



KEY POPULATIONS MANUAL

FOR HEALTHCARE PROVIDERS

First edition

JUNE 2018

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FOREWORD

Zimbabwe continues to bear one of the highest global burdens of a broadly generalised HIV epidemic, with HIV prevalence among adults aged 15–49 estimated at 14% (ZDHS 2015). While prevention of mother-to-child transmission has improved immensely over the last few years, the impact of HIV infection on certain key populations (KP) has continued to rise. For these populations, vulnerability and high risk converge. For the purposes of this Training Manual, key populations are defined as: male and female sex workers (SWs); men who have sex with men, including men in prisons and in other closed settings (MSM); people who use and/or inject drugs, (PWUD, PWID); transgender and intersex people (TI). The extended National Multi Sectoral Strategic Framework (2014–2018) was cognisant of the higher levels of mortality and/or morbidity in these groups and of their low and limited access to and uptake of relevant services.

For this reason, Zimbabwe can no longer ignore the impact of negative social and cultural attitudes towards these groups, which leave them out of HIV prevention messaging while discouraging them from accessing health services, HIV testing, care and treatment. Much of this is a result of stigmatising attitudes among service providers, who until now, have not been given sufficient information and awareness-raising of the needs of these key populations, which includes: male and female sex workers (SWs); men who have sex with men, including men in prisons and in other closed settings (MSM); people who use and/or inject drugs, (PWUD, PWID); transgender and intersex people (TI).

While globally these groups are often referred to as key populations, signalling them out in this way can also further isolate and stigmatise. There is a strong link between marginalisation, stigmatisation and discrimination and heightened risk of HIV, depending on the extent to which such people find themselves outside their social context and norms. These populations are therefore key to finding solutions to each country's epidemic, based on their epidemiological and social context and their active engagement and involvement is key to the success of the HIV response.

This training programme seeks to remove the barriers to engaging key populations in the continuum of care by raising awareness among service providers of their own often unintended biases towards these groups, and improving their understanding of the specific care and prevention needs of these populations in order to provide better quality of care and retention within the continuum of care. Accordingly, the MoHCC, through the Zimbabwe National AIDS Programme and in collaboration with other partners, has developed this service providers training programme to contribute to Zimbabwe's goal of reducing the spread of HIV and halting new HIV infections.

Equipping our service providers with appropriate knowledge and skills will not only improve access to and uptake of services for these groups but ensure standardised levels of care and healthcare training across the country.

Major General G Gwinji, (retired)

Permanent Secretary, MoHCC.



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In addition, the Ministry acknowledges the coordinating team that provided leadership oversight throughout the process of adaptation and finalisation of the training programme.

Getrude Ncube - National-HIV Prevention Coordinator, Taurai Bhatasara, DREAMS and Key Populations Coordinator, MoHCC, Roy Dhlamini, PSI, Phibion Manyanga, Clinical Advisor, I-TECH.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy/ treatment
ARVs	Antiretrovirals
CHTC	Couples-Based HIV Testing And Counselling
DSM	Diagnostic and Statistical Manual of Mental Disorders
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
HTC	HIV Testing and Counselling
KPs	Key Populations
LGBT	Lesbian, Gay, Bisexual, And Transgender
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
LGV	Lymphogranuloma Venereum
MDR-TB	Multi-drug Resistant TB
MSM	Men Who Have Sex With Men
MSW	Male Sex Worker
PEP	Post-Exposure Prophylaxis
PID	Pelvic Inflammatory Disease
PLHIV	Person/ People Living with HIV
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
STI	Sexually Transmitted Infection
SW	Sex Worker
TasP	Treatment as Prevention
UNAIDS	United Nations Joint programme on HIV and AIDS
WHO	World Health Organization
XDR-TB	Extremely Drug Resistant TB

OVERVIEW OF THE KP TRAINING PROGRAMME

This training programme has been developed to sensitise and train healthcare providers (including all staff and other personnel who work at healthcare sites) on the healthcare needs of populations at high risk of HIV in Zimbabwe. Its emphasis is particularly on how to meet those needs in a friendly, non-judgmental and non-discriminatory way. The training has been designed to be completed in four days, with half a day dedicated to a site visit to an already functioning KP friendly clinic setting. The Zimbabwe Constitution Amendment (No. 20) ACT 2013 (under Chapter 2 Section 29 and Chapter 4 Section 76) guarantees the right of every Zimbabwean citizen and resident to access healthcare, including reproductive healthcare and not to be turned away from any facility; furthermore, Chapter 4, Section 56 recognises the equality of all persons under law and their right not to be treated in an unfairly discriminatory manner ... regardless of nationality, race, colour, tribe, place of birth, ethnic or social origin, language, class, religious belief, political affiliation, opinion, custom, culture, sex, gender, marital status, age, pregnancy, disability or economic or social status. This is particularly important for those populations marginalised from mainstream society, such as male and female sex workers and men who have sex with men, including men in prisons and other closed settings (MSM); and people who use and/or inject drugs, (PWUD, PWID), referred to here as 'key populations'. We should remember the impact of our broader society and attitudes in increasing the vulnerability of key population members to HIV infection.

Research conducted in Zimbabwe in 2017, by the MoHCC, indicated significant stigma and discrimination experienced by sex workers and drug users (including injecting drug users) as well as people who identify as gay, lesbian, transgender and intersex at our public health facilities. All these groups are at elevated risk for HIV infection and other sexually transmitted infections (STIs). However, stigma and discrimination also risk their being excluded from the continuum of HIV prevention, treatment and care.

What is the goal of the training?

The goal of this training is to educate and equip everyone working at Zimbabwe's public health facilities with the knowledge and skills to enable them to provide health services that support and adequately cater for the unique healthcare needs of those at greatest risk of HIV. Leaving no-one behind is critical if Zimbabwe is to meet its commitment to an AIDS-free society by 2030. The training programme has been produced by the MoHCC, in partnership with PSI and I-TECH Zimbabwe. The content has been adapted from a number of sources, building on the hard work of many individuals, groups, organisations and government facilities. Much of the content and process of this training has already been tried and tested at local facilities. This training programme thus provides a standardised means to ensure that lessons from all past and ongoing efforts are mainstreamed within both our public health facilities and their critical linkages and partners.

Who is the training for?

In addition to the medical, administrative and other staff (including full-time, part-time and voluntary staff) working at public health facilities who will be trained through this programme, it can also serve as a reference for anyone who is tasked with making policies, managing programmes or in the provision of health related services in the country.

Healthcare providers are ethically obliged to provide services without discrimination. No consumer/client should be seen as worthy or unworthy, and no one should be excluded from compassion and care. De-coupling personal moral beliefs from core service provision tasks is paramount and is embedded within the MoHCC Patients Charter. The medical and scientific imperatives are clear – for those at high risk for HIV infection the denial of appropriate services can be literally life threatening.

What are the guiding principles of this training?

The principles guiding the training and delivery of health and related services to highly vulnerable groups and key population members are as follows:

1. The human rights of all the people of Zimbabwe must be protected, including the right to access quality healthcare free from discrimination.
2. Access to justice is particularly important for those individuals and key populations who face undue discrimination in society and must be upheld by our law makers and enforcement agents.
3. Interventions to reduce the burden of HIV and STIs among vulnerable individuals and key population members must be respectful and acceptable to recipients as well as appropriate and affordable.
4. Groups at high risk of HIV require accurate health and treatment information to enable their decision-making.
5. Integrated service provision is essential to meet the multiple co-morbidities, including mental health problems and poor social situations, experienced by those at high risk of HIV.

What are the 10 modules?

The ten modules are listed below. The introductory modules are designed to familiarise participants with important terminology and with the legal, policy and practice environment in Zimbabwe that protects, promotes or hinders access to health services for all; as well as providing a broad understanding of why vulnerable individuals and key population members are at high risk of HIV and why it is important to reduce their risk and the critical role service providers play in reducing that risk.

The remaining modules focus on critical service provision approaches and tools and wrap up with a site visit and planning towards implementing the training at individual facilities. *Each module is a combination of knowledge sessions, presentations and videos, value exploration through activities and discussion, as well as the critical testimony of key population members themselves.*

Key Populations Training Manual: Module Titles

1. Understanding Key Populations
2. Sexuality and Health
3. Barriers to Health
4. Creating a Friendlier Environment
5. Promoting Mental Health

6. Taking a Sexual History
7. Clinical Care for HIV and STIs
8. Supporting the Needs of Members of Zimbabwe's Key Populations Who Use Drugs and Alcohol
9. Interventions for Improving HIV and STI Prevention for Zimbabwe's Key Populations
10. Action Planning

Accompanying Materials

In addition to the training manual's main content and guidance there is a power point presentation and video links to use in the module sessions as needed.

Each participant will also receive a Participant Handbook that will be referred to throughout the training and should thus be provided to each participant as training begins.

In addition, a reference-friendly job aid is available to support KP consultations.

BEFORE YOU BEGIN TRAINING

Working with adults

This training programme is specifically made with an audience of adult healthcare providers in mind. The training will also include non-medical staff such as security guards, volunteers working with young people or people living with HIV, as well as other administrative staff. As a facilitator, it is important to act in a manner that is appropriate for your audience. Adults are autonomous, capable, and self-directed learners and need to be treated as such. Be sure to guide their learning instead of simply lecturing.

Talking about sex and sexuality

The nature of this training expects you as the facilitator to be well prepared to talk about potentially sensitive topics such as sexual health, non-heterosexual identities and specifically, the needs of sex workers, drug users and other key populations such as gays, lesbians and transgender people. It is important to provide at the minimum, a neutral tone and ideally, a culturally competent, supportive tone.

A constantly evolving learning environment

Adapt your facilitation techniques to the different needs that may arise during your workshop. If participants are reluctant to speak out, use more small group work to encourage discussion. If plenary discussions are dominated by only a few voices try working in pairs or in small buzz groups, or even ask participants to write down their thoughts and share.

