip charts, markers, **Handout 29**, **Handout 30**, **Handout 31**

Steps:

Exercise I: Presentation on supporting diversity in the workplace
Convert the points on **Handout 29** into a PowerPoint presentation. Add images to make more visually appealing. You can shorten the points written on the slide once you speak the words in the handout. Present the power points slideshow.

Exercise II: Direct and Indirect Discrimination
Adapted from: Water Aid. Equity and inclusion: Play your part. Awareness raising training guide.

At end of presentation divide the room into two. Write the definition for Direct discrimination on a chart and give to one group, and write the definition for Indirect discrimination on another and give to the second group. Ask each group to list at least 6 examples of each type of discrimination.

Direct discrimination: Less favourable treatment of a person compared with another person due to a personal characteristic.
Examples
- Employer rejects all female applicants for a job regardless of their qualifications.
- Men are paid more than women for doing the same work.
- Restaurants refuse to serve a person because of their sexual orientation.

Indirect discrimination: The use of an apparently neutral practice, provision or criterion which puts people with a particular characteristic at a disadvantage compared with someone without that characteristic.

Examples

- An employer actively recruits staff based on skills and ability but the workplace is uncomfortable for women because the men who work there make sexist jokes and there are no separate women's toilets.
- Lack of flexible working makes it difficult for parents with young children to work.
- The school has plenty of toilets but none of them are accessible to children who have physical impairments so they cannot come to school.
- No toilet facilities for menstrual hygiene management.
- A post-graduate degree is stated as essential for a job description – even when experience would be just as useful – so groups who have less access to further education are disadvantaged for no good reason.

Exercise III: Job advertisement

Adapted from: Water Aid. Equity and inclusion: Play your part. Awareness raising training guide.

Tell participants: We are now going to consider a scenario which shows how direct and indirect discrimination affect people's lives. Read out the job advertisement in **Handout 30.**

Discussion

- Have the group share examples of discrimination from the ad. You should write them up on a flip chart divided into three sections: direct discrimination, indirect discrimination, both (or not sure where to put it).
- What is the impact of all types of discrimination?
- Share Handout 31 with definitions of discrimination and positive action.

Notes for facilitators:

Participants will probably identify the need for computer literacy and a Masters degree in the job advert as causes of potential discrimination. This is an opportunity to discuss whether it depends on the role and whether the job really requires that level of knowledge and skills.

Sum up:

Write the following on a flip chart:

- Promoting non-discrimination in the organisation is an essential component of applying equity and inclusion in our work.
- We need to think how we can avoid discrimination in our personal attitudes and behaviours and in our work.
- Promoting inclusion and diversity in the organisation is one way of challenging discrimination. Encouraging diversity in the workplace is also good business sense.

MODULE 6

DEVELOPING A CODE OF CONDUCT AND ACTION PLAN FOR A STIGMA FREE FACILITY

MODULE 6:
DEVELOPING A CODE OF CONDUCT AND ACTION PLAN FOR A STIGMA-FREE FACILITY

The Code of Conduct should be written collaboratively by staff and managers, rather than being developed and imposed by the managers. This will help to facilitate a sense of ownership by everyone—and staff will be more likely to implement the new practices. A stigma-free and safe facility is one in which the rights of all persons are supported.

Objectives: The aim of this section is to show you how to support:

- Organizations in writing their own Code of Conduct for a stigma-free and safe facility
- Staff and managers in writing an Action Plan to turn the health facility into a stigma-free service

Adapted from: USAID/PEPFAR. 2015. Facilitator's training guide for a stigma-free health facility: Training Menus, Facilitation Tips, and Participatory Training Modules.

A brief description of each of these documents would be:

DOCUMENT	DESCRIPTION
Code of Conduct	**List of practices describing how services can be provided in a** stigma-free way. The list of practices will be brainstormed by staff during the training course or soon afterward. Examples: - **S**ervices for all clients is not denied, delayed or referred elsewhere. - Information is treated confidentially - Services are provided free of judgmental attitude. - Staff speak to clients in a respectful and dignified manner. - Clients' complaints about stigma and discrimination are dealt with effectively.
Action Plan	List of suggested actions to make the facility stigma-free: **Two to three action that can be taken by the staff themselves **Two to three actions that they recommend be taken by the managers Examples of actions:

- Extra training on counseling skills for health staff
- Extra training on client interactions
- Changing the way records are filed to ensure confidentiality
- Monitoring services to check that it is delivered in a stigma-free way

Staff would make these two lists and give them to the managers, who then would write up an Action Plan for the facility.

The Code of Conduct may be compiled on a gradual basis during the training program.

At the end of each training session, ask participants to identify practices to make their facility stigma free—and keep a list. At the end of the workshop, review and finalize this list as a Code of Conduct and then develop an Action Plan.

At the end of the workshop, organize a session to develop the Code of Conduct and Action Plan; this session is described below.

After the training, hold a separate workshop to develop the Code of Conduct and Action Plan, involving representatives from different departments or facilities who attended the training workshop. This workshop could use the process described in the following exercise. This results of the workshop should be sent to all of the participating departments or facilities so they can give their feedback. A joint Code of Conduct and
Action Plan then can be finalized, based on the feedback.

Exercise or Mini-Workshop to Write a Code of Conduct and Action Plan

Facilitator's Note: This exercise describes how to develop the Code of Conduct (and Action Plan) as a single activity at the end of the workshop or as a separate workshop.

Objectives: By the end of this session, participants will have accomplished the following:

- Described what a stigma-free health facility would look like (Code of Conduct)
- Identified actions health facility staff and managers can take to create a stigma-free facility (Action Plan)

Target group: All groups

Time: 1-2 hours

Materials: Flipchart, markers

Steps:

Existing Forms of Stigma in Health Facilities (Buzz Groups)

Divide into pairs and ask, "What are some of the key forms of stigma that we have identified during the training that occur in our own facilities?" Record the answers on a flipchart. You can also refer to **Exercise 1F: Forms Effects and Causes of Stigma** and review what was discussed in that exercise if it was already a part of your training program.

EXAMPLE RESPONSES

Some of the common forms of S&D practiced are:

- Taking less time with clients, keeping them waiting, treating them last, referring them to other providers, and providing poor or no services.
- For health care persons: Using gloves and masks for routine tasks that don't involve the handling of blood and bodily fluids, e.g., feeding or taking temperature.
- Bureaucratic and unfriendly treatment, and insulting or scolding language.
- ·Breaking confidentiality—revealing clients information to other staff or family members without the consent of the clients.
- Forcing clients to sit in a separate area or on a separate bench.

Effects (Brainstorm)

Ask participants to brainstorm the effects of these forms of S&D on clients.

EXAMPLE RESPONSES

- Clients feel insulted and humiliated, and they do not recieve solutions for their problems.
- Patients may stop using the facility.
- For health care providers: Patients have to find other forms of treatment—e.g., private doctors who treat them with more confidentiality and less stigma—or patients may try self-treatment.
- It may affect clients' self-esteem/self-confidence and security.

Code of Conduct for a Stigma-free Health Facility (Group Work)

Divide into groups (from the same department or facility or from similar jobs). Write the phrase, "A stigma-free facility is one in which …" on the flipchart and ask groups to make a list of practices for creating a stigma-free facility. Give them one or two examples to help them get started. If necessary, ask the questions, "What if your sister/brother/child is a person living with HIV or LGBTQ+ or PWD? How would you want them to be treated?"

Report Back

Ask the groups to report on an alternating basis—one point per group. Make a list of the points and then discuss the full list, combine similar answers, and agree on any changes or additions.

EXAMPLE RESPONSES

"A stigma-free facility is one in which…"

- Clients are treated equally and with respect and dignity, regardless of who they are.
- All clients receive the same high-quality service without discrimination, regardless of ……..
- No clients are denied care, kept waiting, or referred unnecessarily to other providers.
- Services are provided to clients known to be HIV positive without separating them from other patients
- Clients' information is treated confidentially.
- Services are provided free of judgmental attitudes.
- Staff speak to clients in a respectful and dignified manner.
- Clients are able to give their informed consent to the services available to them.
- Clients' circumstances (e.g., their criminalized situation) do not act as a barrier to their accessing healthcare and treatment.
- Clients' complaints about S&D are dealt with effectively.

Action Plan (Groups)

Ask the same groups to do the following tasks:

- Make a list of two to three changes you will make to create a stigma-free facility
- Make a list of two to three things you would like your managers to do

EXAMPLE RESPONSES

Staff List

- We should listen, interact better, and be more patient with clients. Train all staff on the needs of LGBTQ+ persons and PWDs and how to provide appropriate services and information.
- Set up procedures for reporting on breaches of confidentiality. Use supervision and performance appraisals to ensure stigma-free care and treatment.
- Establish a register to record S&D complaints and a team to deal with complaints.
- Organize training on S&D for all levels and types of health facility staff.

Applying the New Code of Conduct on the Job

Each facility can plan and implement various activities to build a stigma-free facility. Here are some ideas.

Set up and identify your Stigma Action Group: Include representatives from senior managers, staff, and service-users. The group will be responsible for implementing the Action Plan and then monitoring its progress.

Assess your facility: If possible, carry out an assessment of the levels of stigma within your facility. The assessment will serve two purposes: to give you a snapshot of the kind of stigma that exists in your facility and to raise awareness about the plan to move toward a stigma-free facility. Be sure to include staff and service users in the assessment, and share the results.

Review current policies and practices: This review has been started in the stigma-reduction training, so use the outputs from the training as a starting point. Use existing structures (e.g., staff meetings, senior management meetings, departmental meetings, etc.) to discuss the outputs and encourage further discussion and ideas from staff who were not at the training. One way of doing this is to get each department to develop its own ideas on new policies to counteract stigma and then bring representatives of all departments together to agree on a Code of Conduct.

Solicit ideas from the community and other local organizations, including LGBTQ+ and PWD organizations: Encourage these groups to come up with their own ideas and then meet with them to document their suggestions to stop stigma in the facility. Even if you are an organisation facilitating these trainings, get input from other organisations in your country that work with other marginalise groups, or even those who work with the same marginalised group.

Launch the Code of Conduct: Make sure as many people as possible (staff, clients, the public) are aware of your Code of Conduct. Display it in service areas and staff rooms. Use meetings to ensure that staff know what it means for their work. Ask for feedback from clients. Celebrate the fact that you are aiming to provide a stigma-free facility!

Monitor progress: Carry out regular assessments of stigma, record success stories, discuss progress with staff, and review the Code of Conduct to see if new points need to be included. Share lessons with other facilities and plan further stigma-reduction training.

APPENDICES

APPENDIX A
DAILY TRAINING EVALUATION

Name of Training:

Department:

Date:

Please circle the response that you most agree with about today's session:

	Strongly Agree				**Strongly** Disagree
The facilitator was knowledgeable on the topics	1	2	3	4	5
This session increased my knowledge/skills	1	2	3	4	5
The program was well placed in the allotted time	1	2	3	4	5
The content was organised and easy to follow	1	2	3	4	5
The objectives of the training were met	1	2	3	4	5
The material was presented in an organised manner	1	2	3	4	5
I felt safe discussing the topics covered	1	2	3	4	5
The facilitator has good communication skills	1	2	3	4	5
I feel I can apply what was learned in the session	1	2	3	4	5
I would recommend this training to others	1	2	3	4	5

Please circle the statement you agree with:

I think that the training was: a. Too Short b. Right Length c. Too Long

In my opinion, this session was: a. Introductory b. Intermediate c. Advanced

Please rate the following:	Poor	Fair	Good	Very Good	Excellent
A. Visuals	☐	☐	☐	☐	☐
B. Meeting Space	☐	☐	☐	☐	☐
C. Handouts	☐	☐	☐	☐	☐
D. Overall Program	☐	☐	☐	☐	☐

Three things I really **liked** about the workshop:

1

2

3

Three things I **didn't like** about the workshop:

1

2

3

Three **major learnings** for me today are:

1

2

3

Two things from today that helped me most to **improve my knowledge** on the issues discussed:

1

2

Areas from today that need **more discussion**:

1

2

My suggestions for **improving** the workshop would be:

APPENDIX B
PRE/ POST TEST

Name of Training:

Department: Unique Symbol:

Date:

The definition of stigma is:
A. Negative attitudes people have towards other persons the deem different
B. Negative reactions people have towards other persons the deem different
C. Preconceived notions people have towards other persons the deem different

Key population members (LGBTQ+ persons, Sex Workers, Persons Living with HIV, etc.) do not face discrimination:
A. Strongly Agree
B. Agree
C. Disagree
D. Strongly Disagree
E. Not sure

Everyone has the right to healthcare regardless of gender identity, sexual orientation or sexual activity:
A. Strongly Agree
B. Agree
C. Disagree
D.Strongly Disagree
E. Not sure

I am comfortable serving someone who identifies as Transgender, Gay or Lesbian:
A. Strongly Agree
B. Agree
C. Disagree
D. Strongly Disagree
E. Not sure

Someone sexual orientation defines who they are:
A. Strongly Agree
B. Agree
C. Disagree
D. Strongly Disagree
E. Not sure

Someone sexual orientation defines who they are:
A. Strongly Agree
B. Agree
C. Disagree
D. Strongly Disagree
E. Not sure

I would be comfortable with people knowing that I have cared for persons from marginalized populations
A. Strongly Agree
B. Agree
C. Disagree
D. Strongly Disagree
E. Not sure

Someone can be Transgender and identify as straight at the same time:
A. True
B. False

If I notice a colleague or another member of staff discriminating against someone from a marginalized population, I would likely intervene:
A. Strongly Agree
B. Agree
C. Disagree
D. Strongly Disagree
E. Not sure

APPENDIX C
MONITORING BEHAVIOUR CHANGE

We here at ..... aim to create an inclusive and non-discriminatory environment. Having undergone sensitisation training, we are aiming to improve our services to all persons no matter their health status, gender or sexual identity or ability. To help us ensure we are achieving this, we would like you to take this short 3 minute survey to ensure we are achieving this.

1. Do you identify as any other the following: (NOTE: NOT A MANDATORY QUESTION! This question can put off persons from answering, you can give them the opportunity to identify in an open-ended questions)
   a. LGBTQ+
   b. Person living with HIV
   c. Disabled
   d. Other
   e. None

2. How would you rate the service you received today? (Overall experience, or sectioned off.)
   a. You can also divide into different staff members if they come across different staff during their time: e.g. security, front desk/reception, nurse, doctor, cashier, other staff (allow them to indicate which other staff)

3. How would you rate the following aspects of your visit?
   a. E.g. friendliness, confidentiality, wait time, clinical environment, customer service, overall experience.

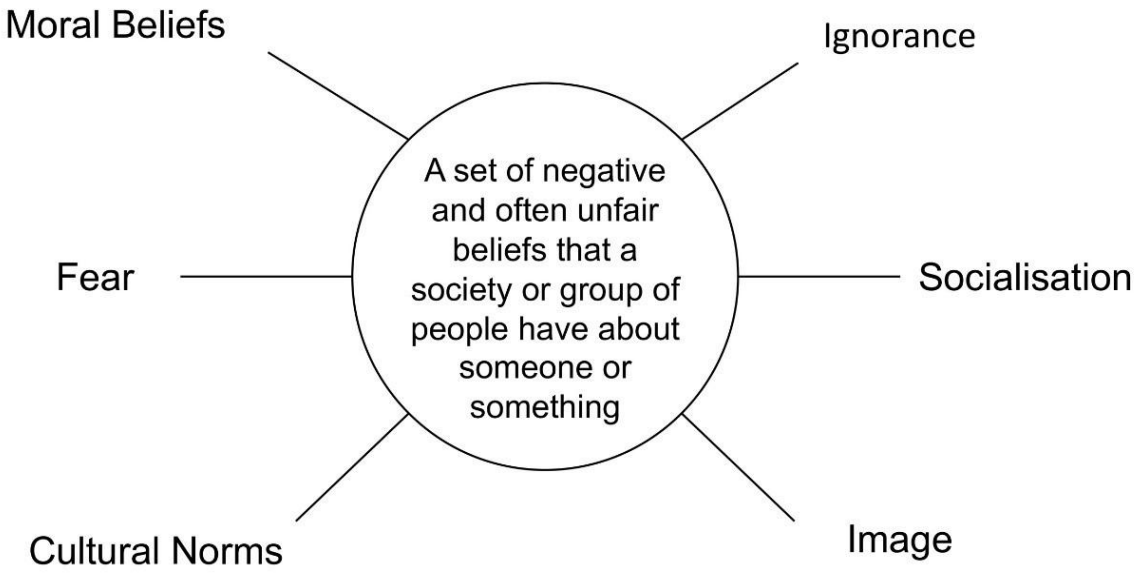
4. When did you visit us?
   a. Can be divided based on how often you see persons, i.e. weekly or monthly

5. If you had any poor service today, please describe what was unsatisfactory about it and any root causes you may identify. This will also help us know what areas to target in future trainings.

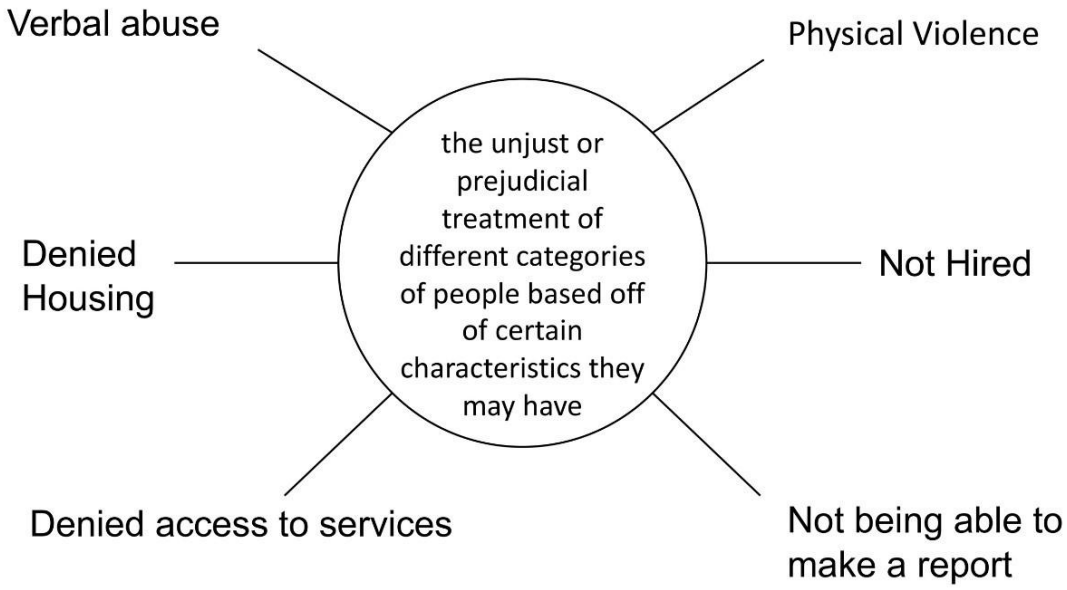
6. Would you recommend us to others?

HAND OUTS

STIGMA



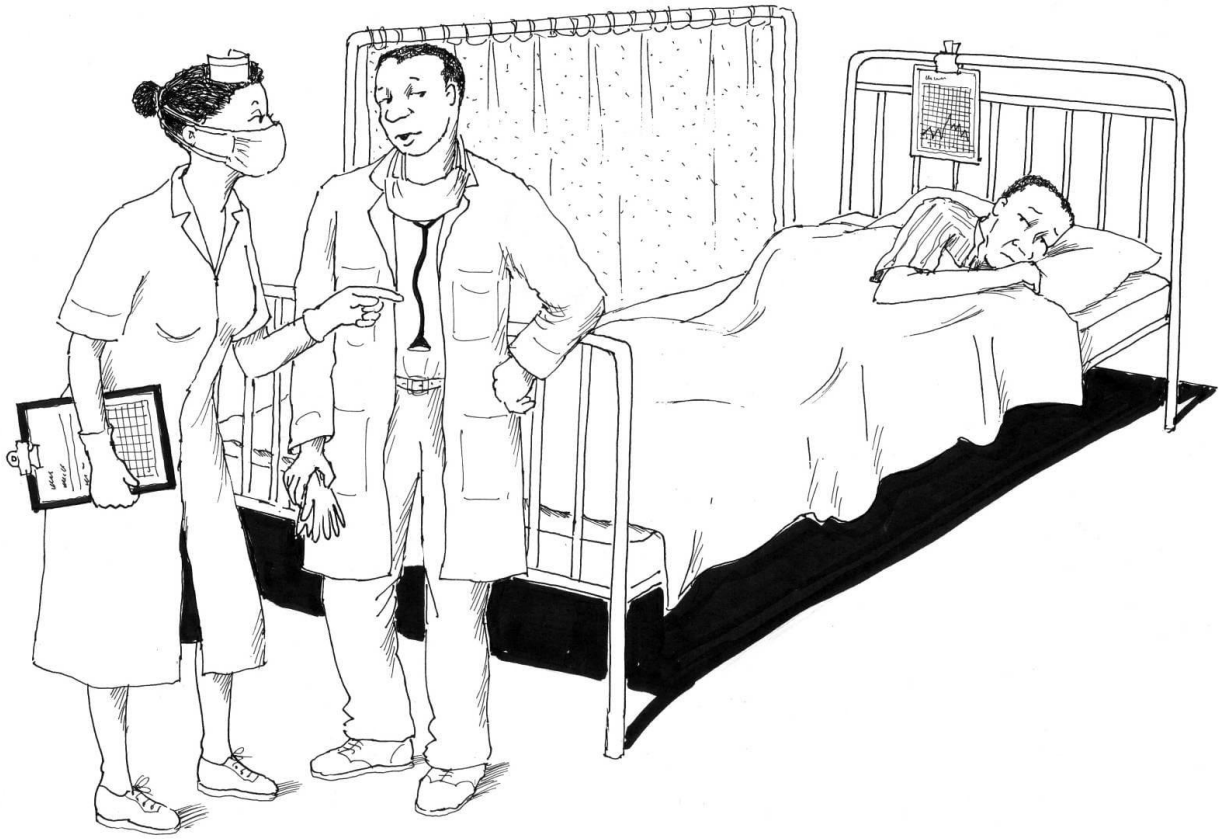
DISCRIMINATION



HANDOUT 2
NAMING STIGMA THOUGH PICTURES

(*From Health Policy Project's Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide; Illustrations by Petra Rohr-Rouendaal*)


Counselling Room
PRIVATE NO ENTRY
What am I going to do now?




