LINKAGES ACROSS THE CONTINUUM OF HIV SERVICES FOR KEY POPULATIONS AFFECTED BY HIV (LINKAGES)

HEALTH4ALL

Training health workers for the provision of quality, stigma-free HIV services for key populations

USAID FROM THE AMERICAN PEOPLE

PEPFAR

LINKAGES
Across the Continuum of HIV Services for Key Populations

Acknowledgments

The Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) project is a five-year cooperative agreement funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Agency for International Development (USAID). FHI 360 and its partners Pact, IntraHealth International, and the University of North Carolina at Chapel Hill are conducting a range of activities to reduce HIV transmission among key populations—sex workers, men who have sex with men, transgender people, and people who inject drugs—to improve their enrollment and retention in care. A critical component of LINKAGES is to ensure key populations have access to better quality, more integrated HIV prevention, treatment, and care services that are closer to home and in settings that protect their privacy. High-quality services for key populations require health care workers who are knowledgeable about the health needs of key populations and who provide services free from stigma and discrimination.

This training guide brings together information from existing training materials that aim to reduce the stigma and discrimination directed at key populations by health care workers. It also orients health care workers to the best clinical standards of care for key populations. The guide has been piloted in several different countries, and feedback from ministries of health, trainers, health care workers, peer educators, and LINKAGES staff has been incorporated into the guide.

We thank the following people for their role in developing this training guide: Chris Akolo, George Ayala, Robert Dodge, Kevin Osborne, Karah Pedersen, Boniface Sebakali, Lucy Stackpool-Moore, and Kate Stratten.

Hally Mahler
Project Director
LINKAGES

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Overview

Over the past 15 years, the world has made remarkable strides in halting and reversing the HIV epidemic: annual new infections have declined by 35 percent since 2000, and 15 million people living with HIV are now on antiretroviral therapy (ART). However, the key populations of sex workers, men who have sex with men, transgender people, and people who inject drugs remain disproportionately affected; 40 percent to 50 percent of all new HIV infections among adults worldwide occur among these populations and their sex partners. As global leaders move toward controlling the epidemic to achieve an AIDS-free generation, programs that support key populations are a priority for many donors and governments.

The Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) project, supported by PEPFAR and USAID, is a global initiative that is accelerating the ability of partner governments, key-population-led civil society organizations, and private-sector providers to plan, deliver, and optimize comprehensive HIV prevention, care, and treatment services at scale to reduce HIV transmission among key populations and extend life for those who are living with HIV. The LINKAGES approach is summarized in the cascade of HIV services[1] (Figure 1), which is aligned with the United Nations 95-95-95 treatment targets for 2030: 95 percent of all people living with HIV will know their HIV status, 95 percent of people diagnosed with HIV will receive sustained ART, and 95 percent of people receiving ART will achieve viral load suppression. The first three bars of the figure represent identification, reach, and HIV testing of communities with key populations and include HIV-negative and HIV-positive key population members. The remaining bars represent the care and treatment portion of the HIV continuum of prevention, care, and treatment (CoPCT) cascade, for those who test HIV positive.

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[1]   LINKAGES. (2015). HIV cascade framework for key populations.
      http://www.fhi360.org/sites/default/files/media/documents/linkages-hiv-cascade-framework-oct15.pdf.
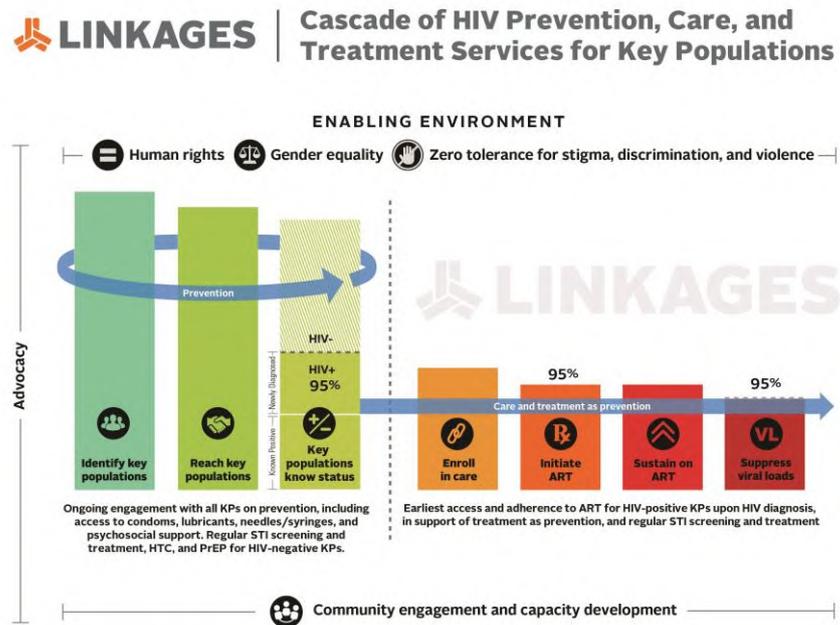
Figure 1. LINKAGES cascade framework

Health care providers play a unique and critical role in helping to meet the 95-95-95 goals, but unfortunately some hold stigmatizing, prejudicial, and discriminatory attitudes toward key populations. These negative attitudes create barriers that can deter access for key populations to the quality health care services that they need and to which they are entitled. LINKAGES is addressing stigma and discrimination at all levels of the cascade, including clinical services—hence, the development of this training guide.

What is the purpose of this training guide?

This training guide is designed to stimulate self-reflection among health care workers on their feelings about, and treatment of, key populations and to promote conversations between health care providers and their key population clients. The training aims to increase health care workers' empathy, clinical knowledge, and interpersonal skills in order to help them provide high-quality and comprehensive services for key populations free of stigma and discrimination.

Learning objectives

After this training, participants will be able to:

■ Articulate the importance of addressing the sexual and reproductive health and rights of key populations in response to HIV.

■ Better understand their own values and attitudes related to key populations and share insights into the stigma and discrimination encountered by key population members and their need for stigma-free and comprehensive services.

- Catalyze positive and inclusive changes in clinics to enable the provision of comprehensive and stigma-free services to key populations.

- Demonstrate refined clinical and interpersonal skills in responding to the needs of sex workers, men who have sex with men, transgender people, and people who inject drugs—including those who are young people.

- Show an enhanced understanding of the challenges unique to young key populations, at different ages, and how to provide services that are more youth-friendly.

- Identify and plan actions and share commitments to meeting the needs of key populations in their clinics.

Who is this training guide for?

This guide was written to support LINKAGES projects and is geared for experienced trainers of health care workers who already have a basic understanding of, and experience in, HIV service provision and are well-versed in training on sensitive topics using participatory, adult-learning methodologies. The training group (or participants) this guide is designed to serve is health care workers who have some knowledge and experience in HIV service provision.

You may adapt the training to respond to the needs of your training group, or to specific health priorities and the local context. Guidance on adaptation is provided throughout the document. For example, this guide has been adapted successfully as a training of trainers (TOT) in which participants trained are then charged with training others. If this is the case, then more discussion should be woven throughout on how to train on this content, as well as more information on practicing participatory learning and adult learning methodologies.

In addition, it is highly suggested that the training be conducted in partnership with local constituencies of sex workers, men who have sex with men, transgender people, and/or people who inject drugs and, if time and resources permit, asking representatives from the different constituencies to co-facilitate the training. If the training has an explicit and more detailed focus on providing services to young people, it would be helpful to plan for and include young people in the facilitation team. Another option is to rearrange one of the modules to include a panel discussion based on real experiences in the local context, as outlined below.

When working with co-facilitators and guest speakers, ensure that enough time is included for planning and discussing how you will work together. Having additional time for planning and preparation is particularly important if the language of facilitation is not the first language of all the facilitators, or if some members of the team are young people.

Clients may experience stigma or discrimination at any stage of their health care journey, so the training should include delegates from many different levels and designations in health care. For example, clinical staff (doctors, nurses), community-based workers (outreach workers, peer navigators, providers of peer support), and support staff (drivers, receptionists, administrators, managers) would all benefit from the training.

How to use this training guide

This training guide is divided into guidelines for facilitators, an introduction session, four modules, and a closing session, described below.

Guidelines for Facilitators

This section provides guidance and steps for developing and facilitating the training.

Key Resources

This section provides numerous references and resources used to develop this training that may be helpful for facilitators and participants.

Introduction Session

This session will introduce participants to the training and help participants get to know each other and reach agreement on the training objectives. Participants will fill out the pre-training questionnaire and, if relevant, will also fill out the LINK health care worker self-assessment.

Module 1: The Rationale for Services for Key Populations

This module introduces participants to key populations and explains why providing quality and comprehensive services for key populations is critically important in the response to HIV.

Module 2: Hearts and Minds: Quality Services for Key Populations

This module encourages participants to recognize and confront stigma and discrimination—including that experienced by key population members, or that experienced by participants, or where participants may have discriminated against others.

Module 3: Appropriate Services for Key Populations

This module reviews the priority clinical standards of care that are tailored to meet the unique needs of sex workers, men who have sex with men, transgender people, and people who inject drugs.

Module 4: Action, Change, Commitment

This module consolidates the commitments that are required of individuals, communities, providers, and facilities to address stigma and discrimination in health care settings.

Closing Session

This includes a question and answer portion, completion of the training evaluation, and participant completion of the post-training questionnaire.

Each module comprises several sessions. A set of PowerPoint slides is included for each session. Choose the sessions that are most relevant for your audience and adapt them as needed to suit the local context and key populations being served.

Closing Session

Guidelines for Facilitators[2]

This section outlines suggestions for developing the training team and the training to ensure that it runs smoothly and is effective. It outlines the training principles, learning objectives, logistics suggestions, a checklist, follow-up suggestions, and other design considerations. However, developing the *training strategy,* or the overarching strategies for who, when, and why to conduct these trainings to support HIV program goals and activities, is beyond the scope of these guidelines and should be addressed prior to developing the training.

Facilitation team

The ideal facilitation team should include the lead LINKAGES facilitator/organizer, a member of the LINKAGES country team, an HIV clinical expert, and representatives of key populations. The lead facilitator should ensure that co-facilitators are included in preparing the training and adapting the material for the local context. The lead facilitator should also ensure that the budget includes co-facilitators' expenses, such as time and travel costs.

If the training is to take place within a strong religious context, consider identifying a champion among local religious leaders who can speak out and provide community leadership to address stigma and discrimination among key populations. In some contexts, this may not be possible, and is only recommended if there is a true champion for inclusion and the rights of key populations.

Training principles[3]

The facilitation team should ensure that each training course is:

- *Locally relevant:* Use this training guide as a foundation and tailor the specific activities, case studies, and discussion points to best respond to the local context.

- *Self-reflective:* Ground each session in the contextual experience of participants (through facilitated reflection and sharing of experiences), and encourage critical and in-depth self-reflection.

- *Open and honest:* Establish a safe space and encourage open and honest dialogue—no question is silly.

- *Representative:* Model the ethos of LINKAGES by involving representatives from key populations as part of the training team, as co-facilitators, or as guest speakers in specific sessions.

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[2] Some of this section has been adapted from MSMGF and the Johns Hopkins School of Public Health. (2014). Promoting the Health of Men Who Have Sex with Men Worldwide: A Training Curriculum for Providers.
[3] Adapted from International HIV/AIDS Alliance. (2015). LINK UP 101 training guide.

■ *Practical:* Be grounded in the details of the HIV context and remain responsive to the specific needs of the participants.

■ *Ongoing:* Support health care workers in delivering quality health services for key populations beyond the context of the training.

Facilitation and training development tips

Know your topic

Choose relevant reading material from the reference list and read before you start the training. Ensure that you are comfortable with the terminology and confident using it with your participants. The key resources list available in this training guide is an excellent resource for additional learning.

Research and collect data on HIV prevalence among key populations in your country and use this information to develop supporting materials tailored to your local context. If local data are not available, refer to global data.

Be familiar with the local and national HIV prevention, treatment, and care policies and procedures, as well as laws and regulations related to sex work, same-sex relationships, drug use, gender identity, and provision of health services to minors. Familiarize yourself with guidelines issued by the World Health Organization (WHO) and the United Nations on HIV diagnosis, prevention, treatment, and care interventions and their delivery.

Know your audience

Although you can assume that the participants will be health care workers, community members, and clinic staff, participants will all have unique backgrounds, belief systems, and needs. Take the following factors into consideration when preparing the training:

■ Gender

■ Age

■ Race

■ Sexual orientation

■ Cultural/ethnic background

■ Level of education

■ Geographic region

■ Religion or spiritual practice

■ Previous experience with key populations

■ Skill level in delivering health care to key populations

■ The context in which the participants are working, including different models of service provision and different levels or roles within the health system

■ Specific key populations served by the participants

Prepare to talk about sensitive topics

You, as the facilitator, should be prepared to talk about potentially sensitive topics such as sexual health, sex work, sexual orientation and gender identities, sexually active young people, and sexual and drug-taking behavior. Examine your own beliefs and attitudes about these issues. Put aside any negative, preconceived notions. Serve as a role model by being accepting, inclusive, and nonjudgmental when facilitating discussions.

Learn to deal with hostility and negative emotions

Your participants might have some strong reactions to the information you present. Here are some useful tips to manage strong emotions:

- Establish ground rules so that productive discussions do not turn into heated arguments.

- Remind the group that discussions about stigma, discrimination, sex, HIV, and issues relating to key populations can bring up feelings of anger, hostility, disgust, and embarrassment for some people.

- Decide how the group can support each other: allow them to share feelings, take breaks, and/or talk to you or someone else privately.

- At the beginning of the training (i.e., before any difficult or heated conversations take place), establish a space for contentious conversations to be "parked" for later discussion. Heated conversations can become easier to discuss rationally once emotions have settled down.

It is important to acknowledge the range of emotional responses and opinions in the room, especially because a key component of this training is to engage with and transform the attitudes, beliefs, and behaviors that fuel stigma.

Participants should all be referred to the code of conduct produced by the International AIDS Society: A code of conduct for HIV and health professionals: strengthening human rights approaches to health. International AIDS Society (2014):
https://www.iasociety.org/Web/WebContent/File/2014__KAPs__Code_of_co nduct.pdf

There are nine guiding principles outlined in the code of conduct:
1. Know your human rights responsibilities
2. Respect dignity
3. Benefit from scientific progress
4. Access to justice
5. Know your epidemic, know your response
6. Meaningful participation
7. Education
8. Monitoring and evaluation
9. Accountability

These principles are useful for all providers and can form the basis of the discussions regarding commitments and action for change in later sessions (see Module 4).

Bring in guest speakers

Invite members of key populations (adult and youth) to attend the training as guest speakers (in addition to having them serve on the facilitation team) whenever possible. They can speak firsthand about how violence, stigma, and discrimination affect their lives and access to services. By sharing varied perspectives, you are also modeling the diversity that exists within different key populations, as well as among different groups according to age, gender, livelihood, wealth or poverty, sexual orientation, and HIV status.

Other guest speakers could include nurses, doctors, and other clinical staff who have direct experience providing services to key populations or making referrals to services. These speakers could give first-hand examples of how they have transformed their own attitudes and addressed stigma within their health care setting. They could also offer advice to their peers about making the same changes in different clinical contexts.

In working with guest speakers:

- Ask guest speakers and trainers to attend a pre-training meeting to discuss logistics, roles, and responsibilities.

- Ensure that they are briefed adequately about what is expected of them, for example, through conversation and a written document. Include enough time for them to ask questions.

- Remind them to adhere to the workshop's ground rules and guidelines around confidentiality.

- Reimburse them for any travel costs and/or their time.

- Provide guidelines that specify the content to be covered, the methodology to be used, and amount of time they will have to present.

- Remain present during the session to provide continuity if any issues arise and to observe and provide useful feedback to the external trainer/guest speaker.

Allow extra time for guest speakers who are young people and/or who may not be fluent in the primary language of the training (and/or the language spoken by facilitators) to understand the agenda, expectations, audience, and key terminology so that they are well prepared for the discussion.

Similarly, be sure to inform participants about the nature of the session well in advance and ensure that they are respectful and open-minded in receiving all the panelists. Advise the participants to avoid using acronyms or jargon and remind them of the importance of creating a safe space.

For guest speakers who are young people, it is desirable to invite more than one so that they do not feel alone in representing the perspectives of young people.

Determine how LINK or other monitoring for service quality content will be covered

LINK is a service quality monitoring system that can be implemented using paper-based forms or with the use of various technologies such as SMS (text messaging) or online survey tools (i.e., Survey Monkey or Facebook Messenger). With LINK, health workers will complete short self-assessments related to service provision for key populations. In addition, key population members are also asked to complete short assessments related to their recent experiences at a health facility. Information gathered through LINK is then analyzed and the data and findings are shared and used for targeted programming to improve the quality of services for key populations, and ultimately increasing accessibility of key-population friendly services.

LINK is incorporated into this training guide because many LINKAGES countries are rolling out and using LINK (formally known as SMS[2]) to help monitor and improve the availability of quality, key population friendly services. LINK data can also be used to understand the outcomes of Health4All health worker trainings over time, including health care workers' change in behavior and changes to the quality of services as reported by key population members. This training guide includes an orientation to LINK (see Introduction) and will enable health care workers trained in LINK to use LINK assessments to improve service quality (see Session 4.3).

It's important to adapt training content on LINK to the needs of your project. LINK can be implemented before, during, or after Health4All trainings. Where a LINKAGES project is at in its stage of LINK "readiness" for implementing LINK will greatly influence how LINK should be covered in this training. The following should help you consider your project's readiness regarding LINK and how to further adapt LINK content for this training:

- **Go! –** *Your project is already using LINK:*
  - You should review and use existing LINK data and dashboards prior to the training to assess current trends and needs by health care workers and at the facility-level to further refine and tailor your training to meet these needs.
  - If health care workers have not already completed LINK self-assessments, they will have an opportunity to do so during the training Introduction.
  - You will need to adapt content on LINK covered in the training to be more advanced if participants are already familiar with LINK. It is suggested that more time is spent, for example, on data analysis and use (see Session 4.1 and 4.2).

- **Ready! –** *Your project would like to use LINK and is strongly considering it. This training may be the launch or beginning of using LINK.*

- The content in this training guide is well-suited for this stage of readiness, although minor adaptations may be necessary.
- It is especially important for the health care workers trained during the Health4All training to take the self-assessment questionnaire at the beginning and end of the training as this can provide valuable data to gauge changes in time related to stigma and discrimination of health care workers who have participated in the training.
- To ensure LINK is appropriate to your context, you may want to adjust or adapt the LINK questionnaires provided as handouts.
- You may need extra support and guidance on implementing LINK. Please contact LINKAGES program management staff for additional tools or support.

■ **Not ready!** – *Your project is not planning to use LINK and/or is not ready to consider using LINK.*
  - The LINK content should be excluded from the training and replaced with activities and discussion that reflect current practices and future expectations of providers in monitoring and improving services.

After the training

A successful training ensures that information and knowledge gained by participants can be successfully applied *after* the training. That is why Module 4: Action, Change, Commitment is an important part of the training and all participants should receive copies of the handouts and PowerPoint presentations covered. It's also important to plan for activities that should take place after the training. Here are few guiding questions that can help in developing the follow-up plans after the training:

■ What do you anticipate participants will do after the training? How will they be supported to enact their action plans?

■ Who is not able to attend the training that should attend? Who are the other gatekeepers or key influencers who could benefit from the training? How can they be engaged moving forward?

■ What is the most important information that should be shared in the training report? For example, are you interested in capturing the key themes, actionable points, and/or sharing specific details of each activity? This will depend on how the report will be used and by whom.

■ How are LINKAGES projects currently involved in the monitoring and quality improvement of services? How should LINKAGES be involved after the training? See the previous section for more about LINK as a quality-monitoring tool.

Planning logistics
Choose an appropriate venue[4]

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[4] Adapted from International Planned Parenthood Federation. HIV Works, How to bring your HIV workplace policy to life: an IPPF facilitator's guide for HIV training in the workplace, 2013.

The learning environment is very important to the learning process, so carefully consider the venue you select. Ideally, you want a meeting room where you will not be disturbed during the training and one that has natural light and adjustable heating or air conditioning to maintain a comfortable room temperature.

It is good practice to arrange the room with chairs and tables in small groups of three to five people so that participants can work together and to encourage participation and discussion. Aim for a minimum of three groups, although four or more is better.

Try to ensure that there is cell phone reception in the venue on major mobile network providers, and a Wi-Fi internet connection. In establishing the ground rules for the training course, set clear expectations about use of internet, email, laptops, etc.

Secure all necessary training materials and equipment[5]

The following is a list of the basic training materials and equipment that you will need:

- A laptop and projector to show the PowerPoint slides and videos
- Access to the internet
- Flip charts
- Note pads
- Marker pens
- Post-it notes
- Blank cards
- Crayons or colored pencils
- Sticky tape
- Question box

Facilitator's checklist

Two months before the workshop:
- ❑ Identify the date of the workshop.
- ❑ Communicate with supervisors of potential participants to secure their support for the training. Supervisors must also be willing to allow participants to be released from their usual duties to attend the training.
- ❑ Send invitations for the training.
- ❑ Reserve the training venue.
- ❑ Arrange for breaks and meals, if necessary.

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[5]   Adapted from HIV Works, How to bring your HIV workplace policy to life: an IPPF facilitator's guide for HIV training in the workplace, 2013.

❑ Identify any additional personnel support you will need (e.g., logistics, administrative, co-facilitators).

❑ With co-facilitators, review training design and refine learning objectives, activities, checklists, pre/post-assessment questionnaires, action plan forms, supporting visual aids, training evaluation forms, and facilitation notes. Modify the material and agenda as needed for the specific group of participants and local context. Allocate training responsibilities among co-facilitators.

❑ Prepare any needed administrative forms, such as a participant roster.

❑ Gather up-to-date on information about key populations and HIV in your country/region; for example, save newspaper articles on the subject.

❑ Consult with community members and organizations to learn more about the local context.

❑ Identify and secure guests, if relevant, for sessions such as the training's opening, discussions with members of key populations, panels of experts, etc.

❑ Communicate with participants about the workshop overview, any advance reading, contact information, training venue, and lodging arrangements, as needed.

❑ Order supplies for the training.

❑ Develop follow-up plans from the training, including how to report on the training outcomes and monitor changes as a result of the training (see the Overview section for more about follow up)

❑ If implementing LINK (formerly SMS2) or interested in LINK: Familiarize yourself with LINK by meeting with a LINK point-person on the LINKAGES team, reading session 4.1, and getting relevant information about the rollout of LINK in the country. If LINK data are already available, obtain and use those data (including copies of facility dashboards) to demonstrate to participants how this tool can be used to monitor and improve quality of care.

One week to a few days before the training:

❑ Visit the training venue to make sure arrangements are in order and to check on logistics (e.g., fire exits, toilets, Wi-Fi, lunch area).

❑ Gather supplies and equipment for your activities (note pads, pens, LCD projector, laptop, flip chart paper and easels, and markers).

❑ Make sure slides and other visuals are finalized and legible.

❑ Print handouts, participant roster and other accompanying materials; assemble packets of information for participants.

❑ Make a final list of participants and any information you have about them.

❑ Confirm any guest speakers.

The day of the workshop:

❑ Arrive early.

❑ Adjust the room's temperature to a comfortable level, if possible.

❑ If using the venue's Wi-Fi, obtain the password.

❑ Set up electronic devices for the workshop and make sure everything works!

❑ Make final adjustments to the room's configuration, if needed.

❑ Set up a table with facilitator and participant materials and supplies.

❑ Greet each person as they arrive and ask them to sign the participant roster.

Summary of Modules and Sessions

Introductory Session and Pre-training Questionnaire

Module 1 – The Rationale for Services for Key Populations

Session 1.1: Know your epidemic (30 minutes)
Session 1.2: Why focus on key populations? (30 minutes)
Session 1.3: Gender and social norms (90 minutes)
Session 1.4: Substance use (45 minutes)
Session 1.5: Violence, key populations, and human rights (30 minutes)

Module 2 – Hearts and Minds: Quality Services for Key Populations

Session 2.1: Beliefs about key populations (60 minutes)
Session 2.2: Our own values, judgments, and opportunities to challenge stigma (60 minutes)
Session 2.3: Forms, causes, layers, and effects of stigma (60 minutes)

Module 3 – Appropriate Services for Key Populations

Session 3.1: Top 10 clinical standards of care for key populations (120 minutes)
Session 3.2: Providing youth-friendly services to key populations (120 minutes)
Session 3.3: Performing a risk assessment (120 minutes)
Session 3.4: Suggested session: Panel discussion (60–90 minutes)

Module 4 – Action, Change, Commitment

Session 4.1: Monitoring service quality using LINK (35 minutes)
Session 4.2: Creating a key-population-friendly clinic (120 minutes)
Session 4.3: Planning for action in your health facility (90 minutes)

Closing Session

Questions and answers, workshop evaluation, post-training questionnaire, and closing (90 minutes)

Sample Training Agenda

This training guide has been developed in such a way that facilitators can pick and choose sessions that are most relevant for their participants, learning objectives, training strategy, and the amount of time and resources available. For example, if most clients whom health care workers serve are sex workers, then create a training agenda that incorporates the sessions that focus on sex workers. If your participants have already received training on stigma and discrimination, then create a training agenda that focuses on the clinical components of serving relevant key populations.

Below is a sample four-day training agenda, which should be tailored for participants' training needs.