Know your audience

Next, you should know your audience. Is everyone a healthcare provider, or do you have a mix of administrative and other staff in the training as well? What language suits all? Ask for a participants list with job titles and include introductions and ice-breakers that help share who the participants are, both at and outside of the workplace. It is important that you take these factors into consideration.

Suggested Training Schedule/ Programme

DATE	TIME	SESSION TITLE
DAY 1		
	08.30 – 09.00	ARRIVALS & REGISTRATION
	09.00 – 09.30	INTRODUCTION, ICEBREAKER, OVERVIEW OF TRAINING
	09.30 – 11.00	MODULE 1: UNDERSTANDING KEY POPULATIONS
	11.00 – 11.30	HEALTH BREAK – TEA
	11.30 – 13.30	MODULE 2: SEXUALITY AND HEALTH
	13.30 – 14.30	LUNCH
	14.30 – 16.00	MODULE 3: BARRIERS TO HEALTH
	16.00 – 16.30	WRAP UP
DAY 2		
	08.30 – 09.00	DAY 1 RECAP
	09.00 – 11.00	MODULE 4: CREATING A FRIENDLIER ENVIRONMENT
	11.00 – 11.30	HEALTH BREAK – TEA
	11.30 – 13.00	MODULE 5: PROMOTING MENTAL HEALTH
	13.00 – 14.00	LUNCH
	14.00 – 16.00	MODULE 6: TAKING A SEXUAL HISTORY
	16.00 – 16.30	WRAP UP
DAY 3		
	08.30 – 09.00	DAY 2 RECAP
	09.00 – 11.00	MODULE 7: CLINICAL CARE FOR HIV AND STIs
	11.00 – 11.30	HEALTH BREAK – TEA
	11.30 – 13.30	MODULE 8: SUPPORTING THE NEEDS OF MEMBERS OF ZIMBABWE'S KEY POPULATIONS WHO USE DRUGS AND ALCOHOL
	13.30 – 14.30	LUNCH
	14.30 – 16.00	MODULE 9: INTERVENTIONS FOR IMPROVING HIV AND STI PREVENTION FOR ZIMBABWE'S KEY POPULATIONS
	16.00 – 16.30	WRAP UP
DAY 4		
	08.30 – 09.00	DAY 3 RECAP
	09.00 – 13.00	KP CLINIC SITE VISIT
	13.00 – 14.00	LUNCH
	14.00 – 16.00	MODULE 10: ACTION PLANNING
	16.00 – 16.45	WAY FORWARD, EVALUATION AND CLOSE

MODULE ONE:

Understanding Key Populations

Introduction

In nearly every country where reliable evidence exists, certain groups shoulder a disproportionate burden of HIV and other sexually transmitted infections (STIs) when compared to other adults. In low- and middle-income countries, key populations are many times more likely to be living with HIV when compared with the general population.

HIV and other STIs are not the only health issues faced by these groups. Accumulating evidence indicates that these groups also present with a host of other unique health needs, require sensitive and targeted services to meet those needs and face significant barriers in accessing life-saving healthcare services. These barriers occur at multiple levels and result from the widespread stigma and social discrimination they experience in their daily lives.

Stigma and discrimination, as well as poor attitudes amongst healthcare providers are key drivers of poor health outcomes among the most vulnerable groups in Zimbabwe. A large proportion of key populations continue to lack basic HIV prevention knowledge and avoid seeking primary or sexual health care altogether, due to stigmatising social and cultural norms or discomfort in talking about their sexuality with healthcare providers.

Healthcare providers, as key actors in the health system, play a critical role in promoting the sexual health of these groups. Knowledge among healthcare providers on key population health issues is, and remains, inadequately addressed by Zimbabwe's mainstream healthcare training and in HIV-related training curricula.

Learning Objectives

After completing this module, participants will be able to:

1. Define the term key populations and describe sexual practices common among this broad group.
2. Identify the unique challenges faced by key populations in accessing health services.
3. Discuss the provider's role in addressing the health needs of key population members in local settings.

Resources you will need

Time: Minimum of 1 hour and 30 minutes

Flip chart and pens, project and power point presentation, paper/ cards for writing, Participant Handbook.

Module Activities

Knowledge Session: ±45 minutes

In sub-Saharan Africa and other parts of the world, some groups experience a disproportionate burden of HIV, TB, STIs and other health problems. HIV prevalence is relatively higher in some groups than others, as are mental health problems. A significant number of new HIV infections occur in those people we call key populations or KPs. They are 'key' to resolving our HIV epidemic in that these people often have the least access to health services, including to HIV prevention, treatment and care because of marginalisation and the stigmatisation they experience when attending for health services.

Who are key populations?

In the context of this training manual, key populations in Zimbabwe are defined as: male and female sex workers (SWs); men who have sex with men, including men in prisons and other closed settings (MSM); people who use and/or inject drugs, (PWUD, PWID); transgender and intersex people (TI).

- Key populations face multiple stigma, exclusion, harassment and violence because of their drug use and sexual behaviour, orientation or identity and their HIV status.
- Discriminatory laws and policies such as the criminalisation of sex work, drug use, and some same-sex acts contribute to and reinforce low levels of access to health services.
- These facts also increase the risk of mental health problems and mental illness among these population groups, leading to a cycle of abuse, high morbidity and poor health outcomes.

It is a public health and human rights imperative that all persons, in particular the most at risk, have optimal access to health services, to ensure they enjoy the right to the highest attainable standard of health.

What does LGBTIQ mean?

- In small groups ask participants to go through the Glossary of Terms in their Training Handbook and write down the meaning of these six terms on the papers/ cards provided.
- Write the six terms as headings on the board and ask the groups to write the meanings of each term on the wall.
- Come back to plenary and ask the participants to volunteer a brief description of what each of these terms means.
- Ask for any questions or clarifications on the terms or the meaning of the words used.

Value Clarification Exercise 1: Thoughts and Feelings About Key Populations ±15 minutes

In the next 5 minutes, write down your ideas for the following sentences (Individually)

- I think key populations are...
- When I see a sex worker/ drug user/ LGBTI person (choose one or refer to all), I feel

Facilitator's feedback:

(NB participants do not have to share their answers if they do not want to):

Ask:

- How do you feel about what you wrote?
- Do you think your thoughts and feelings about key populations are fair?
- Do these attitudes affect us as healthcare providers? How?
- Ask the group to share from their different roles as medical, security, or administrative staff as well as outreach workers and volunteers.

Share:

During this training, we will learn that key population members are people just like us and that how we treat them can actually increase their vulnerability.

- We cannot judge a person by the way they look, dress or talk.
- Anyone in our community can be or may become a member of a key population.
- Whether by birth or by circumstance, members of key populations are some of the most vulnerable people in our communities.
- Stigma and discrimination make the situation worse and put everyone at risk. We need to be careful about our use of language when dealing with all clients as we cannot tell who belongs to a key population and we may unknowingly stigmatise them by the way we talk.

Power Point Presentation: Global Issues Around KP and Health ±40 minutes

The purpose of this presentation is to emphasise that this training reflects global and regional health policy and learning. It discusses key populations' enhanced risk of HIV, and the various factors that contribute to this increased risk. Update and adapt as you need.

Conduct the presentation in an interactive and participatory way, stopping to allow questions and discussion from the group. If there is a question you cannot answer, no problem; write it down and let the group know you will get back to them later in the workshop.

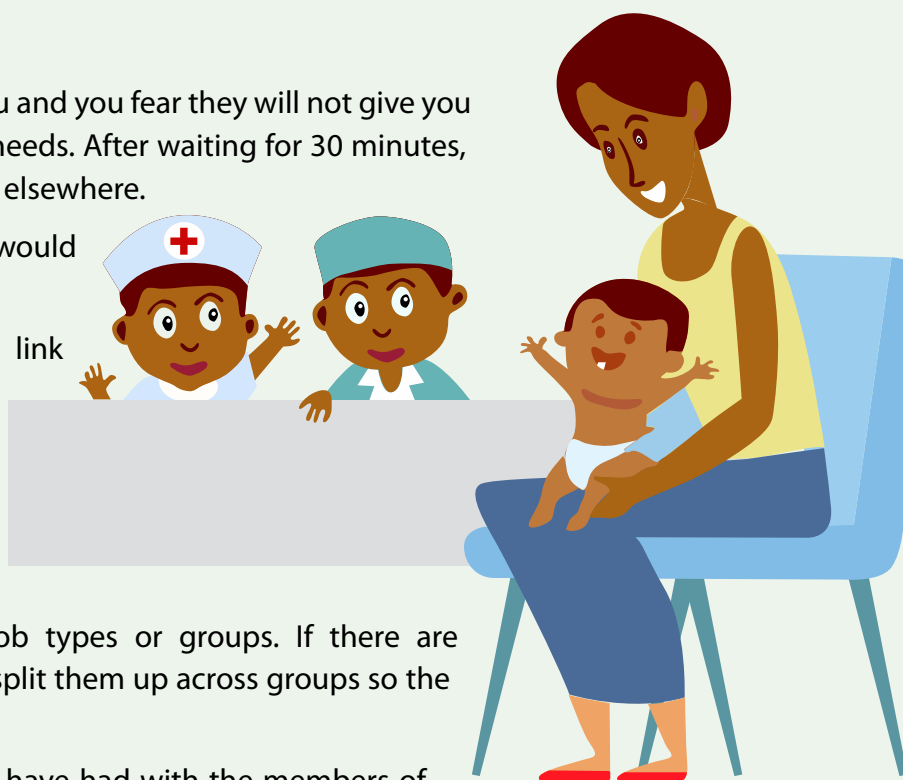
Value Clarification Exercise 2: How Would You Feel? ±15 minutes

Describe the following scenario to the group.