What? You've got an STI in your anus?


Get out of my house!


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


Sinners!

HANDOUT 3
CASE STUDIES

Case Study A

Kemar started to have sex with men when he was a teenager but managed to hide it 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 lived on his own. His family suspected he might be gay, but they didn't bother him until he was 30, when they started to pressure him to get married. He agreed to marry, feeling that he had no choice. Soon after getting married, he found out that one of his previous male 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 questions about Kemar's sex life. When Kemar mentioned having had sex with men, the counsellor said, "No, you are not one of those! You seem different!" Kemar left the health facility without taking the test and told himself he would never go back. He was so worried that his wife would find out about his male partner that he just continued to have sex with her without using condoms.

Discussion

What happened in the story? Why is Kemar behaving this way?.

Case Study B:

Trish is a trans woman who is currently transitioning. She has been seeing a local public doctor for her hormones and sexual health care for the past 2 years. Unfortunately, the doctor has relocated to a private practice and because Trish cannot afford private care, was referred to a new doctor. When Trish sits in front of her new doctor, at a different public facility, not all of her notes have been transferred. While collecting information from Trish, the new doctor notices that the gender on her ID is male, and the name is Trevor.

The doctor indicates that he must put on record Trish's government name and when Trish tries to explain to the doctor what was done before, he aggressively tells her that this is protocol and that is the way things must be. Trish decides to excuse herself, and tells the doctor that she will return when her notes have arrived.

However, Trish never returns, and because she desperately needs the hormones, reverts to sex work to make money to see her original doctor. However, she is unaware that her condom breaks with one of her clients. She continues with sex work as she is much happier seeing her doctor, but after a routine HIV test, she finds out she is positive.

Discussion

What happened in the story? Why did Trish not want to continue with her new doctor? What are the consequences for Trish having to result to sex work to receive the treatment she desires?

Case Study C:

Two young men, Dwayne and Akeem, are at the clinic to get an HIV test done. Dwayne has not had a test in a few years, while Akeem gets tested every 3 – 6 months. The two young men have recently become a couple and Akeem has encouraged Dwayne to get a test if they want to become serious. Once reason Dwayne does not get tested is because he is afraid of being discriminated against if they ask him personal questions about his sex life. Akeem has told Dwayne that he has never been discriminated against and they he will be fine.

When they are called in they indicate that they wish to get the test done together. The counsellor on duty is not the one that Akeem usually sees and she say to the young men that they cannot be seen together. When Akeem says that he has before, the counsellor replies with “this is policy, to ensure your privacy”. So as not to draw attention to themselves, Dwayne goes first. However, when he starts giving answers about his sexual behaviour, he notices a change in attitude from the counsellor. He then excuses himself, saying that he wishes to use the bathroom.

He proceeds to leave and when Akeem asks what’s wrong, Dwayne responds with “You see, I told you they just want to know your business”. They both leave without having a test done. A few months pass and the couple become comfortable with each other and decide to stop using condoms. A few months later they break up and Akeem returns for his regular test, which has come back positive. Dwayne was the only person Akeem had sex with since his last test.

Discussion

What happened in the story? Why did Dwayne not want to be tested? What are the consequences the young men not receiving the test that day?

Case Study D:

Keisha is feeling depressed because she is struggling to come to terms with her sexuality. She goes to church every week and it is taught that homosexuality is bad. She has tried to fight it but no **m**atter what, the feeling for other women are always there. She is in her second year at university and has decided that maybe she should speak with the campus counsellor, since they are free.

Keisha is nervous because she has never gone to a counsellor before, but feels confident that she can disclose to the counsellor. However, when she does, the counsellor seemed to get very uncomfortable and tried to change the subject and he didn't seem to know how to discuss the issue. Keisha left feeling worse than when she went in and swore she would never seek counselling again. Her grades began to drop and there was additional pressure at home because of that, but she could not tell her parents what was bothering her. One day she could not take it anymore and attempted suicide.

***Discussion*:**

What happened in this story? Why did Keisha not want to go back to counselling? What was the result of her not being able to access the appropriate metal health care?

Case Study E:

Justin and John are two gay men in a relationship. However, Justin is very abusive towards John, who is much younger. One day John can't take it anymore and goes to report the incident to the police. At first the officer seems concerned at first, but when John informs the police of the incident and that it is his boyfriend who is abusing him, the officer sucks his teeth and says: "Leave 'bout here and stop wasting my time, I thought this was a family member assaulting you, I don't wanna here about no bulla men issues" and turns around and leaves.

When John gets home, Justin asks him where he has been. After lying to Justin, saying that he was just with friend, Justin tells John that his friend saw him coming out of the police station. Justin then started to beat John, saying "If I ever hear that you been to the police again I will kill you!" John is too afraid to leave Justin and the abuse continues, until one day Justin end up killing John.

***Discussion*:**

What happened in this story? Why did the police officer not take John's report?

What was the result of John not being able to make a report?

Case Study F:

Fabian was a top sales person for a relator, always surpassing targets. Unfortunately, one day he was in a car accident that resulted in his leg having to be amputated. However, the procedure was quick and he was out of hospital in less than a month. He eagerly wanted to get back to work, not only to keep his mind off of what happened, but so he could start making money again. He may have lost one of his legs, but he was still mobile and able to work.

Before he started working again he was called to the manager's office. They said that they would be putting him on extended leave while he recovers, even though Fabian told them he was fine, and he got the okay from his doctor. Having to stay home made Fabians mind wonder, and soon he started to spiral into depression, and started drinking. Before long he lost his possessions as he had to sell them to survive because work would not call him back in, nor would another employer hire him. Eventually he started living on the street.

Discussion:

What happened in this story? Why did Fabian's work not take him back after the accident? What was the result of Fabian not being able to work?

Case Study G:

Violet is a passing trans women who is certified in cosmetology after taking online courses, working at friends' salons and having her own clients come to her home. However, Violet's grandmother was very sick and she was the only one around to take care of her, and she needed more money. An opportunity came by in the form of an international hotel coming to her country, which had a spa. Because this hotel was known to be an equals opportunity employer, Violet decided to apply. She made it to the job fair, ut could not hide the fact that she is trans because they needed her ID card and her assigned gender at birth could not be changed.

However, she did make it to the last stage of the interview, the regional manager informed her that even though she was fully qualified for the job, they will not be accepted her as a staff member, because they were afraid of the treatment she might receive from the other staff members they will employ.Having been unsuccessful with getting employment, Violet did all she could to keep up with her grandmother's medical expenses, even going without food many days. This caused her to lose a lot of weight and persons started to think that she had HIV. This resulted in her losing clients and therefore eventually could not keep up with her grandmother's medical expenses, and soon her grandmother passed away.

Discussion:

What happened in this story? Was the regional manager's excuse for not hiring Violet legitimate? What was the result of Violet not getting the job she was clearly qualified for?

Case Study H:
Michael is a 15 year old student at secondary school, his friend Jason recently came out to him as gay. Michael is not sure how to comprehend this information and so he goes to someone who he thinks can help him; the Guidance Counsellor. When he asks the guidance counsellor if they know anything about gay people, the counsellor quickly tells Michael that he should not be asking those questions and that he should seek guidance from the Bible.

Before Michael even has a chance to explain, the guidance counsellor escorts him out of the room and closed the door behind him. The next day, Michael notices other students seem to be talking about him, and during lunch, a group of students beat him up and call him gay slurs. The guidance counsellor was nearby and even though Michael called out for help, the guidance counsellor ignored him. When he got home, his parents were waiting for him. They immediately started yelling at him and calling him dirty and eventually kicked him out of the house. Michael was too ashamed to say anything to anyone, even Jason, and ended up on the street and dropping out of school.

Discussion:
What happened in this story? What did the guidance counsellor do wrong? What was the result of everyone thinking Michael was gay?

HANDOUT 4
ANSWERS TO REFLECTION QUIZ

GAY MEN AND LESBIANS

1. ***Becoming gay does not just happen. Rather, people decide or learn that they want to be gay or lesbian.***

FALSE. Wanting to have sex with the same sex is part of some people's nature. It is like being right-handed or left-handed. It is natural or inborn and cannot be explained, predicted, or changed by individual will. It is not known what makes some men desire men, or some women desire women; some studies suggest there are genetic influences, whereas other people believe it is a mixture of genetics and social influences. A gay or lesbian person cannot simply be taught to be sexually attracted to women or men respectively. There is no scientific evidence to prove that people can change their sexual orientation by exerting their will.

2. ***Gay men and lesbians are mentally ill but they can be cured.***

FALSE. Being gay or lesbian is not a mental illness. In the past, psychiatrists tried to show that same-sex desire was a mental illness, but they failed. Starting in 1973, the medical profession no longer treated being homosexual an illness. However, some parents still wrongly send their gay or lesbian children to clinics, psychologists, or traditional doctors to be "cured." If being gay or lesbian was accepted by everyone, no one would feel the need to "cure" it.

3. ***Sex between two men or between two women is against religion.***

TRUE/FALSE. Religions have different views and interpretations of homosexuality. Islam and some Christian churches consider it a sin, whereas other religions consider it a weakness that can be cured, and some feel it is an acceptable and normal sexual orientation. In all religions, there is a difference between their texts and daily practice. Some people read their holy books literally and use such texts to condemn gay men and lesbians. Others use the texts as a source of inspiration, but in daily life they accept gay men and lesbians as human beings. Others emphasize that religious teachings mention compassion and tolerance of other people. There are many gay men and lesbians who find ways to keep their faith and still be who they are. Many religious people are faithful to their religions and also accepting of gay men and lesbians.

4. ***Gay men and lesbians have been too influenced by Western values.***

FALSE. Historical research shows that homosexuality existed in Asia and Africa long before Europeans arrived in these regions. Research has shown that 5–10 percent of people in every community in the world are attracted to the same sex. In all countries of the world, gay men and lesbians existed in the past—they kept it secret, but they existed. Today, it is relatively more open; it is estimated that people who have sex with people of the same sex live in every community, although because of stigma and discrimination, many keep it hidden.

5. *Gay men and lesbians are all the same. You can identify them by the way they dress and behave.*
FALSE. As with all people, gay men and lesbians are individuals who look and behave in different ways. Some gay men wear their hair longer and dress in a feminine way, whereas others may wear their hair short and dress and act like other men. In some cases, some lesbians are married and have families, or act one way in public and another way in private. Many gay men and lesbians dress and act no differently from heterosexual people. It is impossible to tell whether someone is gay or lesbian just by the way they look and behave.

6. *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.

7. *Gay men and lesbians engage in the same sexual practices as other couples*.
TRUE. Gay men and lesbians use many of the same sexual practices as heterosexual couples, including kissing, masturbation, touching, anal sex, and oral sex. These sexual activities are not restricted to sex between a man and woman or sex between two men or two women, but are commonly practiced by all groups. Some of us, for example, assume that all gay men practice anal sex; in fact, many do not, and many heterosexual couples practice anal sex.

8. *Gay men do not want long-term partners; they want only casual sex*.
FALSE. Many people think that gay men are interested only in sex, and that their relationships are shallow and based only on physical attraction, not love. In fact, gay men are equally capable of deep, long-term, loving relationships as non-gay men are with women. Some gay men may have lots of sexual partners, whereas some may have only a single partner and maintain a permanent relationship.

9. *Children with gay or lesbian parents become homosexuals*
FALSE. There are no more gay or lesbian children of homosexual couples than of heterosexual couples. All the scientific evidence reaches the same conclusion: children raised by same-sex parents are no different than children raised by heterosexual parents. In February 2002, the American Academy of Pediatrics unequivocally stated that children raised by same-sex parents develop equally well in all areas as do children raised by heterosexual parents. The academy also concluded that it is in the child's best interest to officially acknowledge both his or her parents. The American Psychiatric Association also expressed the same opinion. These two associations have cleared up any ambiguities about the supposed "dangers" and inadequacies of same sex parents.

BISEXUALS

1. *Bisexuals are just confused about their sexuality.*
FALSE. Bisexuality is as valid a sexual identity as being heterosexual, homosexual, or anything else. Some people are simply attracted to people of more than one sex.

Being bisexual means that you are capable of finding people of your own sex attractive sexually and/or romantically, as well as finding people of another sex attractive sexually and/or romantically.

2. *Sexual identity never changes. If you're gay, you're always gay, if you're straight, you're always straight.*

FALSE. The way people characterize their sexual identity can change over time, and people's attractions can also change over time. What attracts us and arouses us is extremely variable, and our desires can change quite a lot over the course of our lives. Sometimes people will identify as heterosexual, only to get to a point later in life where they can acknowledge that they are also attracted to members of their own sex. They might decide to identify as bisexual at that point. Similarly, someone who has identified as gay might discover that they are attracted to someone of another sex somewhere down the road, and their self-identification might change because of it. It's very common and not weird or sick in any way to have that happen.

3. *To be a bisexual, you have to have had sex with people of both sexes.*

FALSE. To be a bisexual, you need to have the capability of being attracted sexually and/or romantically to members of more than one sex. You don't need to have had sex with someone of the opposite sex to be a heterosexual, or to have had sex with someone of the same sex to know that you are a homosexual - you just know what you like and what is attractive to you. You know who you get crushes on and who you think is sexy. If you know that you find people of more than one sex to be attractive and sexy, you might decide to call yourself bisexual, whether or not you ever have sex with partners of more than one sex.

4. *Bisexuals are equally attracted to both men and women.*

FALSE. Some bisexual people find themselves equally attracted to men and women, but many bisexuals find that they are more attracted to people of their own sex, or more attracted to people of another sex. Some bisexual people choose to say that they are "identified" with either the straight/heterosexual world or with the queer/homosexual world, which is a way of saying "I am attracted to people of more than one sex, but I am more invested in this particular kind of community." People can be attracted to members of more than one sex in a lot of different proportions. Sometimes, the degree to which a person is attracted to one sex or another can change with time. A person might be attracted to members of his or her own sex 30% of the time, and members of another sex 70% of the time when they are 15, and then by the time they are 30, it could be 75% and 25%... or anything else in between.

5. *Bisexuals are just opportunists. They just want to have sex, they don't even care who it's with.*

FALSE. Bisexuals aren't necessarily sex fiends. Some bisexuals are even celibate (people who choose not to have sex with partners). All that being bisexual means is that you have the ability to find people of more than one sex attractive. Most bisexual people, like most people of any other kind, have a variety of kinds of relationships over the course of their lives, from one-night-stands to long-term, heavily committed relationships, and they are just as likely to be responsible, loving, faithful partners as

anyone else.

6. *Most people who are bisexual are really gay or lesbian. They just say they're bi because it's easier when you can "pass" as straight.*
FALSE. Most people who say that they're bisexual are bisexual. Being bisexual is not the same as being straight. Sometimes it is confusing to people to remember that a bisexual person is really bisexual if they see them with a partner of one sex or another - when people see a bisexual person with a same-sex partner, they are likely to be assumed to be gay, and when people see a bisexual person with an opposite-sex partner, they are likely to be assumed to be straight. The truth is that if you're bisexual, you don't change orientations based on your partner's sex: you are bisexual all the time, regardless of whom you sleep with.

This isn't to say that life isn't sometimes easier for bisexuals when they're in relationships with opposite-sex partners. It is. Our culture values opposite-sex relationships more, something called "heterosexual privilege" that means that people who look like heterosexuals are less likely to have people give them crap in a lot of situations. One of the things that is important to the bisexual community is to be out as bisexual no matter what the sex of a person's partner, so that people don't get to assume they know whether a person is gay or straight by the sex of their partner. This is one way to combat bisexual invisibility.

7. *If you're bisexual, you have to have a male and a female partner to feel fulfilled.*
FALSE. While some people may find that they feel best in unconventional relationships where they have more than one partner of whatever sex or gender,
that's certainly not something that you have to do if you're bisexual. Like everyone else, bisexuals fall in love, form bonds, and make commitments to individual people. And like everyone else, bisexuals are capable of being either unfulfilled or fulfilled in their relationships depending on how good the relationship is - which very rarely has a whole lot to do with the shape, size, or type of genitals either partner has

8. *Bisexual people spread HIV to straight people.*
FALSE. Dishonest and irresponsible people spread diseases of many kinds, including HIV, by having unprotected sex with infected partners and passing diseases on to uninfected partners. Sexual orientation has nothing to do with it. People who are not honest about their sexual behavior or desires may also not be honest about their need to protect themselves with safer sex, as if it can't hurt them if they don't really admit it's true that they want or like something they don't think they are "supposed to" like or want.

Being honest about whether or not you are engaging in a sexual act that might put you at risk for an STI (including HIV), and using appropriate safer sex methods, is the only way to help cut down on your risk of contracting an STI or of getting infected and passing it on to someone else. Germs and viruses can't tell what your sexual orientation is, what your sex is, who you are, how old you are, or who you sleep with. They don't care. The only thing you can do - whether you consider yourself bi, gay, lesbian, straight, or something else entirely -- is be honest with yourself about when you need

to protect yourself and the people you have sex with, and play safe at all times.

9. *If you've never had sex, you can't know whether you're bisexual or not.*
FALSE. You can know who you have crushes on, who you are attracted to, and what types of things and people are arousing for you without having sexual activity of any kind with another person. This is true whether you are homosexual, bisexual, heterosexual, or anything else.

TRANSGENDER PERSONS

1. *Being transgender is just a recent thing.*
FALSE. While it may seem like being trans is only a recent thing, trans people have existed for thousands of years across a diverse range of cultures. The perception that there are more trans people now stems from a few things. First it is safer for a trans person so be out, second public awareness of trans people have increased, third the internet and social media can highlight and showcase trans people and finally there are simply more people than ever, thus more trans people.

2. *Transgender people are unnatural and what we are assigned at birth is our real and correct gender.*
FALSE. The gender that someone identifies with is independent in many ways from their sex. Someone's biological sex generally refers to the sex characteristics that one had at birth, such as genitalia, as well as chromosomes and hormones. Gender is an internal sense one has about themselves and the social role they inhabit. Sex and gender are two separate things. A trans person is not unnatural as a person's sex does not determine their gender and a person is allowed to identify in the way that makes them feel most comfortable.

3. *Transgender people are not confused or mistaken about what gender identity they identify as.*
TRUE. A trans person is not confused about their identity by identifying differently than the gender they were assigned at birth. Their identity as a man, woman or non-binary person has been a part of them from the start and they have not been influenced by outside factors to "become" this. They may feel more comfortable coming out because of outside factors but those did not make them trans. A person may struggle with their identity and may change how they identify but that does not mean trans people are merely confused men or women who are just going to change their identity "back to normal" soon.

4. A *person assigned female at birth but who identifies as male is a trans woman.*
FALSE. This person is a trans man (or female-to-male transgender person). One way to remember the correct terminology for persons of trans experience, is that trans goes in front of the gender that the person identifies as.

5. *Being transgender is just a fetish or kink.*
FALSE. Partially due to media presentation, there exists the myth that being trans is a fetish or all sexual. That is entirely unrelated.

As well, being trans is something that is a part of you and affects every aspect of your life, rather than an activity to be enjoyed under certain circumstances.

6. *There are both trans men and trans women.*
TRUE. Trans men do exist and are far more common than believed. Partially due to trans women being more likely to medically transition, the statistics have been skewed away from the fact that there is an equal amount of trans men and trans women.

7. *A person can not know their gender identity as a child.*
FALSE. Some people know and fully understand their identities when they are children. A study from the TransYouth Project found that trans children as young as 5 years old respond to psychological gender-association tests, which evaluate how people view themselves within gender roles, as quickly and consistently as those who ***don't*** identify as trans. Researchers at Boston University School of Medicine conducted a review of the current scientific research, and concluded that the available data suggests there's a biological link to a person's gender identity, indicating that trans people are essentially assigned genders at birth that don't match their inherent, biologically set identity. The same way a cisgender person likely knew they their gender identity from young, a transgender person can be the same.