DAY 1

Time	Topic	Module/Session
8:45 – 9:00	Facilitators meeting – set up	
9:00 – 10:30	Welcome, introductions, and pre-training questionnaire	Introductory session <u>Pre-training questionnaire</u>
10:30 – 11:00	Know your epidemic LINKAGES presentation	Module 1: Session 1.1
11:00– 11:30	Why focus on key populations?	Module 1: Session 1.2
11:30 – 11:45	TEA BREAK	
11:45 – 13:15	Sexual orientation and gender identity	Module 1: Session 1.3
13:15 – 14:00	LUNCH BREAK	
14:00 – 14:45	Substance use	Module 1: Session 1.4
14:45 – 16:15	Violence, key populations, and human rights	Module 1: Session 1.5
16:15 – 16:30	TEA BREAK	
16:30 – 17:30	Beliefs about key populations	Module 2: Session 2.1
17:30 – 17:45	Closing summary and reflection	
17:45 – 18:00	Facilitators' meeting	Prep Day 2

DAY 2

Time	Topic	Module/Session
8:45 – 9:00	Facilitators' meeting – set up	
9:00 – 9:30	Welcome, summary of previous day, and agenda for today	
9:30 – 10:30	Our own values, judgments, and opportunities to challenge stigma	Module 2: Session 2.2

10:30 – 10:45	**TEA BREAK**	
10:45 – 11:45	Forms, causes, layers, and effects of stigma	Module 2: Session 2.3
11:45 – 13:00	Top 10 clinical standards of care for key populations	Module 3: Session 3.1
13:00 – 14:00	**LUNCH BREAK**	
14:00 – 15:00	Top 10 clinical standards of care for key populations (continued)	Module 3: Session 3.1
15:00 – 15:30	**TEA BREAK**	
15:30 – 17:30	Providing youth-friendly services for key populations	Module 3: Session 3.2
17:30 – 17:45	Closing summary	
17:45 – 18:15	Facilitators' meeting	Prep Day 3

DAY 3

Time	Topic	Module/Session
8:45 – 9:00	Facilitators' meeting – set up	
9:00 – 9:30	Welcome, summary of previous day and agenda for today	
9:30 – 10:30	Performing a risk assessment	Module 3: Session 3.3
10:30 – 11:00	**TEA BREAK**	
11:00 – 12:00	Performing a risk assessment (continued)	Module 3: Session 3.3
12:00 – 13:00	Suggested session: panel discussion	Module 3: Session 3.4
13:0 – 14:00	**LUNCH**	
14:00 – 14:30	Monitoring service quality using LINK	Module 4: Session 4.1
14:30 – 16:30	Creating a key-population-friendly clinic	Module 4: Session 4.2
16:30 – 17:00	**WORKING TEA BREAK**	
17:00 – 17:15	Closing summary	
17:15 – 17:45	Facilitators' meeting	Reflection and evaluation

DAY 4

Time	Topic	Module/Session
8:45 – 9:00	Facilitators' meeting – set up	
9:00 – 9:30	Welcome, summary of previous day and agenda for today	
9:30 – 11:00	Planning for action in facilities	Module 4: Session 4.3
11:00 – 11: 30	**WORKING TEA BREAK**	
11:30 – 12:00	Final questions and answers	Closing session
12:00 – 13:00	**LUNCH**	
13:00 – 13:30	Post-training questionnaire and workshop evaluation	Closing session
13:30 – 14:00	Final summary and closing	
14:00 – 14:30	Facilitators' meeting	Reflection and evaluation

Key Resources

Below are the key resources that have informed this training guide. You may decide to add this as an additional handout for participants. These resources can provide more details about reducing stigma and discrimination for key populations in a health care setting, as well as more specific information on the different communities of key populations.

Key populations

WHO. (2014). HIV prevention, diagnosis, treatment and care for key populations: consolidated guidelines.
http://www.who.int/hiv/pub/guidelines/keypopulations/en/

International AIDS Society. (2014). Code of conduct for HIV and health professionals: strengthening human rights based approaches to health.
https://www.iasociety.org/Web/WebContent/File/2014__KAPs__Code_of_conduct.pdf

Global Fund. (2014). Key populations action plan 2014–2017.
https://www.theglobalfund.org/media/1270/publication_keypopulations_actionplan_en.pdf

FHI 360. (2015). HIV cascade framework for key populations.
http://www.fhi360.org/sites/default/files/media/documents/linkages-hiv-cascade-framework-oct15.pdf

U.S. Centers for Disease Control (CDC). (2014). Providing key-population-friendly services: a sensitivity training for health care workers. (not available online)

Young people and providing youth-friendly services

Making health services adolescent friendly: developing national quality standards for adolescent friendly health services.
http://apps.who.int/iris/bitstream/10665/75217/1/9789241503594_eng.pdf?ua=1

Advocates for Youth. Best practices for youth friendly clinical services.
https://www.advocatesforyouth.org/storage/advfy/documents/bp-youth-friendly-services.pdf IPPF. (2012). Keys to youth-friendly services: understanding evolving capacity.
http://www.ippf.org/sites/default/files/key_evolving_capacity.pdf

Link Up. (2016). Aiming high: 10 strategies for meaningful youth engagement.
http://www.athenanetwork.org/assets/files/Link%20Up%20mentoring%20programme/Aiming%20High_ENG_HiRes.pdf
International HIV/AIDS Alliance. (2015). Workshop guide: safeguarding the rights of children and young people.

http://www.aidsalliance.org/resources/480-safeguarding-the-rights-of-children-and-young-people

Sex workers

WHO. (2015). Technical brief on HIV and young people who sell sex.
http://www.who.int/hiv/pub/toolkits/hiv-young-sexworkers/en/

WHO, UNFPA, UNAIDS, NSWP, World Bank, UNDP. (2013). Implementing comprehensive HIV/STI programs with sex workers: practical approaches from collaborative interventions.
http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1

WHO, UNFPA, UNAIDS, NSWP. (2012). Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries: recommendations for a public health approach.
http://apps.who.int/iris/bitstream/10665/77745/1/9789241504744_eng.pdf?ua=1

Global Network of Sex Work Projects (NSWP).
http://www.nswp.org

Global Network of Sex Work Projects (NSWP). (2016). Policy brief: young sex workers.
http://www.nswp.org/resource/young-sex-workers

Men who have sex with men

UNFPA, Global Forum on MSM and HIV, UNDP, UNAIDS, WHO, USAID, PEPFAR, Bill & Melinda Gates Foundation. (2015). Implementing comprehensive HIV and STI programs with men who have sex with men: practical guidance for collaborative interventions.
http://www.who.int/hiv/pub/toolkits/msm-implementation-tool/en/

WHO. (2015). Technical brief: HIV and young men who have sex with men.
http://www.who.int/hiv/pub/toolkits/hiv-young-msm/en/

PEPFAR. (2011). Technical guidance on combination HIV prevention for men who have sex with men.
http://www.pepfar.gov/documents/organization/164010.pdf

Global Forum on MSM and HIV.
http://msmgf.org

Transgender people

WHO. (2015). Policy brief: transgender people and HIV.
http://apps.who.int/iris/bitstream/10665/179517/1/WHO_HIV_2015.17_eng.pdf?ua=1&ua=1
WHO. (2015). Technical brief on HIV and young transgender people.
http://www.who.int/hiv/pub/toolkits/hiv-young-transgender/en/

Center of Excellence for Transgender Health.
http://transhealth.ucsf.edu

The TRANSIT, a guide to implement HIV/STI programs with Transgender people.
http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html

People who inject drugs

WHO. (2015). Technical brief on HIV and young people who inject drugs.
http://apps.who.int/iris/bitstream/10665/179865/1/WHO_HIV_2015.10_eng.pdf

PEPFAR. (2010). Comprehensive HIV prevention for people who inject drugs, revised guidance.
http://www.pepfar.gov/documents/organization/144970.pdf

International Network of People Who Use Drugs.
http://www.inpud.net

Introduction Session[6]

Time: 90 minutes

Materials

- Post-it notes
- Marker pens
- Flip chart
- Blank cards
- Question box
- Handout 0: Participant sign-in sheet
- Handout 1: Pre-training questionnaire
- Handout 2: Health care worker LINK self-assessment

Learning objectives

After completing this session, participants will be able to:

- Introduce other participants in the training
- Describe their expectations of the training and understand how those align with the training objectives
- Briefly explain the use of the LINK system to monitor quality of services (if applicable)

Trainer preparation

Make copies of Handouts 0, 1, and 2 for participants.

Before the session, write the core principles and ground rules for the training on a piece of flip chart paper. Some suggestions include:

- Keep to the times on the agenda.
- Participate.
- Agree to disagree.
- Respect others.
- Wait for your turn to speak.
- Ask questions—there are no stupid questions.
- Give honest feedback.
- Do not use laptops during the training.

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[6] Adapted from International Planned Parenthood Federation. HIV works, how to bring your HIV workplace policy to life: an IPPF facilitator's guide for HIV training in the workplace, 2013.

■ Turn off mobile phones or put in silent mode, and do not answer calls while in the room.

Activities

Activity 1: Welcome and introduction (40 minutes)

■ Officially open the training with a greeting by the local head of LINKAGES and/or another suitable senior representative from one of the partner organizations. The main purpose of this opening is to welcome the group and describe why the training is an important and integral component of LINKAGES (i.e., link to project deliverables, PEPFAR goals, partner priorities in country, etc.). The opening should frame the training in terms of its relevance to the project and inspire and motivate participants. (10 minutes)

■ Welcome participants to the training session and introduce yourself and your co-facilitators. (5 minutes)

■ Ask participants to introduce themselves by stating their name, their position, and the organization/clinic they represent. (15 minutes)

■ Ask participants to pair up and discuss their experience in areas relevant to the training. Next, after a few minutes, ask each pair to share something from their conversation that will be interesting to the rest of the participants and relevant to the training. (10 minutes, including feedback)

Activity 2. Training expectations and learning objectives (10 minutes)

■ Ask participants to write on post-it notes their expectations of the three-day training course. Ask them to also write any questions they may have about key populations on the blank cards.

■ Then invite participants to stick their post-it notes onto the flip chart and to put the cards in the question box at the front of the room.

■ Once participants have put up their post-it notes, group the expectations that are the same or similar. Keep the post-it notes up so that you can refer to the expectations when you talk about the learning objectives of the training.

■ Once everyone has sat down again, review the training's learning objectives and which expectations the training will, or will not, be able to meet. Mention that you will return to the question box later in the session.

Facilitation tip

Responding to participants' expectations

When reviewing the learning objectives for the training, you can respond to participants' expectations by saying things like, "I see some of the

expectations have been about (xyz) and we can cover those. Given the time constraints, unfortunately we will not be able to meet (abc) expectations. We can address some of those at the end if there is extra time, and we can see if we can schedule another training in the future to focus on those issues."

Activity 3. Principles and ground rules (10 minutes)

As you introduce this session, put up the flip chart paper on which you wrote ground rules.

Explain that the training is built on core principles of **S**ensitivity, **O**penness, **U**nderstanding, and **L**istening (SOUL).

Sensitivity—remind participants to be mindful that some people in the group may be living with HIV or may represent a member of a key population.
Openness—encourage participants to be open and honest about their own beliefs, perceptions, and experiences and to be open to new ideas.
Understanding—emphasize that the training focuses on creating understanding about key populations and how to provide accessible, stigma-free, quality services.
Listening—ask participants to listen to and respect each other's differences and opinions, because there may be lots of varied opinions about key populations.

Discuss the ground rules for the training and ask participants whether they agree with them or want to add others. Ask participants to help you adhere to the principles and ground rules throughout the training. For example, if someone is not participating, ask others to encourage them to do so.

Facilitation tip
Establishing ground rules
Remember, facilitators set the tone! Respect the principles and ground rules yourself and lead by example. Make sure that you listen to participants and that you are sensitive, open, and respectful when answering questions or responding to differences of opinion. If staying on time is a rule, then finish your sessions promptly. However, if group sessions are taking more time than planned and risk running over, ask participants if they would prefer to continue, or to rearrange, the sessions.

Activity 4. Pre-training questionnaire (15 minutes)
Distribute *Handout 1: Pre-training questionnaire,* and give participants 15 minutes to complete it and then return it to you. Explain that the questionnaires are anonymous and that they should not write their name on them. However, ask them to develop unique identifiers to help analyze the training results. Instructions for creating a unique identifier are included on the questionnaire.

Activity 5. Orientation on the LINK service quality monitoring system and initiate health care worker self-assessment (15 minutes)

This activity for LINKAGES projects who are or are planning to implement LINK. If there are no plans to use the data collected from the LINK self-assessment after the training, it is suggested that you do not conduct this activity and greatly modify the session. See the "Guidelines for Facilitators" section for more details.

- Explain to participants that they will now complete a self-assessment using a LINK questionnaire. Inform participants that the self-assessment is anonymous and confidential. The results will help participants in the last module of the training when they identify issues for improving the quality of services at the facility level. The self-assessment will ask a series of questions to assess participants' knowledge, attitudes, and practices related to stigma and discrimination that can affect quality of health services for key populations.

- Administer the self-assessment via a paper-based form (Handout 1) or using a virtual technology developed prior to this training (such as SMS, Survey Monkey, etc.). For example, if using SMS, the assessment questions will be sent directly to the participant's phone and they can reply to them with an SMS response.
  - To obtain specific directions for how to administer LINK, you should work with the LINKAGES staff responsible for implementation of LINK in your country. Even if participants take the survey virtually, it is suggested that you give them a paper-based form for their reference.

- Thank participants for being candid and thoughtful in their responses to the LINK questionnaire. Let them know that many of the types of stigma and discrimination mentioned in the questionnaire will be talked about more in the coming modules.

Module 1

The rationale for services for key populations

"Being seen does have value. A voice does have value. I have the support of my boyfriend, my great friends, and my loving parents. Many do not and this is, in part, for them."— Ji Wallace (HIV-positive Olympian accepting the silver medal)

At a glance

This module provides an opportunity for participants to learn the facts about key populations and to dispel myths and misconceptions they may have about sex workers, men who have sex with men, transgender people, and people who inject drugs. It sets the foundation for the modules that follow, in which participants will be encouraged to reflect on a personal level about their experiences and to explore their values and attitudes toward providing services to members of key populations.

Sessions

Session 1.1: Know your epidemic
Session 1.2: Why focus on key populations?
Session 1.3: Sexual orientation and gender identity
Session 1.4: Substance use
Session 1.5: Violence, key populations, and human rights

Handouts

Handout 3: Genderbread person: sexual orientation and gender identity
Handout 4: Key terms
Handout 5: Questionnaire—sexual orientation and gender identity

Learning objectives

After completing this module, participants will be able to:

- Define the term "key populations" and articulate why providing health services for key populations is critical to an effective response to HIV

- Explain the differences within and between key populations, including differences among age groups for each of these key populations, and how to tailor services appropriately to respond to the needs of sex workers, men who have sex with men, transgender people, and people who inject drugs

- Use correct and appropriate terminology regarding key populations

- Describe the difference between gender, sex, and sexual orientation

- Explain how key populations may experience violence and abuse and how this affects their health

Key messages

- All people are entitled to receive quality, comprehensive sexual and reproductive health (including HIV) services.

- Tailoring outreach and service provision to meet the diverse needs of sex workers, men who have sex with men, transgender people, and people who use drugs is essential in the response to HIV in every context around the world.

- There is an increased risk that young people within the different key populations are not receiving the services they need. This is because health/HIV programs aimed at key populations often fail to address the needs of young people/adolescents, and generic youth HIV services may not address the specific needs of young people exploring their sexual orientation or gender identity.

- Stigma, discrimination, and punitive legal environments continue to create barriers to service access for key populations.

- Health care providers can be champions in the community and create positive change within their facilities to enable key populations to access stigma-free, quality, and comprehensive health services.

- Many people from key populations engage in more than one high-risk behavior (e.g., injecting drugs and sex work, or a man who has sex with other men who also injects drugs). Even if health care providers do not agree with certain behaviors, they are still responsible for delivering quality and stigma-free care.

- Gender norms and inequalities, violence, and abuse affect health outcomes for all people.

Additional resources

Violence prevention and response training curriculum for health care workers and other direct service providers. (2017). (Available for LINKAGES programs). Contact Robyn Dayton at rldayton@fhi360.org.

WHO. (2016). Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.
http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/

PEPFAR. (2012). PEPFAR blueprint: creating an AIDS-free generation.
http://www.pepfar.gov/documents/organization/201386.pdf

Bridging the Gaps. (2013). Key populations in the driver's seat–on the road to universal access to HIV prevention, treatment, care and support.
http://www.hivgaps.org/

Center of Excellence for Transgender Health
http://transhealth.ucsf.edu/

Global Network of Sex Work Projects–Promoting Health and Human Rights
http://www.nswp.org/

Global Forum on MSM & HIV (MSMGF)
http://www.msmgf.org/

International Network of People Who Use Drugs
http://inpud.net/

Session 1.1: Know your epidemic[7]

Time: 30 minutes

Materials

- Laptop and projector to show presentation
- Copies of the Session 1.1 PowerPoint presentation for participants

Learning objective

After completing this session, participants will be able to explain the dynamics of the HIV epidemic within their country and community contexts.

Trainer preparation

Prepare a presentation about the HIV epidemic in the context where you are holding the training. This will require customizing or adding to the existing PowerPoint presentation. To develop the presentation, review relevant national strategic plans (for prevention, HIV, key populations) and the UNAIDS *Know Your Epidemic* resources for the country where the training is taking place. Include discussion of the structural elements and other factors that relate to the global burden of HIV among key populations. Make copies of the presentation and any other supplementary materials you want to give to participants regarding the epidemiology.

Facilitation tips

- When time is limited, Sessions 1.1 and 1.2 can be combined.
- Be well prepared and knowledgeable about current HIV epidemiology in the country/community where the training is taking place.
- Be sure to focus on information about HIV and specific key populations, even if situated within a generalized HIV context.
- Clarify definitions of key populations, how they are specific communities of people as well as part of the "general" population.
- Know where to refer people for more information (e.g., UNAIDS, national policies, UNDP)

Introduction

Tell participants that in this session you will review current trends and priorities in the national response to HIV. Participants will discuss the latest prevalence information and identify populations that are most vulnerable to and at risk of contracting HIV.

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[7] Adapted from International HIV/AIDS Alliance. (2015). Sexual and reproductive health and rights, and HIV 101 workshop guide.

Activities

Activity 1: Show a presentation that explains the current HIV dynamics in the context where the training is taking place. (10 minutes)

Cover the following information:

■ HIV prevalence (by gender and age) and among specific key populations (i.e., sex workers, men who have sex with men transgender people, and people who inject drugs, and also by age within these groups, if possible). Be mindful of differences between young people who are members of key populations compared with older members of key populations.[8]

■ Relevant national laws and policies that affect the response to HIV, including national strategies and guidelines for providing services to key populations, and any policies or laws that restrict services based on age or provide guidance for youth-friendly services. Introduce structural elements and other factors related to the global burden of HIV among key populations (i.e., poverty, age, social exclusion, power, and gender inequality).

Sources of information could include UNAIDS country reports, GAP reports, UNGASS country reports, national strategies, WHO resources, and UNDP legal environment assessments, as well as civil society monitoring and reporting where that exists.

Activity 2: Brainstorm about the following questions with the group and write their responses on a flip chart. (15 minutes)

■ What are the main factors contributing to the HIV epidemic in your country?

■ Are these similar to other sexual and reproductive health (SRH) issues, like unintended pregnancies and sexually transmitted infections (STIs)?

■ Which communities get to benefit from your services and programs?

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[8]   See for example:
WHO. (2016). Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/
WHO. (2015). HIV and young people who inject drugs: a technical brief. Inter Agency Working on Key Populations. http://www.unfpa.org/sites/default/files/pub-pdf/WHO_HIV_2015.9_eng.pdf
WHO. (2015). HIV and young people who sell sex: a technical brief. Inter Agency Working on Key Populations. http://www.unfpa.org/sites/default/files/pub-pdf/WHO_HIV_2015.7_eng.pdf
WHO. (2015). HIV and young men who have sex with men: a technical brief. Inter Agency Working on Key Populations. http://www.unaids.org/sites/default/files/media_asset/2015_young_men_sex_with_men_en.pdf
WHO. (2015). HIV and young transgender people: a technical brief. Inter Agency Working on Key Populations. http://www.unaids.org/sites/default/files/media_asset/2015_young_transgender_en.pdf
IPPF. (2012). Keys to youth-friendly services: understanding evolving capacity. http://www.ippf.org/sites/default/files/key_evolving_capacity.pdf

- Are some services more available than others for different key populations? Why?
- Are quality services available to key populations? If not, why not?
- Do key populations access services?
- Are quality services available to young people?
- Do young people from key populations access services?
- Why should we work with key populations?

Summarize by checking whether there are services available that are tailored to specific groups:

- People living with HIV
- Men who have sex with men
- People who inject drugs
- Sex workers
- Transgender people
- Young people

Wrap-up (5 minutes)

End by summarizing the key points of the presentation and discussion. Explain that certain populations are at higher risk of HIV transmission and that this means they are also essential partners in an effective response to HIV.

Session 1.2: Why focus on key populations?

Time: 30 minutes

Materials

- Laptop and projector to show presentation
- PowerPoint Presentation Module 1
- Copies of PowerPoint Presentation Module 1 for participants
- Flip chart paper
- Markers
- Blank cards
- Tape

Learning objective

After completing this session, participants will be able to articulate how addressing the health needs of key populations with high-quality care and support is critical to HIV prevention.

Trainer preparation

Review and familiarize yourself with the following information in the slides for Session 1.2:

- A definition of key populations
- An explanation of why they are called key populations
- A review of the points made in Session 1.1 about why key populations are vulnerable to HIV, and the rationale for focusing on structural and behavioral risk factors
- Data showing HIV prevalence for each of the key populations compared to the general population
- A review of specific human rights and constitutional laws that affect aspects of the response to HIV and different key populations
  The International AIDS Society Code of Conduct for HIV and Health Professionals

Facilitation tip

When time is limited, Sessions 1.1 and 1.2 can be combined.

Introduction

Tell the participants that UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people, and people who inject drugs as the four main key populations, but it acknowledges that prisoners and other incarcerated people also are particularly vulnerable to HIV and frequently lack adequate access to services. Countries should define the specific populations that are key to their epidemic and response based on the

epidemiological and social context. Key populations are distinct from vulnerable populations, which are subject to societal pressures or social circumstances that may make them more vulnerable to exposure to infections, including HIV.[9]

Explain that key populations are highly affected by HIV around the world. Even within generalized epidemics, like in sub-Saharan Africa, HIV prevalence is substantially higher among key populations. This session aims to raise awareness about the importance of providing HIV prevention, care, and treatment services to key populations if we are to control the HIV epidemic.[10]

Activities

Activity 1: Define key populations and discuss their vulnerability to HIV (20 minutes)

Step 1: (10 minutes) Ask participants to write down the following on separate blank cards:

- Their definition of key populations
- Why key populations are vulnerable to HIV

While participants are doing this, write the following risk factors on blank cards: "biomedical," "structural," and "behavioral." Tape them on the wall in three separate spots.

Tell them that as defined by the U.S. Centers for Disease Control and Prevention (CDC), determinants of health are **factors that contribute to a person's current state of health.** The determinants of health include the range of behavioral, biological, socioeconomic, and environmental factors that influence the health status of individuals or populations. Scientists generally recognize five determinants of health of a population:

- Biology and genetics. Examples: sex, age, and family history.
- Individual behavior. Examples: alcohol use, injection drug use (needles), unprotected sex, smoking, sexual orientation, and gender identity.
- Social environment. Examples: discrimination, income, sexual orientation, and gender identity.
- Physical environment. Examples: where a person lives, population density, modes of transport.
- Health services. Examples: Access to quality health care and having or not having health insurance.

See https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html for more information.

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9   UNAIDS. (2015). Terminology guidelines.
     http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf
10   amfAR. (2013). Tackling HIV/AIDS among key populations: essential to achieving an AIDS-free generation.

Explain that for this activity,

- Biomedical = medicine and biology for health care and public health

- Structural = social and physical environment, including systems and institutions that can influence health inequities and access to services, such as the social environment, income, physical environment, health service institutions and models of service delivery, laws and policies, and other social norms

- Behavioral = individual behaviors that affect health outcomes such as testing, adherence, practicing sexual practices that mitigate HIV risk, or injecting behaviors using a harm reduction approach.

Step 2: (10 minutes) Ask participants to tape their "why key populations are vulnerable to HIV" cards on the wall, under the proper risk factor. Give participants time to read each other's answers.

Activity 2: Present the session 1.2 slides. (10 minutes)

Allow time for questions and discussion after the presentation and then go back to the responses written on the cards and correct any inaccuracies or misconceptions about key populations.

Key messages

These are the key messages that should be conveyed for participants throughout the session activities and discussion. Be sure to wrap up the session by reinforcing these messages (also listed in the Module 1 PowerPoint).

- Reinforce that human rights apply to everyone, equally, regardless of gender, age, sexual orientation, means of earning a living, sexual practices, drug use, and any other behaviors. Human rights are universal.

- Remind the participants that because key populations have the same human rights as everyone else, health care providers have the duty to provide quality and appropriate services to key populations, as they do for all their clients.

- Emphasize that it is impossible to fully address HIV in any community without also taking into consideration the needs of key populations. Sex workers, men who have sex with men, transgender people, and people who inject drugs are not segregated from the rest of our communities. They are active members of society.

- Remind participants that "key populations" is a public health term. Among non-public-health specialists, it is better to be clear about which specific groups they are referring to. However, not all members of key populations identify with labels such as "sex workers"—this is especially true for those who are young—and we should be led by the language that individuals use to describe themselves.

■ Be mindful of language and emphasize behaviors and associated risks of key population members, rather than labeling the key population members in ways that suggest they are "risky," "bad," or "deviant."

Session 1.3: Gender and social norms[11]

Time: 90 minutes

Materials

- Laptop and projector for presentation of slides
- Markers
- Tape
- Handout 3: Genderbread person: sexual orientation and gender identity
- Handout 4: Key terms
- Handout 5: Questionnaire–sexual orientation and gender identity

Learning objectives

After completing this session, participants will be able to:

- Explain that gender is a concept constructed by society and how notions of gender interact with other social norms relating to sexual orientation
- Define the terms "homosexual," "sexual orientation," "sexual identity," "gender identity," and "transgender" and explain why it is important to understand these terms when serving members of key populations

Trainer preparation

Ensure that you are familiar with and comfortable using relevant terminology. Make copies of Handouts 3, 4, and 5 for participants. This session will be best if materials, definitions, examples, and anecdotes from the local context are used to explain the terminology being discussed.

Gender, especially in relation to men who have sex with men and transgender people, is an important part of PEPFAR 3.0's Impact Action Agenda, Partnership Action Agenda, and Human Rights Action Agenda. The LINKAGES project has a gender strategy that provides more guidance on integrating gender into HIV prevention, care, and treatment programs for key populations.

Facilitation tips

Be comfortable talking about gender, inequality, and social constructs, and be sure to use accurate terminology!

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[11] Adapted from International HIV/AIDS Alliance. (2015). Sexual and reproductive health and rights, and HIV 101 workshop guide. Session 2.2 and 2.3.

Additional resources

WHO. Gender and human rights:
www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/
BRIDGE website:
www.bridge.ids.ac.uk

UN Women website:
www.unwomen.org

The Genderbread Person: Health Policy Project.
http://www.healthpolicyproject.com/index.cfm?id=GSDTraining

Introduction

Tell participants that this session explores what we mean by gender and sex, how these terms interact with other social norms, and how social norms affect the way men and women are expected to behave and how they are perceived and valued in our society.

Explain that sexual orientation and gender identity shape every aspect of our lives. We know and understand our bodies, minds, and selves through our gender and sex. Social expectations and legal definitions about men, women, and reproduction influence how we organize our medical, legal, education, and political systems.