Imagine this situation. Your child is very sick but you don't know what is wrong. You rush to the clinic but when you speak to the receptionist and show her your child, instead of helping you she ignores you. Soon, you notice the receptionist and the nurses huddled together in a corner. They start whispering and giggling and keep looking over at you and your child.

You know they are talking about you and you fear they will not give you the help your child so desperately needs. After waiting for 30 minutes, you decide to leave the clinic and try elsewhere.

- Ask the group to describe how this would make them feel.
- Ask them what they think is the link between this scenario and that of a member of a key population coming into your clinic.



Value Clarification Exercise 3: How Will Clients Feel? ±15 minutes

Divide participants into their different job types or groups. If there are participants from the same health facility, split them up across groups so the groups are mixed.

Ask each group to share experiences they have had with the members of different key populations during their work. First, they should take turns to describe their experiences to each other.

Then the group should think about whether they would classify each story as a positive or a negative experience and why. The group should address the following:

- How do we know if a client is a member of a key population?
- Do clients feel comfortable telling us that they are members of a key population?
- What are the challenges in our work related to these vulnerable groups?

Ask the groups to share a few points from their discussion in plenary.

Facilitator's feedback:

Ask:

- Were the shared experiences positive or negative?
- Can we be an effective healthcare providers if members of key populations cannot be open and honest with us?
- Are there any ways to try and improve the experiences of key population members?

Share:

- Ask the participants to turn again to the Training Handbook and open up at the Patients Charter section (this is also available from MoHCC as both a booklet and a poster).
- Discuss and reflect on its guidance and bring the group back to the need to be principled in our service provision at all times.
- Remind the group that this may mean leaving aside our personal and/or religious beliefs.
- Close the session by asking the various groups within the health facility (medical, administrative, etc.) to share how they feel about the Patients Charter and what their role is in supporting it.

MODULE TWO:

Sexuality and Health

Introduction

Sexuality is the way people express themselves sexually. Understanding sexuality helps us understand how important sexual expression is in a person's life, which in turn influences the partners they choose, the sexual acts in which they engage and the level of satisfaction and pleasure they experience.

- Scientific evidence confirms that same-sex behaviour is a normal expression of human sexuality.
- Like all human beings, key population members express their sexuality in a range of both sexual and non-sexual ways that include love, intimacy, relationship, romance, dating, courting, marriage, family, children and community.
- To better serve key population members in healthcare settings this module provides information on sexuality, including same-sex sexuality.
- It explores the commonality of sexual practice and demystifies some of the sexual practices that are often considered taboo and not mainstream or heterosexual practice.
- Finally, it continues to discuss the need for healthcare providers to serve all their clients in a non-judgmental, compassionate, and respectful manner.

Learning Objectives

After completing this module, participants will be able to:

1. Define basic concepts concerning sexuality and sexual health.
2. Understand the importance of sexual health among key populations for Zimbabwe's *Health For All* targets and in the fights against HIV and AIDS.

Resources

Time: A minimum of 2 hours to complete this module.

Flip chart and pens, small pieces of paper, Participant Handbook.

Module Activities

Knowledge, Reflection & Discussion Session: ±90 minutes

Inform participants that the purpose of this session is to orient them to issues of sexuality and gender and how these influence sexual practice. In the process, participants will explore the diverse sexual practices and how they can be made safe.

Using the Binaries & Boxes to Understand Sexuality¹

Suggested process for facilitation for each of the four components

Inform participants that information written on the flip chart will be repeated often and will be unpacked, step by step. This, (SEX) is the first part of the puzzle that we will unravel. By the end of this session on Human Sexuality, the puzzle will be put together again.

Component One – Sex as a Biological Concept

Although a separate discussion from components two, three and four, this activity should not be seen as a separate entity. The four components together make up the puzzle of human sexuality.

Divide a flip chart paper into four quadrants. This specific activity starts in the top left corner, the first quadrant. Only the word 'SEX' is written on the top of the first quadrant (for now). Place the flipchart where everyone can see it.

1.	1. SEX Male Female Intersex	2.
	3.	4.

The first section is 'SEX' as a biological concept. Start the discussion by asking: **"When I say the word 'SEX', what comes to mind?"**

Allow the group to give their take on what the word means to them. Most will answer that it is something that happens between the sheets, some might give the correct answer.

When a participant mentions 'MALE' or 'FEMALE', write it down, with one below the other.

Now ask: **"How do you know what sex somebody is?"**

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

Ask if the group knows of any other biological sex? Probe by asking what they have heard from the media. Write down the word 'INTERSEX'.

¹ Adapted from Van Dyk, D. & Matlou, J. Binaries & Boxes, Understanding Human Sexuality. OUT Wellbeing (unpublished), (2010)

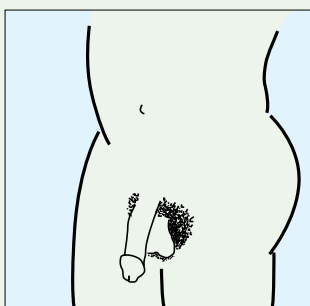
Explain the word Intersex.

- We don't exactly know what an intersex person has in their pants, but that is not important. However, it is important to know that they exist.
- Intersex people used to be called hermaphrodite but this is an offensive and inappropriate, politically incorrect term and should not be used.
- In some cases the genitals are not clear at birth;
- In others individuals discover much later in life that they are intersex.
- Intersex can manifest in many ways.

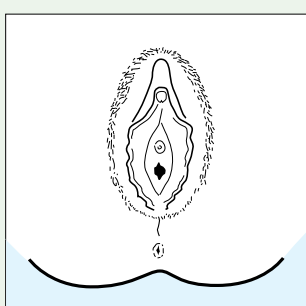
Refer (with respect) to the well known South African athlete, Caster Semenya who has (according to media reports) a vagina and internal testes. Testes produce the male hormone, testosterone, resulting in masculine features. Another example is that of the case of a woman who wanted to have a baby in her late 20s and found that she did not have a uterus – another type of intersex.

- Many years ago, even maybe today, when a baby was born intersex, doctors urged parents to choose the sex of their baby. The genitals would then be surgically modified to fit the chosen sex binary. Cases were reported where the choice was that of a boy but, later in life at about puberty, the 'boy' developed breasts.
- These days, parents are referred to endocrinologists. A choice is not made immediately and the child is allowed to grow up without any 'corrective' surgery and supported to make their own choice in terms of sex and gender identity.
- Having an intersex child can be very traumatic for parents. According to Intersex SA, one in 500 babies in Africa is born intersex today. This is a very sensitive issue and clients should be referred to the correct healthcare providers for help with the various challenges.
- Because of stereotypes, we look for a penis or a vagina.

Penis



Vagina



*Intersex



**Born with ambiguous genitalia, or sex organs that are not clearly distinguishable as female or male.*

- Explain to the group that this information is just the tip of the iceberg and that they should read more on the topic.
- End this session with a statement, for example something along the lines of "Intersexuality challenges the notion that there are only two sexes. But who knows, there may be even more than just male, female and intersex."
- Check with the group if all the information is understood so far.

Component Two: Gender as a Social Construct

Although a separate discussion from components one, three and four, this activity should not be seen as a separate entity. All four components make up the puzzle of human sexuality.

The word 'GENDER' is written on the top of the second quadrant e.g...

1.	1. SEX Male Female Intersex	2. GENDER
	3.	4.

GENDER - Ask what this word means. If sex is male, female and intersex, what is gender?

Most people express confusion between the terms sex and gender. Sex is a biological concept; gender is a social construct.

- A construct is something that is put together by society, – in the case of gender – where meaning is placed on what it means to be male or female.
- Encourage a discussion about 'who' is society?
- Who decided what a man or woman should or should not do? It would also be useful to have a discussion on why society decided how men and women should be.

Write the following two terms on the flip chart:

- Masculine
- Feminine

2.	1. SEX Male Female Intersex	2. GENDER Masculine Feminine
	3.	4.

- Continue with a discussion on gender expectations. Use an example of what is represented in the media, e.g. the well known beer advertisement, of "Real men don't drink pink drinks, Dave". This advertisement reinforces the stereotypical masculine male model in a very subtle way. So who only drinks pink drinks? Stereotypically, women. What about those women who prefer to drink a strong beer? Are men not real men when they drink pink drinks? Encourage a discussion around these notions.
- Ask: "What are some of the social expectations for men and women respectively?" "What is the impact of these social expectations for men and women's health, intimate relationships, relationships with your children?"
- Some behaviour/roles are perceived to be masculine – like drinking too much – and are accepted by society, even if they are pathological in nature. If a woman portrays masculine behaviour, e.g. being dynamic, what is the perception of that woman? That she is a bitch? That she wants to be a man? As soon as a person is boxed or stereotyped, there is a danger of discrimination.

Use examples you feel comfortable with. Further examples: Female jobs: administration, teachers, nurses, housewives, counsellors. Male jobs: engineers, directors, doctors, preachers.

- Masculine – is tough, hard, driven, while femininity represents soft and caring.

Another example: Women wearing denims or pants. Thirty years ago only cowboys wore jeans. One hundred years ago women were not allowed to wear pants at all. Now most women wear denims or pants because they are comfortable or for various other reasons. What if a man wears a dress? What is the perception of such a man? Maybe in another 50 or 100 years men will wear dresses.

Another example: What happens at a baby shower? Girls get pink, and boys get blue. Who decided that blue was a 'boy colour' and pink a 'girl colour'?

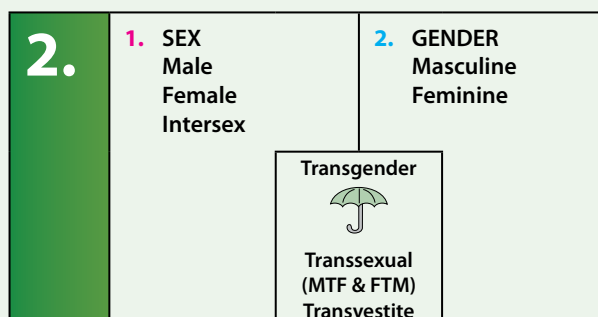
- Human beings are (usually) born with a sex, not with a gender. Gender is what human beings are 'taught', what is expected of male bodied people and female bodied people.
- The irony is that for a human being to be whole, they need both masculine and feminine characteristics.