8. *Being transgender is a mental illness.*
FALSE. A psychological state is considered a mental disorder only if it causes significant distress or disability. Many transgender people do not experience their gender as distressing or disabling, which implies that identifying as transgender does not constitute a mental disorder. For these individuals, the significant problem is finding affordable resources, such as counseling, hormone therapy, medical procedures and the social support necessary to freely express their gender identity and minimize discrimination. Many other obstacles may lead to distress, including a lack of acceptance within society, direct or indirect experiences with discrimination, or assault. These experiences may lead many transgender people to suffer with anxiety, depression or related disorders at higher rates than non-transgender persons.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), people who DO experience intense, persistent gender incongruence can be given the diagnosis of "gender dysphoria." Some argue that it is essential to retain the diagnosis to ensure access to care through insurance companies.

9. *Trans people always want to or are going to get surgery.*
FALSE. Being trans doesn't mean that someone will undergo any medical interventions. For some trans people hormone therapy or surgeries would be the right choice, but not for all. Some may choose to change their name, come out to others and dress differently but not seek medical intervention. It's up to an individual and their preferences.

Q PLUS

1. *Asexuals have taken a conscious decision to not take part in sexual activity despite experiencing sexual attraction.*

FALSE. Asexuality describes a lack of sexual attraction. Asexual people ("aces") may experience romantic attraction, but they do not feel the urge to act on these feelings sexually. Asexuality is a sexual orientation. Typically, an asexual person would always have had little interest in sexual contact with other people. It is not the same as suddenly losing interest in sex or choosing to abstain from sex while still experiencing sexual attraction.

2. *Pansexuals are attracted to people regardless of their sex or gender identity.*

TRUE. Although being pansexual has existed as long as the human race has, it's only been recently that the word has become more mainstream, The prefix 'pan' comes from the Greek term for "all" and when you couple that with the word sexual, you get 'pansexual' which is a more modern term that refers to people who are attracted to everyone, no matter their sex or gender. While being bisexual means being attracted to more than one gender, being pansexual means being attracted to all gender identities, or attracted to people regardless of gender, and there is definitiely overlap between the 2 terms.

3. *Queer is a derogatory term that should never be used.*

FALSE. Since the 1980s, many LGBT people have reclaimed the word queer to remove the negative connotations it originally had. Today, 'queer' is used to unite LGBT people under an umbrella broad enough to cover diverse experiences and as a sexual orientation. Queer has become an inclusive term that refers to diverse genders and sexualities, identity, way of life, and scholarship, but for some members of the LGBTQ+ community the word queer remains a loaded and offensive term.

4. *Intersex is the same as transgender.*

FALSE. Intersex' is used as an umbrella term to denote a number of variations in a person's bodily characteristics that do not match strict medical definitions of male or female. Intersex is NOT a medical condition but stands for the spectrum of variations of sex characteristics that naturally occur within the human species, in 1 in 200 persons. These characteristics may be chromosomal, hormonal and/or anatomical and may be present to differing degrees. Many of these characteristics are immediately detected at birth and sometimes these variants become evident only at later stages in life, often during puberty. Most intersex people are healthy, and only a very small percentage may have medical conditions, which might be life-threatening, if not treated.

Gender is one's identity of being male, female, non-binary, and the many other gender identities we have come to be more aware of. Sex refers to your biology, the body you are born into, which is where the term intersex fits. So intersex is distinct from one's gender identity as it relates to one's anatomy or biology.

5. *Intersex children should have surgery as soon as possible.*
FALSE. The American Academy of Family Physicians (AAFP) opposes medically-unnecessary genital surgeries performed on intersex children. Many intersex children are subjected to genitalia-altering surgeries in infancy and early childhood without their consent or assent. The surgery can lead to decreased sexual function and increased substance use disorders and suicide. Scientific evidence does not support the idea that being intersex means a greater risk of psychosocial problems. The risk of cancer in intersex individuals has also not been verified, and genitalia-altering surgeries should not be offered to decrease this risk. Genital surgeries should only be recommended for intersex infants and children for the purpose of resolving significant functional impairment or removing imminent and substantial risk of developing a health- or life-threatening condition.

6. *Hermaphrodite is an acceptable term for intersex people.*
FALSE. Although intersex people were labeled "hermaphrodites" historically, today the term is considered outdated and offensive.

7. *Pansexuals are just opportunists. They just want to have sex, they don't even care who it's with.*
FALSE. Pansexuals aren't necessarily sex fiends. Some pansexuals are even celibate (people who choose not to have sex with partners). All that being pansexual means is that you have the ability to find all people attractive. Most pansexual people, like most people of any other kind, have a variety of kinds of relationships over the course of their lives, from one-night-stands to long-term, heavily committed relationships, and they are just as likely to be responsible, loving, faithful partners as anyone else.

PERSONS WITH DISABILITIES

1. *Everyone is likely to experience disability at some point in his/her life.*
TRUE. According to the UN's Convention on the Rights of Persons with Disabilities Handbook for Parliamentarians, "Everyone is likely to experience disability at some point during his/her lifetime because of illness, accident, or aging."

2. *Accessibility means equal access to only the physical environment.*
FALSE. Accessibility is equal access to the physical environment, transportation, information, communications, technology, and other services open to the public.

3. *Words such as wheelchair bound, handicapped or special needs child are acceptable to use.*
FALSE. Children and adults living with disabilities are like everyone else, except they happen to have a disability. In using People first language, you will be reinforcing the basic rights of individuals with disabilities to be referred to not as a disability, but as a person first who happens to have a disability. People-first language puts emphasis on placing the individual BEFORE the disability. Two examples are people with disabilities, not disabled people, or the manager who is blind and not the blind manager.

4. *The words 'disability' and 'impairment' mean more or less the same thing.*
FALSE. Impairments refer to the physical or intellectual problem, such as hearing, visual, intellectual, or mobility impairments. People with impairments are disabled when society does not include them by making services or goods accessible to them.

5. *It is better to talk to the person supporting someone who is visually impaired, rather than the person themselves.*
FALSE. Always talk to the person directly, no matter what impairment they have, or who else is in the room.

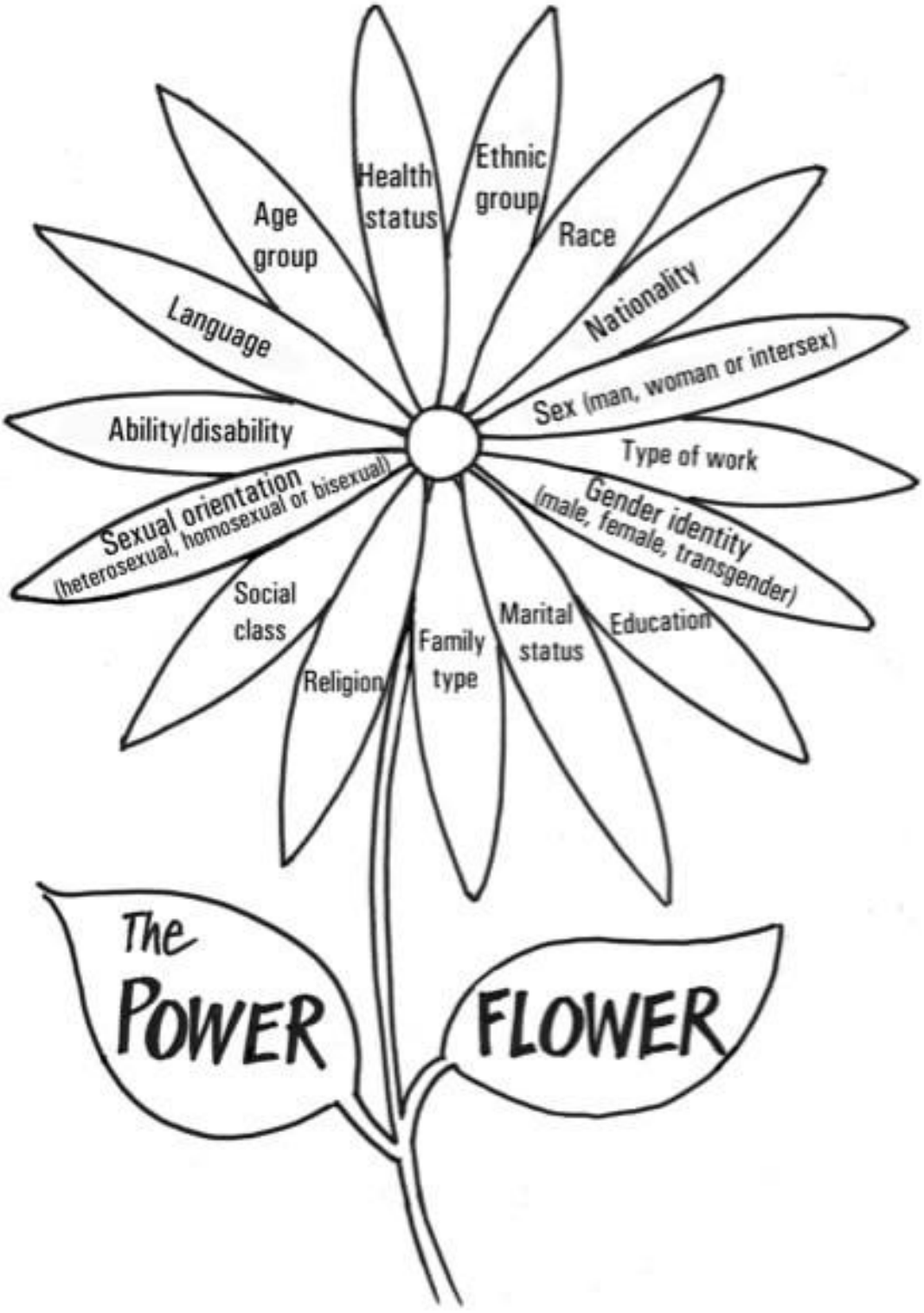
6. *Persons with disabilities always need assistance.*
FALSE. Don't assume a disabled person wants or needs your help, as a basic courtesy, ask before you help and wait until the disabled person accepts your offer. Once the person has accepted your offer, listen or ask for specific instructions. Don't worry if your offer is turned down.

7. *It is always obvious if someone has a disability.*
FALSE. According to the Invisible Disabilities Association (IDA), "The term invisible disabilities refers to symptoms such as debilitating pain, fatigue, dizziness, cognitive dysfunctions, brain injuries, learning differences and mental health disorders, as well as hearing and vision impairments. These are not always obvious to the onlooker, but can sometimes or always limit daily activities, range from mild challenges to severe limitations and vary from person to person." Other examples of this would include congestive heart failure (which prevents people from walking very far), lung disease, neurological disorders, chronic pain, lupus and arthritis.

8. *Shouting at a person who is deaf will enable them to hear you better.*
FALSE. Hearing loss is the second largest disability, and an invisible one. Many people try to help by shouting and by exaggerating the pronunciation of words. This does not help. People who wear hearing aids can experience extreme discomfort if people shout at them. It is better to speak clearly, a little more loudly than usual and not too fast. Shouting and over-mouthing words will alter the lip pattern and speaking too slowly will destroy the natural rhythm of speech.

9. *Mental health disorders and intellectual disabilities are the same thing.*
FALSE. Mental illness, also known as mental health disorder or behavioral health disorder, is not the same as Intellectual Disability. Mental health disorders affect mood, thought processes or behavior and can manifest in anyone at any time in their life. Mental Illness does not directly impact cognitive abilities, but can change a person's perceptions and thought processes and affect a person's everyday functioning and ability to relate to others. With an Intellectual Disability, the person must have a well below average IQ (70 points or lower) and have severe limitations on daily functioning skills, which include Conceptual skills, such as language and literacy; Social skills, such as social responsibility and problem solving; and Practical skills, such as personal care, use of money, and occupational skills. When mental illness and intellectual disability occur together, the descriptive term used is "dual diagnosis.

HANDOUT 5
THE POWER FLOWER



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.

- Some persons are marginalised and stigmatised 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 marginalised groups, 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 stigmatised identity.

- In focusing narrowly on this single identity, we stop dealing with marginalised 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 marginalised 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, or community members, not just gay men, persons with disabilities, or people who use drugs. We need to respect them by treating them like anyone else.

- There are also layers of stigma. For example, a woman could be stigmatised as a woman, a sex worker, a PWD, 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 them to access health and other services and to get out of their hidden, marginalised existence.

HANDOUT 6
CHARACTER CARDS

A.

White
Man (Sex)
Male (Gender)
Straight
Has not disabilities
Master's Degree
US Passport
US Citizen
Earns Over 200K

B.

White
Woman (Sex)
Female (Gender)
Straight
Has no disabilities
Undergraduate Degree
UK Passport
UK Citizen
Earns 60K

C.

Black
Man (Sex)
Male (Gender)
Straight
Has depression
College
US Passport
Dual Citizen – US and Caribbean
Earns 40K

D.

Black
Man (Sex)
Female (Gender)
Straight
Has depression
Secondary School
Caribbean Passport
Caribbean Citizen
No steady Job

E.

Asian
Woman (Sex)
Female (Gender)
Bisexual
Blind
Secondary School
Caribbean Passport
Caribbean Citizen
No steady Job

F.

White
Man (Sex)
Male (Gender)
Gay
Has depression
Undergraduate Degree
Canadian Passport
Dual Citizen – Canadian and Caribbean
Earns 70K

G.

Black
Woman (Sex)
Male (Gender)
Pansexual
Has anxiety
College
Barbadian Passport
Barbados Citizen
Earns 20K

H.

Mixed Race
Man (Sex)
Male (Gender)
Bisexual
Uses a wheelchair
College
Caribbean Passport
Caribbean Citizen
No Steady Job

I.

Black
Woman (Sex)
Female (Gender)
Straight
Has no disabilities
Secondary School
Caribbean Passport
Caribbean Citizen
Earns 20K

J.

Mixed Race
Female (Sex)
Woman (Gender)
Straight
Deaf
Undergraduate Degree
Caribbean Passport
Caribbean Citizen
Earn 30K

K.

Black
Man (Sex)
Woman (Gender)
Straight
Has no disabilities
Primary School Education
Caribbean Passport
Caribbean Citizen
No Steady Job

L.

Asian
Man (Sex)
Male (Gender)
Bisexual
Has no disabilities
Master's Degree
Caribbean Passport
Caribbean Citizen
Earns 45K

HANDOUT 7
DOS AND DON'TS

DO:

Do keep both of you safe.

- Assess your surroundings - are there others nearby you can pull in to support? Working in a team is a good idea, if it is possible.
- Can you and the person being harassed move to a safer space/place?

Do make your presence as a witness known.

- If possible, make eye contact with the person being harassed and ask them if they want support.
- Move yourself near the person being harassed. If possible and you feel you can risk doing so, create distance or a barrier between the person being harassed and the attacker.
- If it's safe to do so, and the person being harassed consents—film or record the incident.

Do take cues from the individual being harassed.

- Is the person engaging with the harasser or not? You can make suggestions, "Would you like to walk with me over here? Move to another seat? For him to leave you alone?," and then follow their lead.
- Notice if the person being harassed is resisting in their own way, and honor that.
- Follow up with the individual being harassed after the incident is over, see if they need anything else.

DON'T

Don't necessarily jump to call the police .

- For some communities experiencing harassment right now the police can cause a greater danger for the person being harassed. Don't escalate the situation.
- The goal is to get the person being harassed to safety, not to incite further violence from the attacker. Don't do nothing.
- Silence is dangerous--it communicates approval and leaves the victim high and dry. If you find yourself too nervous or afraid to speak out, move closer to the person being harassed to communicate your support with your body.

HANDOUT 8
PRESENTATION ON HISTORY OF LGBTQ+ IDENTITIES

Egypt
24th century BCE:
The ancient Egyptian royal servants, Niankhkhanum and Khnumhotep are believed to be among the first recorded same sex couple in history, as reflected in the drawing in their tomb.

Ancient Greece
6th Century BCE – 6th Century CE
Male homosexuality was an accepted phenomenon, practiced by high status individuals usually with younger men. The poet Sappho wrote about her affections and desire for other women. The philosopher Plato spoke of a third sex which was both male and female, as part of original human nature.

Korea
1st Century BCE – 1st Century CE
Songs and poems from the ancient Silla Dynasty spoke of affection among men, especially among a group of elite male warriors, the hwarang, who were known to form same sex relationships.

China
1st century BCE – 17th Century CE
Homosexuality was considered a sign of culture elitism, was not persecuted and have been documented as early as the QI, Han, and Tang dynasties in poetry and songs.

Saudi Arabia
8th – 9th
Islamic Hadith (report of the deeds and sayings of Prophet Muhammed) state that the Prophet of Islam issued rulings regarding the personal rights of gender variant people identified as mukhannathun, especially concerning inheritance.

Iran
13th Century
In Persian poetry, the notion of Shahed (male beauty is testimony to the power of God) was frequently used by many poets, including the Persian poet Saadi Shirazi.

South Africa
16th – 20 Africa
Wealthy and powerful women could – even it already married to a man – marry other women and having many wives was seen as a reflection of prosperity.

Dem. Rep. of Congo
16th – 17th Century
Men who acted and dressed in a manner considered feminine and women who acted and dressed in a manner considered masculine were identified as kitesha.

Angola
16th – 17th Century
Some communities openly accepted homosexuality, cross-dressing, and other behaviour blurring the lines of gender stereotypes.

Portugal
16th – 19t Century
In Lisbon, communities of men and women were known to have same sex relationships, and were targeted by the Inquisition.

Italy
15th – 17th Century
During the early Renaissance "masculine love" was a term used to described male homosexual orientation (also used in France and England). Michelangelo described same sex love in his poems, although these references were later edited out. Ancient marble statues unearthed in Rome depicted intersex people inspired a number of Renaissance artists.

United States
Native American Great Plains tribes viewed gender on a spectrum from male to female, including transgender and interex persons who were considered to have special spiritual significance.

Mexico
In the Mayan culture of the Yucatan Penunsula, sexual relations between men were accepted as part of the social structure. Other indigenous people in the region have similar traditions.

Nigeria
Among the Igbo people of Nigeria (and part of Benin), a married woman with independent wealth may choose to separate from her husband and marry one or more women.

Kenya
Among the Nadi people, women may marry other women. The old generally takes on a traditionally male role and is considered a "female husband". The younger may become pregnant by a man and legal and social father of the child may be the female husband.

India
Same-sex relations were accepted until British colonialism. Third gender and gender-variant people are still today recognised and accepted throughout Indian culutres.

Nepal
The Buddhist term Metta, meaning mental union and loving kindness, is used to identify transgender people (as well as same sex couples) and is an accepted part of Nepalese culture since ancient times.

Samoa
Fa'afafine are a third-gendered people who are mostly born biologically male, but have gender expressions and identity that embody both masculine and feminine behaviour.

Indonesia
The Bugis ethnic group, native to the Indonesian island of Sulawesi, recognises three sexes (female, male and hermaphrodite, four genders (women, men, trans men = calabai, and transwomen = calalai), and a fifth meta-gender group, the bissu.

Russia
The indigenous Chukchi people Siberia identified seven genders in addition to male and female.

Albania
Women indentified and burnesha, who take a chastity vow at a young age, can live as men and assume tradition male roles in traditional society and in their family.

SEXUAL ORIENTATION AND GENDER IDENTITY THROUGHOUT HISTORY
INTERNATIONAL DAY AGAINST HOMOPHOBIA & TRANSPHOBIA

HANDOUT 9
FIRST IMPRESSIONS OF LGBTQ+ PEOPLE

Answer the following questions to the best of your ability:

1. When's the first time you can remember learning that some people are lesbian, gay, bisexual, or queer?

2. Where did most of the influence of your initial impressions/understanding of lesbian, gay, bisexual, and queer people come from? (e.g. family, friends, television, books, news, church)

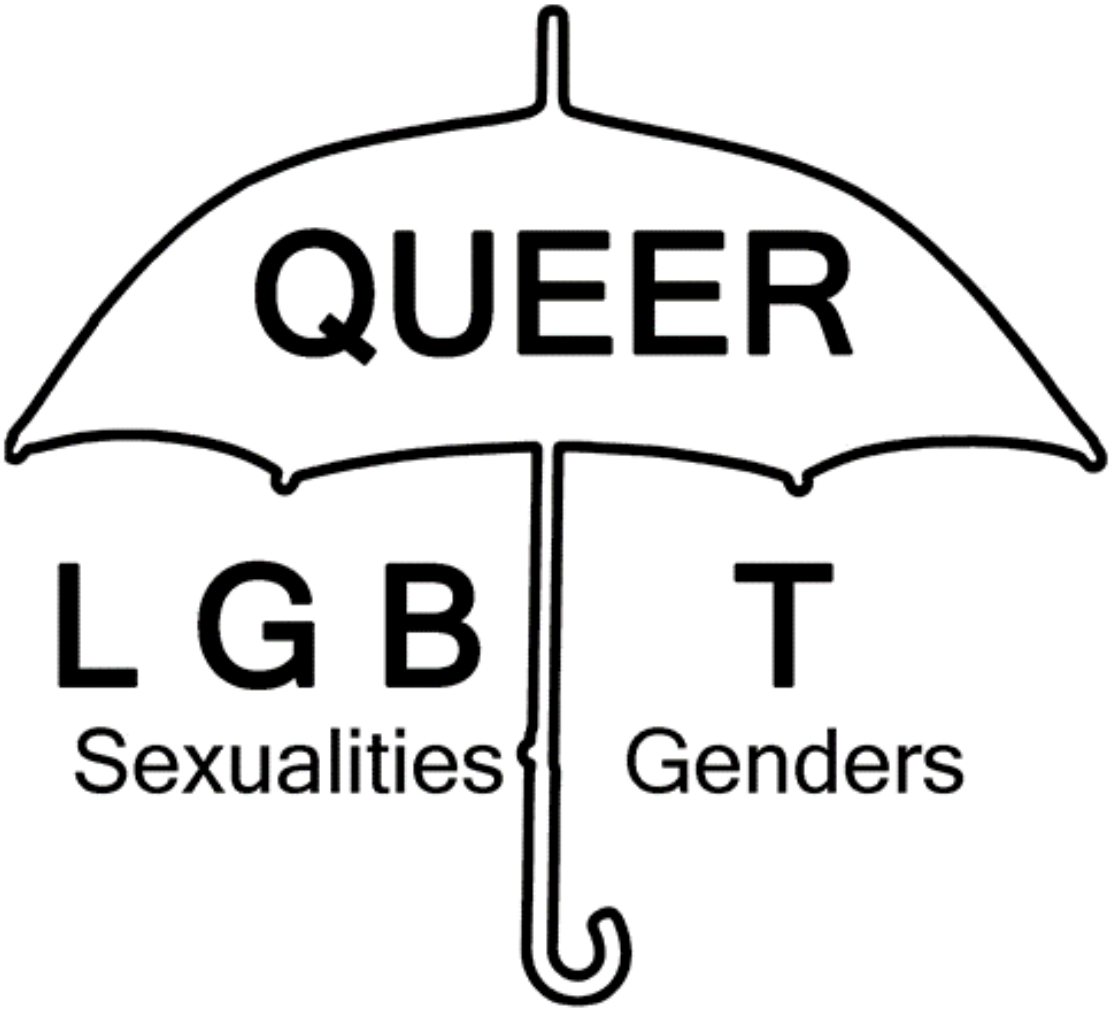
3. When's the first time you can remember learning that some people are transgender?