Activities

Activity 1: The difference between sex and gender (20 minutes)

Write "society" and "biology" on two sheets of flip chart paper and post them on opposite walls. Then ask participants to stand in a straight line in the center of the room. Read aloud one statement at a time (see below). After each statement, ask participants to move a step toward either wall depending on whether they think the statement is socioculturally or biologically based. (Participants should not move back to the center after each statement; just continue to step toward whichever wall matches their opinion.)

Statements
1. Girls are gentle; boys are not.
2. Having sex with her husband is a woman's duty.
3. Women can get pregnant; men cannot.
4. Men are logical and good at analytical thinking.
5. Real men don't cry.
6. Women can breastfeed babies; men cannot.
7. Women are creative and artistic.
8. Men's voices break at puberty; women's voices don't.
9. Men have a greater sex drive than women.
10. Men should be the wage earners of a family, not women.

After all the statements have been read, people should be closer to the "Society" wall since all but three of the 10 statements have a sociocultural basis. The statements that have a biological basis are "Women can get pregnant; men cannot," "Women can breastfeed babies; men cannot," and "Men's voices break at puberty; women's voices don't."

Next, take some time to discuss the following questions as a group:

- Are there statements that you did not agree were correctly labeled as biology or society? Why?

- Why is it important to acknowledge the difference between biological and social influences on sexual orientation and gender identity?

Activity 2: Gender and sex, seeing the difference[12] (25 minutes)

Explain to participants that in this activity you will be talking about gender and sex, two commonly confused words whose meanings are important for all of us.

- Divide participants into two groups (more groups are fine for larger trainings) and assign each group to discuss either a man or a woman. Each group should select someone to serve as an artist. That person, taking directions from the group about what to include, should draw either a woman or a man, as they were assigned. Ask the groups to make sure that they add details that clearly distinguish the figure as a woman or a man using body shape, clothing, and anything else they can think of.

- Give the groups 5–10 minutes to draw their woman/man.

- After time is up, tell the groups that they will now explain their drawings while you, the facilitator, note which of the things they have drawn represent the person's sex and which represent their gender. Use one marker color for sex and one for gender, circling or underlining each attribute they present.
  - For a woman, earrings, a skirt, long hair, long nails, high heels, a purse, a specific stance (for example, one hip out) would all be expressions of gender. Breasts, vagina, wider hips would all be signs of her biological sex. Add discussion prompts relating to transgender women if they are one of the focus key populations for the training.
  - For a man, a specific stance (for example, arms crossed), short hair, short nails, type of clothing, and shoes could all be expressions of gender. Tall height, strong arms, a penis and testicles, and facial hair would be signs of biological sex. Add discussion prompts relating to transgender men if they are one of the focus key populations for the training.

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[12] Adapted from Ghana SHARPER training: Activity 4.5 Understanding the Difference between Sex and Gender and the Gender Norms that Affect KP and PLHIV.

■ Now steer the focus of the session specifically to the dynamics in a clinical setting, to the gendered behaviors of clients and health care providers. Ask participants to list five ways that gender, and sex, have an impact on:

- How clients seek services and interact in the clinical setting (being sure to specify those related to sex, and those related to gender)
- How clients may choose not to present themselves or withhold information in a clinical setting
- How you and colleagues present as health care providers in the workplace, and if there are differences in the home, in the journey to work, etc. (being sure to specify those related to sex and those related to gender)

■ Wrap up this activity by referring *to Handout 3: Genderbread person,* noting the key points from the group discussion, and emphasizing the distinction between sex and gender—sex is biological (including chromosomal, anatomical, and hormonal characteristics), and gender is about the expectations and beliefs of a certain society at a certain point in time.

Activity 3: Gender in depth[13] (15 minutes)

■ Give participants *Handout 4: Key terms,* and give them a few minutes to review the list.

■ Explain the difference between gender-blind, gender-neutral, and gender-transformative programming (defined below and in Handout 4). Gender-blind and gender-neutral are not the same thing, as gender-neutral is an active approach to addressing inequitable gender norms, while gender-blind is passive and suggests a lack of understanding of the concepts of gender or gender inequity.

- **Gender blind:** Failure to identify or acknowledge difference on the basis of sex or gender where it is significant. Gender-blind programs and policies do not consider the impact of sex or gender norms and unequal power relations.
- **Gender neutral:** Avoidance of distinguishing roles according to a person's sex or gender in order to avoid discrimination based on sex or gender and/or avoid prescribed gender norms.
- **Gender transformative:** These programs actively examine and attempt to change inequitable gender norms, policies, and approaches; foster critical examination of gender norms; and strengthen existing equitable gender norms.

■ Facilitate the following questions for discussion:
- How do gender norms affect how you relate to your clients?

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[13] The points for discussion are taken from the Institute of Development Studies. Sexuality and social justice: a toolkit.

- What does the experience of being a transgender person tell us about gender?
- Can you think of examples of women's gender expression that you would describe as masculine?
- What are the positive and negative impacts of gender norms for men and women?
- Does anyone have questions about the terminology in Handout 4?

Wrap-up

Be sure to wrap up this activity by sharing or reinforcing these messages (also listed in the Module 1 PowerPoint).

- Gender is a continuum. There are different degrees to which someone can "transgress," or break the social norms related to the "ideal" woman and man. According to our understanding, everyone is assigned a gender (either male or female) at birth. Society creates strict norms that are meant to be followed by the two genders. These norms are upheld by a system of punishment and privileges. The norms are not only expected by societies, but also internalized by individuals.

- Gender can also be expressed as nonbinary–neither male nor female. Gender nonbinary individuals reject social expectations based on the gender assigned to them at birth.

- Social expectations linked to gender influence how women and men behave, including their sexual behavior, as well as their attitudes and feelings. These expectations tend to be based on the assumption that there are only two categories of people, men and women, and that they behave differently based on their biological sex. There is also a basic assumption within development policy, services, and programming that gender is linked to biological sex and that the recipients of development interventions and services are heterosexual. Some also assume that the normal and natural sexual relationship and basis for the family is a man and a woman in a heterosexual marriage.

- It is commonly assumed that your gender is determined by your biological sex—for example, that you are masculine because you are male. The separation of gender and sex is most apparent in the experience of people who feel that their gender identity is not aligned with their biological sex. Among those people, who may identify as transgender, some will opt to change their biological sex, while others may change their gender identity but not their sex. We cannot make assumptions about the sexual orientation of those whose gender identity does not match their biological sex. Biological males who live as females may be attracted to males, females, or other transgender individuals. In many instances, people who do not conform to society's gender norms are discriminated against and experience violence and abuse because they challenge the idea that gender identity is directly related to biological sex. Not all biological males feel that they have a

masculine identity, and not all biological females feel that they have a feminine identity.

■ Gendered norms affect how sexual behavior and sexual health issues are reported, researched, and funded. Assumptions about women as sexually passive, for example, restrict our knowledge about how women negotiate risk and exert control in their sexual relationships. Because men are considered to be strong and capable of managing sexual relationships, there is very little research into men's experience of vulnerability, in either same-sex or heterosexual relationships. Gendered expectations also determine what we know about the sexual orientation and sexual expression of men and women, which in turn informs decisions about development programming, funding, and research.

Activity 5. Gender identity and sexual orientation self-reflection (20 minutes)

■ Distribute *Handout 5: Questionnaire—sexual orientation and gender identity* and ask participants to complete it in 5 minutes, basing their answers on their honest opinions. Explain that the questionnaires are for their own personal reflection and that you will not be collecting them.

■ Afterward, ask participants how they felt about answering these questions and if they were surprised at their responses to some of them.

■ Facilitate a 10-minute discussion on the responses.

■ Wrap up this activity by asking if there are any outstanding questions related to sexual orientation and gender identity. Be sure the following points have been covered:
  ▪ We all make assumptions about gender roles and how they are performed in society.
  ▪ Various pressures influence decisions we make that can shape the course of our lives (from parents, peers, teachers, partners, and others).
  ▪ Sexuality (and sexual orientation) can be fluid over time.
  ▪ Sexuality is about love and intimacy, as well as the physical act of sex.

Key messages

These are the key messages that should be conveyed to participants throughout the session activities and discussion. Be sure to wrap up the session by reinforcing these messages (also listed in the Module 1 PowerPoint).

■ Gender is socially constructed, which means that it is determined by our social, cultural, and psychological surroundings and environment. It is not innate in the same way that our biology (sex) is believed to be. Gender refers to how societies view women and men, how they are

distinguished, and the roles assigned to them. People are generally expected to identify with the gender that has been assigned to them at birth based on their sex (gender assignment) and then to act in ways deemed appropriate to this gender.

■ Gender is variable and can change from time to time, culture to culture, and subculture to subculture.

■ Gender norms among young people have an enormous effect on how they see the world, evolve, and perceive themselves and others.

■ Stigma and discrimination against those who do not conform to society's gender norms are often compounded by factors (such as their legal status) that affect people's ability to access health information and services and to practice safer sex or safer injecting.

■ Special efforts need to be made to address the realities of those who fall outside of sociocultural gender norms to ensure that they can access life-saving information and services. We can achieve this by first becoming aware of the many ways in which gender norms affect people's identity, sexual behavior, health-seeking behavior, and access to services.

■ Adolescence is often when gender norms become more important and are often when young people develop their sexual identity. This is also a period when people are more open to different gender norms and can be a good opportunity to combat and/or prevent stigma and discrimination.

Session 1.4: Substance Use

Time: 45 minutes

Materials

- ■ Laptop and projector for PowerPoint Presentation Module 1, Session 1.4 slides
- ■ Copies of PowerPoint Presentation Module 1 slides for participants
- ■ Flip chart paper
- ■ Markers
- ■ Tape

Learning objectives

After completing this session, participants will be able to:

- ■ Explain the connections between substance use, key populations, and risk factors associated with HIV acquisition and treatment adherence
- ■ Define key terms relating to harmful and hazardous use of substances, as well as attitudes, behaviors, and structures that may impede access to high-quality health services

Trainer preparation

Know the local context to be able to make links with relevant local examples of how substance use among key populations is managed wherever possible.

Facilitation tips

- ■ Be informed and nonjudgmental about presenting this topic, regardless of your own choices and behaviors in relation to substance use.
- ■ Be mindful that there may be participants in the group who are users, and be sensitive to the needs of the audience.

Additional resources

United Nations Office on Drugs and Crime. (2016). Terminology and information on drugs. Third Edition.
https://www.unodc.org/documents/scientific/Terminology_and_Information_on_Drugs-3rd_edition.pdf

Inter-Agency Working on Key Populations. (2014). HIV and young people who inject drugs: a technical brief.
http://www.who.int/hiv/pub/guidelines/briefs_pwid_2014.pdf

International Network of People Who Use Drugs (INPUD).
http://www.inpud.net

Introduction

Explain that research suggests that people from key populations are more likely to use drugs and alcohol compared with other adults in the general population.

In the clinical setting, candid discussions between health care providers and clients about the use of substances can be challenging. These discussions are made more difficult because drug use and possession are not only highly stigmatized but also criminalized with harsh punishments in nearly every country. Likewise, there may be cultural judgment and disapproval of consuming alcohol.

For people from key populations who use substances, the added stigma they may encounter in relation to their sexual behaviors may make it even harder to talk openly about substance use with their health care providers.

This being the case, it is important to understand the personal and social context in which substance use occurs, and to tailor harm reduction and HIV prevention initiatives accordingly. Structural factors, which relate to the physical, social, and legal environment, can shape HIV risk. For example, substance use may be linked to HIV risk, including sexual behaviors, number of partners, and/or the sharing of injection equipment.

Antiretroviral therapy is effective for people living with HIV who also use substances, but they often need adherence support. Adherence challenges for people living with HIV who also use drugs generally correlate with the degree that drug use disrupts daily activities rather than with drug use, per se. Providers need to remain attentive to the possible impact of disruptions caused by drug use for their clients, in addition to any drug interactions between antiretroviral treatment and other drugs.

Specific considerations related to services for people who inject drugs will be considered in Module 3.1, including needle and syringe programs (NSPs) and evidence-based drug dependence treatment, specifically opioid substitution therapy (OST) for people dependent on opioids.

Activity 1: Brainstorm (15 minutes)

In the main group, ask participants: Why do you think people from key populations are at higher risk of using drugs and alcohol than the general population? Ask for a volunteer to help record their responses on a flip chart.

Some of the reasons include:

- To cope with anxiety, depression, isolation, and loneliness that result from stigma, homophobia, and social marginalization
- Because drugs and alcohol may be common or appear normalized in some social venues where key populations socialize

- Drugs and alcohol help individuals relax, overcome social inhibitions, and increase confidence while seeking sexual partners

- Drugs and alcohol can provide psychological enhancement of sexual experiences, the ability to engage in sex for extended periods of time, and lower sexual inhibitions

- For individuals from key populations who are living with HIV, drugs and alcohol may help them cope with a diagnosis of HIV and escape from the fear of rejection, given their HIV-positive status

Activity 2: Approaching substance use in the clinical setting (15 minutes)

Provide participants with the following information.

- Drug and alcohol use can be a difficult topic for both health care providers and their clients.

- If a client identifies a problem with drugs or alcohol, a useful technique for having a client-centered conversation is to ask questions about the client's perception of the importance of the issue and their confidence in, or ability, to make changes related to their drug use.

- Some useful principles to consider when working with people who may be suffering from substance use include:
  - Begin by building rapport and confidence with the client.
  - Remind clients that any information they share will be kept confidential. If information will be shared, providers must reveal to the client with whom it will be shared and under what circumstances. This is the same for information that the provider documents. Clients have a right to know if what they disclose will be documented and how that information will be used.
  - Remember to use a nonjudgmental and nonconfrontational approach when discussing substance use with clients.

Then, get participants into pairs. In pairs, ask the group to create some examples of useful questions to raise with clients–as part of a conversation about their drug-taking habits and potential risk behaviors linking drug use and vulnerability to HIV.

Ask the pairs to work together to create some questions for health care providers to ask their clients (10 minutes), and then come back and share examples in the main group (5 minutes). You may need to reiterate the importance of confidentiality of client information.

Activity 3: Knowing the terminology (15 minutes)

It is important to understand the difference in the terms and associated risks related to substance-taking behaviors.

In the main group, ask for a volunteer to define each of these key terms:

- Addiction
- Drug dependence
- Abuse
- Harmful use
- Hazardous use

Refer to the United Nations Office of Drugs and Crime glossary of key terms[14] for reference, to clarify the definitions for participants:

- **Addiction.** The terms "addiction" and "habituation" were abandoned by WHO in 1964 in favor of "drug dependence." However, since those terms are still widely used, "addiction" refers to the repeated use of a psychoactive substance or substances, to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means.

- **Drug dependence.** A cluster of physiological, behavioral, and cognitive phenomena of variable intensity in which the use of a psychoactive drug (or drugs) takes on a high priority. It implies a need for repeated doses of the drug and indicates that a person has impaired control of substance use, as its use is continued despite adverse consequences.

- **Abuse.** Due to the ambiguity of the term "abuse," the WHO Lexicon has replaced this term with "harmful use" and "hazardous use." In the context of international drug control, drug abuse constitutes the use of any substance under international control outside therapeutic indications, in excessive dose levels, or over an unjustified period of time.

- **Harmful use:** This is a pattern of psychoactive substance use that is causing damage to health, either physical (e.g., hepatitis following injection of drugs) or mental (e.g., depressive episodes secondary to heavy alcohol intake). Harmful use commonly, but not invariably, has adverse social consequences. The term has supplanted "nondependent use" as a diagnostic term.

- **Hazardous use:** This refers to a pattern of substance use that increases the risk of harmful consequences for the user. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user, for example, reoccurring incidences of drinking alcohol and then driving. This is not a diagnostic term.

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[14]   See https://www.unodc.org/documents/scientific/Terminology_and_Information_on_Drugs-3rd edition.pdf. pp. 59-66.

Key messages

These are the key messages that should be conveyed to participants throughout the session activities and discussion. Be sure to wrap up the session by reinforcing these messages (these are also listed in the Module 1 PowerPoint).

- The use of alcohol and drugs by key populations is often a reaction to homophobia, discrimination, isolation, or violence that people may experience because of their sexual orientation.

- Some drugs lead to increased desire for sex, multiple partners, and less frequent use of condoms.

- There is also a risk that drug and alcohol use can lead to interruptions in antiretroviral therapy, which can increase chances of HIV transmission and reduce treatment efficacy.

- Health care workers should adhere to good practices of taking a risk assessment (to be covered in Session 3.3), respecting confidentiality, and using nonjudgmental approaches when discussing drugs and alcohol with all clients, including those from key populations.

Session 1.5: Violence, key populations, and human rights[15]

Time: 90 minutes

Materials

- ■ Flip charts
- ■ Markers

Learning objective

After completing this session, participants will be able to explain the types of violence and abuse that members of key populations experience.

Trainer preparation

Prepare four flip charts labeled "physical," "emotional," "sexual," and "economic."

Facilitation tips

Be mindful that some participants may have had personal or first-hand experience with violence.

Introduction

Explain that violence and gender-based violence cut across ethnicity, race, religion, class, and education. However, key populations are among those most affected because of a range of causal factors—ongoing inequalities for women and girls, combined with prejudice and discrimination against people (such as sex workers, men who have sex with men, and transgender people) who may not conform to mainstream gender role expectations or whose gender expression is nonbinary. Depending on their circumstances, the risk factors, such as for sex workers, include social stigma and isolation, lack of gender-based violence prevention services, low self-esteem, and negative community attitudes about "immorality."

In many countries, key populations' social vulnerability to gender-based violence and other forms of violence is fueled by oppressive legal and policy frameworks that criminalize their wider status and/or behavior. For example, laws deeming drug use or same-sex relationships illegal are in place in most the world's countries and are often used to ignore, or even justify, violence against these populations by the police and community members, at times within a culture of impunity. Meanwhile, stigma and discrimination create barriers to services for key populations, who may even be denied support within mainstream gender-based violence services.
Violence fosters the spread of HIV by limiting one's ability to negotiate safe sexual practices, disclose HIV status, seek HIV treatment, and adhere to HIV

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[15]   Adapted from FHI 360. (2015). Gender, gender norms, and introduction to gender-based violence core concepts training curriculum.

treatment and access health care and other critical services due to fear of reprisal, discrimination, and denial of services.

Activities

Activity 1: Small-group exercise (30 minutes)

- Explain that there are many forms of violence and abuse that key populations experience. They are usually categorized into four types: physical, emotional, sexual, and economic, but some types of abuse do not fit neatly into these categories, so we should consider these as well.

- There are also system-level abuses, or structural abuses, that are often experienced by key populations. One example is harassment by the police—confiscating a sex worker's condoms or holding a sex worker in jail for several days because she was found carrying condoms.

- Tell the participants that during this exercise, they will think about the different forms of violence that sex workers, men who have sex with men, transgender people, and people who inject drugs experience.

- Next, hang up the four flip charts labeled physical, emotional, sexual, and economic.

- Divide the large group into four small groups and assign each group to one of the flip charts.

- Ask groups to generate examples of types of violence relevant to their assigned group and write these on the flip charts.

Activity 2: Large-group exercise: Who is perpetrating violence and abuse? (20 minutes)

- Re-form the large group. Before reviewing the types of violence and abuse they listed, ask the participants to identify who is perpetrating violence and abuse against key populations. Ensure that all of the following are included in their response: spouses, intimate partners, family members, community members, teachers, clergy members, strangers, police, health care workers, and other service providers. For sex workers of any gender, other perpetrators may also include the military, clients, pimps, brothel owners, and hotel owners.

Activity 3: Large-group exercise – types of violence and abuse (40 minutes)

Review the responses from the small-group exercise (types of violence and abuse). Ask the group if any examples are missing. Make sure the flip charts include the examples listed below.

- **Physical:** Hitting, pushing, kicking, choking, spitting, pinching, punching, poking, slapping, biting, pulling hair, throwing objects, dragging, beating someone up, shaking someone, deliberately burning, using a

weapon or threatening with a weapon, kidnapping, holding against will, physically restraining

- **Sexual:** Rape; gang rape; sexual harassment; physically forcing, coercing, or psychologically intimidating someone to engage in any sexual activity against one's will (undesired touching, oral, anal, or vaginal penetration with penis or with an object); emotionally, socially, or economically pressuring someone into sexual activity; refusing to wear a condom

- **Emotional:** Psychological and verbal abuse, humiliation, threats, coercion, controlling behaviors, calling names, verbal insults, blackmail, threatening someone with loss of custody of children, isolating people from friends/family, threatening harm, repeated shouting, intimidating words/gestures, destroying someone's possessions.

- **Economic:** Using money or resources to control an individual, refusing someone's right to work, taking earnings, withholding resources as "punishment," refusing to pay someone for a service.

Other human rights violations have been cited by key populations and should be considered in the context of violence and abuse. Some of these human rights violations include:

- Having money extorted

- Being denied or refused food or other necessities

- Being refused or cheated of salary, payment, or money that is due to the person

- Being forced to consume drugs or alcohol

- Being arbitrarily stopped or detained by police

- Subjected to invasive body searches (e.g., anal exams)

- Being arbitrarily stopped/subjected to invasive body searches/detained by police

- Being arbitrarily detained or incarcerated in police stations, detention centers, and/or rehabilitation centers without due process

- Being arrested or threatened with arrest for carrying condoms

- Being refused or denied health care services

- Being subjected to coercive health procedures, such as forced STI and HIV testing, sterilization, abortions

- Being publicly shamed or degraded (e.g., stripped, chained, spat upon, put behind bars)

- Being deprived of sleep by force

Summarize by linking the discussion of gender-based violence and vulnerability of key populations to previous discussions relating to the structural determinants of health.

Consider the importance of partnerships and quality referrals facilitated through "champions" in law enforcement agencies. Working with these champions can help marginalized groups and those groups whose behavior may be criminalized access services to promote their health and protect their human rights.

If a client presents for a health service after being exposed to violence, it can be an entry point for offering a range of HIV and other health services. It can also be an opportunity to refer that client to legal and other psychosocial support services, as appropriate (assuming that they are supplied by trusted providers equipped to support key populations and provide quality services free from stigma). Likewise, local law enforcement and traditional authorities could be encouraged to refer people reporting experiences of violence to appropriate health services.

Key messages

These are the key messages that should be conveyed to participants throughout the session activities and discussion. Be sure to wrap up the session by reinforcing these messages (these are also listed in the Module 1 PowerPoint):

- We know that male, female, and transgender sex workers; men who have sex with men; and transgender people may face violence because of the stigma associated with sex work, which in most settings is criminalized, or due to discrimination based on sexual orientation, gender identity, race, HIV status, drug use, or other factors.

- Much of the violence against sex workers, men who have sex with men, and transgender people stems from or is exacerbated by the perception that these groups do not conform to gender norms.

Hearts and minds: Quality services for key populations

"Be the change you want to see in the world." — Mahatma Gandhi

At a glance

This module guides participants in exploring the beliefs and attitudes—including their own—that may result in stigmatizing judgments about key populations. The purpose of this module is to identify examples of where stigma poses a barrier to health care and to allow participants to examine the forms, causes, and results of stigma that may occur in health facilities. We will then identify opportunities to remove stigma from health care to enable key populations to attain stigma-free HIV services.

Sessions

Session 2.1: Beliefs about key populations
Session 2.2: Our own values, judgments, and opportunities to challenge stigma
Session 2.3: Forms, causes, layers, and effects of stigma

Handouts

Handout 6: Case studies for Session 2.3
Handout 7: My commitment—10 values to guide my work with
key populations

Learning objectives

After completing this module, participants will be able to:

■ Articulate how their own values, attitudes, and behaviors may be expressed as stigma, and also how stigma may affect access to, and uptake of, health care services by key populations

■ Demonstrate increased empathy for the experiences of key populations

■ Identify experiences of stigma, including where and how they occur

■ Explain the difference between stigma and discrimination and how to appropriately tailor responses to mitigate the impact of both

■ Understand the potential compounded stigma that may be experienced in a health care setting by, for example, a person living with HIV who is a sex worker, a man who has sex with men and who also injects drugs, or a transgender person who is a sex worker

Key messages

■ Stigma continues to be a barrier toward the provision of quality and comprehensive services and an obstacle for people who wish to access the full range of health and HIV services they need.

■ Stigma and discrimination are different. Stigma is a process of devaluation, a mark of disgrace that can be associated with a particular behavior, context, and/or identity. Discrimination is an action (that can often result from stigma). Stigma can be harder to pinpoint or articulate.

■ Addressing stigma starts with each one of us. Stigma is part of everyday life. Being aware of our own values and attitudes is the first step toward overcoming stigma.

■ We must understand stigma (and how it differs from discrimination) and be able to explain why addressing stigma is imperative for an effective response to HIV in different contexts.

■ Stigma can be attached to one or more layers of someone's identity. Stigma faced by people from key populations may be compounded by issues relating to HIV as well as to behaviors and values associated with key populations.

Additional resources

GNP+ and INPUD. (2010). Advancing the sexual and reproductive health and human rights of injecting drug users living with HIV. Amsterdam: GNP+. http://www.gnpplus.net/resources/advancing-the-sexual-and-reproductive-health-and-human-rights-of-injecting-drug-users-living-with-hiv/

GNP+ and NSWP. (2010). Advancing the sexual and reproductive health and human rights of sex workers living with HIV. Amsterdam: GNP+. http://www.gnpplus.net/resources/advancing-the-sexual-and-reproductive-health-and-human-rights-of-sex-workers-living-with-hiv/

GNP+ and MSMGF. (2010). Advancing the sexual and reproductive health and human rights of men who have sex with men living with HIV. Amsterdam: GNP+. http://www.gnpplus.net/resources/advancing-the-sexual-and-reproductive-health-and-human-rights-of-men-who-have-sex-with-men-living-with-hiv/

The People Living with HIV Stigma Index. www.stigmaindex.org.

Session 2.1: Beliefs about key populations[16]

Time: 1 hour

Materials

■ Agree/disagree cards

■ Statements to be read out loud

Learning objectives

After completing this session, participants will be able to:

■ Explain their attitudes and values about key populations

■ Describe stigma (and how it differs from discrimination)

■ Identify areas within health care facilities where stigma may be generated and experienced

Trainer preparation

■ Write "Agree" on one index card and "Disagree" on another card, and attach them to walls on opposite sides of the room.

■ Review the selection of provocative statements (from the list of examples at the end of this session and/or design your own).

■ Select four to five statements that are most suited to your context or participants (see box below for statements).

Facilitation tips

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:

■ Be open-minded and aware of your own opinions, values, and judgments

■ Remain neutral throughout the exercise. You may, however, provide information to clarify matters, as needed.