A man has to be in touch with his feminine side and a woman with her masculine side; our masculine and feminine characteristics should be in balance in the self.

When there is no balance, the power imbalance may lead to different forms of abuse of the self, or of a partner.

Repeat what has already been covered: Sex, Gender.

- Next, introduce the word, transgender
- Write it somewhere between the blocks for 'sex' and 'gender'.
- Transgender is an umbrella term that encompasses two terms.
- Ask if anyone knows what transgender means.
- Probe the participants with the word 'trans' – think of transport, to move from one to the other.
- Transgender covers two elements: write down the words transsexual and transvestite under a picture of an umbrella:



- Ask the participants if they know the difference between the two words.

A transvestite is a cross dresser, in most cases, a male who has the need, for various reasons, to wear female clothes, underwear, make up etc. It is not related to who they are attracted to. Although women can wear men's clothing, (and some men in Africa wear dresses), men as cross dressers are, sadly, not accepted by society.

Transvestites are generally heterosexual. Often, cross-dressing men – those who like to wear women’s underwear or wear women’s clothes – wonder if they are actually gay.

Transgender has nothing to do with sexual orientation. It is because of the myth that gay men want to be women that even heterosexual transvestites will question their own sexual orientation, although they are well aware of to whom they feel sexually attracted. Some gay men will wear women’s clothes too and are commonly known as **drag queens**.

- Transsexuals, on the other hand, are people who transition, or are in the process of transitioning, to bring their body and gender identity closer together.

Example: A child is born; there is, or appears to be a penis, and there is the assumption that he is a boy. When brought up, the person follows a masculine gender role but feels uncomfortable with the self as a man, and feels more comfortable with a feminine role, and being a woman. She feels trapped in the wrong body.

Remember to use the correct pronoun.

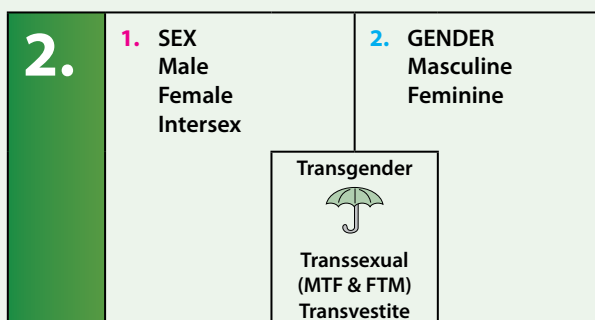
VERY IMPORTANT! Again, it is important that participants understand that gender identity and sexual orientation are not the same, **although they share the same experiences of prejudice and discrimination**. It is about the relation of the person with themselves – their gender identity – not whom they love or feel attracted to.

- Gender identity: refers to how someone feels about themselves in the world as a woman or a man, i.e. a person’s sense of themselves as male or female. While most people’s gender matches their biological sex, this is not always the case. For instance, someone may be born biologically male, yet have a female gender identity.
- Continue by further explaining the complexity of transgenderism, where people who feel they cannot identify with their sex organs (for instance someone feels like a woman inside but has a man’s body or the other way around). Some will try to change their bodies through hormones and/or sex change operations (gender reassignment surgery). Not all transsexual people are the same. A transsexual person can be of any sexual orientation.

For example a man, married to a woman, felt trapped in the wrong body, had a sex change operation to become a woman but remained married to the same woman. This has an impact on their sexual orientation; a lesbian woman trapped in a man’s body. This will be discussed after this component.

In Samoa, *fa’afafine* are biological males who have a strong feminine gender orientation, which Samoan parents recognise quite early in childhood. They then raise them as female children or rather ‘third gender’ children. They grow up as *fa’afafines*, which is a gender category/identity altogether different from men or women and so they have their distinct gender roles specific to them, different from both men and women. It is something which is not discouraged in traditional *fa’asamoa* (Samoan society).

- Terms used to describe transsexual people: MTF (male to female) or FTM (female to male), with or without gender reassignment surgery.

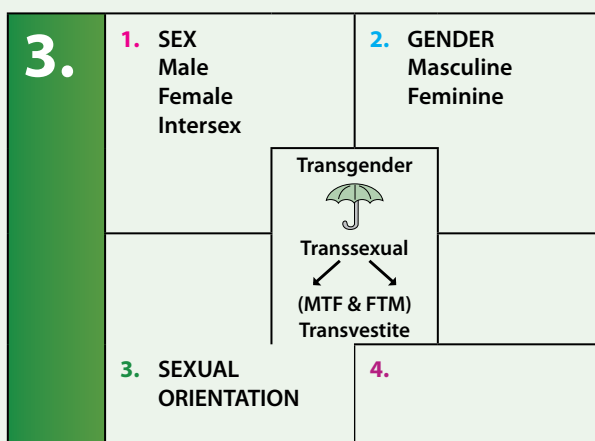


- Check that everyone understands so far and answer any questions. Mention that we are now moving to the third part of the puzzle.

Component Three: Sexual Orientation

Although a separate discussion from components one, two and four, this is not a separate entity. All four components make up the puzzle of human sexuality.

This activity starts in the lower left corner, in the third quadrant. Only the word 'SEXUAL ORIENTATION' is written on the top of the third quadrant e.g.



- Do not give the answer immediately. Allow people to think a bit.

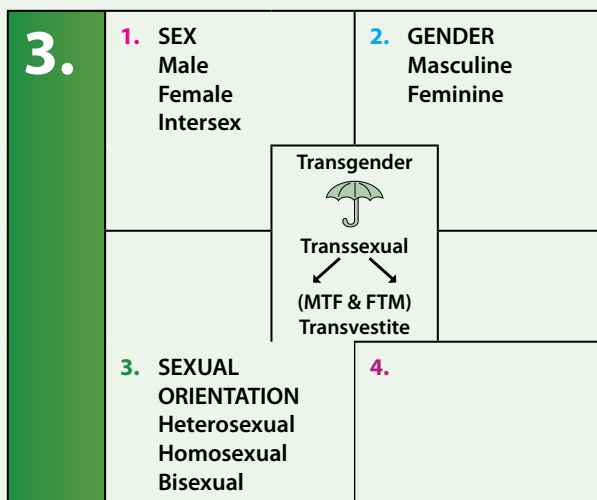
Ask what the 'term 'sexual orientation' means. Participants can either write it down as part of an individual reflective process by pairing with the person next to them, or in group work.

Suggested questions: Ask "What do you think it is? Do you have a sexual orientation? Do all people have a sexual orientation? What are the different sexual orientations?"

- Ask the group if there is anyone who does not have a sexual orientation. Often, there is a misperception that only homosexuals have a sexual orientation. Everybody has a sexual orientation. It is unclear what determines a person's sexual orientation.
- Often people ask; "Where does homosexuality come from?" Well, The answer is, the same place as other sexual orientations. The question is often asked because homosexuality and bisexuality are wrongly seen as different, or an illness. This is because people do not understand human sexuality due to the limited information available and all the shame that used to be connected to homosexuality because of heterosexism and homophobia (we'll talk about these terms a bit later).

Definition of sexual orientation: it is about attraction and feelings. Attraction has many levels – sexual, physical, intellectual, emotional and spiritual. **Thus, it is not only about sex!**

- Now ask the group to call out the different sexual orientations and write them in box 3.

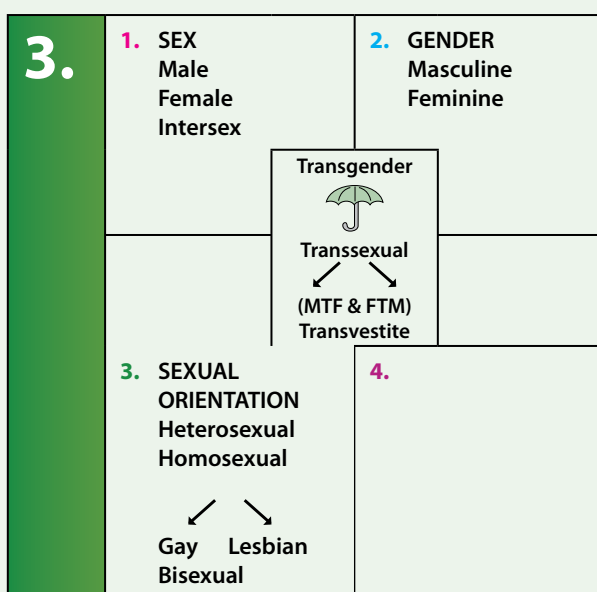


Heterosexual (straight). ‘Hetero’ means opposite, therefore heterosexual people are attracted to the opposite sex; a man attracted to women, or woman attracted to men. This attraction is sexual, emotional, intellectual, physical and spiritual.

Homosexual. ‘Homo’ means same, therefore attracted to the same sex; a man who is attracted to a man, a woman who is attracted to a woman on **ALL** the different levels of attraction, not just sexually (**this is a very important concept for participants to understand. Repeat the definition of a sexual orientation several times if necessary**).

- Write these down next to the term homosexual:

Ask if they understand what the words gay and lesbian mean and what the difference is.



- Although being gay or lesbian is an identity, there are some women who prefer to be called a gay woman. While the term 'gay' was originally used to refer to feelings of being 'carefree', 'happy', or 'bright and showy', it had acquired connotations of 'immorality' as early as 1637.
- Today it usually refers to a homosexual man (<http://www.etymonline.com/index.php?term=gay>.) The 'label' is not important, what is important is that the person feels comfortable within their own identity.