4. Where did most of the influence of your initial impressions/understanding of transgender people come from? (e.g., family, friends, television, books, news, church)

5. How have your impressions/understanding of LGBTQ (lesbian, gay, bisexual, transgender, and queer/questioning) people changed or evolved throughout your life?

HANDOUT 10
LGBTQ+ UMBRELLA

LGBTQ is an Acronym meant to encompass a diversity of sexualities and genders. Folks often refer to Q(queer) as an umbrella term, under which live a whole bunch of identities. This is Helpful because Lesbian, Gay and Bisexual aren't the only marginalised sexualities, and transgender isn't the only gender identity. In fact, there are many more of both.



HANDOUT 11
CONTINUUM DIAGRAM

BIOLOGICAL SEX

Male **Intersex** **Female**

GENDER IDENTITY 1

Cisgender **GenderFluid** **Transgender**

GENDER IDENTITY 2

Male **Agender/Gender Neutral** **Female**

GENDER EXPRESSION

Masculine **Androgynous** **Feminine**

SEXUAL ORIENTATION

Heterosexual **Bisexual** **Homosexual**

SEXUAL BEHAVIOUR 1

Sexual **Asexual**

SEXUAL BEHAVIOUR 2

Sex with different sex **Sex with all** **Sex with same sex**

HANDOUT 12
CASE PROFILES

Makara is a young gay man who works as a computer expert. He first discovered that he was attracted to men in his teens, but didn't start having sex with men until he finished his studies and started work. One day at work, his colleagues teased him that he was holding a tea cup "like a gay man," but he kept quiet and no one bothered him. When he started work, he had lots of short-term relationships with other men until he met Issa, whom he has been seeing for two years. Issa is a gay man who works as a mechanic. He loves to play football and drink with the boys, and no one has ever suspected that he is gay or MSM.

Sam is a 25-year-old trans man. He was born in a woman's body, but from an early age began to think of himself as a male, and used to dress in boy's clothing. After trying to change Sam, his parents gave up and kicked him out of the house. Sam moved to the city where he met a 28- year old, gay man, Bob, a taxi driver. They fell in love, developed a strong sexual relationship, and moved in together.

Sean is a married businessman of 40 years. He has a few effeminate gestures, but everyone sees him as a happily married man. But he loves to have sex with men and arranges this with male sex workers. One of the sex workers is Peter, a poor, uneducated young man who makes his living as a sex worker. Peter only has sex with men for money. He is sexually attracted to women and, in the future, when his finances allow it, hopes to get married to his girlfriend.

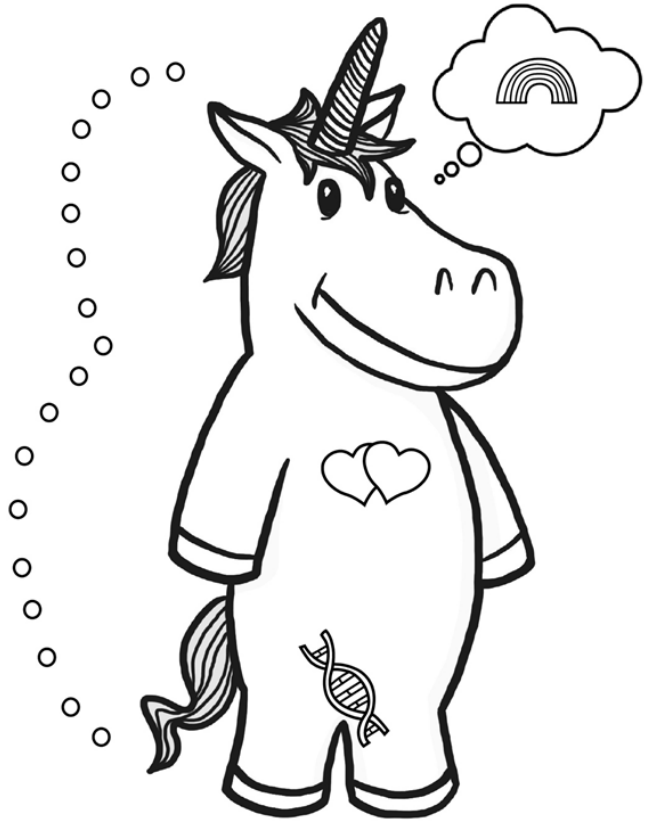
Brook is an artist who was born a man but does not identify as a male, nor do they identify as a female. They dress however they feel on a day to day basis. They are currently dating Sally. Sally is female and identifies with the gender that corresponds to her sex, she is the manager of an art supply store and finds persons attractive not based on their gender identity, but how they express themselves, and enjoys anyway that Brook expresses themself.

Tash is a female lawyer who has done very well for herself. She identifies as a woman and enjoys feminine attire, but is not afraid of suits. She has both men and women flirting with her daily, but shy's away from anyone who expresses intentions of getting sexual.

Mandy is a trans woman who has her own salon. Many times persons still get her gender wrong and use the wrong pronouns because she still likes to dress masculine and has a short haircut. She is married to Jessie, a woman who is attracted to masculine presenting women.

The Gender Unicorn

Graphic by:
TSER
Trans Student Educational Resources



To learn more go to:
www.transstudent.org/gender

Design by Landyn Pan
Illustration by Anna Moore

Gender Identity

- Female/Woman/Girl
- Male/Man/Boy
- Other Gender(s)

Gender Expression

- Feminine
- Masculine
- Other

Sex Assigned at Birth

Female ○ Male ○ Other/Intersex ○

Sexually Attracted To

- Women
- Men
- Other Gender(s)

Emotionally Attracted To

- Women
- Men
- Other Gender(s)

HANDOUT 14
LGBTQ+ TERMINOLOGIES

Ally	(*noun*) a straight identified person who supports, and respect members of the LGBTQ community
Androgyny/ous	(*adj*)(1) a gender expression that has elements of both masculinity and femininity; (2) occasionally used in place of "intersex" to describe a person with both female and male
Asexual	(*adj*) having a lack of (or low level of) sexual attraction to others and/or a lack of interest or desire for sex or sexual partners
Bicurious	(*adj*) a curiosity about having attraction to people of the same gender/sex (similar to questioning)
Biological Sex	(*noun*) 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. Often abbreviated to simply "sex".
Biphobia	(*noun*) a range of negative attitudes (e.g., fear, anger, intolerance, resentment, or discomfort) that one may have/express towards bisexual individuals. Biphobia can come from and be seen within the queer community as well as straight society. Biphobic (adj) a word used to describe an individual who harbors some elements of this range of negative attitudes towards bisexual people

Bisexual	(*adj*) A person whose primary sexual and affectional orientation is toward people of the same and other genders, or towards people regardless of their gender. Some people may use bisexual and pansexual interchangeably. This attraction does not have to be equally split between genders and there may be a preference for one gender over others.
Cisgender	(*adj*) a person whose gender identity and biological sex assigned at birth align (e.g., man and male-assigned)
Cissexism/Genderism	The pervasive system of discrimination and exclusion founded on the belief that there are, and should be, only two genders and that one's gender or most aspects of it, are inevitably tied to assigned sex. This system oppresses people whose gender and/or gender expression falls outside of cis-normative constructs. Within cissexism, cisgender people are the dominant group and trans/ gender non-conforming people are the oppressed group.
Closeted	(*adj*) an individual who is not open to themselves or others about their (queer) sexuality or gender identity. This may be by choice and/or for other reasons such as fear for one's safety, peer or family rejection or disapproval and/or loss of housing, job, etc. Also known as being "in the closet." When someone chooses to break this silence they "come out" of the closet. (See coming out)

Coming Out	(1) the process by which one accepts and/or comes to identify one's own sexuality or gender identity (to "come out" to oneself). (2) The process by which one shares one's sexuality or gender identity with others (to "come out" to friends, etc.).
Cross Dresser	A word to describe a person who dresses, at least partially, as a member of a gender other than their assigned sex; carries no implications of sexual orientation. Has replaced "Transvestite."
Drag King	(*noun*) someone who performs masculinity theatrically.
Drag Queen	(*noun*) someone who performs femininity theatrically.
Fag(got)	(*noun*) derogatory term referring to a gay person, or someone perceived as queer. Occasionally used as an self-identifying affirming term by some gay men, at times in the shortened form 'fag'.
Fluid(ity)	generally with another term attached, like gender-fluid or fluid-sexuality, fluid(ity) describes an identity that is a fluctuating mix of the options available (e.g., man and woman, bi and straight)
FTM / F2M	abbreviation for female-to-male transgender or transsexual person.

Gay	(*adj*)(1) a term used to describe individuals who are primarily emotionally, physically, and/or sexually attracted to members of the same sex. More commonly used when referring to males, but can be applied to females as well. (2) An umbrella term used to refer to the queer community as a whole, or as an individual identity label for anyone who does not identify as heterosexual.
Gender Binary	(*noun*) the idea that there are only two genders – male/female or man/woman and that a person must be strictly gendered as either/or.
Gender Expression	(*noun*) the external display of one's gender, through a combination of dress, demeanor, social behavior, and other factors, generally measured on scales of masculinity and femininity.
Gender Fluid	(*adj*) gender fluid is a gender identity best described as a dynamic mix of boy and girl. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more man.
Gender Identity	(*noun*) the internal perception of an one's gender, and how they label themselves, based on how much they align or don't align with what they understand their options for gender to be. Common identity terms include man, woman, genderqueer.
Gender Normative / Gender Straight	(*adj*) someone whose gender presentation, whether by nature or by choice, aligns with society's gender-based expectations.

Genderqueer	(*adj*) is a catch-all term for gender identities other than man and woman, thus outside of the gender binary and cisnormativity (sometimes referred to as non-binary). People who identify as genderqueer may think of themselves as one or more of the following: • both man and woman (bigender, pangender); • neither man nor woman (genderless, agender); • moving between genders (genderfluid); • third gender or other-gendered; includes those who do not place a name to their gender • having an overlap of, or blurred lines between, gender identity and sexual and romantic orientation.
Gender Non-conforming (GNC)	Adjective for people who do not subscribe to societal expectations of typical gender expressions or roles. The term is more commonly used to refer to gender expression (how one behaves, acts, and presents themselves to others) as opposed to gender identity (one's internal sense of self).
Gender Variant	(*adj*) someone who either by nature or by choice does not conform to gender based expectations of society (e.g. transgender, transsexual, intersex, gender-queer, cross-dresser, etc.).
Heteronormativity	(*noun*) the assumption, in individuals or in institutions, that everyone is heterosexual, and that heterosexuality is superior to all other sexualities. Leads to invisibility and stigmatizing of other sexualities.

Heterosexism	(*noun*) behavior that grants preferential treatment to heterosexual people, reinforces the idea that heterosexuality is somehow better or more "right" than queerness, or makes other sexualities invisible
Heterosexual	(*adj*) a person primarily emotionally, physically, and/or sexually attracted to members of the opposite sex. Also see straight.
Homophobia	(*noun*) an umbrella term for a range of negative attitudes (e.g., fear, anger, intolerance, resentment, or discomfort) that one may have towards members of LGBTQ community. The term can also connote a fear, disgust, or dislike of being perceived as LGBTQ.
Homosexual/Homosexuality	An outdated term to describe a sexual orientation in which a person feels physically and emotionally attracted to people of the same gender. Historically, it was a term used to pathologize gay and lesbian people.
Intersex	(*adj*) someone whose combination of chromosomes, gonads, hormones, internal sex organs, and genitals differs from the two expected patterns of male or female. Formerly known as hermaphrodite (or hermaphroditic), but these terms are now considered outdated and derogatory.

Lesbian	(*noun*) a term used to describe women attracted romantically, erotically, and/or emotionally to other women. However, some nonbinary people also identify as lesbians, often because they have some connection to womanhood and are primarily attracted to women.
Metrosexual	(*noun & adj*) a straight man with a strong aesthetic sense who spends more time, energy, or money on his appearance and grooming than is considered gender normative.
Misgendering	Attributing a gender to someone that is incorrect/does not align with their gender identity. Can occur when using pronouns, gendered language (i.e. "Hello ladies!" "Hey guys"), or assigning genders to people without knowing how they identify (i.e. "Well, since we're all women in this room, we understand...").
MSM	an abbreviation for men who have sex with men; they may or may not identify as gay.
MTF/ M2F	abbreviation from male-to-female transgender or transsexual person.
Non binary/Nonbinary/ Non-binary	A gender identity and experience that embraces a full universe of expressions and ways of being that resonate for an individual, moving beyond the male/female gender binary. It may be an active resistance to binary gender expectations and/or an intentional creation of new unbounded ideas of self within the world.

	(For some people who identify as non-binary there may be overlap with other concepts and identities like gender expansive and gender non-conforming.
Orientation	Orientation is one's attraction or non-attraction to other people. An individual's orientation can be fluid and people use a variety of labels to describe their orientation. Some, but not all, types of attraction or orientation include: romantic, sexual, sensual, aesthetic,intellectual and platonic.
Outing	(*verb*) involuntary or unwanted disclosure of another person's sexual orientation, gender identity, or intersex status.
Pansexual	(*adj*) a person who experiences sexual, romantic, physical, and/or spiritual attraction for members of all gender identities/expressions
Passing	(*verb*) (1) a term for trans people being accepted as, or able to "pass for," a member of their self-identified gender/sex identity (regardless of birth sex). (2) An LGB/queer individual who can is believed to be or perceived as straight.
Queer	(*adj*) used as an umbrella term to describe individuals who identify as non-straight. Also used to describe people who have non-normative gender identity or as a political affiliation. Due to its historical use as a derogatory term, it is not embraced or used by all members of the LGBTQ community. The term queer can often be use interchangeably with LGBTQ.

Questioning	(*verb, adjective*) - an individual who is unsure about or is exploring their own sexual orientation or gender identity.
Sexuality	The components of a person that include their biological sex, sexual orientation, gender identity, sexual practices, etc.
Sexual Orientation	(*noun*) the type of sexual, romantic, physical, and/or spiritual attraction one feels for others, often labeled based on the gender relationship between the person and the people they are attracted to (often mistakenly referred to as sexual preference)
Sexual Preference	(1) the types of sexual intercourse, stimulation, and gratification one likes to receive and participate in. (2) Generally when this term is used, it is being mistakenly interchanged with "sexual orientation," creating an illusion that one has a choice (or "preference") in who they are attracted to.
SOGIE	An acronym that stands for Sexual Orientation, Gender Identity and Expression. Is used by some in a similar way to the umbrella acronym: LGBTQIA.
Straight	(*adj*) a person primarily emotionally, physically, and/or sexually attracted to members of the opposite sex. A more colloquial term for the word heterosexual.

Trans	(*noun*) an umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. Trans people may identify with a particular descriptive term (e.g., transgender, transsexual, genderqueer, FTM).
Transgender	(1) An umbrella term covering a range of identities that transgress socially defined gender norms. (2) A person who lives as a member of a gender other than that expected based on anatomical sex.
Transition(ing)	(*noun & verb*) the process of taking steps to live as one's true gender identity. Transitioning is different for each individual and may or may not involve medical interventions like taking hormones or having surgery. Some people may not choose to transition in certain ways for a variety of reasons. The extent of someone's transition does not make that person's gender identity any less or more valid.
Trans man	(*noun*) A person may choose to identify this way to capture their gender identity as well as their lived experience as a transgender person.
Trans woman	A person may choose to identify this way to capture their gender identity as well as their lived experience as a transgender person.
Transphobia	(*noun*) the fear of, discrimination against, or hatred of trans people, the trans community, or gender ambiguity. Transphobia can be seen within the queer community, as well as in general society.

Transsexual	(*noun & adj*) a person who identifies psychologically as a gender/sex other than the one to which they were assigned at birth and has transformed their bodies hormonally and surgically to match their inner sense of gender/sex.
Transvestite	(*noun*) outdated term for a person who dresses as the binary opposite gender expression ("crossdresses") for any one of many reasons, including relaxation, fun, and sexual gratification
Two-Spirit	(*noun*) is an umbrella term traditionally used by Native American people to recognize individuals who possess qualities or fulfill roles of both genders
Ze / Hir	alternate pronouns that are gender neutral and preferred by some trans people. Pronounced /zee/ and /here/ they replace "he" and "she" and "his" and "hers" respectively. Alternatively some people who are not comfortable/do not embrace he/she use the plural pronoun "they/their" as a gender neutral singular pronoun.

Advanced Activity
Add these definitions to the activity if you think your group is ready for them.

Allosexism	The pervasive system of discrimination and exclusion that oppresses asexual people built out of the assumption that everyone does and should experience sexual attraction.

Allosexual	A sexual orientation generally characterized by feeling sexual attraction or a desire for partnered sexuality.
Androsexual/Androphilic	(*adj*) attraction to men, males, and/or
Aromantic	(*adj*) is a person who experiences little or no romantic attraction to others and/or a lack of interest in forming romantic relationships.
Bigender	(*adj*) a person who fluctuates between traditionally "woman" and "man" gender-based behavior and identities, identifying with both genders (and sometimes a third gender)
BlaQ/BlaQueer	Folks of Black/African descent and/or from the African diaspora who recognize their queerness/LGBTQIA identity as a salient identity attached to their Blackness and vice versa. (T. Porter)
Butch	(*noun & adj*) a person who identifies themselves as masculine, whether it be physically, mentally or emotionally. 'Butch' is sometimes used as a derogatory term for lesbians, but is also be claimed as an affirmative identity label.
Cisnormativity	(*noun*) the assumption, in individuals or in institutions, that everyone is cisgender, and that cisgender identities are superior to trans identities or people. Leads to invisibility of non-cisgender identities

Demi-sexual	(*noun*) an individual who does not experience sexual attraction unless they have formed a strong emotional connection with another individual. Often within a romantic relationship. Most demisexuals feel sexual attraction rarely compared to the general population, and some have little to no interest in sexual activity. Demisexuals are considered to be on the asexual spectrum.
Dyke	(*noun*) a term referring to a masculine presenting lesbian. While often used derogatorily, it can is adopted affirmatively by many lesbians (and not necessarily masculine ones) as a positive self identity
Femme	(*noun & adj*) someone who identifies themselves as feminine, whether it be physically, mentally or emotionally. Often used to refer to a feminine-presenting lesbian.
Gender Expansive	An umbrella term used for individuals who broaden their own culture's commonly held definitions of gender, including expectations for its expression, identities, roles, and/or other perceived gender norms. Gender expansive individuals include those who identify as transgender, as well as anyone else whose gender in some way is seen to be broadening the surrounding society's notion of gender.

Hermaphrodite	(*noun*) an outdated medical term previously used to refer someone who was born with both male and female biological characteristics; not used today as it is considered to be medically stigmatizing, and also misleading as it means a person who is 100% male and female, a biological impossibility for humans (preferred term is intersex)
Lipstick Lesbian	(*noun*) Usually refers to a lesbian with a feminine gender expression. Can be used in a positive or a derogatory way. Is sometimes also used to refer to a lesbian who is assumed to be (or passes for) straight.
MLM	an abbreviation for men who love men, which includes gay men as well as men who are attracted to men and people of other genders.
Monosexual	People who have romantic, sexual, or affectional desire for one gender only. Heterosexuality and homosexuality are the most well-known forms of monosexuality.
Multisexual	An umbrella term to describe attraction to more than one gender. It can include sexual attractions like bisexual, polysexual, omnisexual, and others. The aforementioned terms are used by some interchangeably and for others the subtle differences among
Omnigender	Possessing all genders. The term is used specifically to refute the concept of only two genders.