■ Allow other participants to challenge someone who expresses extreme views that reinforce stigma, or if no one responds, do it yourself

■ Emphasize that the aim of the exercise is not to win or lose but to explore different views.

■ Be energetic and encourage people to be opinionated, while also encouraging people to be open to changing their minds (i.e., to let themselves be convinced by others in the group)

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[16] This session was adapted from: Health Policy Project. (2013). Understanding and challenging HIV and key population stigma and discrimination: Caribbean facilitator's guide. Washington, DC: Futures Group, Health Policy Project.

- Understand that building trust—in this training session and in a health care facility—is an important component of addressing stigma

Introduction

Explain that next you will be leading a values clarification exercise— participants will review a number of statements about key populations and decide if they agree or disagree.

Encourage participants to take a strong position on some of the statements. Welcome a lively debate but also remind participants of the ground rules to encourage respect and consideration of others' views.

Remind participants that some people might hold opinions that are unpopular and that they need to be respectful of people with whom they might not agree.

Activities

Activity 1: Voting with your feet (50 minutes)

Step 1. (30 minutes) Agree/disagree

- Ask participants to stand in the center of the room.

- Read the first statement out loud. (See box below for statements.)

- Emphasize that these statements are not based on fact. The statements have been chosen to be deliberately provocative. Unpacking the attitudes and reasons behind these statements can isolate some of the underlying assumptions that drive stigma.

- Ask participants to respond by "voting with their feet," that is, walking to a point in the room where signs are posted— "Agree" on one end, "Disagree" on the other, or "convince me" in the middle for those who aren't sure how they feel.

  (Facilitator's note: You can adapt these directions if you think participants would be more comfortable having their view be anonymous. To do that, state that each person can represent their own opinions or the opinions of someone they know.)

- Ask two to three participants from the minority group (i.e., the group with the lesser number of people) to explain why they either agree or disagree (depending on which side of the room they have stood on).

- Ask two to three participants from the majority group (i.e., the other side) to explain their views.

- Ask the people standing in the undecided or "convince me" part of the room to then explain why they are undecided. Then ask if they would like to move, having been convinced by one side or other of the arguments put forward.

- If it was a particularly lively discussion, you could ask people on each side of the room if they have changed their opinion or think of things differently.

- Repeat this process for the rest of the statements. If the debate is lively you may only have time for a few statements.

STATEMENTS FOR THE VALUES CLARIFICATION EXERCISE

Select four to five statements suited to your context and training group, or make up your own statements as appropriate.

Statements: Sex workers

- Sex workers are like other people—they have long-term, loving relationships with their regular partners.

- Sex workers deserve to get HIV because of their immoral behavior.

- Sex workers love money and are too lazy to work. They could easily get other jobs.

- 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.

- Sex workers are sex maniacs—they love to have sex with anyone.

- Young people who sell or trade sex should be considered sex workers.

Statements: Men who have sex with men

- Men who have sex with men deserve the same rights as everyone else.

- Men who have sex with men can be good fathers, brothers, and uncles, the same as other men.

- Sex between men is unnatural.

- Sex between men should be criminalized.

- Men who have sex with men deserve to get HIV because of their immoral behavior.

- Men who have sex with men are mentally ill, so they should be given treatment and cured.

- Men don't decide they want to love men. It just happens to them.

- Preventing HIV is more important than condemning men who have sex with men.

- If you hang around with men who have sex with men as friends, you will start wanting to have sex with men.

- Young men should be discouraged from having sex with other men.

- You can identify men who have sex with men by the way they dress and behave.

- Men who have sex with men are the result of child abuse.

- All young men should be supported in their sexual orientation and gender identity.

Statements: Transgender people

- Transgender people deserve to be ostracized because they are deviants.

- Transgender people are confused or mentally disturbed.

- Transgender people aren't "real" men or women.

- Transgender people usually desire wider social relationships and would like to have committed relationships.

- Transgender people want to be seen as women or as men, not always identified as transgender.

Statements: People who inject drugs

- People who inject drugs are untrustworthy.

- People who inject drugs deserve to get HIV because of their immoral behavior.

- Drug addiction should be considered a disease, not a crime.

- People who inject drugs cause harm to society, so they should all be locked up.

- People who inject drugs should be registered so that their use of drugs can be closely monitored by health workers.

- People living with HIV who use drugs are unreliable and won't adhere to antiretroviral treatment, so don't give them antiretroviral treatment.

- People who inject drugs have the same human rights as everyone else.

Mixed statements

- I believe that having sex without love is wrong.

- I believe that girls should not have sex before getting married.

- I believe that young people are all promiscuous.

- I believe that sex workers can continue to work and be married.

- I believe that 16-year-olds who are sexually active and unmarried should have access to condoms and other contraceptives.

Step 2. (20 minutes) Processing and reflection

Ask participants to return to their seats and spend the first 10 minutes on their own, silently reflecting on the statements that have just been discussed in the group.

- Which statements were the most controversial and why?
- How do our attitudes toward key populations affect the way we behave toward them?
- How can we keep our own values from influencing our behavior toward key populations in a negative way?

Ask participants to discuss their responses with their neighbor. (10 minutes)

Wrap-up (10 minutes)

Summarize the key points related to stigma, values, and moral judgments that emerged in the debate. Correct any factual errors. Commend everyone for their openness and willingness to share their opinions. Congratulate people who were open to changing their minds after listening to others' opinions.

Review the following points in summary if they have not otherwise been raised by the group by asking the following questions:

What happens if we stigmatize clients from key populations?

- Clients may stop using the clinic and not have their STIs treated.
- Fear of stigma might prevent men who have sex with men or sex workers from sharing information about their sexual behaviors.
- Stigma may affect the self-confidence of key populations and, as a result, they may take less care in using condoms with partners and negotiating safe sex.

Why is stigmatizing clients wrong?

- Our role as health care workers is to care for people, not hurt them.
- Our code of practice tells us to treat all clients equally.
- If we stigmatize key population clients, this will undermine their ability to manage their health, including their sexual health, and may result in more HIV transmission.

Session 2.2: Our own values, judgments, and opportunities to challenge stigma[17]

Time: 1 hour

Materials

- Flip chart
- Marker pens
- Masking tape

Learning objectives

After completing this session, participants will be able to:

- Describe some of their personal experiences related to stigma
- Identify some of the feelings involved in experiencing stigma or stigmatizing others

Facilitation tips

- Presume as a starting point that everyone in their life has stigmatized someone else and/or experienced stigma themselves (for a variety of reasons, including those relating to sexual orientation and gender identity, HIV, and maybe other aspects such as race or religion).

- Model stigma-free behavior through open-minded facilitation and acceptance of different opinions (in this session and throughout the workshop).

- Emphasize that sharing is voluntary—no one is forced to tell their story—and emphasize the importance of confidentiality.

- Emphasize that attitudes and behaviors that establish stigma are often inadvertent parts of our daily interactions, based on the social and cultural context in which we were brought up.

- Remind participants that HIV status, or gender, age, or sexual orientation, etc. are all only parts of a person's life. One way to overcome stigma is to consciously challenge ourselves to remember that people are complicated and comprise multiple identities. We need to be open to this fact if we want to adopt nonjudgmental attitudes.

Introduction

Explain to the group that this is an important session because it draws on personal experiences of stigma. Participants will think about their own experiences and feelings to get an insider's view of stigma. This session looks at stigma in general, not stigma toward key populations.
Introduce the exercise carefully to help participants overcome their initial discomfort about sitting and reflecting and then sharing their own experiences

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[17] This session was adapted from International HIV/AIDS Alliance. Link Up 101.

with others. This exercise requires a lot of trust and openness within the group, so be sure to explain that all sharing is voluntary and confidential; the conversation should not be repeated outside the training room.

Activities

Activity 1: Brainstorm (10 minutes)

Review the difference between stigma and discrimination. This could be done as a word association exercise by asking people what comes to mind when you say the word "stigma" and what comes to mind when you say the word "discrimination."
(Stigma = a set of negative and often unfair beliefs that a person or society holds about specific groups. Discrimination = action.)

Activity 2: Our own experience of being stigmatized (10 minutes)

Ask participants to sit on their own and think about a time when they felt isolated or rejected for being seen as different from others—or when they saw other people treated this way.

Explain that their example does not need to be related to HIV—it could be any form of isolation or rejection. Ask them to think about what the circumstances were when they felt stigmatized (or were witness to another person's experience of feeling stigmatized), how they felt, and what impact stigma had on them or the person being stigmatized.

Then ask participants to share their experience and/or thoughts with another participant with whom they feel comfortable.

Invite participants to share their stories in the group, but only if they feel comfortable doing so.

Activity 3: Our own experience stigmatizing others (10 minutes)

Ask participants to sit on their own and think about a time when they isolated or rejected other people because they were different. Ask them to think about the circumstances under which this occurred, how they felt, what their attitude was, and how they behaved.

Then ask participants to write down any thoughts, feelings, or words that they associate with stigmatizing others.

Activity 4: Naming the feelings associated with stigma (20 minutes)

Ask participants to form two groups.

Group One will spend 5 minutes brainstorming and consolidating their thoughts about feelings related to *being stigmatized*. Examples could include feeling ashamed, powerless, not in control, etc. Have participants write their ideas on a piece of flip chart paper.

Group Two will spend 5 minutes brainstorming and consolidating their thoughts about feelings related to *stigmatizing others*. Examples could include feeling powerful, regretful, dominant, etc. Have participants write their ideas on a piece of flip chart paper.

Bring the two groups back together and spend 10 minutes discussing the thoughts and feelings identified. Talk about the implications of both sets of feelings, and brainstorm about how to overcome or mitigate the impact of stigma. Examples could include empathy, recognizing the power dynamics involved in the process of stigma and identifying ways to make those more equal, and empowering people—clients and providers alike—to speak up and respond to incidents of stigma and/or discrimination when they occur.

Wrap-up (10 minutes)

Explain that everyone has felt ostracized at some point in their lives. They are not alone in feeling that way—we have all experienced this sense of social exclusion.

Discuss the similarities and differences among emotions related to experiencing stigma versus generating it. (Refer to the flip charts from Step 4.) What are the implications for addressing and findings solutions to stigma?

Finally, ask participants what the impact of stigma and discrimination can be on key populations' access to HIV services.

Session 2.3: Forms, causes, layers, and effects of stigma[18]

Time: 2 hours

Materials

- Flip chart paper (x 4) attached to wall
- Flip charts for group work (mapping exercise)
- Marker pens (multiple colors for mapping exercise)
- Post-it notes for group work (brainstorming exercise)
- Handout 6: Case studies for Session 2.3
- Handout 7: My commitment—10 values to guide my work with key populations

Learning objectives

After completing this session, participants will be able to:

- Analyze forms of stigma, their causes, and their effects in relation to key populations
- Explain solutions and interventions to reduce stigma and/or mitigate its impact
- Identify practical things that each participant can do to stop or reduce stigma in the health care setting
- Strengthen their commitment to providing stigma-free services

Trainer preparation

- Prepare four flip chart papers, each with one of the following headings: Forms of Stigma, Causes, Layers, Effects
- Tape the flip charts to the wall in visible places in the room
- Make copies of handouts 6 and 7 for participants

Facilitation tips

- Keep flip charts on the wall of the training room for reference when participants begin developing their action plans for making their facilities more key-population-friendly.
- Be available to answer any questions in breaks between sessions and after the final session. Given the sensitivity of the discussion points in Module 2, some participants may want to raise concerns or discuss ideas on a one-on-one basis.

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[18] This session was adapted from: Health Policy Project. (2013). Understanding and challenging HIV and key population stigma and discrimination: Caribbean facilitator's guide. Washington, DC: Futures Group, Health Policy Project. Brown B, Duby Z, Van Dyk D. Health care provision for men who have sex with men, sex workers, and people who use drugs. The Desmond Tutu Foundation, 2013.

Introduction

Tell participants that stigma is complex in that it is experienced differently by different people and changes over time. Stigma can be attached to one or more aspects of a person's identity, including HIV status, gender, sexual orientation, and/or association with a key population.

Stigma manifests in different ways, for example, through social oppression or marginalization, criminalization, and barriers in the access to and provision of health care services.

It is important to recognize the sites where stigma occurs most often or most acutely. These sites may differ among different key populations, and may also vary depending on age, gender, and HIV status.

Young people—especially those under the age of 18 or the legal age of consent—may face additional stigma in accessing services. The quality of services and the way they are treated at health facilities may discourage young people from continuing to access services or follow a service provider's recommendations.

It is also important to recognize and understand how people from key populations may experience multiple layers of stigma—internally and externally.

Activities

Activity 1: Mapping (45 minutes)

Step 1: (10 minutes) Ask participants to form small groups (maximum five people per group). Each group needs a blank flip chart and at least one marker (ideally two or three different-colored markers per group).

Ask each group to draw the journey a person from a key population would take when accessing a health care facility and receiving services (for example, walking to/from the community, taking public transport, talking to the clinic receptionist, being seen by the nurse or doctor).

Step 2: (10 minutes) Ask each group to map sites where a person from a key population may experience stigma and/or discrimination during that journey. (Hint: sites could include self, community, and different settings within the health care facility.)

Step 3: (10 minutes) Ask each group to select the three most important sites that need to be addressed to prevent stigma and to enable more people from key populations to access comprehensive HIV services.

Step 4: (15 minutes) In the main group, ask each smaller group to describe their map by talking about the three most important sites that they identified for addressing stigma.

If there is time, you could add a **step 5** and ask participants to consider how their scenarios might differ for a young person. For a **step 6,** you could ask people to consider young people of different age ranges (such as 10–14, 15–18, and 19–24 years).

Activity 2: Discussion—Forms, causes, layers, and effects of stigma (15 minutes)

Stigma is a process of minimizing someone's value (including the self), based on a particular behavior, context, and/or identity. Previous experiences of stigma can result in an expectation of stigma or a perception of stigma.

Tell the participants that you'll now be defining the forms, causes, layers, and effects of stigma.

Explain the following to them (also listed on the Module 2 PowerPoint):

- The different forms and layers of stigma
  - **Form =** different types of stigma, such as real, perceived, anticipated, enacted, and stigma by association. This is a good opportunity to clarify again the difference between stigma and discrimination.
  - **Layers =** different aspects of a person's identity that stigma could be attached to, for example, HIV status, gender, sexual behavior, migration status, or drug use.

- Who or what **causes** stigma
  - **Causes =** typically social or personal in origin. Can be internalized and externalized.

- The effects of stigma
  - **Effects =** the impact that stigma might have on a person seeking health services, reluctance to test, preventing full disclosure of risk factors in a consultation, inadequacy of health services provided (e.g., a provider not doing a thorough STI screening for men who have sex with men).

Activity 3. Case study review (35 minutes)

Break into small groups. Hand out copies of *Handout 6: Case studies for Session 2.3*.

Because of time limitations, consider focusing on only two of the case studies (more than one group can discuss the same case study).

Ask the groups to take 10 minutes to read the case study assigned to them and consider the following questions:

- What forms of stigma are present in the case study? Is the situation realistic?
- What layers of stigma are described in the case study?
- How did stigma and discrimination affect the client in the case study?
- How can we challenge stigma and make our health facilities more friendly and accessible?

Ask the groups to take notes of their discussion.

To conclude the activity, ask one spokesperson from each group to share one interesting or surprising thing they learned from the discussion.

Activity 4. Identifying solutions and opportunities for overcoming stigma (20 minutes)

Brainstorm about potential interventions to address stigma (being precise in identifying which form of stigma from the previous discussion is being addressed). Put up a flip chart and ask participants to think of suggestions and strategies to find solutions to overcome stigma for:

- People who are stigmatized
- People who stigmatize

Participants should focus on solutions that they can directly be involved in and/or action in the context of their facility.

Be sure to prompt participants to discuss internalized stigma as well as stigma from other people.

Conclude by focusing on solutions (looking ahead to Module 4)
In the large group ask:

- Which solutions are the most practical to implement in the participants' facilities?
- Which solutions need to be more specific to be able to act on them?

Write the answers on flip chart paper and encourage participants to write them down for future reference.

PROMPT: The following are possible solutions to consider, if not already raised by the group, and are also included in the Module 2 PowerPoint slides. These include:

- Educate service providers on specific health concerns for different key populations.
- Promote self-reflection and open-minded change among service providers to provide stigma-free quality services for all and to respond to the specific needs of key populations.

- Re-establish the code of practice, which emphasizes treating all clients equally.

- Train all health care workers, including ancillary workers, on basic skills in the management of sexual and reproductive health (including STIs and HIV) for different key populations.

- Train all staff, clinical and nonclinical, on how to withhold judgement, adopt neutral and supportive language, and use appropriate body language when interacting with all clients.

- Distribute *Handout 7: My commitment—10 values to guide my work with key populations*. Ask participants to read it, add their own commitments in addition to the ones listed, and sign and date the commitment to close the session. Mention that we will refer to these commitments again in Module 4. Suggest that participants attach the commitment to the wall near their desk when they return to the workplace.

Key messages (10 minutes)

Be sure to wrap up the session by reinforcing these messages (also listed in the Module 2 PowerPoint):

- It is important to distinguish between internal and external stigma and think about and address the forms, causes, layers, and effects of both.

- Stigma is common and has multiple impacts.

- People from a key population who are living with HIV may experience the burden of multiple and compounded stigma.

- Appropriate support and counseling can minimize the effects of stigma and help clients access and adhere to HIV services.

Finally, be sure to cover the module's concluding remarks before moving to the next session (see Module 2 PowerPoint slides).

Appropriate services for key populations

"My humanity is bound up in yours, for we can only be human together."
— Desmond Tutu

At a glance

This module focuses on the top 10 clinical standards of care that health care workers should address with key populations and the importance of creating a key-population-friendly clinic environment. Handout 8 details the top 10 standards of care, which have been selected after consulting WHO guidelines and other relevant resources.

The first nine out of 10 standards apply to all key populations. The tenth standard has been broken down to meet the different, specific needs of sex workers, men who have sex with men, transgender people, and people who inject drugs. Typically, health care workers do not follow these standards of care, because they are not aware of the needs of key populations (it is unlikely that this topic has been covered in pre-service curricula), they are uncomfortable talking about the client's sexual behavior, or they discriminate against key populations because of their own attitudes and values.

Sessions

Session 3.1: Top 10 clinical standards of care for key populations
Session 3.2: Providing youth-friendly services to key populations
Session 3.2: Performing a risk assessment

This module will benefit all participants, not only those with a clinical background.

You might decide to divide the group into two groups—one for those with a clinical background and one for those without—if you want a more intensive focus on clinical issues for those to whom they are relevant.

Handouts

Handout 8: Clinical standards of care for key populations—a self-evaluation
Handout 9: Best practices for youth-friendly clinical service delivery
Handout 10: Meaningful youth engagement
Handout 11: Individual reflection
Handout 12: Tips for conducting a risk assessment

Learning objectives

After completing this module, participants will be able to:

- Describe and apply the top 10 clinical standards of care for sex workers, men who have sex with men, transgender people, and people who inject drugs

- Articulate how young key populations differ from adults and learn how to provide youth-friendly services

- Conduct an effective, respectful, and appropriate risk assessment with key populations

- List the relevant community services to which they may refer key populations

Key messages

- Individuals in key populations need to know the full range of services to which they are entitled, so that they can hold their health care workers and facilities accountable for providing them. Promoting access and identifying demand for quality comprehensive services is just as important as the supply and provision of those services.

- Health care workers have a duty to provide the best quality services they can to all people (regardless of what they personally think about their clients' actions, age, identities, or health conditions).

- Health care workers must orient services to the unique health needs of young key populations and the added barriers young people experience in accessing services. They also need to consider that the term "young people" covers a wide age range of people with varying levels of knowledge and experience, and then adjust services accordingly.

Additional resources

WHO. (2014). HIV prevention, diagnosis, treatment and care for key populations: consolidated guidelines.
http://apps.who.int/iris/bitstream/10665/128049/1/WHO_HIV_2014.8_eng.pdf?ua=1&ua=1

International AIDS Society. (2014). A Code of conduct for HIV and health professionals: strengthening human rights approaches to health.
https://www.iasociety.org/Web/WebContent/File/2014__KAPs__Code_of_conduct.pdf

Sex workers

WHO. (2015). Technical brief on HIV and young people who sell sex.
http://www.who.int/hiv/pub/toolkits/hiv-young-sexworkers/en/

WHO; UNFPA; UNAIDS; NSWP; World Bank; UNDP. (2013). Implementing comprehensive HIV/STI programs with sex workers: practical approaches from collaborative interventions.
http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1

Global Network of Sex Work Projects (NSWP).
http://www.nswp.org

Global Network of Sex Work Projects (NSWP). (2016). Policy brief: young sex workers.
http://www.nswp.org/sites/nswp.org/files/Policy%20Brief%20Young%20Sex%20Workers%20-%20NSWP%2C%202016.pdf

WHO. (2015). HIV and young people who sell sex: a technical brief.
Inter-Agency Working on Key Populations.
http://www.unfpa.org/sites/default/files/pub-pdf/WHO_HIV_2015.7_eng.pdf

Men who have sex with men

UNFPA, Global Forum on MSM and HIV, UNDP, UNAIDS, WHO, USAID, PEPFAR, Bill & Melinda Gates Foundation. (2015). Implementing comprehensive HIV and STI programs with men who have sex with men: practical guidance for collaborative interventions.
http://www.who.int/hiv/pub/toolkits/msm-implementation-tool/en/

WHO. (2015). Technical brief on HIV and young men who have sex with men.
http://www.who.int/hiv/pub/toolkits/hiv-young-msm/en/

PEPFAR. (2011). Technical guidance on combination HIV prevention for men who have sex with men.
http://www.pepfar.gov/documents/organization/164010.pdf

WHO. (2015). HIV and young men who have sex with men: a technical brief.
Inter-Agency Working on Key Populations.
http://www.unaids.org/sites/default/files/media_asset/2015_young_men_sex_with_men_en.pdf

Global Forum on MSM and HIV.
http://msmgf.org

Transgender people

"TRANSIT." United Nations Development Program, IRGT: A Global Network of Trans Women and HIV, UNPD, UCSF Center of Excellence for Transgender Health, Johns Hopkins Bloomberg School of Public Health, WHO, UNAIDS, USAID, PEPFAR. (2016). Implementing comprehensive HIV and STI programs with transgender people: practical guidance for collaborative interventions (the "TRANSIT").
http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html

WHO. (2015). Policy brief: transgender people and HIV.
http://apps.who.int/iris/bitstream/10665/179517/1/WHO_HIV_2015.17_eng.pdf?ua=1&ua=1

WHO. (2015). Technical brief on HIV and young transgender people.
http://www.who.int/hiv/pub/toolkits/hiv-young-transgender/en/

WHO. (2015). HIV and young transgender people: a technical brief. Inter-Agency Working on Key Populations.
http://www.unaids.org/sites/default/files/media_asset/2015_young_transgender_en.pdf

Centre of Excellence for Transgender Health.
http://transhealth.ucsf.edu

People who inject drugs

"IDUIT." UNODC, INPUD, UNAIDS, UNDP, UNFPA, WHO, USAID, PEPFAR. (2017). Implementing comprehensive HIV and HCV programs with people who inject drugs: practical guidance for collaborative interventions (the "IDUIT").
http://www.who.int/hiv/pub/idu/hiv-hcv-idu/en/

WHO. (2015). Technical brief on HIV and young people who inject drugs.
http://apps.who.int/iris/bitstream/10665/179865/1/WHO_HIV_2015.10_eng.pdf

Step by step tool kit: preparing for work with children and young people who inject drugs.
http://www.ihra.net/contents/1660

PEPFAR. (2010). Comprehensive HIV prevention for people who inject drugs, revised guidance.
http://www.pepfar.gov/documents/organization/144970.pdf

WHO. (2015). HIV and young people who inject drugs: a technical brief. Inter-Agency Working on Key Populations.
http://www.unfpa.org/sites/default/files/pub-pdf/WHO_HIV_2015.9_eng.pdf

International Network of People Who Use Drugs:
http://www.inpud.net

Harm Reduction International.
http://www.ihra.net/

Young key populations

Advocates for Youth. Best practices for youth friendly clinical services.
https://www.advocatesforyouth.org/storage/advfy/documents/bp-youth-friendly-services.pdf
IPPF. (2012). Keys to youth-friendly services: understanding evolving capacity.
http://www.ippf.org/sites/default/files/key_evolving_capacity.pdf

UNFPA. (2015). Youth participation and leadership.
http://www.unfpa.org/youth-participation-leadership#sthash.ken5LDSb.dpuf

WHO. (2015). HIV and young people who inject drugs: a technical brief.
Inter-Agency Working on Key Populations.
http://www.unfpa.org/sites/default/files/pub-pdf/WHO_HIV_2015.9_eng.pdf

WHO. (2015). HIV and young people who sell sex: a technical brief.
Inter-Agency Working on Key Populations.
http://www.unfpa.org/sites/default/files/pub-pdf/WHO_HIV_2015.7_eng.pdf

WHO. (2015). HIV and young men who have sex with men: a technical brief.
Inter-Agency Working on Key Populations.
http://www.unaids.org/sites/default/files/media_asset/2015_young_men_sex_with_men_en.pdf

WHO. (2015). HIV and young transgender people: a technical brief. Inter-Agency Working on Key Populations.
http://www.unaids.org/sites/default/files/media_asset/2015_young_transgender_en.pdf

Stackpool-Moore, L., et al. (2017). Linking sexual and reproductive health and rights and HIV services for young people: the Link Up project. Journal of Adolescent Health. Volume 60, Issue 2, Supplement 2.

Orza, et al., 2017. Searching for the second R in sexual and reproductive health and … rights. Journal of Adolescent Health. Volume 60, Issue 2, Supplement 2.

Session 3.1: The top 10 clinical standards of care for …. (insert the key population/s you are focusing on in this training)

Time: 2 hours

Materials

- ■ Flip charts
- ■ Markers or pens
- ■ Note pad and pen
- ■ Handout 8: Clinical standards of care for key populations—a self-evaluation

Learning objective

After completing this session, participants will be able to list and describe the clinical standards of care for one or more of the following key populations: sex workers, men who have sex with men, transgender people, and people who inject drugs.

Trainer preparation

- ■ Make copies of Handout 8 for participants.
- ■ Identify the slides from the slide deck that you need for the presentation and familiarize yourself with the content.
- ■ Familiarize yourself with Handout 8 and how participants are to fill this out.
- ■ Invite a member of the key population/s that you're addressing to co-facilitate this session with you and to participate in a role play.

[An additional session could be added here, framed as a panel discussion involving different representatives from key populations talking about their experiences accessing health services. See description below.]