Bisexual. 'Bi' means two and therefore refers attraction to both sexes; a person attracted to people of both sexes on **ALL** the different levels of attraction, not just sexually (as mentioned above). It is a sexual orientation in its own right. However, it is often misjudged and stereotyped as those who have multiple concurrent partnerships or people who 'can't choose'. This could be the case for some, but for most bisexual individuals this is a slap in the face.

Very important to remember: People of all sexual orientations can have multiple partners (preferably do **not** use the term 'promiscuous' – it is judgmental).

- For many years, people thought that homosexuality could be cured or fixed but the reality is that homosexuality cannot be cured or fixed. It is not a disease or an illness but a natural expression of human sexualities; there is nothing to fix or cure.

Give an example by choosing a heterosexual person in the group (always ask permission first!) by saying: "Change your sexual orientation now; choose to be a homosexual person". Ask the person if they would feel comfortable with a change/to be cured/to be fixed?

- In 1973, homosexuality was removed as a mental illness from the Diagnostic and Statistical Manual of Mental Disorders (DSM). Yet almost 40 years later, some professionals and lay people still look for a cause as if there is a 'cause' of hetero or homo orientation. Statistically, one in every ten people is lesbian or gay, according to the Kinsey study from the 1950s.
- Sexual orientation is not a choice. Usually participants want to talk about the 'Nature versus Nurture' debate. Unfortunately, there is no clear answer, maybe because there is nothing wrong with the homosexual person. It is natural to look for the cause to a problem or illness, but if nothing is the matter, why look for a cause?

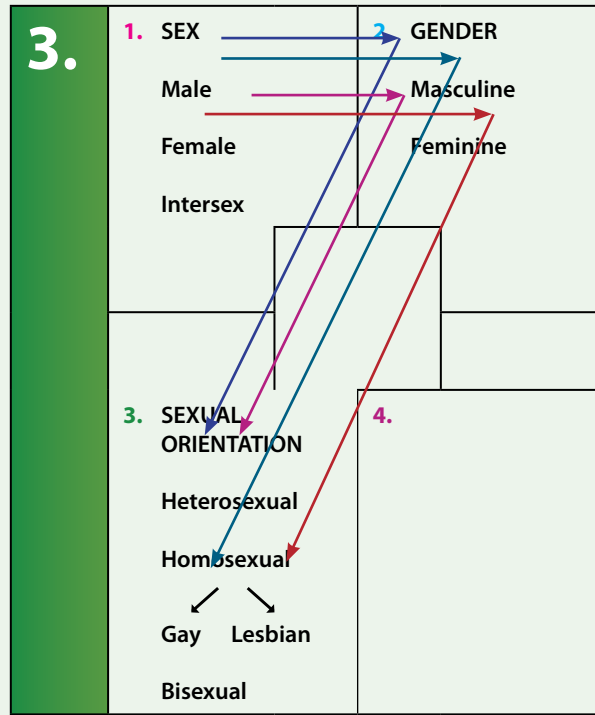
Discuss an example of what happens in life: A child is born with a penis; society teaches the baby to be masculine and have relationships with the opposite sex. Society assumes he must be straight. Another assumption: If you are female, you must be feminine, and therefore straight.

Or another assumption: If a boy is gay, then as a male he must be feminine – that is how a homosexual man should be. These are just gross stereotypes; if lesbian, you are female and therefore you must be masculine, another gross stereotype.

It does not always work like that. You can get a male who is very masculine, who is homosexual. Or a female, who is very feminine, and homosexual.

- Behaviour (masculine or feminine) does not determine a person's sexual orientation. There are males with feminine characteristics who are straight and females with masculine characteristics who are straight.
- Sex does not inform gender, nor does it inform sexual orientation.

- Start to make the links on the flipchart, by using examples of different people in terms of sex, gender and sexual orientation. Use a pen. You can use yourself as an example, or with their permission, a participant or two.
- Mention that the pieces of the puzzle are coming together.



- How do you know what a person's sexual orientation is? You will only know if they tell you. Never assume. If you don't know, ask. Don't ask to intrude but if you need to know, ask, with a professional attitude (as a professional needing information from your client). Again, never ever assume.

The world (or most of the people in it!), assumes that everybody is heterosexual.

- Relate this discussion back to the work the group does. For instance, if they are counsellors, give the following example:

A woman comes in. She tells you her problems. You automatically assume that person is straight and ask "How is your boyfriend or husband doing". You are assuming. Maybe she has a girlfriend, or a boyfriend AND a girlfriend. Maybe she is married, to a man, but has sex with a woman. Surely, you would have lost your client!

Another example: A man, a dad, sits next to you. He has problems. You assume he is married, maybe he is but he also confides in you that he also has sex with men on the side. You cringe –client lost! Do not let your own judgment and belief systems interfere with your job.

- If you let a person, your client, tell you more about their intimate lives and if you respond in a non-judgmental manner, you will be surprised at how much you learn.
- Discuss the importance of understanding some discriminatory concepts. Lets have a look at the terms heterosexism or homoprejudice: Look at the -ism, think of racism – when one race acts as if it is better than all the other races and discrimination follows.

What was the impact of racism in Zimbabwe, or of and apartheid in South Africa? How did racism play out in practice? Were proper health services availed to black people? People were abused. Gross humans rights violations and even murder were perpetrated on people. Remember those times?

- Heteronormativity is a cultural bias that only heterosexuality is 'normal' or accepted. Because most people, including homosexuals, look at the world through a heteronormative lens, they assume and even expect same-sex partners in relationships to have male/female roles. They expect one to be more masculine and the other to be more feminine. This comes from the cultural assumption that a family consists of a mother, father and children (heteronormative model). Even most gay and lesbian individuals and couples try to fit within the stereotyped gender expectations. Remember the discussion on how stereotypes are internalised in the last session?

Example: two masculine gay men in a relationship confuses people, they want to know who is the 'wife' and who is the 'husband' in a homosexual relationship. Some gay men refer to their partner as 'my wife', because the other partner is more effeminate. Even though people joke about it, such statements validate the acceptance of negative stereotypes about gender roles and homosexual people.

- In many societies, including most in Africa, men are considered superior to women and their roles are dominant. In these so-called patriarchal, heteronormative, heterosexist societies: males, 'masculine' characteristics (such as rationality and competitiveness) and roles assigned to men are considered superior and valued above those of females; those characteristics considered 'feminine' (such as emotion and nurturing) and roles assigned to women.

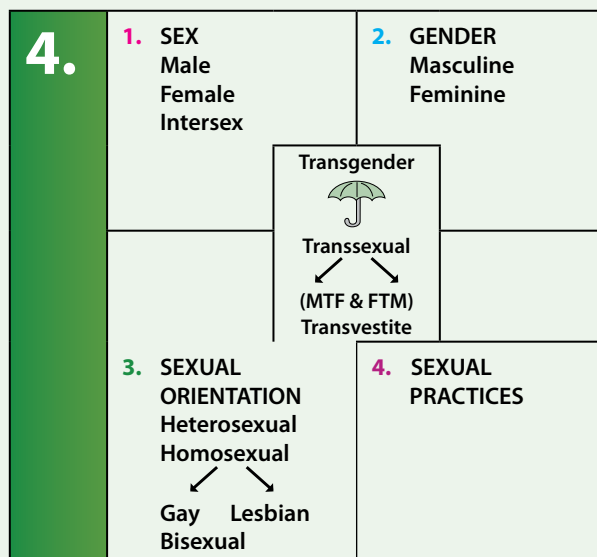
Gender and gender roles are, however, not fixed as society and culture are forever changing.

- Now we're ready to move on the final piece of the puzzle.

Component Four: Sexual Practices

Although a separate discussion from components one, two and three, this activity is not a separate entity. All four components make up the puzzle of human sexuality.

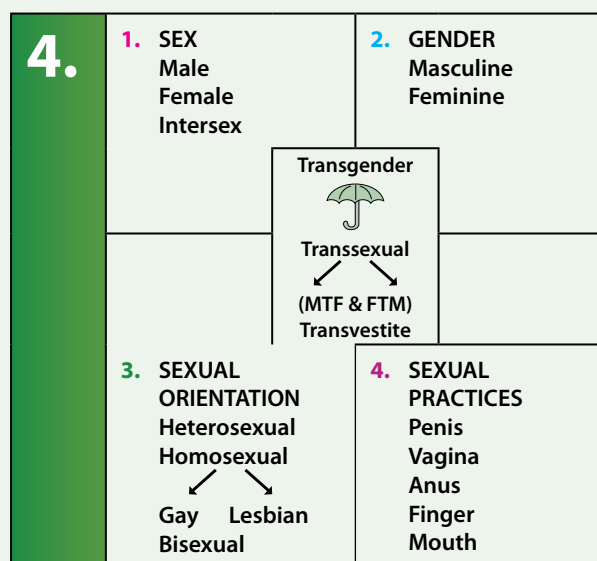
In the lower right corner, the fourth quadrant write only the word 'SEXUAL PRACTICES':



- Ask the group to name the different body parts that people use to experience sexual pleasure and reach orgasm. Write them down in the fourth quadrant:

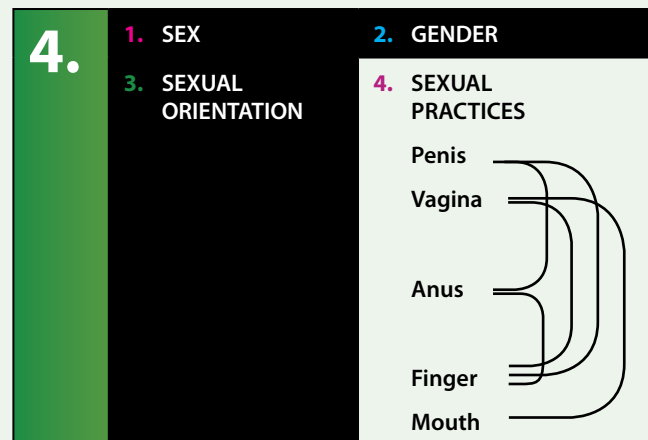
Examples:

- Penis
- Vagina or vulva
- Anus
- Fingers
- Mouths



- Ask the group if a penis and a vagina can go together? Connect the body parts on the flip chart with different colour pens.