Polysexual	People who have romantic, sexual, or affectional desire for more than one gender. Not to be confused with polyamory (above). Has some overlap with bisexuality and pansexuality.
Romantic Orientation	Romantic Orientation is attraction or non-attraction to other people characterized by the expression or non-expression of love. Romantic orientation can be fluid and people use a variety of labels to describe their romantic orientation.
MLM	an abbreviation for men who love men, which includes gay men as well as men who are attracted to men and people of other genders.
Same Gender Loving / SGL	(*adj*) a term sometimes used by members of the African-American/Black community to express an alternative sexual orientation without relying on terms and symbols of European descent.
Sex Reassignment Surgery/ SRS	A term used by some medical professionals to refer to a group of surgical options that alter a person's biological sex. In most cases, one or multiple surgeries are required to achieve legal recognition of gender.
Skoliosexual	(*adj*) attracted to genderqueer and transsexual people and expressions (people who don't identify as cisgender)
Stud	(*noun*) an African-American and/of Latina masculine lesbian. Also known as 'butch' or 'aggressive'.

Top Surgery	(*noun*) this term refers to surgery for the construction of a male-type chest or breast augmentation for a female-type chest.
Womxn	some womxn spell the word with an “x” as a form of empowerment to move away from the “men” in the “traditional” spelling of women.

HANDOUT 15
FIRST IMPRESSIONS OF TRANS PEOPLE

Answer the following questions to the best of your ability:

1. When's the first time you can remember learning that not all people identified as cisgender and that some people identified as transgender or genderqueer?

2. Where did most of the influence of your initial impressions/understanding of transgender and genderqueer people come from? (e.g., family, friends, television, books, news, church)

3. How have your impressions/understanding of transgender and genderqueer people changed or evolved throughout your life?

4. What is something that you are still in the process of unlearning about in regards to transgender and genderqueer identity?

HANDOUT 16
SCENARIOS - PRONOUNS

1. You're interacting with someone new, and they introduce themselves as Alex and they look very androgynous. You're not really sure what pronouns to use - what should you do?

2. A staff member shares at a staff meeting that they are trans* and would like everyone to use a new name and the pronouns "they/them/theirs,". You now have to use their new name and preferred pronoun.

   a) How do you help yourself practice using their new pronouns? b) How would you (re)introduce them to people?

3. You are a front desk attendant and someone approaches your desk presenting themselves as male. They introduce themselves with a male name. You need to see their ID before you let them continue but their ID has their gender as female. How would you refer to them?

HANDOUT 17
COMING OUT

Coming out (of the closet) is the process by which someone:

1. Accepts and identifies with the gender identity and /or sexual orientation, and;
2. Share their identity willing with others

Sometimes we talk about coming out as a onetime thing. But for most folks, coming out is a series of decisions, sometimes daily, that LGBTQ+ people navigate in every new setting they enter.

People may be OUT in some spaces, and IN in others. They may or may not be out to family, friends, classmates/coworkers or their religious community. A decision to come out to a person or group is one of safety, comfort, trust, and readiness.

It's dangerous, unhealthy, and unhelpful to force someone to come out, or to 'out" someone else (i.e. disclosing someone gender identity or sexual orientation to others without the person's consent), regardless of your intentions. (Sometimes people think they are being helpful, or acting on the person's behalf to conquer their fears)

If someone comes out to you:
Don't:
1. Say "I always knew", or downplay the significance of their sharing with you
2. Go tell everyone, bragging about your new "gay/trans friend"
3. Forget that they are still the person you knew, befriended, or loved before.
4. Ask probing questions, or cross personal barrier you wouldn't have crossed earlier
5. Assume you know why they came out to you

If someone comes out to you:
Do:
1. Know this is a sign of huge trust
2. Check0in on how confidential this is (Do other people know?)
3. Remember that their gender/sexuality is just one dimension of them
4. Show interest and curiosity about this part of them that they are sharing with you
5. Ask them how you can best support them

Remember, LGBTQ+ persons come out for a number of reasons:
- To develop a healthy LGBT identity
- It is honest and real
- To end the stress of living a double life
- To reduce isolation and alienation
- To get increased support from other LGBT people.
- To live a fuller life

They will expect the following from someone they come out to;
- Support and acceptance
- Understanding
- Comfort
- To be treated as the same person they were before coming out
- Closer friendship(s)
- That knowing they are LGBT won't affect their friendship
- A hug and a smile
- An acknowledgement of their feeling

Remember, they have legitimate fear about coming out, which include;
- Rejection and loss of relationships
- Gossip
- Harassment and abuse
- Being ostracized by family
- Being thrown out of the house
- Loss of financial support
- Losing their job
- Physical Violence
- Being treated differently

When an LGBTQ+ person come out they will be feeling a range of emotions. They may be scared or your reaction, and vulnerable for sharing this intimate part of them. Depending on how you react, they may feel relieved that you accept them. As a loved one you would not make the regret their decision.

HANDOUT 18
SCENARIOS – INTERVENING

1. You've noticed someone you know making comments that are subtly homophobic and/or transphobic, which are making you and others uncomfortable. You're unsure if this person realizes what they are saying is problematic or not. What might you do?

2. You're interacting with someone new, and they introduce themselves as Alex and they look very androgynous. You're not really sure what pronouns to use - what should you do?

3. There is a very flamboyant young man who has come into the shop where you work. You notice your co-workers pointing and making fun at the potential customer, and it is clearly making him feel comfortable. What can you do to make him feel more conformable?

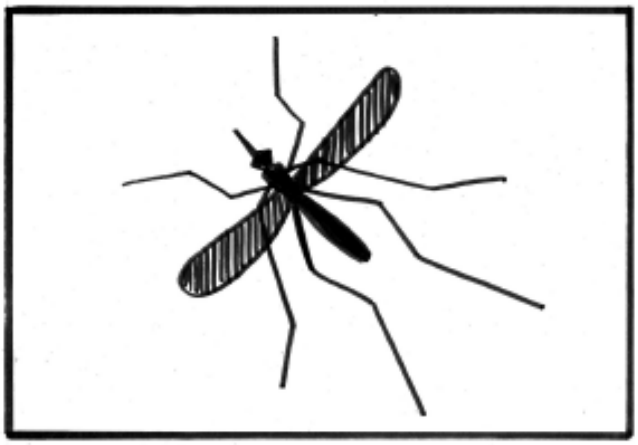
4. You see someone being harassed on the street as they pass by a group of men, you cannot tell if it is a girl or a boy, and clearly neither can the men as they shout slurs and make statements such as "wait, dat is a boy or a girl?". How could you possibly help this situation?

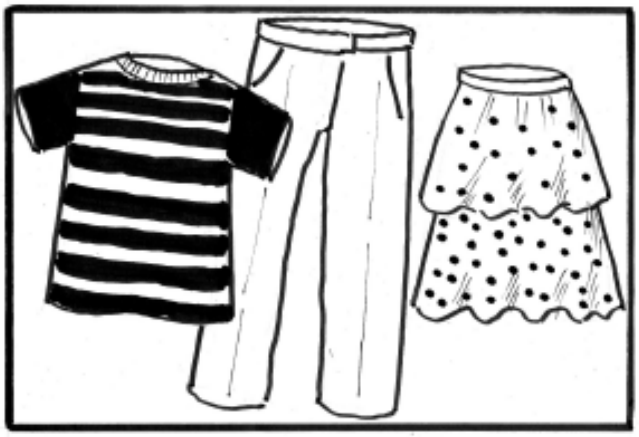
HANDOUT 19

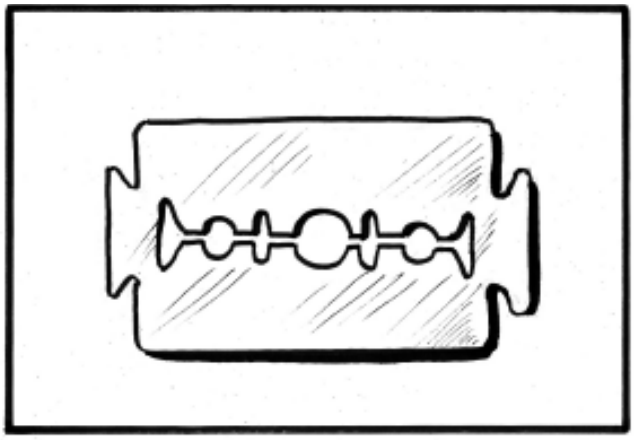
PICTURES (*From Health Policy Project's Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide*; Illustrations by Petra Rohr-Rouendaal)

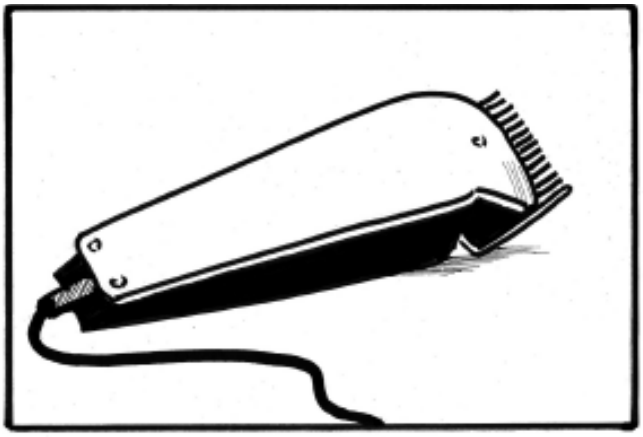
These pictures can be photocopied as is or the following images can be searched online for printing:

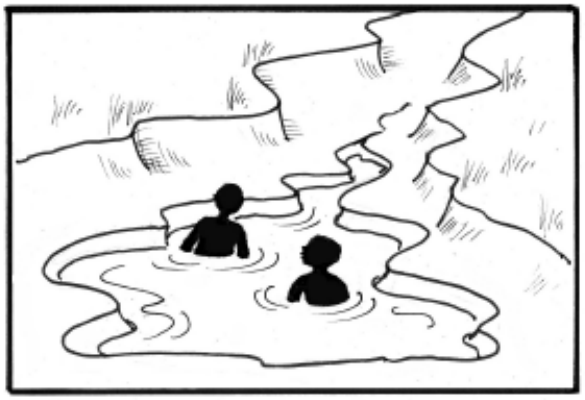
- Mosquito
- Shaking hands
- Clothes
- Touching food
- Razor blade
- Electric razor
- Toilet
- Kissing
- Swimming
- Blood transfusion
- Cup
- Pot
- Car accident
- Toothbrush
- Bed
- Plate, spoon and knife
- Comb
- Coughing
- Nurse bathing patient
- Woman giving birth
- Taking blood
- Wound being stitched
- Nurse feeding patient
- Nurse taking temperature
- Nurse taking blood pressure

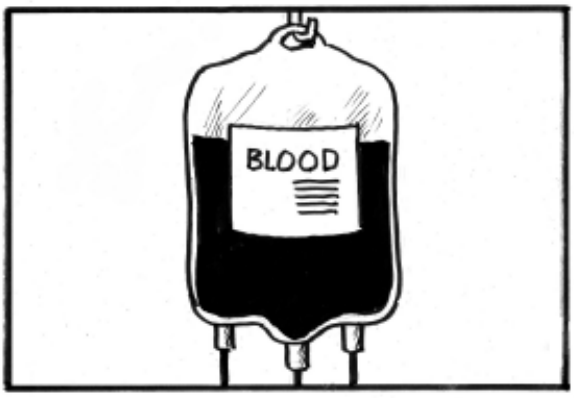








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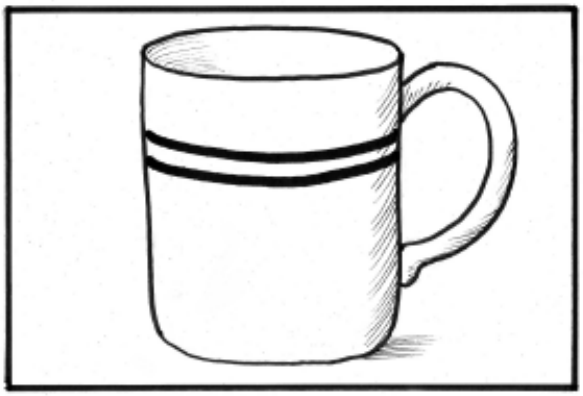

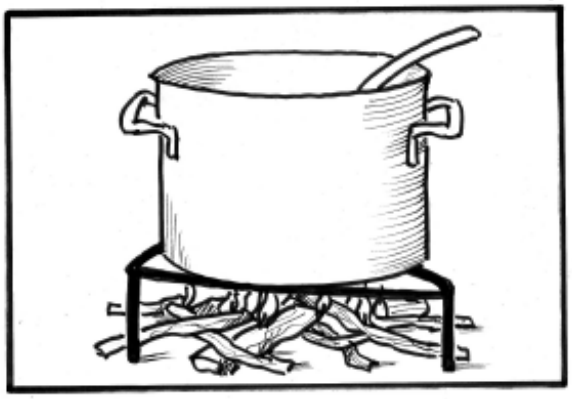

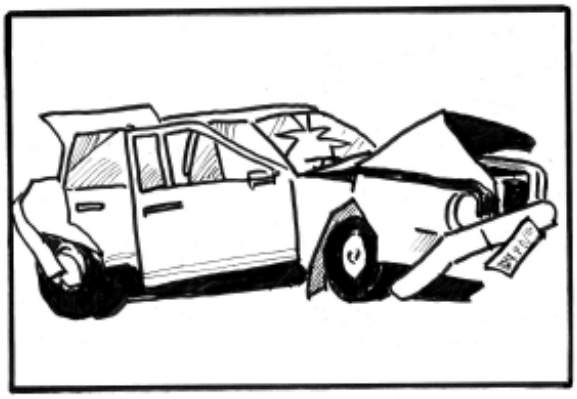

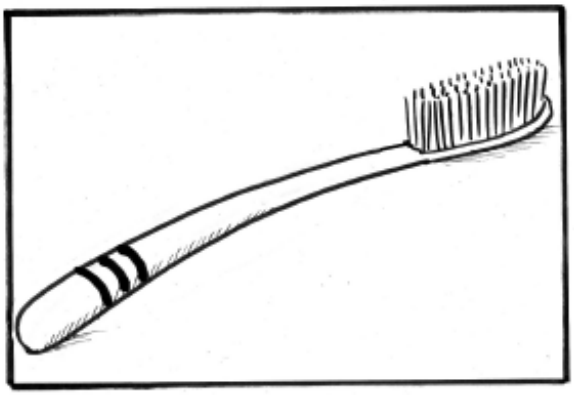

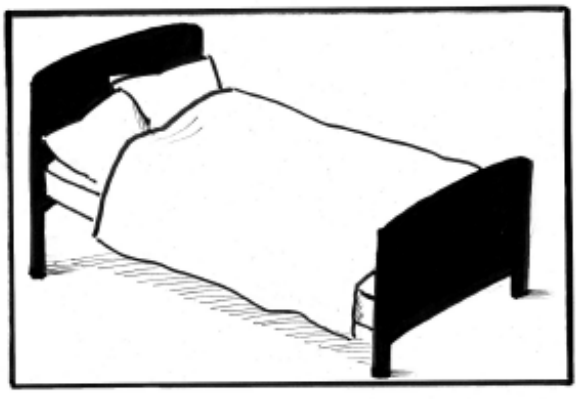

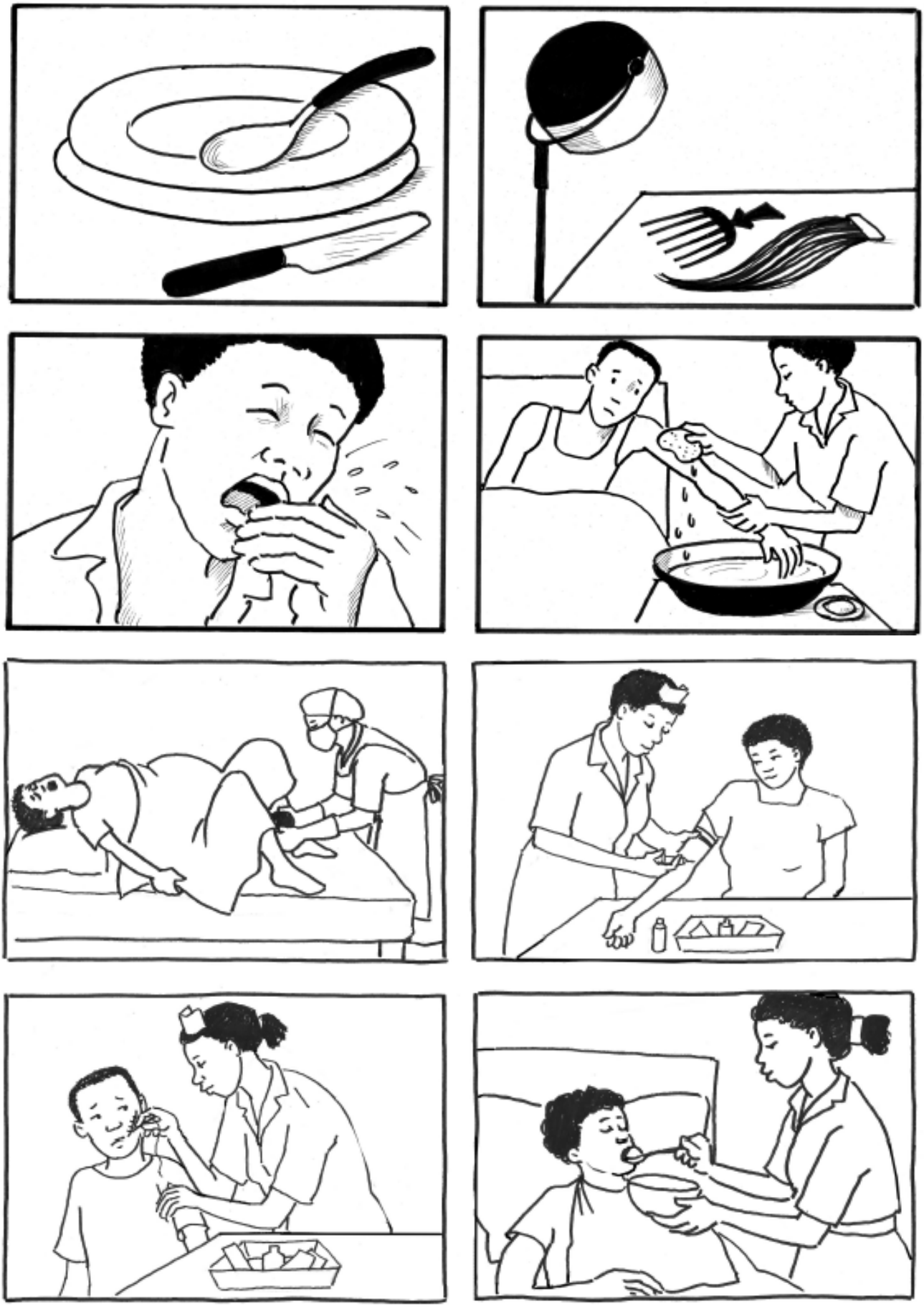

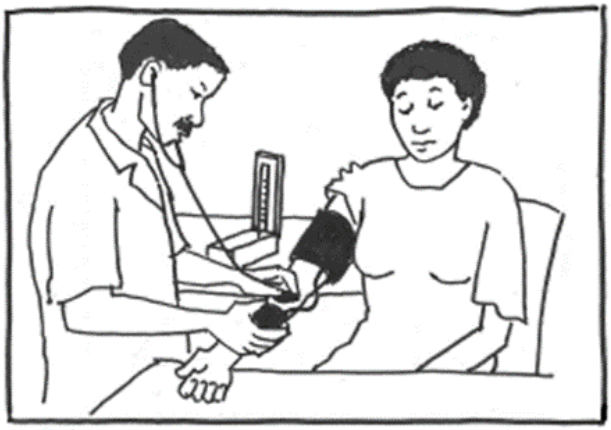

HANDOUT 20
QQR—QUANTITY, QUALITY, AND ROUTE OF TRANSMISSION

What is QQR?

For HIV transmission to take place, the quality of the virus must be strong, a large quantity must be present, and there must be a route of transmission.

Quality

For transmission to take place, the quality of the virus must be strong. HIV does not live on the surface of the skin—it lives inside the body. HIV cannot survive outside the human body—it starts to die as soon as it is exposed to air. If it is exposed to heat (e.g., if someone bleeds into a cooking pot), it will die. The only place the virus can survive outside of the body is in a vacuum (like a syringe), where it is not exposed to air.

Quantity

For transmission to take place, there must a sufficient quantity of the virus in body fluids to pose any risk. HIV is found in large quantities in blood, semen, vaginal fluids, and breast milk—so with these fluids, there is a risk of transmission. HIV is found in small amounts in saliva, vomit, feces, and urine, and not at all in sweat or tears—in all of these cases, there is no risk of transmission unless blood is present. Thus, cleaning or bathing a patient is also quite safe, provided all wounds are covered. It is easiest to transmit HIV when someone tests negative (but is actually positive) because it is during the "window period" that someone has the highest quantity of virus. Once infected, it can take up to three months for someone to test positive for HIV.