Introduction

Explain that provision of quality health services for key populations requires a tailored approach. Specific, comprehensive services are required to meet individual needs and should follow international human rights principles and health sector quality standards. Service users and clients may identify with more than one key population. To provide quality and comprehensive services to key populations, providers need to consider:

- ■ The process of providing the services
- ■ The content of the services offered
- ■ The tailoring of services to meet the specific needs of different key populations

Activities

Introduce the session, touching on the points discussed in the introduction. Explain that this session will cover the first nine out of 10 priorities that apply to all key populations. The tenth priority has been broken down to meet the different, specific needs of sex workers, men who have sex with men, transgender people, and people who use drugs. **(5 minutes)**

Activity 1: Completing a self-evaluation (55 minutes)

Step 1: (35 minutes) Give participants *Handout 8: Clinical standards of care for key populations—a self-evaluation*. Ask participants to work in pairs to complete the first column of the handout—that is, to write down one to three standards of care procedures *they currently provide* to key populations in their own facility.

- Prompt example: Do you address viral hepatitis screening and what aspect of it?

Step 2: Feedback in the main group **(20 minutes)**
Ask each pair to report on the key points from their self-evaluation and allow time for questions and discussion.

Activity 2. Presentation, small groups, and discussion (85 minutes)

Step 1. (15 minutes) Presentation
Using the slides for this session, present the following top 10 clinical standards for key populations.
1. Provide HIV testing and comprehensive prevention services (including condoms and lubricants, HIV risk counseling and strategies for minimizing risk mitigation, behavioral interventions, small-group support).
2. Provide HIV care and treatment services
3. Offer or refer to pre- or post-exposure prophylaxis (PrEP or PEP)
4. Screen, test for, and treat vaginal and/or anal sexually transmitted infections
5. Provide or refer female clients to family planning/contraceptive services
6. Screen for tuberculosis
7. Screen for viral hepatitis and provide prevention information
8. Screen for substance abuse and provide or refer for harm reduction services
9. Screen for and respond to gender-based violence
10. Promote mental health

After the presentation, allow time for questions.

Step 2. (40 minutes) Small groups
Divide participants into four small groups and assign each group one of the key populations. Ask each group to answer the following questions for each of the 10 services in the context of the key population they were assigned:

■ Why is this service so important for this key population?

■ What other services does each key population need? (See examples below.)

■ Do you have the knowledge and resources to provide or refer for these services?

■ If not, what are the barriers to providing these services to key populations?

Emphasize the following sexual and reproductive health and rights, and primary care services for key populations.

Female sex workers

■ Family planning

■ Pregnancy testing

■ Offer or refer for abortion care

■ Cervical and anal cancer screening

■ Services to prevent vertical transmission of HIV (prevention of mother-to-child transmission [PMTCT] services)

■ Young people: Youth-friendly health services provide a holistic approach centered on improving access to information and health services that meet the specific needs of young people and that enable them to protect themselves from unintended pregnancies and HIV and other STIs.[19]

Men who have sex with men

■ PrEP (if/when available)

■ Condom distribution

■ Hepatitis B and C screening

■ Anal cancer screening

■ Support groups and services for "coming out," relationship counseling, and other sexual and reproductive health and rights services

■ Youth-friendly services for young MSM: Offer counseling services that recognize that young people are exploring their sexual orientation and may be responding to behaviors rather than labels

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[19] NSWP. (2016). Policy brief: young sex workers. NSWP also stresses the importance of recognizing the sensitive matter and the tension between approaches that seek to protect children from sexual exploitation and those seeking to improve their access to HIV prevention and treatment.

Transgender people

- Assess clinical needs as transgender clients might include those post-surgery and already on hormone therapy

- Offer or refer for hormone therapy

- Offer or refer for surgical options

- Youth-friendly services for young transgender people: Offer counseling services that recognize that young people are exploring their gender identity and consider implications associated with puberty.

People who inject drugs

- Needle and syringe programs (NSPs)

- Opioid substitution therapy (OST) and other drug dependency treatments

- Awareness of potential drug-to-drug interactions with OST and antiretroviral agents

- Wound care management

- Family planning, pregnancy testing, abortion referrals, and postabortion care for women who inject drugs

- Youth-friendly services for young people who inject drugs: link to primary health services, including services for survivors of physical, emotional, and sexual violence. Be mindful that harm-reduction interventions are usually not designed with young people in mind.[20]

Step 3. (15 minutes) Feedback in main group
Ask each group to share additional services they identified and the main barriers that prevent health care workers from providing comprehensive HIV and sexual and reproductive health services to key populations.

Step 4. (15 minutes). Ask participants to pair up and refer to their copy of Handout 8. Ask them to identify one to three standards of care that are new to them and identify existing gaps in their knowledge where they will need to develop or expand on their practices, based on the information in the presentation and small-group discussions.

Key Messages (15 minutes)
Answer any questions participants may have. Be sure to wrap up the session by reinforcing these messages (also listed in the Module 3 PowerPoint).

- People from key populations are diverse and have a variety of health needs.

- Laws, policies, social discrimination, and self-stigma can create barriers to health care for key populations. Some of these barriers and

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20 WHO. (2015). Technical brief: HIV and young people who inject drugs.
http://apps.who.int/iris/bitstream/10665/179865/1/WHO_HIV_2015.10_eng.pdf?ua=1

experiences are generated within the health system and impede the ability of key population members to talk about their substance use, sexual orientation, or health issues with their health care providers.

■ Access to the highest attainable standard of health is a universal human right, and quality and comprehensive services should be available and accessible to everyone including for key populations.

Now think about age, and how provision of services for members of young key populations needs to be adapted appropriately to their needs. The next session will address the needs of young key populations in more detail, but following are some ideas to consider in preparation.

■ Develop youth-friendly services that actively involve young people in program design and delivery.[21]

■ Offer programming that does not require young people to stop selling sex or using drugs to access services.[22]

■ Develop guidelines to provide age-appropriate, youth-friendly, and differentiated services (for example considering appropriate information, education, and communication materials and counseling approaches for young people ages 10–15 years, 16–19 years, and 20–24 years).

■ Be mindful of safeguarding children and adolescents.[23]

■ Consider working with new technologies to engage young people with age-appropriate messaging.[24]

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[21] Link Up. (2016). Aiming High: 10 strategies for meaningful youth engagement. http://www.athenanetwork.org/assets/files/Link%20Up%20mentoring%20programme/Aiming%20High_ENG_HiRes.pdf

[22] See NSWP. (2016). Policy brief: young sex workers. http://www.nswp.org/sites/nswp.org/files/Policy%20Brief%20Young%20Sex%20Workers%20-%20NSWP%2C%202016.pdf

[23] International HIV/AIDS Alliance. (2015). Workshop guide: safeguarding the rights of children and young people. http://www.aidsalliance.org/resources/480-safeguarding-the-rights-of-children-and-young-people.

[24] See, for example, some of the initiatives supported by ViiV Positive Action for MSM & Transgender: Supporting global efforts to alleviate the impact of HIV/AIDS and enable MSM and transgender individuals to safely seek culturally competent care and services.

Session 3.2: Providing youth-friendly services to key populations

Time: 2 hours

Materials

- Laptop and projector to show presentation
- Copies of presentation for participants
- Flip chart and marker pens
- Handout 9: Best practices for youth-friendly clinical service delivery
- Handout 10: Meaningful youth engagement

Learning objectives

After completing this session, participants will be able to:

- Explain concerns, perspectives, and specific considerations related to providing HIV services for young people
- Differentiate the nuances associated with providing services to young people associated with different key populations
- Identify considerations for age-appropriate service provision for people ages 10–15 years, 16–19 years, and 20–24 years

Trainer preparation

Make copies of Handouts 9 and 10 for participants.

Think through your own values and knowledge relating to young people's sexuality—for example, your views regarding sex before marriage or sex below the age of legal consent. Try to relate to the perspectives of young people who sell or trade sex for school fees or other necessities, who may be young males having sex with other males, young people coming to understand their gender identity, and young people who may be experimenting with drugs. You should try to empathize with your participants and consider that some may have long-held values that might make this topic difficult for them. Your participants may be providers who are not experienced in providing services to young people, and they might also be parents themselves. Anticipate some of the main challenges that participants may experience in planning and providing services that would appeal to, and meet the needs of, a range of young people from key populations.

Be familiar with the concept of youth-friendly services. Understand that different levels of service provision will be required at the various stages of young peoples' development and that these should be age-appropriate. Then be prepared to discuss how these concepts apply specifically to young people associated with key populations, recognizing that a young person may be associated with more than one of the groups.

Facilitation tips

Stress the importance of listening to and learning from young people to ensure that service provision responds to their needs. For example, develop a youth advisory group for the clinic and/or including young people as part of the current governance structure. This could be at board level and/or in client consultations and community engagement processes.

Additional resources

Global Network of Young People Living with HIV.
http://www.yplusleadership.org

WHO. (2015). HIV and young people who inject drugs: a technical brief.
Inter-Agency Working on Key Populations.
http://www.unfpa.org/sites/default/files/pub-pdf/WHO_HIV_2015.9_eng.pdf

WHO. (2015). HIV and young people who sell sex: a technical brief.
Inter-Agency Working on Key Populations.
http://www.unfpa.org/sites/default/files/pub-pdf/WHO_HIV_2015.7_eng.pdf

WHO. (2015). HIV and young men who have sex with men: a technical brief.
Inter-Agency Working on Key Populations.
http://www.unaids.org/sites/default/files/media_asset/2015_young_men_sex_with_men_en.pdf

WHO. (2015). HIV and young transgender people: a technical brief.
Inter-Agency Working on Key Populations.
http://www.unaids.org/sites/default/files/media_asset/2015_young_transgender_en.pdf

International HIV/AIDS Alliance. (2015). Workshop guide: safeguarding the rights of children and young people.
http://www.aidsalliance.org/resources/480-safeguarding-the-rights-of-children-and-young-people.

MEASURE Evaluation. (2017). Guidelines on best practices for adolescent- and youth-friendly HIV services: an examination of 13 projects in PEPFAR-supported countries.
https://www.measureevaluation.org/resources/publications/sr-16-134/

MEASURE Evaluation. (2017). Best practices for adolescent- and youth-friendly HIV services: a compendium of selected projects in PEPFAR-supported countries.
https://www.measureevaluation.org/resources/publications/tr-16-134/ .

Introduction

Relay the following information to your participants.

Most people become sexually active during their youth (before age 25 years). Young people may have limited access to services related to sexual and reproductive health and rights (SRHR) or comprehensive sex and relationship education. In fact, more than 50 percent of young women ages 1519 who are sexually active have unmet need for modern contraception.

Currently, more than half the world's population is below the age of 25, with 1.8 billion young people between the ages of 10 and 24. Most of these young people (85 percent) live in developing countries. HIV is the second largest contributor of adolescent mortality globally and the number one contributor in Africa, where young people ages 15–24 account for 40 percent of new HIV infections.

Young people who engage in activities associated with key populations are vulnerable to HIV by criminalization, discrimination, stigma and violence, power imbalances in relationships, and alienation from family and friends.

Young people are often unable to access comprehensive information and services regarding SRHR that are free from stigma or judgment; these services include family planning; screening and treatment for sexually transmitted infections; and HIV testing, counseling, and treatment services.

Young members of key populations may feel ostracized or isolated within mainstream youth services, which do not typically take their specific needs and concerns into account.

The term "young key population," which is a derivative from public health terminology, does not resonate with many young people, who may still be questioning sexual orientation and gender identity and may be exploring transactions of sex and experimentation with drug use.

This session calls attention to the importance of age differentiation and understanding the different needs of young people compared to older people associated with key populations.

Here, "young people" are defined as those ages 10–24, including children 10–17 years and adults 18–24 years (per the WHO's definition).

Activities

Distribute *Handout 9: Best practices for youth-friendly clinical service delivery.*
Activity 1. Brainstorm in small groups (30 minutes)

Ask participants to think about current practice in their clinics when they have a young person (under the age of 25) as a client.

Divide participants into four or five small groups. Ask each group to discuss these questions. These questions are also listed in the Module 3 PowerPoint. (15 minutes)

- What is your current practice for providing services to young people under 25 years and under 18 years?

- Do you adapt your services to different age groups—for example 10–14 years, 15–18 years, and 18–24 years?

- Within your current practice what do you do well for young people and where is there room for improvement?

- What kinds of factors do you need to consider in providing sexual health services for young people?

Ask one group to present the key points of their discussion, and then ask the other groups if they have anything to add. (10 minutes)

Review the list of factors identified for consideration and add others, if necessary. (5 minutes)

Some prompts for the groups to consider:

- How do different clinics operate within national laws but also provide essential services to young people under 18?
  - Where operational guidelines or protocols exist, are they inclusive and non-stigmatizing for all?
  - Does this differ for HIV or SRHR services? If so how?
  - What are the protocols or practices for referring young people if gender-based violence or abuse is suspected?

- What is the legal framework in this country for service provision to young people under 18?
  - What guidance is available from the funder or the national government on supporting a client under 18 who reports that she or he is selling sex?
  - Is there an operational guideline or protocol?

- How are people younger than 18 recorded in service statistics?

- Does the clinic respect the confidentiality of a young person, particularly those under the age of 18?
  - If so, how?

Activity 2: Barriers for accessing services (40 minutes)

In the same small groups, ask participants to consider the barriers to providing HIV services (including sexual health services) for different young key populations, and then identify possible solutions.

There should be four to five groups. Assign each group one of the categories of young people listed below.

Group work (20 minutes)
Group 1: Young men who have sex with men
Group 2: Young people who sell or trade sex
Group 3: Young transgender people
Group 4: Young people who inject drugs
Group 5: Young people living with HIV

Ask each group to imagine a young person from their assigned category. Have participants give their young person a name and a context. For example, if their young person is in Group 1, they might imagine someone named Joseph, aged 17 years, who sometimes attends school when he can get money for transport. They might imagine that Joseph lives with his older brother, two sisters, and his parents in a high-density area just outside the capital city.

Next ask the groups to:

- Identify barriers that the young person may face in accessing high-quality and comprehensive health services
- Identify ways to improve the quality of care provided to the young person

Report back in main group (20 minutes)
Next, ask each group to share the key points of their discussion with the larger group. (20 minutes in total, 5 minutes per group).

Activity 3: Case studies and scenario practice (30 minutes)

Form three groups, and encourage each group to role-play the discussion in each of the following three case studies. Let the groups practice in small groups (15 minutes), and then ask each group to perform their role-plays for the main group in the order listed below (15 minutes, 5 minutes per group).

All the groups work with the same case study (below), only from different perspectives:

Group 1: Modeling provision of youth-friendly services (but blind to the needs of young key populations)
Group 2: Modeling provision of key-population-friendly and stigma-free service provision (but blind to the needs of the young person)

Group 3: Modeling best practice for provision of key-population-friendly and youth-friendly stigma-free services that meet the needs of the young person.

Case study

You are an outreach worker. You have met a 16-year-old youth who has been in a sexual relationship with an adult who is 20 years older for the past two years. The youth *[you can choose if Casie is male, female, or transgender]* is being paid for sex by the adult. The young person has clearly stated that they are happy for this situation to continue.

This young person has been living on the streets for four years following the death of his/her mother. During this time, he/she has supported two younger siblings, who are still in school.

He/she is seeking HIV counseling and testing and is diagnosed HIV positive during the consultation with you.

Facilitation tip

Be mindful of time! Participants generally love to role play and can get carried away.

In the following activity, which is a discussion about the role plays with the whole group, make connections between what occurred during the role plays and the key messages for the session.

Activity 4: Main group discussion and summary presentation by facilitator (20 minutes)

Ask participants to comment on the role play—what did they notice were the main differences between the scenarios presented by the three groups?

Step 1: Explain (and refer to relevant examples from the opening discussion as appropriate):

- Young people will experience their association with a key population differently from adults, for example:
  - A young man who is having sex with men may not identify as gay but as someone who is exploring his sexuality and sexual orientation.
  - A young sex worker may not think of him or herself that way. In fact, they might be exchanging sex for school fees or materials other than money and often may be classified outside a more traditional definition of sex work. While older sex workers share problems and concerns with their younger counterparts, young people under 18 exist as a distinct legal category in international law, and governments carry a separate set of legal responsibilities for this group.
  - A young transgender person may not be aware of the concept of transgender, or may be unsure of his or her gender identity and

facing questions about starting hormone therapy or adopting treatment for preventing or intervening with the changes in the body associated with puberty.

- A young person using drugs may be experimenting with different drugs and at risk of progressing from smoking drugs to snorting them and then to injecting. While the harm-reduction approach has been proven to reduce HIV infections among people who inject drugs, as a rule such programs are not designed with the specific needs and vulnerabilities of young people in mind. Failing to serve young drug users results in missed opportunity for early intervention.

Step 2. Discuss and encourage responses from participants:

- Which communities get to benefit from your services and programs?
- Are high-quality services available to people who need them the most, including young key populations? If not, why not?
- Why should we work with young key populations?

As you discuss, remind participants about the importance of listening to the voices, experiences, and priorities of young people in an open-minded, age-appropriate, and practical way.

Distribute and discuss *Handout 10: Meaningful youth engagement* and explain that this details several ways to meaningfully work with young people before moving to the wrap up.

Step 3. Wrap up with key messages:
Be sure to wrap up the session by reinforcing these messages (also listed in the Module 3 PowerPoint).

- Young people will experience their association with a key population differently from adults.
  - That's why it is important to offer age-appropriate and age-differentiated interventions (i.e., what is appropriate for 14-year-old male who is exploring his sexuality may include counseling about first sexual debut, sexuality and sexual orientation, self-esteem, and positive relationships, whereas, for a young man who is already sexually active and identifies as gay at age 19, services may include providing condoms, information about and access to pre-exposure prophylaxis (PrEP), STI screening, and HIV testing and counseling). [Refer to Session 1.3 on sexual orientation and gender identity if more explanation is needed.]
- There is not much evidence available about young members of key populations, because young people are often excluded from research about key populations.
- Most young people face challenges in accessing youth-friendly services and may face judgment or refusal of services if they are sexually active and/or outside of marriage and/or if they are under the legal age of

consent. Young people associated with key populations may face additional barriers to accessing services because of laws and prevailing social values that may stigmatize or discriminate against key populations.

- Most clinics have their own service provision guidelines and protocols in line with the national legal context.
  - Encourage all participants to find out what their clinic policy/approach is to providing services (including HIV and gender-based violence) for young people under the age of 18.

- Participants should be inspired to follow up the training with a review of the "youth-friendliness" of their facilities, with attention to readiness and capacity to provide high quality services to young key populations.
  - It's important to recognize and explore if young people often are denied assistance because of their involvement with selling sex and/or using drugs, or their sexual orientation or identity, gender expression, or HIV status.

Session 3.3: Risk assessment[25]

Time: 2 hours

Materials

- Copies of Handout 11: Individual reflection
- Copies of Handout 12: Tips for conducting a risk assessment

Learning objectives

After completing this session, participants will be able to:

- List the benefits of conducting a risk assessment with a client
- Identify barriers to conducting a risk assessment and list ways to overcome them
- Describe when to conduct a risk assessment
- Provide clients with appropriate messages, services, and referrals

Trainer preparation

- Make copies of Handouts 11 and 12 for participants.
- Familiarize yourself with the risk assessment process and the tips for conducting one.
- Draw the risk-reduction messages table on a piece of flip chart paper.

Introduction

Explain to participants that a thorough risk assessment specific to sexually transmitted infections is a critical component of HIV services. Sexual risks and the use of drugs should be determined during a routine health history with every new patient and updated regularly during periodic health care visits. Risk assessments help to identify individuals at risk; support recommendations for HIV, sexually transmitted infections, and hepatitis screening; and establish risk-reduction and education strategies. Risk assessments can help people who are already infected access treatment and learn how to avoid transmitting HIV to others.

Activities

Activity 1: Small-group work (30 minutes)

Step 1. (15 minutes) Ask participants to break into small groups to discuss the following questions (also listed in the Module 3 PowerPoint).

- What is a risk assessment?

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[25] This session is adapted from CDC. (2014). Providing key population-friendly services: a sensitivity training for health care workers (HCWs), participant workbook.

■ What is being assessed?

■ When should you conduct a risk assessment?

Step 2. (15 minutes) Ask the groups to provide their answers and compile a comprehensive response to each question.

Make sure the following points are mentioned.

What is a risk assessment?

■ A risk assessment is a conversation between health care workers and their clients guided by some key questions.

■ The assessment's goal is to identify client characteristics that will help providers understand more about the clients' health care needs.

■ The assessment helps health care workers gather enough information to know:
  ▪ What prevention messages the client needs
  ▪ What service referrals are needed
  ▪ What are potential barriers for the client

■ Risk assessments must go beyond routine questions such as:
  ▪ "What brings you in today?"
  ▪ "What medical problems are you having?"

What is assessed?

■ Sexual behaviors
  ▪ Number of partners
  ▪ Gender of partners
  ▪ Types of sex they engage in

■ Drug use
  ▪ Medical or recreational
  ▪ Type of drugs
  ▪ Type of use

■ Medical history
  ▪ HIV/STI/tuberculosis/hepatitis diagnoses
  ▪ Chronic and acute conditions

■ Contextual issues
  ▪ Mental health
  ▪ Employment
  ▪ Social support
  ▪ If client is a minor, the unique issues that concern young key populations (see Session 3.2) should also be addressed

When to conduct a risk assessment?

■ Routinely with all clients; you cannot judge a client's risk factors based on how he or she looks

■ When confidentiality can be assured

■ Alongside a routine assessment

■ After the client understands the purpose and importance of the assessment

Activity 2: Group work (30 minutes)

In the same groups, brainstorm (for 15 minutes) the benefits of conducting a risk assessment for:

■ Clients

■ Providers

■ Community in general

Ask for feedback on each of the three questions, compiling a comprehensive response from the answers from each of the groups. (15 minutes)

Make sure the following points are discussed as listed in the Module 3 PowerPoint.

Benefits of conducting a risk assessment

For the client:

■ Helps client think about behaviors that affect risk

■ May motivate behavior change

■ Provides an opportunity to ask questions

■ Normalizes the process—all clients know to expect questions and no one feels singled out

For the provider:

■ Assists in clinical exam and intervention

■ Provides direction for giving messages and referrals

■ Increases skill and comfort in talking about sensitive issues

■ Helps them provide better care to clients

For the community at-large:

■ Helps to identify and serve those at highest risk of becoming infected or transmitting HIV

■ Improves the reputation of health care services as being accessible and acceptable, leading to higher uptake

Activity 3. Individual reflection (30 minutes)

Ask participants to review *Handout 11: Individual reflection* and think about some of the listed challenges to conducting an effective risk assessment. How would they overcome these challenges? Ask them to write their thoughts on the handout. (15 minutes)

Ask for volunteers to share their solutions to some of the challenges listed in the handout. (15 minutes)

Activity 4: Group session (15 minutes)

As a group, brainstorm an example of a risk-reduction message, services provided, and referrals relevant for each of the key populations. Draw the table below on a flip chart and ask participants to help complete each column.

What messages, services, and referrals can I provide to clients?

Key Population Group	Risk Reduction Messages	Services	Referrals
MSM	Example: Condom use during anal sex	Example: STI testing	Example: HIV test

Activity 5: Review tips for conducting a risk assessment (15 minutes)

Distribute *Handout 12: Tips for conducting a risk assessment* and review it together as a way to wrap up this session. Leave time to answer any remaining questions from the group.

If you are not planning on doing the Panel Discussion, be sure to review the key messages from this module that are listed at the end of Session 3.4 (and also available in the Module 3 PowerPoint).

Session 3.4: Suggested session: Panel discussion

Time: 60–90 minutes

The panel discussion, while optional, is highly recommended in order for participants to learn about the real experiences of key population members in their context. It requires that you give adequate prior notice to invite and brief LINKAGES implementing partners and speakers. People from key populations and health care providers (specifically, ones who are trusted and seen as champions in the provision of services for different key populations) could speak about the kinds of stigma and discrimination they have faced (both the key population member and health care worker) and the impact this has had on their lives.

Invite three to four panelists to share their perspectives. A key consideration in the invitation of panel speakers is the extent to which they are open about their experiences and relevant aspects of their identity and sexual practices. Invitations should be extended through LINKAGES partner organizations in-country to ensure that they have institutional/network support.

Panelists could include some combination of the following people, as relevant for your training group:

- Men who have sex with men (if they are open about their sexual orientation)
- Sex workers
- Transgender people
- People living with HIV
- People who inject drugs
- Young key populations
- Health care workers who provide services to key populations

Learning objectives

After the completing this session, participants will be able to describe real-life experiences faced by key populations at different points in their health care journey. (Remind participants of the role plays they did in Session 3.1. They may want to compare their role plays to the real-life experiences of the panelists.)

Facilitator's tips for ensuring meaningful and safe participation

- Tell participants that clients have valuable insights into their own health and well-being (as do health care providers who champion comprehensive and stigma-free care).
- Remind participants that the panelists are a diverse group speaking about their own experiences; some of their experiences may be

unique, while some may be representative of many other people in health care settings.

- Make sure the panel participants are well-briefed, have given their informed consent, and are adequately supported (by friends and family and/or by an institutional representative accompanying them to the session, if required).

- Make sure privacy and confidentiality are guaranteed and respected by the group—you could do this by referring to the group contract agreed upon at the start of the workshop. Confidentiality is an expectation and a professional obligation for health care workers. We also need to take individual responsibility for ourselves, both in what we feel able to share and in how we respect and keep secure the disclosures of others.

- Make the panelists feel comfortable. One way to protect the panelists is by having a mediator (the lead facilitator) who filters all questions from the audience to the panel and vice versa. This way, if something inappropriate is asked, the facilitator can rephrase the question in a respectful way. Or, if any answers from the panel need clarification, the facilitator can provide it or ask the panelist for more information.

The panel discussion also could be conducted in the style of a television chat show with celebrity guests. This exercise will allow for discussion of topics like the impact of double standards, gender-based violence, and stigma and discrimination. The facilitator could interview the panelists to seek their input on the questions below.

INTERVIEWER'S QUESTIONS

- *Have you experienced or witnessed stigma in a health care setting? Please share your experiences.*

- *Have you experienced or witnessed someone standing up to stigma or discrimination in a health care setting? What happened? Did it generate a longer term or immediate change?*

- *What do you think creates barriers for different key populations to access quality and comprehensive services? And what solutions would you suggest for overcoming these barriers?*

- *What challenges do health care providers face in offering quality and comprehensive services to key populations? And what solutions would you suggest for overcoming these challenges?*

- *Are there wider issues related to society, law enforcement agencies, and the education and health systems that affect the access of key populations to health services?*

- *What is your overall message, wish, or advice (e.g., to policymakers? To program managers? To the people in this room? To the LINKAGES project?)*

Allow time for questions from the participants in the group—either during the interview process (using the questions above more as prompts if the participants are reserved about asking any questions), or at the end of the session.