- Can a penis and an anus go together? Can a penis and mouth go together? Can a finger and vagina go together? Can a finger and anus go together? Can a mouth and vagina go together?



- Now, ask them if you mentioned who the body parts belonged to? What the sex of the two (or three or more) people was? The answer is NO! Thus it is all possible. And it is all seen as sex. Ask the group if they agree. Why is it important to know how people view sex? Because for many years sex was only seen as penetration of the vagina by the penis. Remind the group of the heteronormative view of relationships and sex. The primary risk linked to that kind of practice was limited to pregnancy.
- Nowadays we know the risk is also in contracting a STI (including HIV), but still many people think that because there is no vagina in the sex act there is no chance of contracting an infection, because they link risk, consciously or unconsciously, with pregnancy. Therefore, any sex practices that do not involve the vagina and the penis are perceived by many as not being sex and are considered non-risky. As a matter of fact, we know that unprotected anal sex with an infected partner is the sexual practice that carries the highest HIV transmission risk.
- Let's talk about MSM (men who have sex with men) and WSW (women who have sex with women); people who have sex with those of the same sex do so for a variety of reasons other than as an expression of their sexual orientation or identity.
- Some may regularly have sex with others of the same sex without seeing themselves as lesbian or gay (whether due to cultural, religious or personal reasons).
- Others may do so due to circumstances, such as being confined to a facility (e.g. a prison, mines) or a period of separation from the opposite sex (such as during military training or operations).

VERY IMPORTANT! People have sex for different reasons. Men have sex with men for different reasons, but they could still identify as heterosexual. An MSM can have any sexual orientation.

- How people perceive anal sex differs. You may refer to the Durex Sexual Health and Wellbeing Study.
- The inside of the anus is a very sensitive place, like the inside of the mouth. Because it can be easily damaged, it is highly susceptible to a sexually transmitted infection.

- Inside the male anus is a gland called the prostate. For most men the prostate is a very pleasurable spot when stimulated, no matter what their sexual orientation.
- However, if you look at the Durex study results, some homosexual men do not prefer anal sex. Some lesbian women prefer anal sex.

Below are the reported percentages of how men and women experience anal sex according to the results of the Durex study.

- Anal sex – giving (8% hetero female, 19% hetero male, 72% homo male, 10% homo female)
- Anal sex – receiving (18% hetero female, 11% hetero male, 67% homo male, 15% homo female)
11% of heterosexual men reported that they like receiving penetrative anal sex from their female partners
- Oral sex– giving (56% hetero female, 58% hetero male, 83% homo male, 77% homo female)
- Oral sex – receiving (55% hetero female, 56% hetero male, 81% homo male, 74% homo female)
- Discuss the issue of guilt and shame associated with certain sexual practices, e.g. the 'anal taboo'. Because of that, some people take part in hidden and risky sexual activities.

A heterosexual man might feel too shy to ask his wife or girlfriend to perform anal sex on him; he might try to find the sexual satisfaction he needs elsewhere, often putting himself and his male and female partner(s) at risk.

- Originally anal sex was seen as a gay sexual practice. We are now aware of more and more women who include anal sex, both giving and receiving, in their sexual repertoire.
- A challenge arises when trying to identify an MSM. You cannot say an MSM is 1.8 m tall, has a beard, and wears only blue shirts. From experience we know that MSM are not easily identified and would not necessarily disclose to service providers, so may end up not receiving services appropriate to their needs.

Not all MSM see the sexual practices they have with other men as sex, for example, anal penetration without a condom and water-based lubrication. They might assume that, since there is no vagina and no chance of pregnancy, what they are doing is not sex, but rather 'just playing around with the boys'! The reality is that they are engaging in high risk sex and are vulnerable to HIV transmission without even being aware of it.

VERY IMPORTANT: Men who engage in anal intercourse, irrespective of whether this is insertive (**TOP**), receptive (**BOTTOM**) or both (**VERSATILE**) and whether it is with men or with women, or both, must be informed that HIV can pass through the delicate mucosal membrane of the rectum. For this reason, receptive anal intercourse poses a particularly high risk of HIV infection.

Don't assume people know what sex is all about. Again, **never ever assume**.

- When talking about responsible and safer sex strategies with a client, never assume the sexual practices they may be indulging in. The message must be all encompassing.

For example, when giving safer sex messaging to lesbian women, say something like, 'Here is a safer sex pack, use condoms on toys or when you have sex with men etc,' act as if it is the most natural thing in the world for you to talk about. When speaking to men, try something along the lines of "Here is a condom.

Use it when you have sex with a male or female partner, anal or otherwise."

Close the binaries and boxes session by saying: **"Who we have sex with is not important for healthcare providers. How safely we have sex with others – that is what is important to ensure good community health!"**

Value Clarification Exercise 4: How We Have Sex ±30 minutes

- Begin by assuring everyone that this process is anonymous; no one will need to reveal the answers they write.
- Encourage participants to be open and honest to promote learning and understanding.
- Now give each participant a small piece of paper and ask them to write which parts of their bodies they enjoy bringing together for sex.
- Collect the completed papers in a black cloth or bag so that no one can see whose note is where.

Facilitator's feedback:

Ensure that no one sees the papers or feels worried about what is being read out. Read out the written papers ignoring any repeats, once they have all been collected. This exercise aims to demonstrate and acknowledge that sexual practices are diverse and to normalise the not so common practices. Reinforce that the discussion is not to focus on the identities of the people but on their sexual practices and how they can be made safe. **You can never assume another person's sexual orientation or their preferred sexual practices.**

Ask the group:

- Why would a man have anal sex with a woman?
- If everyone has the potential to have sexual pleasure in these many different ways, how would we ensure everyone gets the best support when they come to the clinic, whether they are a key population member or not.

Share:

- Some people may regularly have sex with others of the same sex without seeing themselves as lesbian or gay (whether due to cultural, religious or personal reasons).
- Gender presentation has nothing to do with being lesbian or gay. Most lesbian women consider themselves as women and similarly, most gay men consider themselves to be men.
- Being transsexual has nothing to do with being lesbian or gay. Transsexual people can be heterosexual, lesbian, gay or bisexual.
- Being transvestite has nothing to do with sexual orientation. Transvestites can be heterosexual, gay or bisexual.
- Intersex is a biological variant and NOT a sexual orientation nor does it refer to sexual behaviour.
- Having a penis does not make you a man; having breasts does not make you a mother; being heterosexual does not make you 'normal'.
- Our language is too limited to fully describe a human being's sexuality and sexual expression.

Round up by informing the group that how to take a sexual history will be covered in a later module so that important tools and communication skills can be learned to ensure that this is done in a way that is both respectful and in line with professional etiquette. Not all those in the training will do this but the section activities will give everyone a role to play.



MODULE THREE:

Barriers to Health

Introduction

Members of key populations experience social discrimination in many ways, precluding them from accessing necessary healthcare services. While some of these barriers and experiences are within the health system, other factors, such as laws concerning sex work, drug use and homosexuality, or the lack of proper legal recourse in the case of human rights abuses, impede the ability of key population members to talk about their sexuality or health issues with healthcare providers.

- It is important for everyone at a healthcare facility (including the people clients meet right at the entrance) to be equipped with knowledge concerning the social context in which key population members navigate their healthcare needs; this ensures that they can create a safe and welcoming environment within their respective healthcare settings and includes the need to ensure that all staff – even groundsmen and security guards – are educated about treating ALL clients in a friendly nonjudgmental manner. Structural barriers have the potential to exacerbate vulnerability and increase high-risk behaviours and HIV and STI transmission among key population members.

Another way of ensuring your facility is key population friendly is to consider engaging peer educator 'patient champions' and also to EMPLOY members of KP groups in the healthcare system to be based at your clinic, even if only on certain days. This will help encourage members of key populations to understand that the facility will treat them with respect.

This module is designed to increase provider understanding of the well-known barriers faced by key population members in Zimbabwe and how these may negatively affect health outcomes.

Learning Objectives

After completing this module participants will be able to:

1. Identify barriers, facilitators, and critical enablers that impact access to and utilisation of healthcare services.
2. Describe how stigma undermines the health of key populations.
3. Identify the advocacy role of providers in mitigating barriers to healthcare access.

Resources

Time: This session requires a minimum of 1 hour and 30 minutes to complete.

Flip chart and pens, project and power point presentation, Participant Handbook.

Module Activities

Power Point Presentation: Title 'Barriers to Health'. ±45 minutes

- Begin with a brainstorm, asking the group to share and list all the barriers that a key population member might face in accessing the healthcare they need.
- Make sure you get different perspectives from administrative staff, volunteers, medical staff and guards etc.
- Once you have filled a flip chat (or two), introduce the PowerPoint section entitled '*Barriers to Health*' and take the group through each slide. Adapt and update this as you need.

Value Clarification Exercise 5: Which Barriers are Real? ±45 minutes

This exercise can be conducted as a 'snowball' exercise, whereby the three questions below are asked one at a time and participants discuss in pairs for a very short time, then snowball (or enlarge) to a group of 4, then to a group of 8, before giving feedback on each question. Do not start a new question until feedback on the first is complete. The last question can be presented on flip charts by each group.

1. Are there instances or examples that you can think of where government law and policy may render harm to key population members such as sex workers or gay men in Zimbabwe?
2. What are some of the guiding principles that help healthcare providers deliver competent and high quality care regardless of a client's sexual identity and behaviour or gender expression?
3. Of the barriers listed in the brainstorm exercise, group them under the following headings:
 - **Structural** (includes how things are done, availability of services, social justice and human rights)
 - **Behavioural** (what people do to put them at risk of HIV infection or other poor health outcomes)
 - **Medical** (co-infections, science and technologies).