Route of Transmission

For HIV transmission to take place, the virus must get inside your bloodstream. Our body is a closed system. Healthy skin is an excellent barrier against HIV. It cannot pass through unbroken skin, or even broken skin, very easily. If you cut yourself, the blood flows outward, away from the bloodstream. If you touch someone else's cut, blood will not swim into your bloodstream!

These three conditions—**Quantity**, **Quality**, **and Route of Transmission (QQR)**—help to explain why HIV cannot be transmitted by such activities as the following:

- Touching the skin or sweat of a person living with HIV
- Changing the clothes of or serving food to a person living with HIV
- Taking the blood pressure of a person living with HIV
- Shaking hands with someone living with HIV
- Hugging someone with HIV
- Kissing someone with HIV when your mouths are clean and clear of cuts or sores

Common sense and everyday hygiene mean that many concerns people have would not really happen in everyday life. For example, you wouldn't share a toothbrush if it was covered in blood, you would wash if you cut yourself, and you would wear gloves or cover your hands if you were cleaning up someone's diarrhea.

Other Factors that Increase the Risk of Sexual Transmission
Viral load of infected person. Higher viral load increases the risk of HIV transmission. The highest viral loads occur at the initial stage of HIV infection (before an individual even tests positive for HIV) and the final stages of AIDS.

Having multiple partners. If you have sex with multiple people regularly and do not use condoms with all partners, HIV can pass quickly through your sexual network. Remember, a viral load (quantity) is highest right after infection. If you became infected last week and have unprotected sex with someone else today, you can pass on the virus. This is during the window period, before you would even test positive.

Presence of cuts or wounds. Wounds or cuts on either partner increase the chance of HIV entering the bloodstream.

Presence of other STIs. STIs can cause sores or broken skin, making it easier for infected blood to get through the skin into the bloodstream.

Having sex during the menstruation period or when a woman is bleeding.

Not using a water-based or silicone-based lubricant during anal sex. Lack of lubricant could cause additional tearing to the rectum and even cause the condom to break.

THE HIV TRANSMISSION EQUATION
Human host with HIV—someone has to carry the virus to infect someone else
+
Body fluid that carries large amount of HIV—blood, semen, vaginal fluid, breast milk
+
Opening into the bloodstream—needle holes; mucous membranes such as those of the vagina, rectum, urethral opening of the penis and foreskin, esophagus, eyes; cuts/tears in the vagina, anus, penis, or mouth
+
Activity that can move these fluids between people—unprotected sex (anal, oral, or vaginal), sharing injection needles, breastfeeding, blood
transfusion
= POSSIBILITY OF HIV INFECTION

HANDOUT 21
HIV TRANSMISSION AND MEN WHO HAVE SEX WITH MEN— RISK CONTINUUM

Borrowed from:
ICRW and Pact International. 2010. Understanding and Challenging Stigma Towards Men Who Have Sex with Men: Toolkit for Action (Cambodia). Phnom Penh, Cambodia: International Center for Research on Women and Pact International.

Receptive anal intercourse without a condom: HIGHEST RISK. The rectum has a large surface area, and the skin in the rectum is lined with a mucous membrane, a very sensitive part of the body that tears very easily, especially if the insertive partner is not using lubricant. Once the skin of the rectum gets broken/cut, HIV in the sperm or blood from cuts on the penis of the insertive partner can easily get into the body and bloodstream of the receptive partner, if the former is not using a condom. Adolescent boys, whose skin in the rectum is not fully mature, are more likely to develop cuts during anal sex and are therefore at higher risk of getting HIV.

Insertive anal intercourse without a condom: HIGH RISK. This is also risky for HIV transmission, but not as risky as receptive anal sex. The skin on the penis is stronger than the skin in the anus. It is less prone to cuts, so it is less vulnerable to penetration by HIV. However, HIV contained in blood and rectal fluids can pass through the urethra of the penis or under the foreskin of someone who is uncircumcised.

Receptive oral sex: VERY LOW RISK. Receptive oral sex is more risky than insertive oral sex. The person sucking is more at risk than the person whose penis is being sucked. Why? Sperm gets into the mouth of the person who is sucking and can penetrate the skin around the teeth, which can easily get cut. The skin is strong in most parts of the mouth except around the teeth (the gums), so there is a potential for HIV entering the body through cuts or bleeding in the gums.

Insertive oral sex: VERY LOW RISK. The skin on the penis, especially if circumcised, is strong and less vulnerable to cuts. The person sucking may have cuts in the mouth that produce blood, but saliva in the person's mouth protects the penis, and the acid in the saliva neutralizes the blood from the gums.

Thigh sex: NO RISK. Sperm does not get into the anus or mouth, where it then could get into the body and the bloodstream.

Mutual masturbation: NO RISK. When men masturbate each other, their hands may come into contact with sperm, but the sperm remains outside of the body, where it is exposed to air, and dies. There is no risk if there are no cuts or broken skin on the participants' hands.

Kissing: NO RISK. As long as there are no cuts or sores in the mouth, kissing is completely safe. The saliva of the infected person may get into the mouth, but saliva contains very low quantities of HIV.

Anal sex without lubrication: HIGH RISK. With a condom and water- or silicone-based lubricant, anal sex can be practiced and enjoyed safely. The risk of a man acquiring HIV during unprotected receptive anal sex is 10 times higher than during unprotected insertive anal sex (with a man or woman) or unprotected vaginal sex with a woman. The high risk of HIV transmission in receptive anal sex is because of the following:

- Anal sex is more traumatic than vaginal sex, sometimes resulting in abrasions and cuts that damage the body's barrier to HIV infection. Unlike the vagina, the anus and rectum have no natural lubrication.
- Lack or misuse of inappropriate lubricants (e.g., Vaseline, oil) may worsen trauma or damage condoms. Some MSM do not use condoms for anal sex; when they do, they may not use safe, water-based lubricants.
- Sex between men need not always involve penetrative anal sex: oral sex, masturbation, and thigh sex carry a much lower risk of HIV transmission, and men may choose to avoid anal sex to protect themselves or their partners.
- Use of condoms and water-based lubricants for anal sex considerably reduces the risk of HIV transmission. Water-based lubricants can be used with male latex condoms, as they do not damage the latex. Most male and female condoms already have water-based lubricant on them. However, adding lubricant is especially important for anal sex, as the lining of the anus does not produce its own natural lubrication and is prone to tearing.
- Oil-based lubricants must NOT be used with a male condom, as they damage the latex and may increase the risk of condom breakage. Examples of oil-based lubricants include hand lotion, body lotion, baby oil, vegetable oil, cooking oil, massage oil, and petroleum jelly (e.g., Vaseline).
- Untreated STIs greatly increase one's risk of getting HIV. Many STIs cause sores, which make it easier for HIV to enter the body. MSM may not have symptoms of STIs or see the sores because they are inside the anus or mouth.

HANDOUT 22
DEFINITIONS OF DISABILITY AND REASONABLE ACCOMMODATION

The term disability means, with respect to an individual:

- having a physical or mental impairment that substantially limits one or more major life activities;
- having a record of such an impairment; or
- being regarded as having such an impairment.

If an individual meets any one of these three tests, he or she is considered to have a disability under the Americans with Disabilities Act.

Types of disabilities or the term physical or mental impairment means:

- any physiological disorder or condition, cosmetic difigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic skin, and endocrine;
- any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities;
- physical or mental impairment also includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.

The term major life activities means:

- functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

The term reasonable accommodation means:

- modifications or adjustments to a job application process that enable a qualified applicant with a disability to be considered for the position such qualified applicant desires;
- modifications or adjustments to the work environment, or to the manner or circumstances under which the position is held or desired to be customarily performed, that enable a qualified individual with a disability to perform the essential functions of that position;
- modifications or adjustments that enable a covered entity's employee with a disability to enjoy equal benefits and privileges of employment as are enjoyed by its other similarly situated employees without disabilities.

HANDOUT 23
QUIZ WORDS

Person with Disability	Disabled	Crippled	Handicapped	Physically challenged
Special	Invalid	Dyslexia	Learning disability	Epilepsy
HIV	Psychiatric disability	Spinal cord injury	Cerebral palsy	Muscular dystrophy
Arthritis	Wheelchair	Lift	Ramp	Service animal
Personal assistant	Braille	Tactile surfaces	Sound signal	Personal assistant
Service animal	Closed Captioning	ASL	Lift	Ramp
Ignorance	Attitude	Stairs	Printed material	Sound
Bathroom	Transportation	TV	Phone	Book
Printed material	Computer	Phone	Printed material	Computer

BLIND	DEAF
QUADRIPLEGIA	DYSLEXIA

*Duplicate and cut into four squares; fold each and put into hat for random selection. For more than four groups, make additional copies.

HANDOUT 26
"MANNERS CHARADES"

1. Good manners:
Shake the person`s hand, or touch them on the shoulder/arm to acknowledge their presence.

Act this out: You meet a person using a wheelchair. Walk towards them, greet them, and shake their hand firmly when you meet.

2. Good manners:
Offer assistance, but wait until it is accepted.

Act this out: A person who is blind wants to cross the street. Ask him politely if you can offer him a hand to walk him across the street. Do not touch him or help him before he gives you a positive and confirming answer.

3. Good manners:
To provide help in the way it is asked for.

Act this out: A person that has Cerebral Palsy needs some assistance before she can start playing her instrument. She asks you to place the instrument on top of her left hand that she is not able to bend. Wait until she is done explaining the help she requires and do exactly as she told you.

4. Good manners:
Not feel offended if your offer to assist a person living with a disability is declined.

Act this out: You see a person in a wheelchair struggling to get over a bump in the road. You kindly ask him if he needs any help. The person says no thanks. You respect his choice, say good-bye and walk away.

5. Bad manners:
Patting people on the head.

Act this out: You see a person living with a disability. You want to be kind, so you pat him on the head and talk to him with a childish voice.

6. Bad manners:
Making assumptions about people living with a disability.

Act this out: You are talking to work colleagues about a fellow colleague. You tell them that you haven't spoken to the colleague living with a disability, but that you have decided that she should not come to a concert because you think she will face too many challenges.

7. Bad manners:
Make decisions on behalf of the person with a disability.

Act this out: A person is standing beside another person sitting in a wheelchair. A person comes over to the two of them, and asks if the person sitting in the wheelchair wants to join the upcoming street parade. The person standing answers “no” before the other persons has been given the chance to make a decision.

8. Good manners:
Worry about making mistakes when interacting with people living with a disability.

Act this out: A person watches someone struggling on the computer. It is clear that the person is living with a disability, but the person watching is not sure what they can do to assist and is afraid to make any mistakes, so instead of interfering, they pretend like nothing and let the other person struggle.

HANDOUT 27
DISABILITY ETIQUETTE QUIZ

Questions:

1. As you are being introduced to someone, you notice they have a prosthetic right hand.

You should:
A) Withdraw your hand and continue to introduce yourself without a hand shake.
B) Offer your right hand as you would to anyone.
C) Offer your left hand.

2. When meeting someone who is deaf, and accompanied by an interpreter, you should:
A) Maintain eye contact with the person who is deaf.
B) Maintain eye contact with the interpreter.
C) Look back and forth between them.

3. You are speaking with someone who is deaf or hard of hearing, and they ask you to repeat a statement. You should:
A) Repeat the statement in a louder voice.
B) Repeat the statement more slowly.
C) Rephrase the statement.
D) Use gestures to act out your statement.
E) Offer to write your statement.

4. You see someone who has a disability and they appear to be struggling. You should ignore them so you do not embarrass them, draw attention, or infringe upon their independence.
A) True
B) False

5. What should you do further in the situation described above?
A) Watch for a while to decide if they need help.
B) Offer to help the person.
C) Help the person without being asked.

6. You are talking to a person who has difficulty speaking. You are only able to understand a few words and phrases. What should you do?
A) Pretend you understand what they said.
B) State what you understood, and ask the person to repeat the rest of the information.
C) Stay quiet and walk away as soon as you can.

7. When talking to a person who uses a wheelchair, it is preferable to find a chair if possible, and continue the conversation at eye level.
A) True
B) False

Answers and discussion:

1. B – Offer your right hand as you would to anyone. Discussion: The key is to treat people with disabilities as you would anyone. Remember, however, that each person is an individual and how he or she will react to a particular situation may differ. For example: in this situation, the person with a disability may extend his/her prosthesis or may choose not to extend his/her hand at all.

2. A – Maintain eye contact with the person who is deaf. Discussion: You are speaking directly to the person who is deaf. Therefore, it is appropriate to maintain contact with this person, not with the interpreter.

3. Any, a combination, or all of these answers may be correct. Discussion: This all depends on the person and the circumstances. The best recommendation is to use your judgement based on the individual situation.

4. False. Discussion: The best response in this situation is to offer the person assistance, and then proceed according to his or her response. It is important to remember that each person is an individual and some people may be grateful for the assistance while other may decline ... as would anyone else.

5. B – Offer to help the person. Discussion: See discussion in number 4 above.

6. B - State what you understood and ask the person to repeat the rest of the information. Discussion: It is always best to be honest and politely tell a person if you are having difficulty understanding them. Stating what you think you understand is a way to make sure that your understanding is correct.

7. True Discussion: It is not appropriate to kneel, bend over the person or lean on the wheelchair as support. If a chair is not available, stand like you normally would and continue the conversation.

HANDOUT 28
RULES FOR APPROPRIATE LANGUAGE

USE	AVOID
person with a disability/ has a disability people with disabilities/ have disabilities disabled person/ people	the disabled/ the handicapped invalids, patients crippled, deformed, defective (NEVER)
people without disabilities typical person non-disabled people	normal, healthy, able-bodied
wheelchair user/uses a wheelchair	wheelchair-bound/ confined to a wheelchair
congenital disability/ birth anomaly	birth defect/ affliction
has cerebral palsy (CP) or other condition	a victim of cerebral palsy
has had polio/ experienced polio has a disability as a result of polio	suffers from polio/ afflicted with polio post-polios (as a noun referring to people)
people who have mental retardation (MR) person with mental retardation mentally retarded person (less preferred)	the mentally retarded/ mentally deficient a retardate/ a retard (NEVER) a feeble-minded person
child with developmental delay (DD) person with a developmental disability	
person with Down Syndrome	the Down's person/Mongoloid (NEVER)
person who has epilepsy people with seizure disorders seizure/ epileptic episode or event	the epileptic (to describe a person) the epileptics (to describe people) fits/ epileptic fits
people who have mental illness person with a mental or emotional disorder	the mentally ill crazy, psycho, mental case (NEVER)
people who are blind/ visually impaired person who is hard of hearing person who is deaf/the Deaf (Deafness is a cultural phenomenon and should be capitalized in those instances.)	the blind/ blind as a bat (NEVER) hearing impaired (translates as broken hearing_ in sign language) deaf-mute deaf and dumb (NEVER)
speech or communication disability	tongue-tied, mute

Ten Commandments of Etiquette

1. When talking to a person with a disability, speak directly to that person rather than through a companion or sign language interpreter who may be present.
2. When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand use or who wear an artificial limb can usually shake hands.
3. When meeting a person with a visual impairment, always identify yourself and others who may be with you. When conversing in a group, remember to identify the person to whom you are speaking.
4. If you offer assistance, wait until the offer is accepted. Then listen to or ask for instructions.
5. Treat adults as adults. Address people who have disabilities by their first names only when extending that same familiarity to all others present. Never patronize people who use wheelchairs by patting them on the head or shoulder.
6. Leaning or hanging on a person's wheelchair is similar to leaning or hanging on a person and is generally considered annoying. The chair is part of the personal body space of the person who uses it.
7. Listen attentively when you're talking with a person who has difficulty speaking. Be patient and wait for the person to finish, rather than correcting or speaking for the person. If necessary, ask short questions that require short answers, a nod, or a shake of the head. Never pretend to understand if you are having difficulty doing so. Instead, repeat what you have understood and allow that person to respond. The response will clue you in and guide your understanding.
8. When speaking with a person in a wheelchair or a person who uses crutches, place yourself at eye level in front of that person to facilitate the conversation.
9. To get the attention of a person who is hard of hearing, tap the person on the shoulder or wave your hand. Look directly at the person and speak clearly. Not all people with a hearing-impairment can lip-read. For those who do lip-read, be sensitive to their needs by placing yourself facing the light source and keeping hands, cigarettes, and food away from your mouth when speaking.
10. Relax. Don't be embarrassed if you happen to use accepted, common expressions, such as ‘See you later’ or ‘Did you hear about this’ that seem to relate to the person's disability.

HANDOUT 29

Supporting diversity in the workforce – Persons with Disabilities (From: Disability Confident Scheme. 2018. Recruiting, managing and developing people with a disability or health condition: A practical guide for line managers)

Slide 1:

- Diversity in the workplace is important - it's about valuing everyone in the organisation as an individual. To reap the benefits of a diverse workforce it's vital to have an inclusive environment where everyone can participate and achieve their potential.

Slide 2:

Why it makes good business sense

- Some groups remain under-represented in the jobs market meaning a loss of skills and talent to the economy and employers.
- Many persons with disabilities are unemployed, representing a huge pool of untapped talent that can't be ignored, especially with ageing population and the likelihood that a greater proportion of the workforce will develop a health condition or disability.

Slide 3

Benefits:

- can tap into the different perspectives and skills which can boost innovation and performance.
- increased loyalty and commitment from staff
- Reflects the make-up of consumer base in their workforce – disabled customers and their families have a spending power
- Legal obligations and policies vary across the Caribbean but best practice is that employers make reasonable adjustments' for people with a disability if there are any aspects of a job or workplace which put them at a disadvantage.

Slide 4

Language and behaviour

- Many people feel awkward when they meet disabled people – many reasons including not knowing a person with a disability or worried about offending.
- Disabled people will often have different preferences and views on what language they find appropriate or inappropriate. If unsure, just ask about preferences.
- In general, don't worry about using common expressions, such as 'see you later' in front of someone who has a visual impairment or 'I've got to run' in front of a wheelchair user.

General rules:

- Avoid saying someone is suffering from' as it encourages a view of that person as a 'victim'

- Don't use collective terms or labels like 'the disabled', 'the deaf', 'the blind'
- Don't describe people by their impairment, for example, 'she is a diabetic'
- Don't describe people without a disability as 'able bodied' or 'normal' – not all disability is physical. People with conditions that are not physical, such as autism, may also describe themselves as disabled
- Be respectful in the language you use about disability, and expect the same of others, whether a disabled person is present or not.

Slide 5

Communication

Simple principles for work:

- Talk to a disabled person as you would to anyone else – focus on a person's ability rather than their disability
- How much someone wishes to talk about their disability depends on their individual preferences
- Speak directly to the disabled person, not their support worker or interpreter
- If you are having trouble understanding someone's speech, it's okay to ask them to repeat themselves. Don't pretend to understand or finish someone's sentences – be patient.

Offering assistance

- Don't assume a disabled person wants or needs your help.
- As a basic courtesy, ask before you help and wait until the disabled person accepts your offer. Once the person has accepted your offer, listen or ask for specific instructions.
- Don't worry if your offer is turned down.

Slide 6

Workplace adjustments

- Adjustments are changes in work environment or the way work is executed so that someone with a disability can do their job more effectively.
- Half of disabled employees state that workplace adjustments are the single most important factor helping them to remain in work. It's important to remember that:
- Not all adjustments relate to the physical working environment, such as wheelchair ramps
- Other adjustments can be less tangible but just as important, such as changing work hours
- Workplace adjustments can be made for anyone, and not just employees with a disability or health condition – for example, changing the working hours of someone who has caring responsibilities.
- Most adjustments cost nothing or very little.

- Give every candidate the opportunity to discuss these in advance of an interview or other selection test. You shouldn't make assumptions about what adjustments are needed or are feasible.
- Adjustments in recruitment or selection processes could include:
  - Ensuring that the interview room is accessible or appropriately equipped
  - Allowing a support worker to attend an interview if required
  - Offering communication support if needed
  - Adapting tests or selection exercises, for example, by granting some additional time for completion, or questioning whether timed tests are needed at all.
- Interviewing remotely
- Would a 'work trial' rather than a formal interview give you a clearer indication of a person's suitability for the job (by giving them an opportunity to show you what they can do, rather than tell you about it)?

Slide 10

Welcoming new starters

- Talk about adjustments so these can be put in place before they start.
- It might be useful to confirm next steps and any agreed adjustments in writing.
- Once the new team member is in post and has a clearer sense of their day-to-day work, it may be worth having a further discussion with them to ensure the agreed adjustments are meeting their needs.
- It is important that your team's induction processes are accessible for all new starters and are personalised to their particular needs so they can quickly become productive.

Slide 11

'Disclosure' and confidentiality

- An individual's disability or long-term health condition may not be visible.
- It is an individual's choice to tell you about their disability. Some choose not to say anything because, they are concerned it will jeopardise future career prospects, or they are simply daunted by the prospect
- Sharing information about a disability or health condition can be beneficial for both the individual and the employer. If an employee informs their employer about their disability or health condition, effective adjustments can be put in place for that individual, giving them the opportunity to fully utilise their skills and abilities.
- A positive, open culture about health and wellbeing can increase an individual's trust and confidence to raise any issues with you.
- The term 'disclosure' sounds formal and has negative and/or legal connotations for some people. Using more informal, everyday language might help to break down the barriers – ask people to "share" or "tell" rather than "disclose" or "declare".
- Someone' health or disability can be a sensitive issue, but most people would prefer concerned and genuine enquiry about how they are as opposed to silence.