Wrap-up

Thank all the panelists for their time and mention two to three main points or key messages from the perspectives shared and the discussion that followed.

Key messages

These are the key messages that should be conveyed during throughout the session activities and discussion. Be sure to wrap up Module 3 by reinforcing these messages (also listed in the Module 3 PowerPoint).

- People (clients) are human beings first, then members of key populations.

- Health care providers have a duty of care—regardless of their personal moral code or opinions—to provide comprehensive, quality services to all.
  - It is so important for clients to work with health care providers who have earned the trust of different key populations and communities over time.

- Providers may also face stigma and/or discrimination in the workplace for providing services to key populations, so it is important to connect these providers through professional networks, communities, and peer educators.

- Individuals in key populations need to know the full range of services to which they are entitled, so that they can hold their health care workers and facilities accountable for providing them. Promoting access and identifying demand for quality comprehensive services is just as important as the supply and provision of those services.

- Health care workers must orient services to the unique health needs of young key populations and the added barriers young people experience in accessing services. They also need to consider that the term "young people" covers a wide age range of people with varying levels of knowledge and experience, and then adjust services accordingly.

Action, change, commitment

*"Never believe that a few caring people can't change the world.
For, indeed, that's all who ever have."* — Margaret Mead

At a glance

Participants have discussed many ideas and personal reflections by this point in the training. Module 4 is designed to transform those ideas into concrete practical action. Personal motivation and commitment are critical to influencing change—in attitudes, behaviors, and values—and in providing key-population-friendly services. The sessions in this module will help participants identify specific changes that can be made at the personal and facility levels. This module also allows time to address any outstanding questions and issues and to evaluate the training.

Sessions

Session 4.1: Monitoring service quality using LINK
Session 4.2: Creating a key-population-friendly clinic
Session 4.3: Planning for action in your health facility[26, 27]

Closing Session: Questions and answers, evaluation, and post-test questionnaire

Handouts

Handout 13: Key population LINK health facility assessment
Handout 14: Identifying areas for change in my health facility
Handout 15: Action plan for improving services in my health facility
Handout 16: Messages for challenging stigma in the workplace

Learning objectives

After completing this module, participants will be able to:

- Describe how to create a key-population-friendly clinic environment
- Identify and document strategies and plans to put what they have learned throughout this training into practice

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[26] This session is adapted from: Brown B, Duby Z, Van Dyk D. (2013). Health care provision for men who have sex with men, sex workers, and people who use drugs: an introductory manual for health care workers in South Africa.

[27] Intrah/PRIME II and JHPIEGO. (2002). Transfer of learning: a guide for strengthening the performance of health care workers. Chapel Hill, NC: Intrah/PRIME II and JHPIEGO.

Key messages

■ Translating thoughts into action takes personal commitment. This module consolidates the ideas and personal reflections from the whole training and is designed to channel those into supported actions.

■ Institutional and attitudinal change starts with each one of us. Feedback from this training will help inform future sessions.

Session 4.1 – Monitoring Service Quality Using LINK

Time: 35 minutes

Materials

- ■ Module 4: PowerPoint Presentation on LINK
- ■ Handout 2: Health care worker LINK self-assessment (or technology-based version)
- ■ Handout 13: Key population LINK facility assessment (or technology-based version)
- ■ LINK facility dashboards or copies of select data analyzed through LINK (if already implemented in your setting)

Learning objectives

After completing this session, participants will be able to:

- ■ Explain how to use LINK for monitoring service quality over time
- ■ Define their own role in how to help implement LINK, including better understanding how health care worker data from LINK will be used to identify challenges to providing quality services for key populations and help plan improvements in services.

Facilitation tips

- ■ If LINK is not available and will not be available to participants in the near future, you should not cover this session. How LINK should be covered in this session and throughout the training is dependent on the projects "readiness" to implement LINK. Reread the "guidance to trainers" section of this training guide prior to facilitating or adapting this session, and adapt the session below.
- ■ A more in-depth exercise on how to interpret and use LINK data relevant to their facility is done in in session 4.2.

Introduction

Read this quote: *"What gets measured, gets managed."*

Explain that to manage the quality of health services you need to measure it. In this session, participants will review how they have used data to identify facility-level challenges to providing quality services for key populations. This exercise will help the participants to monitor progress on their service improvement activities and remain engaged after the training ends.

Remind participants that they learned about a variety of issues that affect the quality of services for key populations, including clinical practices, stigma, and discrimination. Review the learning objectives for this session.

Activities

Activity 1. Explain the purpose of LINK and how it works (15 minutes)
Please adapt the content below as per the country program.

Give participants *Handout 16: Key population LINK health facility assessment,* and ask them to refer to *Handout 2: Health care worker LINK self-assessment* (which they completed in the Introduction session) as you explain the LINK system.

Using the PowerPoint presentation, review the following:

- ■ Explain that LINK is a quality monitoring system that allows key population members to assess health facilities and health care workers to complete self-assessments on their own attitudes about key population members and the services they provide to key population clients. With the responses to these assessments, those responsible for service quality can work with LINKAGES to identify challenges and design interventions to improve services. The continued implementation of these assessments over time will help track the outcomes and success of these interventions in removing barriers to key populations' access to quality services.

- ■ Explain that LINK assessments can be completed via paper-based forms or using various technologies such as online tools (FaceBook, Survey Monkey, WhatsApp) or even short messaging systems (SMS) or texts.

- ■ Explain to the participants that they will be requested to complete a quarterly self-assessment via the LINK system. LINK is free and anonymous. Explain to health care workers the process of how the self-assessment is administered as per the technology platform used in the country. LINKAGES staff will review these surveys and get in touch with health care workers about their responses, compare their responses, and monitor progress on service improvements over time. In addition, LINKAGES will review requests and suggestions from health care workers and use these to prioritize activities and help health care workers to implement and track those interventions to improve services. The project will also provide feedback to health care workers on the progress they have made on improving services for key populations (based on the feedback/assessments).

Next, you should provide example dashboards of how LINK data are used and how the data can be used over time. (Note that staff will be asked to review reports of LINK data in the next session as preparation for action planning).

Activity 2. Guided discussion (15 minutes)
Answer any questions the participants may have. If the LINK point person is available during the training, he or she can provide answers. The following are questions that you may want to ask participants:

- What do you think about the LINK system and method of self-assessments? What about the number of questions and length of the self-assessments?

- Will this self-assessment help you monitor your progress on efforts to improve services?

- How will you use this data?

- Do you feel comfortable responding to LINK questions on a quarterly basis?

Take notes on participants' responses to give to the LINK point person working at LINKAGES so that the project can refine the LINK system and Health4All campaign, as required.

Key Messages (5 minutes)

The following are key messages that should be conveyed to participants throughout the session activities and discussion. Be sure to wrap up the session by reinforcing these messages (these are also listed in the Module 4 PowerPoint):

LINK was developed by LINKAGES as a system for monitoring the quality of health services from the perspective of both key populations and health care workers. The data collected are used to:

- Target information on and track the outcomes of efforts such as health care worker trainings to improve service delivery

- Initiate a feedback loop among clients, project staff/community-based organizations, and providers to improve health services (as providers will receive regular feedback from key populations on their performance through facility reports from patients/clients)

- Continuously engage providers and patients/clients through SMS to encourage both high-quality service provision and positive health behaviors

Session 4.2 Creating a key-population-friendly clinic

Time: 2 hours

Materials

- ■ Paper and pen (for personal reflection)
- ■ Flip chart paper and markers
- ■ Copies of participants' *Handout 7: My commitment—10 values to guide my work with key populations* for participants to reflect on these and the additional commitments they wrote during Session 2.3
- ■ Report detailing feedback on services from key populations, such as LINK dashboards or report (if available).

Learning objectives

After completing this session, participants will be able to:

- ■ Explain key elements of key-population-friendly services relevant to their professional roles and the health facilities where they work in order to provide more effective care for key populations.
- ■ Use the information and new knowledge gained to inform action planning.

Trainer preparation

- ■ Be mindful of the issues that have emerged in the training so far because this session is designed to build on key points or examples that have already been raised by the group in other sessions regarding the provision of key-population-friendly services free of stigma and discrimination.
- ■ You may need a break between Activity 3 and 4 given the intensity and length of these activities.
- ■ For Activity 4, it is important to have prepared ahead of time a report that provides feedback on services from members of key populations, such as a LINK report, if available.

Facilitation tips

If the group is comfortable with each other, this session will generate a very rich and interesting discussion. The term key-population-friendly is used in this session because it's an accepted short-hand term for describing comprehensive, high-quality services to key populations free of stigma and discrimination in the context of HIV service provision. If this term does not work for your setting, please feel free to use something different.

Introduction

Explain that this session will aid participants in designing their action plans (to be conducted in a future session) by helping them identify and determine what comprehensive, high-quality key HIV services and support should look like for each key population group.

- Key-population-friendly services involve a tailored approach to meet individual needs, follow international human rights principles, and meet government or other relevant medical guidelines.

- It is helpful for us to understand what makes services truly "key-population-friendly" in order for us to generate small and large changes within institutions to improve the quality of health care service delivery for key populations.

- Making these improvements takes personal motivation and commitment to influence change in attitudes, behaviors, and values.

Activities

Activity 1: Brainstorm key-population-friendly service characteristics (50 minutes)

Step 1: (25 minutes) Ask participants to get into small groups of 3–5 people and answer the following two questions. If short on time, you can have some groups answer question #1 and others answer question #2. These are also on the PowerPoint slides for Module 4.

1. Imagine a health facility that is truly key-population-friendly from the perspective of an MSM (or other key population member client). What does the facility look like? How is this person treated? How are services provided and organized? What are other characteristics of care?

2. Imagine a health facility that is truly key-population-friendly from the perspective of a health care provider. What does the facility look like? How is this health care provider supported? How are services provided and organized? What are other characteristics of care?

Facilitation tip

Some participants may ask if the questions refer to clinical care standards or specific medial guidelines. It may be best to focus the brainstorming about how services are delivered given that clinical standards were covered in a previous session.

Step 2: (25 minutes) Ask several groups to briefly report their answers and discuss. You may want to highlight when characteristics of care differ between how key populations may perceive key-population-friendly services and how health care providers perceive key-population-friendly services.

Consider how much consensus there is among groups regarding the most important aspects of key-population-friendly services and write this list on a flipchart.

Activity 2: Personal reflection (25 minutes)

Step 1. (15 minutes) Ask participants to think about the following questions in the context of their work and their day-to-day lives and reflect alone. Ask each question one by one as reflected in the PowerPoint slides, and move on to the next question only when the group is ready.

- Can you recall an inspiring story of when someone (or you) has stood up to stigma and sought to achieve change in your clinic/office/workplace?

- Can you identify priorities for challenging stigma and key actions in your clinic/office/workplace to catalyze change to promote key-population-friendly services?

You may ask participants to share their answers either with a partner or in the larger group. Remind participants that sharing is entirely optional, and it is encouraged that they write down their answers to these questions.

Step 2: (10 minutes) Review *Handout 7–My commitment*
Thinking about their personal reflections and those shared with the group, ask participants to revisit Handout 7 and to think through what their commitment really means, in practical terms, for them in their context given the list of key-population-friendly service characteristics they have just brainstormed.

Ask them to write down their commitments. Ask several people to share one of their new commitments.

Activity 4: Know your services (35 minutes)

Remind participants about why it is important for clients and communities to demand the full range of services they deserve—and be able to recognize quality and comprehensive care both when it is offered, as well as when it is withheld.

Use this time to review any available feedback from key population members on health services. This step will inform participants of the clients'/patients' perspectives on the key issues, challenges, and opportunities at the facility level. You can use a variety of data sources for this step, including key populations' facility assessments, such as those completed through LINK (if the LINKAGES program in your country is LINK) or data from health facility exit interviews, comment boxes, or research findings on barriers to health services among key populations.

- **If LINK is already implemented in the country,** distribute the LINK facility-level reports that aggregate key populations' assessments of facilities. If it is a training of trainers (TOT), you can distribute to trainers all the reports for the facilities at which each trainer is later expected to train. Note to these participants that when they are

training others, they can distribute these LINK reports to facility workers in the training so that they can see how their facility fares.

■ **If LINK is not available,** distribute a prepared report that provides feedback on services from members of key populations. This report can be based on other activities that are ongoing in the country (such as health facility exit interviews), from comment boxes, or from research findings on barriers to health services among key populations.

■ **If no data are available from key populations,** ask the participants to think about the following questions and compare their answers to the brainstormed list of key-population friendly service characteristics: (1) What were the major issues that the key population members mentioned earlier in the training about barriers to accessing services? (2) What are other barriers that might limit or deter key populations from accessing services at my facility?

Using the available data, ask participants to reflect on these questions:
1. What are the major issues that key populations identified?
2. What can the facility or staff do to help resolve those issues?
3. What other stakeholders or organizations should be involved to resolve these issues?

Facilitator tip

This exercise can be done individually but is best to do in small groups, particularly if small groups can be organized by facility or practice area (as they may be organized during action planning).

Wrap-up (5 minutes)

Remind participants about the duty of care (for providers), as well as our own responsibility—and accountability—for enabling the provision of quality and comprehensive services for key populations.

Conclude with an appreciation of the group's honesty and openness—including their personal reflection and any thoughts they chose to share with the group. Encourage them to revisit their commitment in six months later as a way of holding themselves accountable for follow-up action after the workshop.

Session 4.3: Planning for action in your health facility

Time: 1 hour and 30 minutes

Materials

- ■ Access to photocopier for completed handouts at the end of the session

- ■ Optional: Handout 2: Health care worker LINK self-assessment

- ■ Handout 14: Identifying areas for change in my health facility

- ■ Handout 15: Action plan for improving services in my health facility

- ■ Handout 16: Messages for challenging stigma in the workplace

Learning objectives

After completing this session, participants will be able to describe their action plans to transform their facilities into key-population-friendly environments and to provide more effective services for key populations.

Trainer preparation

Make copies of the handouts for participants.

Facilitation tip

Move among the groups to ensure that all participants understand the activity and understand how to complete the handouts.

This session may need to be extended in time depending on the pace of group work.

Introduction

This session is to help transform learning into actions that will improve services for key populations.

Explain that during this session, participants will identify areas that need to be changed to provide more effective care for key populations. Remind participants that key populations experience many challenges in accessing health care services. These can range from stigma and discrimination to breeches in confidentiality, as explored in case studies and other exercises in previous modules.

Participants will develop individual action plans for carrying out these changes. Some participants may wish to develop action plans in small groups, especially if they are participating in the training with other members of their health facility team.

Activities

Introduce the session by explaining the key learning objectives.

Activity 1: Identifying areas for change (30 minutes)

Step 1: (5 minutes) Ask participants to retrieve their health care worker self-assessments (Handout 2) that they completed earlier in the training (either the paper version or the version on their phone). In addition, they should review the materials developed in session 4.2 including the list of key-population-friendly characteristics, personal commitments, and report detailing feedback on services from key populations.

Distribute *Handout 13: Identifying areas for change,* and explain the information they should write in each column.

- ■ **My name, Name of health facility, Date completed:** Write this information at the top of the chart.

- ■ **Challenge:** List the specific challenges that you believe most affect key populations at your clinic. If you are not able to identify these easily (perhaps you are not aware of any members of key populations who attend your clinic), then select the challenges or barriers that make it difficult for other types of clients. For this activity, select one of the challenges or barriers that you would like to support changing at your health care facility.

- ■ **Cause(s):** Identifying the underlying cause of a challenge/barrier will help you determine a course of action that will correct it. Example: you might identify that clients from key populations do not attend your clinic and this is the problem you are attempting to change. Or perhaps clients from key populations do attend your clinic but do not disclose that they are men having sex with men, or selling sex, or transgender, or injecting drugs. This problem could have many different causes. Are key populations not coming or not disclosing because they do not know about the services you offer at the clinic or because they have come before but have had poor experiences? You may not always know the cause, but this doesn't prevent taking action to make services safer and more acceptable and accessible for clients from key populations. Each of these causes could lead to the same problem (key populations not attending or not openly disclosing at your clinic) but they would require different courses of action to change.

- ■ **Type of cause:** Identify whether the cause of the barrier or challenge is linked to individual health care workers (either you or colleagues), or whether it is associated with facility-level difficulties (hours of operation, service limitations, etc.).

- ■ **Goal:** Set a goal that you would like to achieve toward changing this barrier or challenge. Make sure to use the SMART criteria when setting your goal (see description below).

SMART Goals = Specific, Measurable, Achievable, Realistic, and Timely
Specific: Your goal should be clear and direct.
Measurable: You should be able to effectively monitor your progress toward achieving your goal. It should not be ambiguous.
Achievable: You should be able to reach your goal within a set amount of time.
Realistic: Your goal should be feasible and not impossible to reach.
Timely: Your goal should include a specific timeframe within which it could feasibly be achieved.

Step 2: (25 minutes) Ask participants to individually complete *Handout 13: Identifying areas for change.*

Activity 2: Developing an action plan (60 minutes)

Step 1: Explain handout (5 minutes)
Distribute *Handout 14: Action plan for improving services in my health facility,* and explain the information they should write in each column (5 minutes for explanation, 15 minutes for individual or group work).

- **Goal #1:** Write the goal you have selected to achieve.

- **Problems to overcome:** Describe the anticipated challenges or barriers that must be eliminated or reduced for you to achieve your goal. Include how this will be done.

- **Activities and steps:** Break down your goal into a series of smaller steps. Each should be easily achievable and move you one step closer to achieving your overall goal.

- **Person(s) responsible:** Identify who will need to be involved to make sure you successfully reach this goal. Can you implement the activity yourself, or will you need to involve other staff or managers of the facility?

- **Resources and assistance:** Identify what resources and other assistance you will need to carry out the activity. Will this activity require additional funding or other tools that your facility would need to contribute? Will you or your colleagues need to contribute additional time during work hours?

- **Time period:** Include a specific time schedule for.

- **Indicators of success:** Specify how you will know you have successfully completed each activity and how you know you will have reached your goal.

Step 2: Complete the action plan (45 minutes)
Invite participants to fill out the action plan based on their work from *Handout 13: Identifying areas for change* as well as the other resources they used when developing Handout 13. This may be done best in small groups organized to enact plans together when returning from the training.

Facilitator tip

It is important that facilitator's walk around and offer support and encouragement to groups that may be struggling to fill out the action plan.

Step 3: Group feedback and discussion (10 minutes)

Bring the group back together, and ask people to reflect on the exercise by asking the following questions (also on the PowerPoint slides):

- What was the hardest part of action planning? What was the easiest part?

- Do you anticipate significant barriers to implementing the changes they have planned to make?

- What changes have you identified that you or others will make or pursue immediately upon returning to the facility?

- Are there any areas that require technical or other support to make the changes?
  - Can participants identify specific parts of their institution's strategy that align with the ideas discussed in this session?

Give participants *Handout 15: Messages for challenging stigma in the workplace* and encourage them to make a copy of this to put on the wall of their clinic.

Make copies of the completed action plans, and give the originals back to the participants. You can refer to the copies of the completed action plans when you follow up with participants to review and support their progress on the activities.

Closing Session

Time: 30 minutes

Materials

- ◼ Flip charts
- ◼ Sticky notes
- ◼ Anonymous questions box (optional)

Learning objectives

After completing this session, participants will be able to:

- ◼ Identify outstanding issues of concern and clarify any remaining questions
- ◼ Find and use local sources of support and other additional information resources

Trainer preparation

- ◼ Attach two pieces of flip chart paper to the wall. Label one of them as "remaining questions" and the other as "sources of information and support."
- ◼ Develop a list of local sources of information and support related to the rights of, and services for, key populations.

Facilitation tips

- ◼ Remain open-minded. No question is silly, and some people take longer than others to grasp core concepts and ideas (even if you feel these ideas have been covered in detail during the training).
- ◼ Where possible, link the specific questions and outstanding issues to specific sources of support and information.
- ◼ Do not assume that every person or institution put forward as a source of information or support will meet LINKAGES' standards. Be diligent to ensure these are suitable sources of support.

Introduction

Tailor this session to meet the needs of your group, depending on the nature of the discussions so far and the extent of questions remaining. If you are unable to address every outstanding question, you can provide local sources of expertise (people, organizations, champions) where participants can receive more information.

Activities

Activity 1. Answering remaining questions (30 minutes)

Step 1: (5 minutes) Ask participants to take at least two sticky notes and to spend five minutes on their own thinking about any outstanding questions or issues on their mind. Tell them to write their questions/issues on the sticky notes (or, if they have no questions, write "no questions" on a note).

For some groups it may be more appropriate to create an anonymous way for people to ask any outstanding questions—for example by asking people to write questions on a sticky note or plain paper and put them into an envelope or box for anonymous questions. The facilitators can then respond to these.

Step 2: (5 minutes) Next, ask participants to put their sticky notes on the flip chart labeled "remaining questions." As they are doing that, also ask them to read any notes that have been put up before theirs to see what questions other people still have.

Step 3: (5 minutes) Ask participants to return to their seats, think of some resources in the local area that could provide more information and support, and then write their ideas on a sticky note.

PROMPT: Potential sources for more information could be providers who are already trusted by key populations, champions for the rights of key populations within local NGOs or policy bodies, and networks or groups of key populations.

While the participants are brainstorming sources of information and support, review the sticky notes on the "remaining questions" flip chart and group them into key themes.

Step 4: (5 minutes) Ask participants to stick their notes on the flip chart labeled "sources of information and support." Again, ask them to also read the ideas offered by others in the group.

Step 5: (10 minutes) In the group session, summarize the key themes identified on the "questions" flip chart and either answer them (if they only require a short clarification) or match the questions/issues with the local sources of support identified. Add any other sources of information and support (you may have identified before the workshop) to complement those identified by the group.

Evaluation and Post-test Questionnaire

Time: 40 minutes

Materials

- ■ Copies of Handout 1: Pre- and post-training questionnaire
- ■ Copies of Handout 17: Evaluation form

Learning objectives

After completing this session, participants will be able to share ideas about how the training could be improved or adapted in the future. Participants will also complete the post-training questionnaire to show what they learned over the course of the training.

Trainer preparation

Make copies of Handouts 1 and 17 for participants.

Facilitation tips

This content of the training, and the personal reflection it required, may have been unusual for many participants, who might be more comfortable and familiar with purely technical training. Recognize and express appreciation for your participants' open-mindedness and thoughtfulness. Thank the group for their feedback that will help inform future trainings.

Introduction

Let participants know that their feedback on this training, and the results of their post-training questionnaire, will help to strengthen future trainings. Tell them that you'd like to receive their honest, constructive criticism and specific recommendations for how to improve the training guide. Remind participants that the information from the evaluation forms and post-test questionnaire is anonymous.

Activities (40 minutes)

Distribute the evaluation forms and the pre- and post-training questionnaires (Handouts 1 and 17), and ask participants to complete them. Rather than collecting the completed forms from the participants, ask them to place the forms in a central location (e.g., on a chair or table), so that their responses remain anonymous. (20 minutes)

Thank the participants for their time, energy, and honest and open reflection throughout the training. Ask if anyone would like to share any final thoughts or comments with the group. (10 minutes)

In closing, remind participants that action and change can start with each of them, and remind them about the commitment statements that they have

made. Clearly explain any follow-up training or support opportunities available to them. (10 minutes)

Key messages

- Change starts with each of us.

- Reducing stigma and enabling key populations to access quality comprehensive health services is a critical part of any response to HIV.

- Each one of them has committed to take action (in themselves, their communities, and their facilities) as a result of this training.

List of Handouts

Introduction

Handout 0: Participant sign-in sheet
Handout 1: Pre- and post-training questionnaire
Handout 2: Health care worker LINK self-assessment

Module 1

Handout 3: Genderbread person: sexual orientation and gender identity
Handout 4: Key terms
Handout 5: Questionnaire—sexual orientation and gender identity

Module 2

Handout 6: Case studies for Session 2.3
Handout 7: My commitment—10 values to guide my work with
key populations

Module 3

Handout 8: Clinical standards of care for key populations—a self-evaluation
Handout 9: Best practices for youth-friendly clinical service delivery
Handout 10: Meaningful youth engagement
Handout 11: Individual reflection
Handout 12: Tips for conducting a risk assessment

Module 4

Handout 13: Key population LINK health facility assessment
Handout 14: Identifying areas for change in my health facility
Handout 15: Action plan for improving services in my health facility
Handout 16: Messages for challenging stigma in the workplace

Closing session

Handout 17: Evaluation form

Other

Answers to the pre- and post-training questionnaire

Handout 0: Participant sign-in sheet

Please use this sign-in sheet for each day of the training and ask participants to be sure that their details are clear and legible.

Health4All Training—Daily sign-in sheet

Venue_____ Date _____

Name	Organization/Clinic	Title of your position	Contact phone number
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			

Handout 1: Pre- and post-training questionnaire[28]

Please respond to the following questions as best you can according to your beliefs and knowledge. You will be asked to complete this questionnaire at both the beginning and the end of the workshop. The purpose of this questionnaire is for LINKAGES to know how well they are doing to increase your knowledge and skills in the workshop.

Please do not include your name on this paper. You will create a unique identifier to maintain your confidentiality and allow facilitators to match your pre- and post-workshop responses. This number should be the same each time you respond to this questionnaire.

My Unique Identifier:			
	Number of sisters	Birthday month	Last three digits of your phone number
Example	0	June	749

Date_____

Your position (e.g., health worker, peer navigator, trainer, educator)

_____

Part I
1. Which of the following statements best describes key populations?
(Choose only one answer)
    a.   They rarely engage in high HIV risk behaviors.
    b.   Their behavior is stigmatized and often criminalized.
    c.   They have no problems accessing high-quality HIV services.
    d.   All of the above

2. Statements such as "girls don't like science" or "real men don't cry" are examples of:
(Choose only one answer)
    a.   Gender identities
    b.   Gender stereotypes
    c.   Sexual identities
    d.   Gender-role behaviors

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[28] Adapted from CDC. (2014). Providing key population-friendly services: a sensitivity training for health care workers.

3. Repeatedly putting down or making fun of someone is a type of
_____ abuse.
(Fill in the blank with an appropriate word)

4. Only men who have sex with men practice anal sex.
(Choose only one answer.)
   a. True
   b. False

5. A harm-reduction approach to reduce HIV risk for people who inject drugs could include:
(Choose all correct answers)
   a. Injecting only certain types of drugs
   b. Not sharing injection equipment and using sterile needles
   c. Living with a family member to monitor drug use behavior
   d. Receiving harm reduction information and commodities such as clean injecting equipment and naloxone

6. A transgender person is any person whose gender identity or expression differs from their _____at birth.
(Fill in the blank with an appropriate word.)