Facilitator's Feedback:

- Understanding barriers to care is a very important factor in being able to support the most vulnerable people in our community. Without this understanding, healthcare providers are much less able to support and treat those at highest risk of HIV.
- Consider engaging peer educator 'patient champions' to be based at your clinic, even if only on certain days to reassure members of key populations that the facility will treat them with respect. And don't forget the support staff in your educational awareness campaigns.
- Everyone entering your premises should feel respected and not judged. However, even the greatest knowledge of barriers will fall short if the service provider has a negative and judgmental attitude.
- There may be need to remind participants of Zimbabwe's protective Constitution, excerpts of which can be found in the Training Handbook under the section 'Key populations, health and the law'.

*“There is a thin line between our lack of knowledge *and a poor attitude* for some of us in the healthcare sector.”*

Taurai, MoHCC, Stakeholder Consultation Process, May 2018

MODULE FOUR:

Creating a Friendlier Environment

Introduction

Key populations experience a variety of barriers to receiving appropriate health services. Many delay seeking care or receive inappropriate care because of stigma or discrimination by healthcare providers and other staff. One important way to help overcome these barriers is to ensure that the healthcare service environment is respectful and welcoming to all. A welcoming and enabling environment helps clients feel safe and encourages them to build trusting relationships with healthcare providers. It alleviates concerns about discrimination and can lead to better quality healthcare. Healthcare providers can take positive steps to promote the health of key populations by examining their practices and policies and by providing staff training. There are simple ways to make any clinical setting more welcoming.

- This module asks us to reflect on why members of key populations might avoid seeking healthcare or disclosure about their sexual practices. It provides powerful testimony from key population members themselves, in the belief that stigma and discrimination is often born of ignorance that can be overcome by sharing experiences and simply getting to know one another.
- This module should also discuss how to involve ALL staff at a health facility, from security guards, to administrative staff, volunteers and outreach workers connected to the facility. Medical staff alone do not make an enabling environment and the health teams must ensure everyone on their site is sensitised and trained.

Learning Objectives

After completing this module, participants will be able to:

1. Understand why key population members may avoid seeking care.
2. Identify strategies for creating safer and friendlier environments for key population members to access care.
3. Understand the importance of communication and confidentiality while engaging with key population members.

Resources

Time: This module requires a minimum of 2 hours to complete.

Flip chart and pens, videos and KP volunteers to give testimony (work with partners ahead of training to ensure their participation), Participant Handbook.

Module Activities

Value Clarification Exercise 6 (±60 minutes): How Friendly is my Facility?

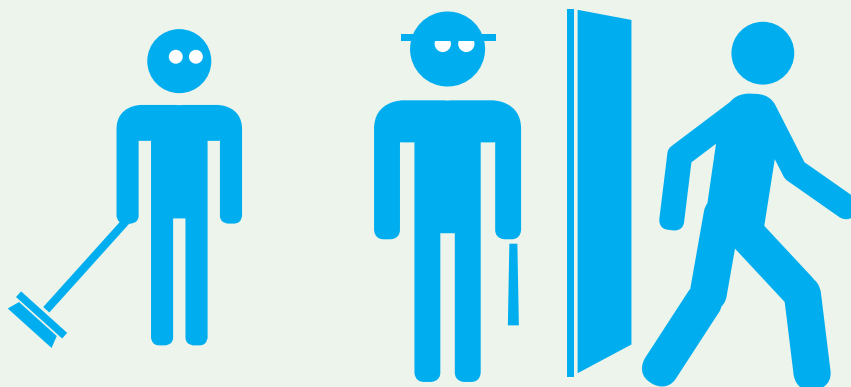
This works best if participants are grouped by facility or local area network. Make sure everyone participates, this is not just about medical staff. All staff need to get involved.

Which services does your health facility, or the facilities you work with support or offer? Make a list and share with others in the group. Now refer the participants to the list of ideal services in the Participant Handbook.

- Identify gaps in your service provision.
- How can you cover those gaps?
- Discuss the following examples:
 - ✓ Imagine a sex worker has come to your facility because she was forced to have unprotected sex by one of her clients. She has an itchy discharge and is worried. Where would she go in your clinic? What would her experience be? What do you think she would say? How would the provider most likely respond?
 - ✓ Imagine a married man (you may know him from the community or surrounding area) who has a boyfriend he sees from time to time outside of his marriage, visits your clinic with a suspected anal STI. You see from his records he has been here several times before with the same problem. His wife has also attended and been seen. You sense there is something he is not telling you (you may not know about the boyfriend). How would the healthcare provider most likely respond?
 - ✓ How can everyone at the facility be more involved in supporting members of key populations access the services they need?

Facilitator's Feedback

- Go through each question with the plenary group and ask for suggested responses. In particular, go through the examples given.
- Discuss how comfortable the sex worker or the MSM might feel telling the truth of what has happened and whether they might make something up instead.
- Discuss how the person might even reach the medical staff after talking to other staff at the facility first.



Movie Screenings! ±30 minutes

There follows a series of short videos that highlight the very real difficulties many key population members face on visiting a healthcare service. They are presented to show healthcare providers that these are 'real people' like anyone else. They have volunteered to be part of these short films to help increase understanding and empathy. It is important to respect their confidentiality, as many have taken a personal risk to participate in the films to help educate others about their lives. A short summary of each video can be found below.

<https://www.facebook.com/safaids/videos/1381625501875770/> SEX WORK

<https://www.facebook.com/PositiveTalkTv/videos/856266097774654/>

Positive Talk TV – Life of a Sex Worker

The story of how Tendai became a sex worker. Her's is not a straightforward journey but begins at her birth and the challenges she faced finding a job and a husband. When her husband died she was unable to get a regular income, despite her seven O-level passes. The bars offered some support and she found herself having to sell sex to pay her children's school fees. Both children are very clever, driving her to keep in sex work to ensure they do well. She is now living with HIV as a result of the challenges of sex work. Her dream is to leave sex work and become a nurse.

Positive Talk TV – Young People and Drugs

This short interview is about young people in South Africa addicted to a drug called nyaope. It is a mixture of ARVs, dagga and heroin. Drugs also make them too brave to ask for help. Sometimes, the drugs drive them to aggressive and dangerous acts. They are driven to take drugs to chase away hunger. Watch their plea for help. Many young Zimbabweans are in the same situation.

Before you show and discuss each film, ask everyone to take notes while they watch and to reflect on the following areas:

1. How did you feel when watching the film?
2. What did you find surprising or unexpected? Do these stories change your perception of key population members in any way? If so, how?
3. How can you involve everyone at your health facility? What do you need to do?

Testimonials! ±30 minutes

This is a very important part of the training. Interaction between these vulnerable groups and healthcare providers is designed to help break down barriers and mistrust, dispel stereotypes and give healthcare providers a more in-depth understanding of how stigma and discrimination affect these individuals, as well as giving an opportunity for the voices of key population members to be heard and their experiences validated.

- This session needs to be mobilised in advance and be given plenty of time. Each testimonial should have the space to be given freely without interruptions and followed by a question and answer session.
- The people giving the testimony should be invited to stay, participate and mingle with the training group for tea or lunch. However, this is voluntary and should not be forced.
- Ask the group to read the article on protecting transgender people from HIV in the Participant Handbook.



MODULE FIVE:

Interventions for Improving HIV and STI Prevention for Zimbabwe's Key Populations

Introduction

Promoting the health of members of key populations requires a positive and respectful approach to sexuality and sexual relationships. It requires the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination, and violence. Many organisations embrace a positive sexual health approach in their HIV services to key populations. This approach takes the whole person into account, including the importance of pleasure and intimacy, mental and physical health, shame and guilt concerning sex, stigma, discrimination, and other social and structural factors.

This module presents established interventions for HIV and STI prevention (sometimes called a Minimum Service Package). It discusses combination HIV prevention and World Health Organization (WHO) recommendations for HIV prevention, care, and treatment for key population members. This includes:

- Correct and consistent condom use with condom-compatible lubricant.
- Newer biomedical approaches to risk reduction: pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and voluntary medical male circumcision.
- The risks of sex without a condom.
- Possible risk reduction strategies for those who practice sex without a condom.
- An in-depth discussion of HIV testing and counselling for both individuals and couples.
- Triple site assessment, and
- The importance of HIV prevention for people living with HIV.

Learning Objectives

After completing this module, participants will be able to:

1. Understand more about combination HIV prevention and why it is important for key population members to have service options.
2. Understand the WHO consolidated guidelines for reducing HIV in key populations and adapt them to support Zimbabwe's clinical setting and health for all targets.

Resources

Time: This module needs a minimum of 1 hour and 30 minutes to complete.

Flip chart and pens, Participant Handbook, a hard or soft copy of WHO Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations (2016 update).

Module Activities

Knowledge & Discussion Session: ±45 minutes

About Combination HIV Prevention

Currently, most HIV researchers and practitioners agree that to effectively address HIV prevalence and incidence among key population members a comprehensive approach sustained over time and tailored to local needs, is necessary.

- A combination approach involves combining and integrating biomedical, behavioural, community-level and structural approaches to address HIV epidemics. One example is delivering behavioural interventions like risk reduction counselling, together with biomedical interventions like HIV treatment, while also addressing barriers to access, thereby addressing numerous issues at once.
- Focusing only on one factor, whether it be prevention, treatment and care, or psychosocial support, does not sufficiently address HIV incidence at the population level. Similarly, addressing HIV with only one type of intervention is unlikely to result in significant long-term gains. This is why a combination approach is recommended.

With biomedical approaches such as PrEP, for example, there are inequities in access to basic health care. Key populations cannot benefit from biomedical interventions if their access to these interventions is reduced because of cost, stigma, discrimination, or criminalisation. Having a combination of the following interventions available directly (ideally) or by close and reliable referral is critical in supporting key populations for HIV prevention.