Slide 12

- Discussions on disabilities or health conditions should be private and in a place where the individual is comfortable. Listen with empathy and respond with openness and common sense.
- The information should be treated as confidential and all team members given reassurance of this.
- Make sure you have consent from an employee before sharing their details with anyone. This should include what can be shared and with whom.

Slide 13

Retaining people

- Having an effective framework in place to retain people with a disability or health condition is crucial – it saves money on recruitment and training, and prevents businesses from losing valuable skills and talent.
- If a member of your team becomes disabled or if their existing condition worsens, as far as you can, treat them in the same way as a new starter who has a disability. But be aware that they may still be coming to terms with their disability and how it is affecting their day-to-day life.
- Talk to the person about potential workplace adjustments. However, if they have only recently acquired their disability, they may not know the barriers they are likely to face at work yet, or how they can be overcome.
- If a person is looking to return to work after a long absence, make it clear you are open to have a discussion with them about making adjustments to help ease them back into work.

These could include, for example:

- A phased return to work initially working certain days a week or having shorter days for a period of time (and adjusted duties during that time)
- Re-designing a person's job role
- A move to a different role.

Slide 14

- There should never be assumptions about someone's ability to perform to a high standard due to a disability or health condition.
- Developing an inclusive culture means recognising that people with a disability or long-term health condition can thrive at work if they have the appropriate understanding and support.
- Ensure all team members have equal access to training and development and career opportunities. If training is being delivered outside your team member's workplace, check that the training is accessible.
- Consider adjustments to formal performance management and appraisal processes so that a team member with a disability can participate fully and is not disadvantaged by any part of the process.

Adjustments could include, for example:

- Using accessible meeting rooms
- Allowing the team member longer to prepare for meetings and appraisals

- Having a work colleague or advocate present to support them.

Slide 15

- Discussions or meetings about performance should focus on the employee's work, but asking straightforward, open questions about how they are and whether anything is affecting their performance can encourage people to open up about any health issues.
- It's important that the performance management process takes full account of any health condition or disability where there is under-performance on the part of an individual.
- These should be fully explored and discussed before any formal process is initiated. The focus of any performance management process should be on positive improvement, and supportive measures put in place to help someone reach their potential.
- If under-performance is an issue, discuss potential adjustments or support that could help bridge someone's gap in performance. Possible adjustments could include extra training or supervision, providing a mentor or adjusting someone's responsibilities.

Slide 16

- Don't assume that team members with a disability or health condition will have more sickness absence than any other team members – this is often not the case.
- Employees may need time off for a variety of reasons, from short-term sickness to longer term health issues. Effective absence management is vital to support the needs of individuals and minimise the impact on the business.
- If one of your team members is taking a lot of time off sick, and you are not aware of any disability or health condition, discuss this with them to find out exactly the cause of the problems they are experiencing and whether workplace adjustments can be made to help them.
- Discussions about health issues can be difficult for both employees and managers. An informal approach can be a good way to encourage an open, two-way dialogue about any barriers your team member is facing, and how they might be overcome.

Slide 17

Long-term absence and returning to work

- Stay in regular contact with any employee who is absent for a long time, not only to find out how they are, but also to keep them in touch with work. This will make the transition back to work easier
- If a person is looking to return to work after a long-term absence, discuss with them adjustments which can help to ease them back into the work routine, including:
  - A phased return to work
  - Re-designing a person's job role
  - A move to a different role.
- In some circumstances, some people with a disability or long-term health condition may need to take additional time off, for example, for medical treatment or rehabilitation.
- Standard treatment and recording of these absences can mean that that person faces a disadvantage as a result of their disability.

Slide 18

Examples of adjustments

- Flexibility, for example, allowing someone to work from home or changing their hours so they don't have to travel to work in the rush hour
- More one-to-one supervision or additional training, or providing a mentor
- Making a physical change to the workplace or workstation, for example, changing a desk height, or moving office furniture to improve access
- Altering assessment procedures – such as giving extra time, providing assistive technology or offering a 'work trial' instead of a traditional formal interview
- Providing extra equipment or assistance, for example, a new chair or specific software.
- By discussing with the employee how a job can be done differently, you can often find ways it can be done better.
- Keep agreed adjustments under review to see how well they are working and if any others are needed.
- Once an adjustment has been agreed, it should be implemented as soon as possible.
- Don't make assumptions about an individual's abilities or requirements. Some people with a disability or long-term health condition don't need any adjustments
- Treat each employee as an individual. An adjustment for one person may not be appropriate for someone else

Slide 19

Recruiting people

- When recruiting hire the most suitable person for the job, so the person with the skills, qualities and experience needed for the role. Therefore, job and person specifications, application forms and interview questions etc. should focus on these.
- Recruitment processes should attract a wide range of talent and give all candidates, including those with a disability or long-term health condition, the opportunity to demonstrate their abilities and potential.
- Make clear in ads that your organisation is committed to inclusion and diversity, and welcomes applications from people with a disability or long-term health condition
- Advertise vacancy through a range of media to appeal to a diverse audience and consider using a mix of channels, including those that specifically reach disabled people
- Provide a contact point for people who may have questions about the recruitment process

Slide 20

- You can't ask questions about an individual's health or disability (except in limited circumstances), but it's important to ask all applicants whether they need any particular adjustments or arrangements for any part of the recruitment or selection process.

- Record disability-related absence separately from other sickness absences, so that employment decisions, such as bonuses or disciplinary action, are not affected by a person's disability.

Be clear, consistent and open about your approach on sickness absence to avoid misunderstanding and concern.

Slide 21

- Disabled people and those with long-term health conditions should have the same opportunities for promotion and progression as all team members.
- If you are considering dismissing an employee with a disability, you need to make sure you have taken all reasonable steps to, for example, improve that person's performance or attendance.
- All employees who resign should be offered an exit interview. They can be asked if their decision to leave was influenced by a disability or health condition. The feedback can be useful for future changes.
- If a disabled member of your team asks you for a reference, remember to focus on that person's skills, experience and qualities. Don't mention their disability or health condition.
- If you are considering making redundancies, make sure disabled people are not disadvantaged in your redundancy selection criteria or in the way you manage the process.

HANDOUT 30

Job advert template (from: Water Aid. Equity and inclusion: Play your part. Awareness raising training guide)

Job title: Policy Advocacy Officer
Location: Bridgetown
Salary: $1,000,000

WeHire, a leading international NGO is seeking a mature policy and advocacy officer.

The Policy and Advocacy officer will be responsible for carrying out research into water and sanitation issues and for carrying out advocacy strategies which will result in sustainable improvements in the provision of safe water and sanitation to beneficiaries. The postholder will be responsible for networking and collaborating with different stakeholders to encourage the development of pro-poor policies and the achievement of water and sanitation sector goals. This role will at times require long working hours so we will not accept applications from females with young children.

Minimum requirements:
Candidates over six foot should apply.
Office hours are 08:30 – 17:00.
Masters degree standard with at least ten years relevant work experience.

The job description can be downloaded from www.pretend.com

Applicants should submit a typed CV and cover letter

Applications should be sent to:

Closing date:

Interviews will be held on the fifth floor of the Big Glassy building on main street.

Candidates will be required to complete a written test within 30 minutes at the interview.

HANDOUT 31
DEFINITIONS OF DISCRIMINATION

Direct discrimination

Less favourable treatment of a person compared with another person due to a particular characteristic (for example, sex, race, age, disability, HIV status, religion, sexual orientation).

For example, it would be direct discrimination if a driving job was only open to male applicants.

Indirect discrimination

The use of an apparently neutral practice which puts people with a particular characterstic at a disadvantage compared to others who do not share that characteristic.

For example, saying that applicants for a job must be clean shaven puts members of some religious groups at a disadvantage.

Positive discrimination

Treating someone with a particular characteristic more favorably to counteract the effects of past discrimination.

For example, deliberately short-listing only women for a senior position to provide a more balanced senior management team (this may not be lawful in some countries, such as the UK).

Positive action or affirmative action

Definitions vary in different countries. Both terms generally mean a range of actions that seek to overcome or minimise discrimination that people who share a particular characteristic have experienced, or to meet their particular needs.

For example, sending job adverts to disabled people's organisations and providing the support potential candidates with disabilities need so they can compete fairly at an interview with candidates without disabilities.

Affirmative action in many African nations focuses on gender. It is enforced by a quota system.

For example, in Uganda a third of the individuals in government must be women. In sub-continental Asia, quotas are largely focused on the caste (class) system.

COMPLETE LIST OF TERMINOLOGIES

Ability - The quality of having the means or skill to do something. Ability is not permanent, can fluctuate throughout one's life, and is another aspect of diversity in our communities. Disabilities do not necessarily limit people unless society imposes assumptions that do not account for the variation in people's abilities.

Able-bodied - Sometimes used incorrectly as an antonym of "disabled" in phrases such as "Disabled people, unlike able-bodied people..." The preferred antonym for disabled' is 'non-disabled' or 'person without a disability'

Ableism - The pervasive system of discrimination and exclusion that oppresses people who are differently abled, including differences in mental, cognititive, emotional, and/or physical abilities, through attitudes, actions, or institutional policies.

Access - Suitability of a building or other structure for use by people with disabilities. In a broader sense, access also included making forms and information accessible to people with visual or cognitive disabilities; making alarms and signals accessible to people who are deaf or hard of hearing; and making services such as education and transport accessible to people with disabilities.

Access aisle -An accessible pedestrian space, for example, between parking spaces, seating or desks that provides appropriate clearance for use of those parking spaces etc.

Access audit - Detailed examination of a building or other structure, generally by independent experts, to ascertain its suitability for use by people with disabilities.

Accessibility - The degree to which a building or other structure provides access for (mainly physically) disabled people.

Activities of daily living - In the context of rehabilitation and independent living by people with disabilities, these include dressing, making the bed, showering, shaving, combing hair, eating, making drinks and all other activities which will assist in enabling a person with a disability to function to the maximum of his or her capacity within the family and the community.

ADHD / Attention Deficit Hyperactivity - This term now includes ADD/ Attention Deficit Disorder - a disorder that appears in early childhood. ADHD makes it difficult for people to inhibit their spontaneous responses (responses can involve everything from movement to speech to attentiveness). People with ADHD may be: · Inattentive, hyperactive, and impulsive (the most common form) · Inattentive, but not hyperactive or impulsive. · Hyperactive and impulsive, but able to pay attention.

Advocate – (*noun*) (1) a person who actively works to end intolerance, educate others, and support social equity for a marginalized group. (verb) (2) to actively support/plea in favor of a particular cause, the action of working to end intolerance, educate others, etc.

Ageism - The pervasive system of prejudice and discrimination that marginalizes people based on their age. This can be perpetuated through stereotypes of youthfulness versus life at an older age and through oppressive policies that subordinate and exclude older folks. Ageism can impact different age groups besides older folks, such as children who are stereotyped as being unable to make big decisions.

Allosexism - The pervasive system of discrimination and exclusion that oppresses asexual people built out of the assumption that everyone does and should experience sexual attraction.

Allosexual - A sexual orientation generally characterized by feeling sexual attraction or a desire for partnered sexuality.

Allistic - An adjective used to describe a person who is not autistic and is often used to emphasize the privilege of people who are not on the autism spectrum.

Ally – (*noun*) a straight identified person who supports, and respect members of the LGBTQ community.

ALS, also known as amyotrophic lateral sclerosis, motor neurone disease or Lou Gehrig's Disease - A disease of the parts of the nervous system that control voluntary muscle movement. Nerve cells that control muscle cells are gradually lost, causing the muscles to become weak and eventually non-functional. Walking, talking, eating, hugging and even breathing become nearly impossible, although the mind stays sharp.

ALT attribute - Provides an alternate text for a computer user, if (s)he cannot view the image (for example because of a slow connection or because (s)he uses a screen reader/ is visually impaired.

Alzheimer's Disease - A progressive degenerative disease of the brain that may involve a combination of symptoms including delirium, delusions, memory disturbance, depression and behavioural disturbances. There is no cure for it. It is not a normal part of the ageing process.

Androgyny/ous – (*adj*) (1) a gender expression that has elements of both masculinity and femininity; (2) occasionally used in place of "intersex" to describe a person with both female and male anatomy.

Androsexual/Androphilic – (*adj*) attraction to men, males, and/or masculinity.

Aromantic - (*adj*) is a person who experiences little or no romantic attraction to others and/or a lack of interest in forming romantic relationships.

Asexual – (*adj*) having a lack of (or low level of) sexual attraction to others and/or a lack of interest or desire for sex or sexual partners.

Autism - A neurological variation encompassing a wide range of presentations and experiences. Common characteristics of autism include repetitive behavior and differences in social interaction, interpersonal relationships, and communication. For some people, their gender identity is significantly tied to their identity as an autistic person.
*****For this glossary, we use identity-first language instead of person-first language for describing autistic people because for some people, their disability is an important part of who they are (this practice comes from the Autistic Self Advocacy Network). However, we acknowledge that language and how people describe their identities can vary for each person and change over time.

Behaviour, emotional and social difficulties (BESD) or emotional and behavioural disorders (EBD) - These terms describe a wide range of difficulties including children who are very withdrawn, children who are hyper-active, children with mental health problems, children who are unable to control their temper and those who are aggressive or disruptive

BDSM - Bondage and Discipline, Dominance and Submission, Sadism and Masochism. BDSM refers to a wide spectrum of activities and forms of interpersonal relationships. While not always overtly sexual in nature, the activities and relationships within a BDSM context are almost always eroticized by the participants in some fashion. Many of these practices fall outside of commonly held social norms regarding sexuality and human relationships.

Bigender – (*adj*) a person who fluctuates between traditionally "woman" and "man" gender-based behavior and identities, identifying with both genders (and sometimes a third gender)

Bicurious – (*adj*) a curiosity about having attraction to people of the same gender/sex (similar to questioning)

Biological Sex – (*noun*) 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. Often abbreviated to simply "sex".

Biphobia – (*noun*) a range of negative attitudes (e.g., fear, anger, intolerance, resentment, or discomfort) that one may have/express towards bisexual individuals. Biphobia can come from and be seen within the queer community as well as straight society. Biphobic (adj) a word used to describe an individual who harbors some elements of this range of negative attitudes towards bisexual people

Bisexual – (*adj*) A person whose primary sexual and affectional orientation is toward people of the same and other genders, or towards people regardless of their gender. Some people may use bisexual and pansexual interchangeably. This attraction does not have to be equally split between genders and there may be a preference for one gender over others.

BlaQ/BlaQueer -Folks of Black/African descent and/or from the African diaspora who recognize their queerness/LGBTQIA identity as a salient identity attached to their Blackness and vice versa. (T. Porter)

Body Policing - any behavior which (indirectly or directly, intentionally or unintentionally) attempts to correct or control a person's actions regarding their own physical body, frequently with regards to gender expression or size. (ASC Queer Theory)

Butch – (*noun & adj*) a person who identifies themselves as masculine, whether it be physically, mentally or emotionally. 'Butch' is sometimes used as a derogatory term for lesbians, but is also be claimed as an affirmative identity label.

Cerebral palsy (CP) - A group of disorders that affect a person's ability to move and maintain balance and posture. CP is the most common motor disability in childhood. Cerebral means having to do with the brain. Palsy means weakness or problems with using the muscles. CP is caused by abnormal brain development or damage to the developing brain that affects a person's ability to control his or her muscles.

Cisgender – (*adj*) a person whose gender identity and biological sex assigned at birth align (e.g., man and male-assigned)

Cissexism/Genderism: The pervasive system of discrimination and exclusion founded on the belief that there are, and should be, only two genders and that one's gender or most aspects of it, are inevitably tied to assigned sex. This system oppresses people whose gender and/or gender expression falls outside of cis-normative constructs. Within cissexism, cisgender people are the dominant group and trans/ gender non-conforming people are the oppressed group.

Cisnormativity – (*noun*) the assumption, in individuals or in institutions, that everyone is cisgender, and that cisgender identities are superior to trans identities or people. Leads to invisibility of non-cisgender identities

Closeted – (*adj*) an individual who is not open to themselves or others about their (queer) sexuality or gender identity. This may be by choice and/or for other reasons such as fear for one's safety, peer or family rejection or disapproval and/or loss of housing, job, etc. Also known as being "in the closet." When someone chooses to break this silence they "come out" of the closet. (See coming out)

Coming Out – (1) the process by which one accepts and/or comes to identify one's own sexuality or gender identity (to "come out" to oneself). (2) The process by which one shares one's sexuality or gender identity with others (to "come out" to friends, etc.).

Cross Dresser (CD) -A word to describe a person who dresses, at least partially, as a member of a gender other than their assigned sex; carries no implications of sexual orientation. Has replaced "Transvestite."

Culture - A learned set of values, beliefs, customs, norms, and perceptions shared by a group of people that provide a general design for living and patterns for interpreting life. "Culture is those deep, common, unstated, learned experiences which members of a given culture share, which they communicate without knowing, and which form the backdrop against which all other events are judged." (E. Hall.)

Cultural Humility - An approach to engagement across differences that acknowledges systems of oppression and embodies the following key practices: (1) a lifelong commitment to self-evaluation and self-critique, (2) a desire to fix power imbalances where none ought to exist, and (3) aspiring to develop partnerships with people and groups who advocate for others on a systemic level. (Melanie Tervalon & Jann Murray-García, 1998)

Deaf / hard of hearing / hearing impaired / hearing loss - The deaf and hard of hearing community is diverse. How people "label" or identify themselves is personal and may reflect identification with that community, the degree to which they can hear, or the relative age of onset. Some people believe that the term "people with hearing loss" is inclusive and efficient. However, some people who were born deaf or hard of hearing do not think of themselves as having lost their hearing. Over the years, the most commonly accepted terms in the deaf community have come to be "deaf" (total inability to hear) and "hard of hearing" (partial loss of hearing). The term "hearing-impaired", although meant well and regarded by those outside the deaf community as politically correct, is not accepted or used by many deaf and hard of hearing people. The term "hearing impaired" is viewed as negative, establishing the standard as "hearing" and anything different as "impaired" or substandard. The terms "hearing impaired" and "hearing loss" are best used as medical (e.g. describing levels of hearing loss) or technical terms (e.g. when discussing the CRPD or relevant legislation).

Deaf-Blindness (also referred to as dual sensory impairment): A combination of both visual and hearing impairments. A person with deaf-blindness cannot be accommodated by services focusing solely on visual impairments or solely on hearing impairments, so services must be specifically designed to assist individuals with deaf-blindness.

Dementia - A general loss of cognitive abilities characterised by memory loss and one or more of several other symptoms including severe speaking difficulties, reduced organisational and planning abilities, and problems recognising the significance of sights, sounds and other sensory stimuli. The medical profession acknowledges many forms of dementia; examples are boxer's dementia, post-traumatic dementia, presenile and senile dementia, and vascular dementia. Two main types of dementia are Alzheimer's disease and multi-infarct dementia. It is important to note that dementia is an illness and not normal ageing

Demi-sexual – (*noun*) an individual who does not experience sexual attraction unless they have formed a strong emotional connection with another individual. Often within a romantic relationship. Most demisexuals feel sexual attraction rarely compared to the general population, and some have little to no interest in sexual activity. Demisexuals are considered to be on the asexual spectrum.

Developmental disability / developmental - General term for a number of conditions involving mental and/or physical disabilities arising before the age of 18 years.

Disability/(Dis)ability/Dis/ability - A social construct that identifies any restriction or lack of ability to perform an activity in the manner or within the range considered "typical" for a human being given environments that are constructed for and by the dominant or "typical" person.

Discrimination -Inequitable actions carried out by members of a dominant group or its representatives against members of a marginalized or minoritized group.

Down's syndrome - A congenital (and usually chromosomal) disorder characterised by a flattened facial profile, moderate to severe mental disability and short stature. It is a lifelong condition and occurs because some babies' cells contain an extra chromosome 21.

Drag King – (*noun*) someone who performs masculinity theatrically.

Drag Queen – (*noun*) someone who performs femininity theatrically.

Dyke – (*noun*) a term referring to a masculine presenting lesbian. While often used derogatorily, it can is adopted affirmatively by many lesbians (and not necessarily masculine ones) as a positive self identity term.

Ethnicity - A social construct that divides people into smaller social groups based on characteristics such as shared sense of group membership, values, behavioral patterns, language, political and economic interests, history and ancestral geographical base.

Fag(got) – (*noun*) derogatory term referring to a gay person, or someone perceived as queer. Occasionally used as an self-identifying affirming term by some gay men, at times in the shortened form 'fag'.

Femme – (*noun & adj*) someone who identifies themselves as feminine, whether it be physically, mentally or emotionally. Often used to refer to a feminine-presenting lesbian.

Fluid(ity) – generally with another term attached, like gender-fluid or fluid-sexuality, fluid(ity) describes an identity that is a fluctuating mix of the options available (e.g., man and woman, bi and straight)

FTM / F2M – abbreviation for female-to-male transgender or transsexual person.

Gay – (*adj*) (1) a term used to describe individuals who are primarily emotionally, physically, and/or sexually attracted to members of the same sex. More commonly used when referring to males, but can be applied to females as well. (2) An umbrella term used to refer to the queer community as a whole, or as an individual identity label for anyone who does not identify as heterosexual.