7. What is stigma?
(Choose only one answer)
   a. A set of negative and often unfair beliefs or disapproval towards a specific person or group
   b. Treating someone differently and not providing the same quality of service because of a person's behavior, religion, race, etc.
   c. Feeling depressed and unhappy
   d. Making generalized statements about a person or group of people based on a set of characteristics

8. Which example below best illustrates how stigma affects how a man who has sex with men (MSM) receives HIV services?
   a. The receptionist complains that young MSM clients are coming into the clinic right before it closes.
   b. A health care provider makes a general statement to her colleague that all MSM need frequent STI testing.
   c. During a risk assessment, a married man expresses that he is unhappy with his home life but does not disclose that he has sex with men.
   d. A health care provider tells an MSM, "It is my ethical and legal obligation as a health care provider to protect your privacy."

9. Name two primary care services, other than HIV-related services, that a health care worker should focus on with a client who is a female sex worker.
(Write your answer in the space given)

1._____

2._____

10. Name two primary care services, other than HIV-related services, that a health care worker should focus on with a client who is a man who has sex with men.
(Write your answer in the space given)

1._____

2. _____

11. The purpose of providing clients with risk-reduction messages is to...
(Choose only one answer)
   a. Eliminate all HIV risks that clients may experience
   b. Ensure that all clients receive the same messages, regardless of their risks
   c. Decrease the risk experiences by clients according to their behaviors and context
   d. Convince clients to completely change their lifestyle

12. Which of the following statements is false?
(Choose only one answer)
   a. Young people living with HIV face unique health, adherence, and psychosocial issues and challenges.
   b. Young people must have their parent or guardian's permission to receive HIV testing and treatment services.
   c. Health workers need specific knowledge and skills to meet the needs of young clients.
   d. Programs and clinical services need to be youth-friendly to attract and retain young clients.

13. Name one reason why young people in key populations may be extra vulnerable to stigma and discrimination?
(Write your answer in the space given.)

_____

_____

_____

Part 2.
Please read the following statements and indicate the level that you agree or disagree by putting a check mark in the appropriate box. Please answer as honestly as possible.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I have the knowledge and skills to explain to my colleagues why key populations deserve access to stigma-free, high-quality HIV services.					
2. I believe that laws and policies should be in place to prevent men from having sex with men.					
3. I believe that all patients, regardless of their gender identity, age, sexual orientation, and sexual behavior, must be treated equally and fairly.					
4. I feel strong disapproval when I learn that a young woman is receiving goods or money in exchange for sex.					
5. I will continue to educate myself and others about key populations.					
6. I feel strong empathy for a person who injects drugs.					
7. I am highly motivated to ensure that key populations receive stigma-free, high-quality, comprehensive HIV services.					

Handout 2: Health care worker LINK self-assessment

FACILITY STAFF SELF-ASSESSMENT
FOR ALL HEALTH STAFF AT HIV-RELATED SERVICE FACILITIES

Welcome to the Health4All free and anonymous SMS platform to improve health services. Use this simple phone-based self-assessment to review your knowledge, attitudes, and practices related to people living with HIV and key populations at risk to HIV. Reply "STOP123" to remove yourself from this group.

	• Questions	• Response Options
Facility Selection & Staff Profile	1. Where is the health facility where you work?	☐ 1=*Region 1* ☐ 2=*Region 2* ☐ 3=*Region 3* ☐ 4=*Region 4* ☐ 5=Other *(add question to specify if SMS)*
	2. What type of facility?	☐ 1=Public ☐ 2=Private ☐ 3=Community-led ☐ 4=Other *(add question to specify if SMS)*
	3. What is the facility name?	*Select from list of facilities.*
	Facility selection questions can be removed from the assessment if staff can be instructed to input a facility-specific identification code that can initiate the assessment.	
	4. What kind of work do you do at this health facility?	☐ 1=Health staff (nurse, physician, lab technician, phamacist, or counselor) ☐ 2=Non-health staff (receptionist, security or other)
People Living with HIV (PLHIV)	Let's start with some questions on your knowledge about patients and clients at your facility who are living with HIV. Answer each question to the best of your knowledge.	
	5. Would you get in trouble at work if you discriminated against patients who are HIV positive?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	6. Does your facility have written guidelines to protect patients who are HIV positive?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	7. In the past 3 months, have you heard staff at your facility gossip about patients because they are HIV positive?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	8. In the past 3 months, have you heard staff at your facility refuse services to a patient because they are HIV positive?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	9. Should people living with HIV feel ashamed of themselves?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	10. Are people living with HIV to blame for their health issues?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know

	11. How would you rate your facility's services for people living with HIV? Check a number 1–5, where 1 is low quality and 5 is high quality. **(If 3–5, skip 12a)**	☐ 1=Very low quality **(Go to question a)** ☐ 2=Low quality **(Go to question a)** ☐ 3=Average **(Skip question a)** ☐ 4=High quality **(Skip question a)** ☐ 5=Very high quality **(Skip question a)**
	a. Why is the quality of services low for people living with HIV?	*Reply with a short response for SMS or enter common response types for IVR.*
	12. How can your facility improve services and make it easier for people living with HIV to receive services?	*Reply with a short response for SMS or enter common response types for IVR.*
KPs	13. Are you familiar with key populations or KPs? **(If yes, skip below)**	☐ Yes ☐ No or not sure
	Key populations or "KPs" include sex workers, men who have sex with men, transgender people, and people who inject drugs. Key populations are more affected by HIV because of risk factors that include stigma.	
Sex Workers (SWs)	Sex workers include people who exchange sex for money or goods. These populations are at higher risk of HIV than the general population. We will ask you a similar set of questions about sex workers.	
	14. Would you get in trouble at work if you discriminated against patients who are sex workers?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	15. Does your facility have written guidelines to protect patients who are sex workers?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	16. In the past 3 months, have you heard staff at your facility gossip about patients because they are sex workers?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	17. In the past 3 months, have you heard staff at your facility refuse services to a patient because they are a sex worker?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	18. Should sex worker feel ashamed of themselves?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	19. Are sex workers to blame for their health issues?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	20. How would you rate your facility's services for sex workers? Check a number 1–5, where 1 is low quality and 5 is high quality. **(If 3–5, skip 12a)**	☐ 1=Very low quality **(Go to question a)** ☐ 2=Low quality **(Go to question a)** ☐ 3=Average **(Skip question a)** ☐ 4=High quality **(Skip question a)** ☐ 5=Very high quality **(Skip question a)**
	a. Why is the quality of services low for sex workers?	*Reply with a short response for SMS or enter common response types for IVR.*
	21. How can your facility improve services and make it easier for sex workers to receive services?	*Reply with a short response for SMS or enter common response types for IVR.*
MSM	Men who have sex with men can include gay men, bisexual men, and other men who have sex with men, even if they identify as heterosexual. These populations are at higher risk of HIV than	

	the general population. We will ask you a similar set of questions about men who have sex with men.	
	22. Would you get in trouble at work if you discriminated against patients who are men who have sex with men?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	23. Does your facility have written guidelines to protect patients who are men who have sex with men?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	24. In the past 3 months, have you heard staff at your facility gossip about patients because they are men who have sex with men?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	25. In the past 3 months, have you heard staff at your facility refuse services to a patient because they are a man who has sex with other men?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	26. Should men who have sex with men feel ashamed of themselves?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	27. Are men who have sex with men to blame for their health issues?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	28. How would you rate your facility's services for men who have sex with men? Check a number 1–5, where 1 is low quality and 5 is high quality. **(If 3–5, skip 12a)**	☐ 1=Very low quality **(Go to question a)** ☐ 2=Low quality **(Go to question a)** ☐ 3=Average **(Skip question a)** ☐ 4=High quality **(Skip question a)** ☐ 5=Very high quality **(Skip question a)**
	a. Why is the quality of services low for men who have sex with men?	*Reply with a short response for SMS or enter common response types for IVR.*
	29. How can your facility improve services and make it easier for men who have sex with men to receive services?	*Reply with a short response for SMS or enter common response types for IVR.*

Transgender People	Transgender people include those whose gender identity is different than their sex assigned at birth. Transgender women are at higher risk of HIV than the general population. We will ask you a similar set of questions about transgender women.	
	30. Would you get in trouble at work if you discriminated against patients who are transgender?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	31. Does your facility have written guidelines to protect patients who are transgender?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	32. In the past 3 months, have you heard staff at your facility gossip about patients because they are transgender?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	33. In the past 3 months, have you heard staff at your facility refuse services to a patient because they are transgender?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	34. Should transgender people feel ashamed of themselves?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	35. Are transgender people to blame for their health issues?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	36. How would you rate your facility's services for transgender people? Check a number 1–5, where 1 is low quality and 5 is high quality.	☐ 1=Very low quality **(Go to question a)** ☐ 2=Low quality **(Go to question a)** ☐ 3=Average **(Skip question a)** ☐ 4=High quality **(Skip question a)** ☐ 5=Very high quality **(Skip question a)**
	a. Why is the quality of services low for transgender people?	*Reply with a short response for SMS or enter common response types for IVR.*
	37. How can your facility improve services and make it easier for transgender people to receive services?	*Reply with a short response for SMS or enter common response types for IVR.*
People Who Inject Drugs (PWID)	We will ask you a similar set of questions for people who inject drugs. For this assessment, people who inject drugs include those who inject drugs recreationally and without the prescription of a physician. People who inject drugs are at higher risk of HIV than the general population.	
	38. Would you get in trouble at work if you discriminated against patients who inject drugs?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	39. Does your facility have written guidelines to protect patients who inject drugs?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	40. In the past 3 months, have you heard staff at your facility gossip about patients because they inject drugs?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	41. In the past 3 months, have you heard staff at your facility refuse services to a patient because they inject drugs?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	42. Should people who inject drugs feel ashamed of themselves?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	43. Are people who inject drugs to blame for their health issues?	☐ 1= Yes ☐ 2=No ☐ 3=Don't know
	44. How would you rate your facility's services for people who inject drugs? Check a number 1–5, where 1 is low quality and 5 is high quality.	☐ 1=Very low quality **(Go to question a)**

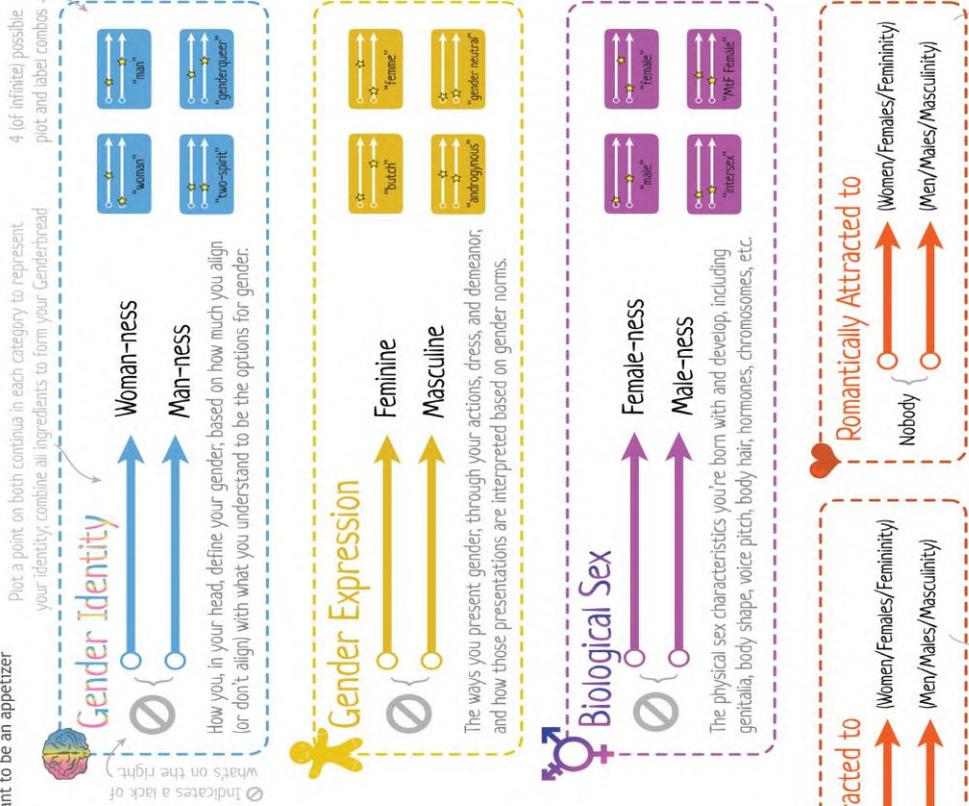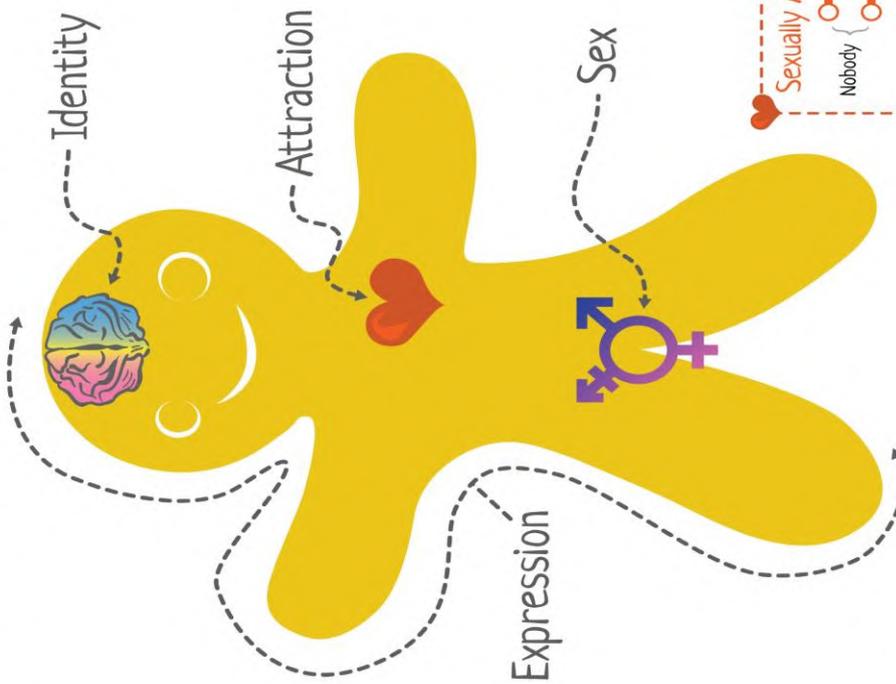|		
		☐ 2=Low quality **(Go to question a)**
		☐ 3=Average **(Skip question a)**
		☐ 4=High quality **(Skip question a)**
		☐ 5=Very high quality **(Skip question a)**
	a. Why is the quality of services low for transgender people?	*Reply with a short response for SMS or enter common response types for IVR.*
	45. How can your facility improve services and make it easier for people who inject drugs to receive services?	*Reply with a short response for SMS or enter common response types for IVR.*
	46. Would you like to learn more about the health needs of PLHIV or key populations through SMS?	☐ 1=Yes ☐ 2=No

Thank you. We will send you another assessment in [insert time period]. Reply "HELP123" to provide feedback at any time.

The Genderbread Person: Health Policy Project:
http://www.healthpolicyproject.com/index.cfm?id=GSDTraining

Handout 4: Key terms[29]

It is important to distinguish between sexual behavior, sexual orientation, and sexual identity as separate concepts. When talking to clients who are gay or men who have sex with men, sex workers, or transgender people, you should be familiar with these and other terms and their relevance in the clinical context.

Homosexual or same-sex sexual behavior: Sexual acts between people of the same sex

Sexual orientation: An enduring emotional, romantic, or sexual attraction to another person of a different sex or gender, the same sex or gender, or to both sexes and more than one gender. The American Psychological Association states that people have "little or no choice about their sexual orientation."

Sexual identity: The label people use to describe themselves in relationship to their sexuality. While a proportion of men who have sex with men may choose to identify sexually as gay, or as bisexual, some relate to other culturally unique identities, or remain identified as heterosexual while engaging in same-sex behaviors.

Gender: A social construct reinforced by attitudes, feelings, behaviors, and clothing associated with a person's sex assigned at birth

Gender blind: Failure to identify or acknowledge difference on the basis of sex or gender where it is significant. Gender-blind programs and policies do not consider the impact of sex or gender norms and unequal power relations.

Gender neutral: Avoidance of distinguishing roles according to a person's sex or gender in order to avoid discrimination based on sex or gender and/or avoid prescribed gender norms

Gender transformative: These programs actively examine and attempt to change inequitable gender norms, policies, and approaches; foster critical examination of gender norms; and strengthen existing equitable gender norms.

Gender identity: An individual's sense that they are male, female, or transgender

Gender expression: The way an individual communicates gender within a culture through clothing, communication patterns, interests, or other means.

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[29] Definitions of some terms are from MSMGF, Johns Hopkins School of Public Health. Promoting the health of men who have sex with men worldwide: a training curriculum for providers.

An individual's gender expression may or may not be consistent with socially prescribed gender roles and may or may not reflect their gender identity.

Men who have sex with men (MSM): Men, including those who do not identify themselves as homosexual or bisexual, who engage in sexual activity with other men

Sex workers: Women, men, and/or transgender people who receive money or goods in exchange for sexual services, and who define those activities as income-generating (even if they do not consider sex work as their occupation)

Transgender: Literally, "across gender" or "beyond gender," transgender is a term that describes a wide variety of cross-gender behaviors and identities. Transgender is not diagnostic and does not imply a medical or psychological condition. Transgender individuals are those whose gender identities are not the same as the sex they were assigned at birth. "Trans" is sometimes used as another term for a variety of transgender identities, as is "trans people" or "transpeople." For more transgender-related terminology, visit the webpage: http://transhealth.ucsf.edu

Trans woman: Assigned male at birth and identifies as female

Trans man: Assigned female at birth and identifies as male

Handout 5: Questionnaire—sexual orientation and gender identity[30]

1. The differences between how males and females are expected to act and dress are decided by _____.
   a. Culture
   b. Biology
   c. Both

2. It is good to talk to a young person about sex, sexuality, and gender because they are exploring their first feelings of attraction and forming their own ideas about sexual orientation and gender identity.
   a. True
   b. False
   c. I don't know.

3. You can reliably predict a person's sexual orientation based on how they act and dress.
   a. True
   b. False
   c. I don't know.

4. No one should experience job discrimination because of their sexual orientation.
   a. Strongly agree
   b. Agree
   c. Neutral/unsure
   d. Disagree
   e. Strongly disagree

5. Gender and sexual minorities should be allowed to be school teachers.
   a. Strongly agree
   b. Agree
   c. Neutral/unsure
   d. Disagree
   e. Strongly disagree

6. Same-sex couples should be able to attend workplace social events together as partners.
   a. Strongly agree
   b. Agree
   c. Neutral/unsure
   d. Disagree
   e. Strongly disagree

7. Same-sex couples should be legally permitted to marry.
   a. Strongly agree

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[30]   SOGI training materials.

    b. Agree

    c. Neutral/unsure

    d. Disagree

    e. Strongly disagree

8. Policies that guarantee equal rights to gender and sexual minorities are bad for society.
   a. Strongly agree
   b. Agree
   c. Neutral/unsure
   d. Disagree
   e. Strongly disagree

9. It is okay for a newspaper to publicize that a person is a gender or sexual minority without that person's permission.
   a. Strongly agree
   b. Agree
   c. Neutral/unsure
   d. Disagree
   e. Strongly disagree

10. A person is either a man or a woman.
    a. Strongly agree
    b. Agree
    c. Neutral/unsure
    d. Disagree
    e. Strongly disagree

11. I am comfortable with masculine women.
    a. Strongly agree
    b. Agree
    c. Neutral/unsure
    d. Disagree
    e. Strongly disagree

12. A man should be able to dress like a woman, if he chooses.
    a. Strongly agree
    b. Agree
    c. Neutral/unsure
    d. Disagree
    e. Strongly disagree

13. I am comfortable with feminine men.
    a. Strongly agree
    b. Agree
    c. Neutral/unsure
    d. Disagree
    e. Strongly disagree

14. I am comfortable working with feminine men.
    a. Strongly agree
    b. Agree
    c. Neutral/unsure
    d. Disagree
    e. Strongly disagree

15. A woman should be able to present herself as a man in public, if she chooses.
    a. Strongly agree
    b. Agree
    c. Neutral/unsure
    d. Disagree
    e. Strongly disagree

16. All legal adults should be able to have any kind of consensual sex in private without being fined or arrested.
    a. Strongly agree
    b. Agree
    c. Neutral/unsure
    d. Disagree
    e. Strongly disagree

17. I can name at least TWO local organizations OR activists in my country that are supporting the health and human rights of gender and sexual minorities.
    a. Yes, I can.
    b. No, I can't.
    c. I don't know.

18. I can list several ways I could take action to reduce stigma and discrimination against gender and sexual minorities in my workplace.
    a. Yes, I can.
    b. No, I can't.
    c. I don't know.

19. It bothers me when I see a man act like a woman.
    a. Strongly Agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly Disagree

20. Under some circumstances, it's okay for a man to discipline his wife.
    a. Strongly Agree
    b. Agree
    c. Neutral
    d. Disagree

  e. Strongly Disagree

21. I prefer my supervisor to be a man.
  a. Strongly Agree
  b. Agree
  c. Neutral
  d. Disagree
  e. Strongly Disagree

22. Under some circumstances, it's okay for a woman to discipline her husband.
  a. Strongly Agree
  b. Agree
  c. Neutral
  d. Disagree
  e. Strongly Disagree

Handout 6: Case studies for Session 2.3

These case studies should be adapted to the context in which the training takes place. The ones provided here are only suggestions as starting points.

Case Study A:

Stigma and discrimination toward men who have sex with men in the health facility

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

When the first nurse returned, I challenged her and said, "I've been waiting a long time. Could you examine me and give me some treatment?" She laughed and said, "Who are you to tell me what I should do? You'll just have to wait. We know you people!" She said this in the presence of the other patients and then left. I was told that she and the other nurses had gone off for tea break. I could imagine them gossiping about me over their tea. I wondered who they would tell about me.

After a long break, a doctor entered and, without even examining me said, "What have you been doing? How did you get this STI?" I explained that I had a sore in my anus. He said, "What did you expect to get from this unusual sexual behavior? I normally treat STIs in the front, not the back. Why are you making my life difficult?" Then he told me to take off my pants. I did so, and he looked at my bum from a long distance away, and said, "Why do you have STIs in your anus? What have you been doing?"

He then began to ask me a lot of questions about my sex life: "What kind of sex have you been having? When was the last time you had sex with a woman? Do you have a girlfriend? How do you have sex with a man?" I told him I just wanted to be tested and given treatment, not asked about my sex life. He responded that "the clinic only did testing for real men, not men pretending to be women."

As soon as the doctor went to the next room, I put my pants on and left the clinic. It was humiliating! I will never go back there again. I went to the clinic with a medical problem to get help from the doctor, but I didn't receive any treatment—all I got was insults and blame!

Case Study B:

Stigma toward young men who have sex with men

Terry is an 18-year-old boy. Since graduating from high school, he has been dating his boyfriend David, who is 20 years old. All through high school, Terry was called a "batty boy." Terry has not come out to his family because of the shame he thinks they will feel because he is gay. His other gay friends told him

that there is a clinic near his house. They caution him that the clinic is new and they are not sure how the staff will act toward him, but they thought it would be convenient. Terry went to the clinic to get free condoms. As soon as he arrived, he noticed the whispering from the staff. One nurse asked him why he needed condoms and told him he was too young to be having sex! Terry was so shocked by the experience that he never returned to the clinic.

Case Study C:

People who use drugs and stigma

Sarah works as a nurse at the government clinic. One afternoon a new client came to see Sarah, complaining about bad stomach pains. The new client was a young woman in her early 20s. Her clothes were old and torn and she smelled unwashed. When the young woman sat down in Sarah's consulting room, Sarah moved her chair away from her and held her nose to avoid the smell. When the client rolled up the sleeve of her jersey so that Sarah could take her blood pressure, Sarah noticed some marks on the inside of her arm that looked like needle wounds. When the young woman slowly started explaining her symptoms, Sarah became impatient and shouted at the young woman, telling her it was her own fault she was sick if she was doing bad things like taking drugs. Sarah told the young woman there was nothing she could do to help her if she continued taking drugs because she was just killing herself. The young woman started crying and left the clinic without receiving any medication for her stomach problems.

Case Study D:

Stigma and discrimination toward sex workers in the health facility

One day, Mary started to get painful sores and a burning sensation in her vagina. Even though she was worried about how she would be treated by the clinic staff, she still went to the clinic to seek out testing and, if needed, treatment.

When she arrived at the clinic, she waited a long time. The nurse kept calling patients who had arrived after her. Eventually, Mary challenged the nurse and said, "I arrived before her. Why can't you treat me now?" The nurse laughed and said, "Who are you to tell me what I should do? You'll just have to wait. We know you ladies of the night! You wait all night for men, so why can't you wait a few more minutes?" She said this in the presence of all the other patients, and Mary felt humiliated. The nurse then left and had a long talk with three other nurses, and she could see them looking in her direction.

Eventually, Mary was called in to see the doctor. Before she went into his room, the nurse had been talking to him, so Mary suspected he knew she was a sex worker. The doctor gave Mary a funny look and asked, "What is your problem?" Mary explained that she had sores and a burning sensation in my vagina. The doctor said, "I don't know why we are wasting our time on you. You are just a virus collector. I don't care if you die. You deserve to get this infection because of your disgusting behavior. It's your own fault sleeping with

all these men." Then he told Mary to take off her dress. She did so, and he looked at her from a long distance away.

He then began to ask Mary a lot of questions about her sex life: "How often do you have sex? What kind of sex do you enjoy the most? Can I see you some time?" Mary told him she just wanted to be tested and treated, not asked about her sex life. He responded that the clinic only did testing for normal women, not sex workers!

As soon as the doctor left, Mary put her dress on and left the clinic. She felt humiliated! Mary decided that she would never go back to that clinic again.

Case Study E:
Sex work and stigma

Gloria is a 32-year-old sex worker from the capital city. She lives with her boyfriend in a flat on the outskirts of the city. Gloria has not told her boyfriend that she sells sex, but told him instead that she has a job working in a factory doing night shifts on the other side of town. One night, Gloria got beaten up quite badly by one of her clients who was drunk and was demanding to have sex without a condom. The client ended up raping Gloria, without using a condom. Gloria was in pain and bleeding but she was too scared to go home and tell her boyfriend what had happened, because she was scared he would throw her out of the house if he discovered that she was a sex worker. Gloria tried to get a room in a nearby hotel, but the doorman of the hotel refused to let her enter, telling her that they don't allow "filthy whores" in the hotel. Gloria instead found a place to sleep behind some empty crates and waited for the clinic to open.

In the morning Gloria went into the clinic to see a nurse. There was a long queue at the clinic and many people were also waiting. After a long time, Gloria was called in to see Sister Penny. Sister Penny arrived at work that day to find that two of her co-worker nurses had called in sick, so Sister Penny had to see all the patients at the clinic on her own. As a result, she was feeling stressed and tired by the time Gloria came to see her, and she was hungry because she hadn't had time for her tea break. Gloria began to tell Sister Penny what happened to her, and Sister Penny started shouting at her, telling her that she was just a "dirty whore"' and had deserved what she got. Gloria ran out of the clinic crying, feeling lost and hopeless.

Case Study F:
Transgender sex worker and stigma

Jenny is a transgender sex worker. She visited a health center in her neighborhood because the night before, while working in the street, a group of drunken young men threw a rock at her from a moving vehicle. Jenny and her companions ran after the car and were able to identify it. They called the police and a patrol car came. Jenny was badly injured and the police offered to take her to the hospital. On the way to the hospital, the police verbally assaulted Jenny

and harassed her until they forced her to have sexual relations with them. After sexually assaulting her, they left her unconscious on the side of the road.

Jenny was badly injured and emotionally very depressed from the encounters with the drunken men and the police. She had an injury over the right eyebrow, and during the rape the police had introduced a bottle into her anus that left her with a serious anal injury. However, Jenny was most concerned that she may have acquired HIV or another sexually transmitted infection during the rape because the police did not use condoms.

At the health center, Jenny was received by a social worker. While the social worker collected Jenny's personal data before admitting her for emergency care, she expressed surprise at Jenny's feminine name. The social worker emphasized that she needed to know Jenny's "real" name and not her professional name. Given her emotional state, Jenny did not have the energy to explain that Jenny is her name, considering that she chose it. Noticing how Jenny lowered her head and sensing that Jenny felt ashamed, the social worker told her that what happened to her was the result of her bad life, and that if Jenny didn't walk the street in women's clothing, such incidents would not happen.

The social worker told Jenny that she didn't believe that the police raped her and instead concluded that the incident occurred with a client.

Jenny felt worse, but she was finally able to see the doctor, who asked her to take off all of her clothes so that he could examine her. He began with the anal injuries. The site was still bleeding, but the doctor did not want to touch her to carry out a more thorough exploration that would verify whether there were more serious injuries. He told Jenny to use her own hand to apply some cotton to the injury. Jenny asked whether he was going to check more thoroughly because she was concerned that she was continuing to bleed heavily. The doctor responded that it was not his obligation to attend to "this type" of injury and told Jenny that she should request an appointment with his colleague, Dr. Pérez.

Jenny left and went home crying. She called a friend who would prepare a treatment with some plants that she knew would work to stop the bleeding.

Source for Case Study F: Egremy G, Betron M, Eckman A. (2009). Identifying Violence against Most-at-Risk Populations: A Focus on MSM and Transgenders. Training Manual for Health Providers. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Handout 7: My commitment—10 values to guide my work with key populations

1. **Educated** — I will continue to educate myself and others about key populations so that we can continue to meet their needs and provide quality services.

2. **Accepting** — I accept that people have beliefs, cultures, sexual orientation, sexual behaviors, gender identities, drug use, involvement in sex work, and other behaviors that may be different from my own, and I won't judge or stigmatize others for who they are.

3. **Respectful** — I will respect people's choices and ensure that all patients, regardless of their gender identity, sexual orientation, and sexual behavior, are treated equally and fairly.

4. **Committed** — I am committed to providing quality, caring HIV services to sex workers, men who have sex with men, transgender people, and people who inject drugs because I care about people who have been rejected, ostracized, stigmatized, and abused. I also care about bringing an end to the HIV epidemic.

5. **Compassionate** — I will reflect on times when I've felt isolated, discriminated against, violated, and rejected; this will remind me to feel compassion for members of key populations.

6. **Open-minded** — I will remain open-minded when serving patients whose beliefs, behaviors, sexual orientation, gender identity, and cultures are different from mine.

7. **Confidentiality** — I will keep all personal information that clients share with me confidential.

8. **Positive** — I will remain positive in my attitude toward assisting key populations and in the belief that we can end the HIV epidemic.

9. **Motivated** — I am motivated to provide accessible, quality HIV services to key populations because I know that this will give them a better quality of life.

10. **Connected** — I will stay connected to key population community groups by networking with them and establishing a referral system that ensures that the needs of all key population clients are met.

Signed: _____Date: _____

Handout 8: Clinical standards of care for key populations—a self-evaluation

CLINICAL STANDARD OF CARE REFLECTION
1. Does your clinic provide HIV testing and comprehensive prevention services? Consider provision of condoms and lubricants, HIV risk counseling, and strategies for minimizing risk mitigation, behavioral interventions, and small-group support.
Notes for improvement:
2. Does your clinic provide HIV care and treatment services?
Notes for improvement:
3. Does your clinic offer or refer to PREP or PEP?
Notes for improvement:
4. Does your clinic screen, test for, and treat vaginal and/or anal STIs?
Notes for improvement:
5. Does your clinic provide or refer female clients to family planning/contraceptive services?
Notes for improvement:
6. Does your clinic screen for tuberculosis?

Notes for improvement
7. Does your clinic screen for viral hepatitis and provide prevention information?
Notes for improvement:
8. Does your clinic screen for substance abuse and provide or refer for harm-reduction services?
Notes for improvement:
9. Does your clinic screen for and respond to gender-based violence?
Notes for improvement:
10. Does your clinic promote mental health?
Notes for improvement?

Handout 9: Best practices for youth-friendly clinical service delivery

Summary from WHO[31]
The following are generic characteristics of adolescent-friendly health services according to WHO-defined dimensions of quality. WHO also includes 20 concrete suggestions to improve the equity of services at the point of delivery.

Equitable
All *adolescents, not just some groups of adolescents,* are able to obtain the health services that are available.

- Policies and procedures are in place that do not restrict the provision of health services.

- Health care providers treat all adolescent clients with equal care and respect, regardless of status.

- Support staff treat all adolescent clients with equal care and respect, regardless of status.

Accessible
Adolescents *are able* to obtain the health services that are available.

- Policies and procedures are in place that ensure health services are either free or affordable to adolescents.

- Point of service delivery has convenient hours of operation.

- Adolescents are well informed about the range of reproductive health services available and how to obtain them.

- Community members understand the benefits that adolescents will gain by obtaining the health services they need, and they support the provision of such services.

- Some health services and health-related commodities are provided to adolescents in the community by selected community members, outreach workers, and adolescents themselves.

Acceptable
Adolescents *are willing* to obtain the health services that are available.

- Policies and procedures are in place that guarantee client confidentiality.

- Points of service delivery ensure privacy.

- Health care providers are nonjudgmental, considerate, and easy to relate to.

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[31] WHO. (2012). Making health services adolescent friendly: developing national quality standards for adolescent friendly health services.
http://apps.who.int/iris/bitstream/10665/75217/1/9789241503594_eng.pdf?ua=1

- Points of service delivery ensure that consultations occur without extended wait times, with or without an appointment, and (where necessary) offer swift referrals.

- Points of service delivery have an appealing and clean environment.

- Points of service delivery provide information and education through a variety of channels.

- Adolescents are actively involved in designing, assessing, and providing health services.

Appropriate

The *right health services (i.e., the ones they need)* are provided to them.

- The required package of health care is provided to fulfill the needs of all adolescents, either at the point of service delivery or through referral linkages.

Effective

The *right health services are provided in the right way* and make a positive contribution to their health.

- Health care providers have the required competencies to work with adolescents and to provide them with the required health services.

- Health care providers use evidenced-based protocols and guidelines to provide health services.

- Health care providers are able to dedicate sufficient time to deal effectively with their adolescent clients.

- Service delivery points have the required equipment, supplies, and basic services necessary to deliver the required health services.

Summary from Advocates for Youth

- **Right to confidentiality** — Make sure that staff have a clear understanding of the laws on informed consent and confidentiality regarding: (a) contraceptive services, (b) STI testing and treatment, (c) HIV testing and treatment, (d) substance abuse treatment, and (e) mental health care.

- **Respectful treatment** — Judgmental and rude attitudes and behaviors of health care workers cause youth to leave the clinic before they get the care they need, as well as fail to comply with treatment requirements (such as taking medicine on time) and/or refuse or forget follow-up care.

- **Integrated services** — Set up protocols so health workers remember to ask about risk-taking behaviors, including unprotected sex, substance use, and violence, as well as about issues like depression, suicidal thoughts, and violence victimization.

- **Access to care** — Although access issues can be important for adults as well, they pose especially significant barriers to young people's ability

to get the health care services they need. These issues include lack of transportation, difficulties making appointments, not knowing where to go, limited hours and days when services are available, and requirements to return for follow-up.

- **Free or low-cost services** — Fear about the cost of services is a major barrier to health care for young people.

- **Reproductive and sexual health services** — These should include education and counseling, contraceptive services, STI/HIV testing and treatment, in addition to prenatal and obstetrical care and abortion services or referral for these services.

- **Services for young men** — Treat young gay, bisexual, and other men who have sex with men holistically and ensure that they receive optimal care that addresses their physical, emotional, and psychosocial health.30 Young men who have sex with men often rely on the experience and recommendations of their peers. So, good client–staff interactions with one young man will be likely to come to the attention of other young men who have sex with men.

- **Services for young women** — Lesbian, gay, bisexual, transgender, and other women should also be treated equally and holistically, and assured of receiving optimal care that addresses their physical, emotional, and psychosocial health.

Handout 10: Meaningful youth engagement

Link Up (2016). Aiming High: 10 Strategies for Meaningful Youth Engagement.[32]

Applying Aiming High: 10 strategies for meaningful youth engagement to a clinical setting to ensure that service provision is informed by the priorities and needs of young people.

1. Youth and other partners/stakeholders should agree on how young people can help guide service delivery through, for example, a youth advisory committee, youth-informed designer of services, and youth's evaluation of services.

2. Support opportunities for young people to influence decision making related to service provision.

3. Regularly ask young people whether their views and ideas are being heard in the management of the clinic and how meaningful participation of young people can be improved in guiding the provision of services, such as through the youth advisory committee.

4. Identify opportunities and support young people to advocate for their issues and to safely share their experience and knowledge as experts.

5. Build skills and knowledge of young people so they can confidently and effectively take part in both decision-making and service delivery, for example, as peer mentors, navigators, or outreach workers.

6. Use language that is understandable, respectful, and accessible to everyone.

7. Give young people enough support and resources (financial and other) in a timely manner; do not expect them to volunteer their time, especially if others are paid for their time for the same involvement.

8. Value and respect the perspectives and views of young people.

9. Support consultation and feedback between young people and the communities they represent, so that youth participation and representation is inclusive of diverse perspectives from young people (and not tokenistic or limited to one individual).

10. Trust young people to take responsibility and be accountable for service delivery where appropriate.

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[32]   http://www.athenanetwork.org/assets/files/Link%20Up%20mentoring%20programme/Aiming%20High_ENG_HiRes.pdf

Handout 11: Individual reflection

Challenge	Response/strategy to overcome it
Not enough time	
Not enough privacy/client not alone	
Language barriers	
Client's shyness or discomfort	
It is culturally insensitive to discuss these issues	
Your own shyness or discomfort	
Fear of ramifications from discussing these issues (particularly if they are criminalized)	
Anything else:	

Handout 12: Tips for conducting a risk assessment

1. Begin by assuring clients of confidentiality.

   - For a risk assessment to be effective, the client must feel safe.

   - Remember that your client is more likely to open up after you assure clients that confidentiality will be maintained.

   - You can begin your conversation by saying phrases like:
     - "Everything you say will remain between you and me."
     - "You have a right to privacy and confidentiality that I will respect."
     - "It is my ethical and legal obligation as a health care provider to protect your privacy."

2. Convey the routine nature of risk assessments.

   - Use language that emphasizes that this type of discussion happens with all patients.

   - It is important to ensure that your client do not feel like they are being singled out.

   - Consider phrases like:
     - "I'm going to ask you some questions that I ask all my clients, because they have a big impact on people's health."
     - "The following topics are standard."
     - "These topics are discussed with all clients."

3. Acknowledge that personal and sensitive information will be assessed.

   - Giving the client an introductory notice that you are about to talk about personal topics will help prepare them and may result in them being more open.

   - Consider phrases like:
     - "I'm going to ask you about some personal topics. I talk to all my clients about these topics because they affect your health. Many people find it hard to discuss these issues at first."
     - "The next set of questions cover sensitive information, but they are routinely discussed with all clients at this clinic."
     - "It may be uncomfortable to discuss some of these topics at first. I talk to all my clients about these issues and am able to provide the best care to those who are open."
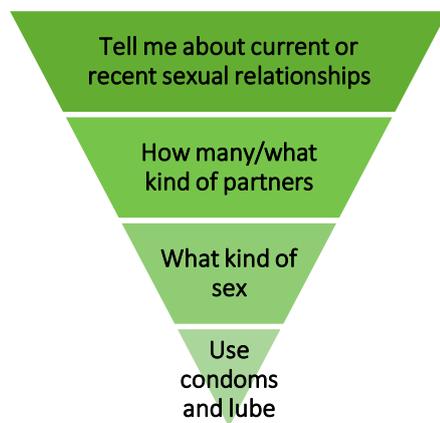
4. Use exploratory questions and open-ended questions.

   - Questions that start with "what" or "how" are particularly useful.

   - Phrases like "tell me about" or "it would be helpful to know about" are also useful.

   - These types of questions are better for engaging in conversation rather than asking questions someone could answer with simply "yes" or "no."

- Open-ended questions allow client to explore their risks and needs, open up, and speak freely about their experiences.

- Follow the five-second rule: Wait at least five seconds after asking a question before speaking again. Give clients time to respond.

5. Go from general questions to specific ones.

- This is the most common way to arrange questions when getting to know client.

- It is helpful to imagine a funnel. (See the figure below.)

- Use the funnel to think about asking clients about sexual risk and behaviors.

Tell me about current or recent sexual relationships

How many/what kind of partners

What kind of sex

Use condoms and lube

6. Use the types of words the client is using.

- This creates a stronger sense of understanding and connectedness.

- Ask for clarification if you are unsure of a term or wording used by the client.

7. Reinforce healthy behaviors.

- Praise clients for positive steps they are taking to maintain or improve their health and/or to minimize their risks.

8. Remain neutral when hearing sensitive information.

- Maintain neutral body language.
  - Smiling or relaxed mouth
  - Nodding
  - Relaxed arms and legs
  - Making eye contact

- Avoid cold and judgmental body language.
  - Looking away
  - Rolling eyes
  - Crossed arms and legs

- Strong gestures or sudden movements in response to client

9. Focus on risk reduction.

- ■ After learning about a client, the next step is to help reduce risk and improve health

- ■ Remember that success is defined as risk reduction

- ■ Abstinence-only messages are not effective or appropriate

- ■ Goals for clients should be achievable and realistic

10. Affirm concerns.

- ■ Clients may express concern in response to disclosing sensitive information.

- ■ To help ease this concern, provide the client with affirmation of their concerns:
  - "I'm glad you told me this."
  - "I know it isn't east to talk about this, and I appreciate your honesty."
  - "I understand why you may be concerned, but let me see how I can help you with that."

- ■ Be prepared for what you might hear.

- ■ Ask your clients to explain anything you don't understand.

11. Give clear and consistent messages.

- ■ After getting to know clients, provide them with messages on:
  - Risk-reduction behaviors
  - Use of additional health services

- ■ Messages can also be called goals because they:
  - Require a client to take action
  - Require the health care provider to follow up

Handout 13: Identifying areas for change in my health facility

My name_____

Name of health facility_____

Date completed_____

Challenge	Cause(s)	Type of Cause		Goals
		Individual	Facility	

Handout 14: Action plan for improving services in my health facility

Goal #1:

_____

_____

Problems to overcome:

_____

_____
(anticipated barriers and how they will be eliminated or reduced)

Activities/Steps	Person(s) Responsible	Resources and Assistance Needed	Time Period (from _____ to _____)	Indicators of Success

Handout 15: Messages for challenging stigma in the workplace

■ **We are all responsible for challenging stigma.** We can all play a role in educating others and advocating for new attitudes and practice.

■ **Be a role model.** Apply what you have learned in your own life. Think about the words you use to talk about key populations and try to change how you think, speak, and act.

■ **Encourage political leaders and senior managers to speak out**—to talk to others about key populations and condemn stigma and discrimination.

■ **Encourage key populations to speak out**—to help people understand how it feels to be the object of stigma and discrimination—and make sure that key populations are listened to.

■ **Share what you have learned.** After the training, tell others what you have learned and get others talking about stigma and discrimination and how to change it.

■ **Talk openly about HIV and key population stigma.** Show that you are not afraid to talk about this issue. This will help people see that it is not a shameful thing that has to be hidden. Talking openly will also empower key populations and help relieve self-stigma.

■ **Discuss stigma with family, colleagues, and friends.** What are the most common forms of stigma in your family, community, or workplace? What can be done to change things?

■ **Avoid using stigmatizing words.** Instead of saying "these sick people," use positive words such as "men who have sex with men" or "brothers and sisters."

■ **Challenge stigma when you see it in your home, workplace, and community.** Speak out, name the problem, and let people know that stigma and discrimination toward key populations hurts them, makes them hide, and helps to fuel the HIV epidemic.

■ **Act against** stigma as a community. Each community can look at stigma in their own situation and agree on practical things they can do to bring about change.

■ **Saying "stigma is wrong" is not enough.** Help people move to action— agree on what needs to be done, develop a plan, and then do it.

■ Think big! Start small! **Have a big vision—but start with something small.**

■ **And don't wait—act now!**

Handout 16: Key population LINK health facility assessment

PATIENT/CLIENT FACILITY ASSESSMENT

PATIENT/CLIENT SELF-ADMINISTERED ASSESSMENT ON SMS OR IVR

Welcome. Use this simple phone-based assessment to review and give feedback for any HIV-related health facility you visited recently or wanted to visit, even if you have not gone for services yet. Any communication through this platform is free and anonymous. We use your feedback to support health facilities to improve services.

1. Did you visit a health facility last month? ☐ Yes **(Assessment 1)** ☐ No, but I wanted to **(Assessment 2)**

	Assessment 1	Assessment 2	Response options
FACILITY SELECTION	2. Where is the health facility you visited?	2. Where is the health facility you wanted to visit?	☐ 1=*Region 1* ☐ 2=*Region 2* ☐ 3=*Region 3* ☐ 4=*Region 4* ☐ 5=Other *(add question to specify if SMS)*
	3. What type of facility?	3. What type of facility?	☐ 1=Public ☐ 2=Private ☐ 3=Community-led ☐ 4=Other *(add question to specify if SMS)*
	4. What is the facility name?	4. What is the facility name?	*Select from list of facilities.*
	Facility selection questions can be removed from the assessment if patients/clients can be instructed to input a facility-specific identification code that can initiate the assessment.		
	Answer the following questions about your most recent visit to the facility in the previous month**.**	Answer the following questions based on your current ideas of the facility	
SERVICE QUALITY	5. What services did you seek during your visit? Select one primary service	5. What services did you want to receive at this facility? Select one primary service	☐ 1=HIV testing ☐ 2=Antiretroviral therapy (ART) ☐ 3=STI ☐ 4=Labs ☐ 5=Reproductive health ☐ 6=Counseling ☐ 7=Other *(add question to specify if SMS)*
	6. Did you receive the care and services you wanted?		☐ 1=Yes ☐ 2=No ☐ 3=Don't know
		6. Why did you not visit this facility yet?	*Reply with a short response for SMS or enter common response types for IVR.*
	7. How would you rate the service quality at this facility? **(If 4-5, skip question a below)**	7. What do you think about the service quality at this facility? **(If 4-5, skip question a below)**	☐ 1=Very low quality ☐ 2=Low quality ☐ 3=Average

			☐ 4=High quality
			☐ 5=Very high quality
			☐ Don't know
	8. What issue did you experience with the quality of services? Select one main issue.	8. What issue do you worry you will experience with service quality at this facility. Select one main issue.	☐ 1=Wait time ☐ 2=Clinic hours ☐ 3=Drug stock out ☐ 4=Unfriendly staff ☐ 5=Expensive services ☐ 6=Medical provider's knowledge ☐ 7= Other *(add question to specify if SMS)*

Continue on next page		

STIGMA & DISCRIMINATION	9. How likely are you to recommend this facility to your friends?		☐ 1=Very unlikely ☐ 2=Unlikely ☐ 3=Neutral ☐ 4=Likely ☐ 5=Very likely
		9. Have you heard anything positive or negative about this facility?	☐ Positive ☐ Negative ☐ Neutral ☐ Heard nothing
	10. Did you experience any kind of stigma or discrimination from staff during your visit to this facility? **(If no, skip a-e)**	10. Are you worried about experiencing stigma or discrimination from staff if you visit this facility? **(If no, skip questions a-e below)**	☐ 1=Yes ☐ 2=No ☐ 3=Don't know
	If a shorter questionnaire is not needed, the skip logic can be removed so all clients/patient to be asked a-e.		
	a. Did staff treat you badly during your visit?	a. Are you worried staff may treat you poorly during your visit?	☐ 1=Yes ☐ 2=No ☐ 3=Don't know
	b. Did staff gossip about you during your visit?	b. Are you worried staff may gossip about you during your visit?	☐ 1=Yes ☐ 2=No ☐ 3=Don't know
	c. Did staff refuse to attend to you or were you denied treatment?	c. Are you worried staff may refuse to attend to you or deny you treatment?	☐ 1=Yes ☐ 2=No ☐ 3=Don't know
	d. Were staff judgmental towards you during your visit?	d. Are you worried staff may be judgmental towards you during your visit?	☐ 1=Yes ☐ 2=No ☐ 3=Don't know
	e. Do you think staff did not keep your information confidential?	e. Are you worried that staff will not keep your information confidential?	☐ 1=Yes ☐ 2=No ☐ 3=Don't know
	We have a few more questions to help us improve services at this facility. Your responses are kept private.		
KP TYPE & HIV STATUS	11. Do you consider yourself…		☐ 1=Male ☐ 2=Female ☐ 3=Transgender ☐ 4=Other ☐ 5=I'd rather not say
	12. What sex were you assigned at birth?		☐ 1=Male ☐ 2=Female ☐ 3=Other

	13. Do you have sex with men, women, or both? ☐ 1=Men ☐ 2=Women ☐ 3=Both men and women ☐ 4=I'd rather not say
	14. Do you inject drugs recreationally or without a doctor's prescription? ☐ 1=Yes ☐ 2=No ☐ 3=I'd rather not say
	15. Do you exchange sex for money or goods? ☐ 1=Yes ☐ 2=No ☐ 3=I'd rather not say
	16. Do you know your HIV status? ☐ 1=Yes ☐ 2=No **(If no, skip question 16a below)**
	16a. What is your HIV status? ☐ 1=HIV positive ☐ 2=HIV negative ☐ 3=I'd rather not say
	17. How old are you currently? ☐ 1=under 25 years old ☐ 2=25 years old or older
	Demographic questions can be removed from the assessment if the client/patient can enter a UIC that the program can use to determine KP and HIV status.
FEEDBACK & ENGAGEMENT	18. Do you want to receive free and confidential sexual health and HIV info via SMS? ☐ 1=Yes ☐ 2=No *(If peer administered and the KP individual says "yes," ask, "What is your mobile phone number where can send SMS?")*
	19. What do you suggest to improve services or make it easier to receive services at this facility? *Reply with a short response for SMS or enter common response types for IVR.*
	Thank you for your feedback.

Handout 17: Evaluation form

Workshop evaluation[33]
Date and location of workshop: _____ _____

1. Overall, I would rate this workshop: ___ / 10

2. What did you like best about the workshop? Please explain.

3. Did anything surprise you in this workshop?
If yes, please describe. If not, please explain why not.

4. How likely is it that you recommend this workshop to a friend or colleague?
Please circle a number 0 –10
0 = Not at all   10 = Extremely likely

0   1   2   3   4   5   6   7   8   9   10

5. How would you improve or change this workshop?

6. Is there anything you would eliminate from the training? If so, what?

7. What other subjects or activities should have been included in
this workshop?

9. How well did the workshop encourage the exchange of experiences
among participants?
Circle your answer: Not at all / Somewhat / Quite a lot
Please explain your answer:

10. Tell us how our workshop went *(tick box for your answer).*

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[33] Adapted from International AIDS Alliance. (2015). Integration works! A guide to facilitating a workshop on
integrating sexual and reproductive health and rights and HIV.

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
i. The objectives of the workshop were met.					
ii. The content was organized and easy to follow.					
iii. There was enough time to digest and reflect on the content.					
iv. The tools, activities, and examples were relevant to my context.					
v. The facilitators were well-prepared.					

11. Please share other comment, thoughts, or ideas about the workshop:

THANK YOU FOR YOUR FEEDBACK.

Answers to the pre- and post-training questionnaire

The following are the correct answers to the pre-/post-test questionnaire and scoring suggestions. An Excel spreadsheet is also available to aid in analysis of the pre/post results. To receive the Excel spreadsheet, please contact LINKAGES/IntraHealth staff.

Part 1: Knowledge Questions

No.	Correct Answer	Scoring Suggestions
	Part 1: Knowledge Questions	
1	D	Score 1 point for correct answer
2	B	"
3	Emotional	"
4	False	"
5	B and D	Score 1 point for two correct answers; .5 points for one correct answer
6	Sex	"
7	A	"
8	C	"
9	Potential answers: • Family planning • Pregnancy testing • Offer or refer for abortion services • Cervical-anal cancer screening • Services to prevent vertical transmission of HIV (PMTCT services) [See session 3.1 for more information]	Score 2 points if they get two correct answers; 1 point for 1 correct answer
10	Potential answers: • PrEP (if/when available) • Condom use • Hepatitis B and C screening • Anal cancer screening • Support groups and services for people for "coming out" or other support needs [See session 3.1 for more information]	Score 2 points if they get two correct answers; 1 point for 1 correct answer
11		Score 1 point for correct answer
12	B	"
13.	Potential answers • May be experiencing sex for the first time • Limited sexual health education/limited knowledge regarding HIV transmission • Lack of youth-friendly services • May not be aware of concepts like transgender or unsure of their gender identity • May face extra judgement, stigma, or discrimination due to age [See session 3.2 for more information]	"
		Maximum Points: 15