Gender - A social construct used to classify a person as a man, woman, or some other identity. Fundamentally different from the sex one is assigned at birth.

Gender Binary – (*noun*) the idea that there are only two genders – male/female or man/woman and that a person must be strictly gendered as either/or.

Gender Expansive - An umbrella term used for individuals who broaden their own culture's commonly held definitions of gender, including expectations for its expression, identities, roles, and/or other perceived gender norms. Gender expansive individuals include those who identify as transgender, as well as anyone else whose gender in some way is seen to be broadening the surrounding society's notion of gender.

Gender Expression – (*noun*) the external display of one's gender, through a combination of dress, demeanor, social behavior, and other factors, generally measured on scales of masculinity and femininity.

Gender Fluid - (*adj*) gender fluid is a gender identity best described as a dynamic mix of boy and girl. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more man

Gender Identity – (*noun*) the internal perception of an one's gender, and how they label themselves, based on how much they align or don't align with what they understand their options for gender to be. Common identity terms include man, woman, genderqueer...

Gender Normative / Gender Straight – (*adj*) someone whose gender presentation, whether by nature or by choice, aligns with society's gender-based expectations

Genderqueer - (*adj*) is a catch-all term for gender identities other than man and woman, thus outside of the gender binary and cisnormativity (sometimes referred to as non-binary). People who identify as genderqueer may think of themselves as one or more of the following:

- both man and woman (bigender, pangender);
- neither man nor woman (genderless, agender);
- moving between genders (genderfluid);
- third gender or other-gendered; includes those who do not place a name to their gender
- having an overlap of, or blurred lines between, gender identity and sexual and romantic orientation.

Gender Non conforming (GNC) - Adjective for people who do not subscribe to societal expectations of typical gender expressions or roles. The term is more commonly used to refer to gender expression (how one behaves, acts, and presents themselves to others) as opposed to gender identity (one's internal sense of self).

Gender Variant – (*adj*) someone who either by nature or by choice does not conform to gender based expectations of society (e.g. transgender, transsexual, intersex, gender-queer, cross-dresser, etc.).

Global Developmental Delay (GDD) - The general term used to describe a condition that occurs during the developmental period of a child between birth and 18 years. It is usually defined by the child not having reached two or more traditional milestones in areas of development (motor skills, speech and language, cognitive skills and social and emotional skills). Gynesexual/Gynephilic – (adj) attracted to woman, females, and/or femininity

Hermaphrodite – (*noun*) an outdated medical term previously used to refer someone who was born with both male and female biological characteristics; not used today as it is considered to be medically stigmatizing, and also misleading as it means a person who is 100% male and female, a biological impossibility for humans (preferred term is intersex)

Heteronormativity – (*noun*) the assumption, in individuals or in institutions, that everyone is heterosexual, and that heterosexuality is superior to all other sexualities. Leads to invisibility and stigmatizing of other sexualities.

Heterosexism – (*noun*) behavior that grants preferential treatment to heterosexual people, reinforces the idea that heterosexuality is somehow better or more “right” than queerness, or makes other sexualities invisible

Heterosexual – (*adj*) a person primarily emotionally, physically, and/or sexually attracted to members of the opposite sex. Also see straight.

Homophobia – (*noun*) an umbrella term for a range of negative attitudes (e.g., fear, anger, intolerance, resentment, or discomfort) that one may have towards members of LGBTQ community. The term can also connote a fear, disgust, or dislike of being perceived as LGBTQ.
** Some people have been intentionally moving away from using words like "transphobic,” “homophobic,” and "biphobic" because (1) they inaccurately describe systems of oppression as irrational fears, and (2) for some people, phobias are a very distressing part of their lived experience and co-opting this language is disrespectful to their experiences and perpetuates ableism.

Homosexual/Homosexuality: An outdated term to describe a sexual orientation in which a person feels physically and emotionally attracted to people of the same gender. Historically, it was a term used to pathologize gay and lesbian people.

Internalized oppression - The fear and self-hate of one or more of a person’s own identities that occurs for many individuals who have learned negative ideas about their identities throughout childhood. One form of internalized oppression is the acceptance of the myths and stereotypes applied to the oppressed group.

Intersectionality - A term coined by law professor Kimberlé Crenshaw in the 1980s to describe the way that multiple systems of oppression interact in the lives of those with multiple marginalized identities. Intersectionality looks at the relationships between multiple marginalized identities and allows us to analyze social problems more fully, shape more effective interventions, and promote more inclusive advocacy amongst communities.

Intersex – (*adj*) someone whose combination of chromosomes, gonads, hormones, internal sex organs, and genitals differs from the two expected patterns of male or female. Formerly known as hermaphrodite (or hermaphroditic), but these terms are now considered outdated and derogatory.

Kink - (Kinky, Kinkiness) Most commonly referred to as unconventional sexual practices, from which people derive varying forms of pleasure and consensually play-out various forms of desires, fantasies, and scenes.

Latinx - pronounced "La-TEEN-ex", is a non-gender specific way of referring to people of Latin American descent. The term Latinx, unlike terms such as Latino/a and Latin@, does not assume a gender binary and includes non binary folks.

Learning disability (also known as intellectual disability or learning difficulty): · a significantly reduced ability to understand new or complex information or to learn new skills; · a reduced ability to cope independently; · an impairment that started before adulthood, with a lasting effect on development.

Lesbian – (*noun*) a term used to describe women attracted romantically, erotically, and/or emotionally to other women. However, some nonbinary people also identify as lesbians, often because they have some connection towomanhood and are primarily attracted to women.

Lipstick Lesbian – (noun) Usually refers to a lesbian with a feminine gender expression. Can be used in a positive or a derogatory way. Is sometimes also used to refer to a lesbian who is assumed to be (or passes for) straight.

Masculine of Center (MOC) -A term coined by B. Cole of the Brown Boi Project to describe folks, including lesbian/queer womyn and trans folks, who lean towards the masculine side of the gender spectrum. These can include a wide range of identities such as butch, stud, aggressive/AG, dom, macha, tomboi, trans-masculine, etc

Mental disability - Refers to any illness or disorder of the mind that: has significant psychological or behavioural manifestations, is associated with 54 painful or distressing symptoms, and impairs an individual's level of functioning in certain areas of life. There are several different types of mental illness with differing levels of severity. The cause may be genetic, congenital, or as a result of physical, psychological, chemical, environmental, or social factors.

People with mental disabilities often face stigmatisation due to a general lack of understanding about their disability and the barriers they face. This is often called an invisible disability due to it not being immediately apparent. Many people with this disability do not like to make the fact they have a mental disability public due to the stigmatisation they are likely to face. This is especially the case when seeking employment.

Metrosexual – (*noun & adj*) a straight man with a strong aesthetic sense who spends more time, energy, or money on his appearance and grooming than is considered gender normative.

Microaggressions - Brief and subtle behaviors, whether intentional or not, that communicate hostile, derogatory, or negative messages of commonly oppressed identities. These actions cause harm through the invalidation of the target person's identity and may reinforce stereotypes. Examples of microaggressions include a person who is not white being told they speak "good English" or someone saying something is "gay" to mean they think something is bad.

Misgendering - Attributing a gender to someone that is incorrect/does not align with their gender identity. Can occur when using pronouns, gendered language (i.e. "Hello ladies!" "Hey guys"), or assigning genders to people without knowing how they identify (i.e. "Well, since we're all women in this room, we understand...").

MLM - an abbreviation for men who love men, which includes gay men as well as men who are attracted to men and people of other genders.

Monogamy - Having only one intimate partner at any one time; also known as serial monogamy, since "true" monogamy refers to the practice of having only one partner for life (such as in some animal species).

Monosexism - The belief in and systematic privileging of monosexuality as superior, and the systematic oppression of non-monosexuality.

Monosexual - People who have romantic, sexual, or affectional desire for one gender only. Heterosexuality and homosexuality are the most well-known forms of monosexuality.

MSM - an abbreviation for men who have sex with men; they may or may not identify as gay.

MTF/ M2F – abbreviation from male-to-female transgender or transsexual person.

Multisexual -An umbrella term to describe attraction to more than one gender. It can include sexual attractions like bisexual, polysexual, omnisexual, and others. The aforementioned terms are used by some interchangeably and for others the subtle differences among them are important.

Neurodiversity - Neurodiversity refers to the natural and important variations in how human minds think. These differences can include autism, attention deficit hyperactivity disorder, dyspraxia,dyslexia, dyscalculia, Tourette Syndrome, and others. Like other variable human traits like race, gender, sexuality, or culture, there is no right or wrong form of diversity. The social dynamics that exert power over other forms of diversity also impact neurodivergent people. Neurodiversity is not something to be cured or corrected to fit some social norm - rather, we should celebrate different forms of communication and self-expression and promote support systems to allow neurodivergent people to thrive. (Neurocosmopolitanism, The National Symposium on Neurodiversity)

Neurodivergent - "Neurodivergent, sometimes abbreviated as ND, means having a brain that functions in ways that diverge significantly from the dominant societal standards of "normal." A person whose neurocognitive functioning diverges from dominant societal norms in multiple ways – for instance, a person who is Autistic, has dyslexia, and has epilepsy – can be described as multiply neurodivergent. The terms neurodivergent and neurodivergence were coined by Kassiane Asasumasu, a multiply neurodivergent neurodiversity activist." (Neurocosmopolitanism)

Neurotypical - "Neurotypical, often abbreviated as NT, means having a style of neurocognitive functioning that falls within the dominant societal standards of "normal." Neurotypical can be used as either an adjective ("He's neurotypical") or a noun ("He's a neurotypical")." (Neurocosmopolitanism)

Neutrois - A non-binary gender identity that falls under the genderqueer or transgender umbrellas. There is no one definition of Neutrois, since each person that self-identifies as such experiences their gender differently. The most common ones are: Neutral-gender, Null-gender, Neither male nor female, Genderless and/or Agender. (Neutrois.com)

Non binary/Nonbinary/Non-binary - A gender identity and experience that embraces a full universe of expressions and ways of being that resonate for an individual, moving beyond the male/female gender binary. It may be an active resistance to binary gender expectations and/or an intentional creation of new unbounded ideas of self within the world. For some people who identify as non binary there may be overlap with other concepts and identities like gender expansive and gender non-conforming.

Omnigender - Possessing all genders. The term is used specifically to refute the concept of only two genders.

Oppression - exists when one social group, whether knowingly or unconsciously, exploits another social group for its own benefit. **Individual Level**: a person's beliefs or behaviors that consciously or subconsciously work to perpetuate actions and attitudes of oppression (See internalized oppression) **Institutional Level**: Institutions such as family, government, industry, education, and religion have policies and procedures that can promote systems of oppression.

Societal/Cultural Level: community norms that perpetuate implicit and explicit values that bind institutions and individuals; social norms on what is valued, accepted, or desirable give the individual and institutional levels the justification for systemic oppression.

Orientation - Orientation is one's attraction or non-attraction to other people. An individual's orientation can be fluid and people use a variety of labels to describe their orientation. Some, but not all, types of attraction or orientation include: romantic, sexual, sensual, aesthetic, intellectual and platonic.

Outing – (*verb*) involuntary or unwanted disclosure of another person's sexual orientation, gender identity, or intersex status.

Pansexual – (*adj*) a person who experiences sexual, romantic, physical, and/or spiritual attraction for members of all gender identities/expressions

Passing – (*verb*) (1) a term for trans people being accepted as, or able to "pass for," a member of their self-identified gender/sex identity (regardless of birth sex). (2) An LGB/queer individual who can is believed to be or perceived as straight.

Phobia -In mental and emotional wellness, a phobia is a marked and persistent fear that is excessive in proportion to the actual threat or danger the situation presents. Historically, this term has been used inaccurately to refer to systems of oppression (i.e. homophobia has been used to refer to heterosexism.) As a staff, we've been intentionally moving away from using words like "transphobic," "homophobic," and "biphobic" because they inaccurately describe systems of oppression as irrational fears, and, for some people, phobias are a very distressing part of their lived experience and co-opting this language is disrespectful to their experiences and perpetuates ableism.

Polyamory – (noun) refers to having honest, usual non-possessive, relationships with multiple partners and can include: open relationships, polyfidelity (which involves multiple romantic relationships with sexual contact restricted to those), and sub-relationships (which denote distinguishing between a 'primary' relationship or relationships and various "secondary" relationships).

Polysexual - People who have romantic, sexual, or affectional desire for more than one gender. Not to be confused with polyamory (above). Has some overlap with bisexuality and pansexuality.

Privilege - a set of unearned benefits given to people who fit into a specific social group. The concept has roots in WEB DuBois' work on "psychological wage" and white people's feelings of superiority over Black people. Peggy McIntosh wrote about privilege as a white woman and developed an inventory of unearned privileges that she experienced in daily life because of her whiteness.

Pronouns - Linguistic tools used to refer to someone in the third person. Examples are they/them/theirs, ze/hir/hirs, she/her/hers, he/him/his. In English and some other languages, pronouns have been tied to gender and are a common site of misgendering (attributing a gender to someone that is incorrect.)

Queer – (*adj*) used as an umbrella term to describe individuals who identify as non-straight. Also used to describe people who have non-normative gender identity or as a political affiliation. Due to its historical use as a derogatory term, it is not embraced or used by all members of the LGBTQ community. The term queer can often be use interchangeably with LGBTQ.

Questioning (*verb*, *adjective*) - an individual who is unsure about or is exploring their own sexual orientation or gender identity.

Race -A social construct that divides people into distinct groups based on characteristics such as physical appearance, ancestral heritage, cultural affiliation, cultural history, ethnic classification, based on the social, economic, and political context of a society at a given period of time. (Racial Equity Resource Guide)

Racism -The systematic subordination of people from marginalized racial groups based on their physical appearance, ethnic or ancestral history, or cultural affiliation. Racism is considered a deeply pervasive, systemic issue perpetuated by members of the privileged racial group holding dominant social power over others. Discrimination, prejudice, or xenophobia may be more accurate terms for describing individual acts of oppression. While these individual acts likely stem from systemic racism, at the individual level the power dynamics that enable racism are not at play in the same way.

Religion - A personal or institutionalized system of beliefs and practices concerning the cause, nature, and purpose of the universe, often grounded in belief in and reverence for some supernatural power or powers; often involves devotional and ritual observances and contains a moral code governing the conduct of human affairs.

Romantic Orientation - Romantic Orientation is attraction or non-attraction to other people characterized by the expression or non-expression of love. Romantic orientation can be fluid and people use a variety of labels to describe their romantic orientation.

Same Gender Loving / SGL – (*adj*) a term sometimes used by members of the African-American/Black community to express an alternative sexual orientation without relying on terms and symbols of European descent.

Sex - a medically constructed categorization. Sex is often assigned based on the appearance of the genitalia, either in ultrasound or at birth.

Sexism - The cultural, institutional, and individual set of beliefs and practices that privilege men, subordinate women, and devalue ways of being that are associated with women.

Sexuality - The components of a person that include their biological sex, sexual orientation, gender identity, sexual practices, etc.

Sexual Orientation – (*noun*) the type of sexual, romantic, physical, and/or spiritual attraction one feels for others, often labeled based on the gender relationship between the person and the people they are attracted to (often mistakenly referred to as sexual preference)

Sexual Preference – (1) the types of sexual intercourse, stimulation, and gratification one likes to receive and participate in. (2) Generally when this term is used, it is being mistakenly interchanged with "sexual orientation," creating an illusion that one has a choice (or "preference") in who they are attracted to.

Sex Reassignment Surgery / SRS – A term used by some medical professionals to refer to a group of surgical options that alter a person's biological sex. In most cases, one or multiple surgeries are required to achieve legal recognition of gender variance.

Sizeism - The pervasive system of discrimination and exclusion that oppresses people who have bodies that society has labeled as "overweight," as well as people of short stature. Hxstorically speaking, fat people's bodies have been labeled as unhealthy, undesirable, and lazy; this fails to complicate narratives around health and healthy living. This form of oppression has been referred to as fatphobia.

Skoliosexual – (*adj*) attracted to genderqueer and transsexual people and expressions (people who don't identify as cisgender)

Social Identities - Social identity groups are based on the physical, social, and mental characteristics of individuals. They are sometimes obvious and clear, sometimes not obvious and unclear, often self-claimed and frequently ascribed by others.

Socialization - The process by which societal norms influence a number of aspects that frame how members of a community live - including how they might think, behave, and hold certain values. Socialization can reinforce assumptions or expectations that give power to systems of oppression.

Social Justice - A goal and a process in which the distribution of resources is equitable and all members are physically and psychologically safe and secure. Begins with an acknowledgement that oppression and inequity exist and must be actively dismantled on all levels. (Adams, Bell, & Griffin.)

Socioeconomic Class - Social group membership based on a combination of factors including income, education level, occupation, and social status in the community, such as contacts within the community, group associations, and the community's perception of the family or individual.

SOGIE - An acronym that stands for Sexual Orientation, Gender Identity and Expression. Is used by some in a similar way to the umbrella acronym: LGBTQIA.

Specific Learning Disability - Disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in difficulties listening, thinking, speaking, reading, writing, spelling, or doing mathematical calculations. When these difficulties are clustered together, often more definitive sub-sets are used such as 'dyslexia', 'dyscalculia', ADHD'

Spectrum - a range or sliding scale. Aspects of one's identity like sexual orientation, gender identity, and gender expression exist on a spectrum. For example, with sexual orientation, the attraction to men, women, or someone of another gender all exist on separate spectrums. Someone might feel a little attracted to men, very much attracted to women, and moderate attraction to people outside this binary.
*The phrase "on the spectrum" is more commonly used to refer to identifying on the autism spectrum rather than sexuality or gender. (AutisticAdvocacy.org)

Spirituality - Having to do with deep feelings and convictions, including a person's sense of peace, purpose, connection to others, and understanding of the meaning and value of life; may or may not be associated with a particular set of beliefs or practices.

Stereotype - A generalization applied to every person in a cultural group; a fixed conception of a group without allowing for individuality. When we believe our stereotypes, we tend to ignore characteristics that don't conform to our stereotype, rationalize what we see to fit our stereotype, see those who do not conform as "exceptions," and find ways to create the expected characteristics.

Straight – (*adj*) a person primarily emotionally, physically, and/or sexually attracted to members of the opposite sex. A more colloquial term for the word heterosexual

Stud – (*noun*) an African-American and/of Latina masculine lesbian. Also known as 'butch' or 'aggressive'.

Top Surgery – (*noun*) this term refers to surgery for the construction of a male-type chest or breast augmentation for a female-type chest.

Trans – (*noun*) an umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. Trans people may identify with a particular descriptive term (e.g., transgender, transsexual, genderqueer, FTM).

Transgender – (1) An umbrella term covering a range of identities that transgress socially defined gender norms. (2) A person who lives as a member of a gender other than that expected based on anatomical sex.

Transition(ing) – (*noun & verb*) Transitioning is the process of taking steps to live as one's true gender identity. Transitioning is different for each individual and may or may not involve medical interventions like taking hormones or having surgery. Some people may not choose to transition in certain ways for a variety of reasons. The extent of someone's transition does not make that person's gender identity any less or more valid. Transitioning may include socially transitioning, such as going by certain pronouns or going by the Lived Name that affirms one's gender identity. Transitioning may involve making changes to one's physical appearance, such as wearing certain clothing, wearing one's hair in a different style or length, or more complex changes such as medically transitioning through hormones or surgery. Transitioning can also involve changing legal documents to match one's authentic sense of self.

Trans man – (*noun*) A person may choose to identify this way to capture their gender identity as well as their lived experience as a transgender person.

Trans woman - A person may choose to identify this way to capture their gender identity as well as their lived experience as a transgender person.

Transphobia – (*noun*) the fear of, discrimination against, or hatred of trans people, the trans community, or gender ambiguity. Transphobia can be seen within the queer community, as well as in general society.

Transsexual – (*noun & adj*) a person who identifies psychologically as a gender/sex other than the one to which they were assigned at birth and has transformed their bodies hormonally and surgically to match their inner sense of gender/sex.

Transvestite – (noun) outdated term for a person who dresses as the binary opposite gender expression ("crossdresses") for any one of many reasons, including relaxation, fun, and sexual gratification.

Traumatic Brain Injury (TBI) - An acquired injury to the brain caused by an external physical force resulting in impairments in one or more areas, including cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behaviour; physical functions; information processing; and speech. The term does not apply to brain injuries that are congenital, degenerative, or induced by birth trauma.

Two-Spirit – (*noun*) is an umbrella term traditionally used by Native American people to recognize individuals who possess qualities or fulfill roles of both genders

Visual impairment / visual disability - Fully or partially reduced functioning in one eye's or both eyes' ability to detect and/or process images. Caused by a wide range of biological and environmental factors, loss of vision typically arises in young people from a genetic / biological condition or injury to part/s of the eye. The term "blind" is not necessarily offensive and is sometimes used within the Blind/Visually Impaired Community. If in doubt, use "visually impaired"

Womxn - some womxn spell the word with an “x” as a form of empowerment to move away from the “men” in the “traditional” spelling of women.

Ze / Hir – alternate pronouns that are gender neutral and preferred by some trans people. Pronounced /zee/ and /here/ they replace “he” and “she” and “his” and “hers” respectively. Alternatively some people who are not comfortable/do not embrace he/she use the plural pronoun “they/their” as a gender neutral singular pronoun.

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