WHO intervention recommendations for HIV prevention, care and treatment for key populations

WHO CRITICAL ENABLERS: WHO acknowledges that a number of conditions will allow recommended health interventions for HIV prevention, care and treatment to be more effective in treating key population members. These are listed below and call all service providers towards advocacy on these issues that create barriers to good health for all:

- Laws, policies and practices must be brought into line to support access to health by all, together with meaningful engagement of stakeholders from key population groups to ensure up to date information, implementation and scale-up of services to key populations.
- Anti-discrimination and protective laws must be present and enforced. These are derived from human rights standards and aimed at eliminating stigma and discrimination and violence against members of key populations.
- Health services must make available services that are affordable, accessible and acceptable to key population members, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the RIGHT to health.
- Programmes that enhance community empowerment amongst key populations (demand creation and targeted outreach).
- Specific laws preventing violence against key population members, with such violence monitored, reported, and redress mechanisms in place to provide justice.

Below is an ideal set of services that would be provided at all sexually active clients at any health centre. This can also be found in the Participant Handbook. Page 72 has a recommended minimum service package for HIV prevention for KPs in Zimbabwe that should also be shared and discussed.

Reflection and discussion exercise in groups:

- Which of the services in the suggested interventions below, is currently offered by your facility?
- Which of these services is offered by a partner or a nearby facility that could be used for referral?
- Which of these services would be a problem for your healthcare facility to offer? Explain why.

WHO INTERVENTIONS: WHO recommends the following specific health sector interventions be made available to key population members.

1. Condoms together with condom-compatible lubricants	2. Oral pre-exposure prophylaxis (PrEP) <i>[new recommendation]</i>
3. Post-exposure prophylaxis (PEP)	4. Voluntary Male Medical Circumcision (VMMC) and Male Sexual Health Education
5. Needle and syringe programme for PWID access to sterile injecting equipment as a minimum.	6. Opioid substitution therapy for people who use drug/dependent on opioids
7. Assessment, feedback and advice on alcohol and other substance abuse	8. Access to naxalone for emergency opioid overdose management <i>[new recommendation]</i>
9. Provider Initiated testing (PITC) & Voluntary HIV testing and counseling (HTC) offered in both clinic and community settings	10. ART and ART management for those presenting or testing HIV positive
11. Prevention of mother-to-child transmission (PMTCT) in line with pregnant women from other populations	12. TB prevention, screening and treatment support , including for HIV positive (isoniazid)
13. Hepatitis B & C prevention, screening and treatment support , including for HIV positive	14. Routine mental health disorder screening and management (esp. depression)
15. Screening, diagnosis & treatment of STIs , including extra-genital, or triple site for sex workers and MSM	16. Reproductive options and contraception , including for those living with HIV, including female sexual health education
17. Abortion services available as appropriate to the law and as for women from all populations	18. Cervical cancer screening for all women from key populations, anal & prostate cancer screening for men from key populations
19. Conception & pregnancy care (referral to specialist services, ante & post natal care (ANC and PNC) as for women from other groups	20. HPV vaccinations for sex workers, young women selling sex and MSM

1. Correct and Consistent Condom Use

Male and female condoms are sheaths of latex or another material used during anal, vaginal, or oral sexual intercourse.

Condoms create a physical barrier between the genitals and sexual fluids of the partners engaging in sexual intercourse. When used correctly for all sex acts, condoms are 80–95% effective at preventing the transmission of HIV and other STIs.

However, many people do not and/or cannot use condoms correctly or consistently, increasing potential exposure to HIV and other STIs.

2. Provision of Lubricants (and other barrier methods)

Promoting condom use must be accompanied by emphasis on the use of appropriate lubricants. This is especially important for key population members and especially for anal intercourse, because the anus does not produce its own lubrication.

Gay men, other MSM and sex workers should be educated on the benefits of and need to use condom-compatible lubricants to ensure that condoms do not break. Key population members often report difficulty accessing condom-compatible lubricants.

Providers should be prepared to advise their clients on what is and what is not appropriate to use as lubricant with latex condoms. Water-based lubricants are the most commonly available. Silicon-based lubricants are also suitable for use with condoms but are less readily available. Saliva is not recommended as a lubricant because it dries quickly and therefore increases risk of damage to the rectal mucosal lining.

3. Pre-Exposure Prophylaxis

Pre-exposure prophylaxis (PrEP) is an HIV prevention intervention whereby an HIV-negative individual takes antiretroviral medications (ARVs) regularly in order to reduce their risk of contracting HIV. An example medication for PrEP is Truvada, an ARV containing tenofovir disoproxil fumarate and emtricitabine (TDF/FTC). Clinical trials have shown that PrEP is effective at preventing HIV infection in both men and women.

PrEP is beginning to be more widely rolled out in Zimbabwe and it is important that healthcare providers are aware of this and seek to provide it to clients who may benefit. However, while PrEP is effective, it is not a 'silver bullet' and depends on strict adherence. Clients should be counselled on the need to take their treatment in the correct way. Research shows that few key populations know about the existence or availability of PrEP in Zimbabwe, meaning additional awareness-raising is necessary.

4. Post-Exposure Prophylaxis

Post-exposure prophylaxis (PEP) is a biomedical HIV prevention intervention whereby an HIV negative individual takes ARVs following a potential exposure to HIV. PEP involves taking ARVs immediately after exposure – usually within 72 hours – and continuing for 28 days. PEP does not reduce risk of HIV acquisition to zero, but is highly effective. It has been used to reduce transmission through several exposure routes, including:

- Occupational exposures (needle sticks, scalpel cuts, etc.)
- Sexual exposures (sex without a condom, condom failure, sexual assault, etc.)
- Percutaneous exposure from injection drug use
- Neonates exposed to HIV through breast milk or during birth.

To best support their needs, clients who are receiving PEP should:

- Receive HIV prevention counselling to reduce risk of future exposure.
- Be monitored to ensure medication adherence.
- Be monitored with laboratory safety evaluations such (liver enzymes, creatinine levels, etc.).
- Be tested for HIV and other STIs, including hepatitis B and C.

As with PrEP, additional awareness-raising is necessary for PEP.

5. Voluntary Medical Male Circumcision

Male circumcision has been shown to reduce the odds that a man will acquire HIV from a female partner who has HIV by more than 60%.

- WHO guidelines recommend sexually active men who have sex with women access voluntary medical male circumcision.
- However, there is no strong evidence showing that male circumcision offers the same benefits during male-male intercourse. This is because most MSM are versatile, engaging in both receptive and insertive sex and circumcision does not protect the receptive partner.
- But it must be noted that there are gay men or MSM who do have insertive sex with women and who would therefore benefit from circumcision as a protective measure against HIV, herpes and HPV.

6. HIV Testing and Counselling

HIV testing and counselling (HTC) refers to a public health intervention whereby an individual, a couple, or a family receives HIV testing and counselling on HIV prevention, treatment, care, and support. The approach may vary in a number of ways, but the core components generally consist of:

1. Pre-test counselling that outlines the testing process
2. A behavioural risk assessment
3. Informed consent of the participant
4. Administration of the HIV test
5. Post-test counselling, which varies depending on the results of the test.

HTC is a key entry point to care, treatment, and support for people living with HIV. Early detection enables linkage to care and support services that not only prolong the life of the individual. It also improves their quality of life and prevents the spread of HIV through risk reduction and behaviour change. Since HTC is a key entry point to care, it should be offered in an accessible and affordable manner. There are several HTC modalities ranging from facility-based to community-based, client and provider-initiated and mobile clinics to door-to-door. Regardless of the modality, several factors must be taken into consideration for HTC with key population members:

- HIV stigma, homophobia, and hostile attitudes create environments in which key population members are unable to safely access services.
- Many key population members believe that health services are primarily geared toward heterosexual people or 'not them'.
- Injecting drug users should be encouraged to test regularly for HIV due to their heightened risk.
- HIV self testing kits are now being rolled out in Zimbabwe and may be a useful option of members of key populations who are reluctant to attend testing centres and clinics. However, it should be remembered these groups may already have mental health issues and without the counselling provided during a normal HIV testing procedure may suffer greater mental health challenges in coping with a positive result from a home test.

7. Couples HIV Testing and Counselling

One important modality of HTC is couples-based HIV testing and counselling (CHTC). CHTC has been tested primarily in heterosexual couples but is a strong intervention for members of key populations, despite the fact that their relationship structures and networks may be very different. CHTC differs from standard HTC in that a couple receives pre- and post-test counselling – including the results of HIV tests – at the same time in the same room. It is a way to interrupt HIV transmission in serodiscordant couples, help seronegative couples negotiate plans to remain negative, and link seropositive couples to care; it also facilitates communication and partner support. Advantages to testing couples together include:

- CHTC provides a safe environment for couples to discuss risk concerns.
- Partners hear information together, enhancing likelihood of a shared understanding.
- The counsellor can ease tension and diffuse blame.
- Counselling messages are based on the test results of both individuals rather than only one.
- An individual who receives a positive test result is not burdened with the need to disclose the result to their partner or persuade their partner to be tested.
- Counselling facilitates the communication and cooperation required for risk reduction.
- Treatment and care decisions can be made together.
- Couples can engage in decision-making for the future.
- CHTC is a voluntary, confidential interaction that respects the right of each client to make decisions. Each client must consent to the counsellor sharing HIV test results with their partner or they will revert to individual HTC. Once consent is given, CHTC will assist couples to establish goals that fit their particular situation.

Minimum Services Package for HIV Prevention For Key Populations in Zimbabwe.

Definition of KPs in Zimbabwe:

Male and female sex workers (SWs); men who have sex with men, including men in prisons and other closed settings (MSM); People who Use and Inject Drugs, transgender and intersex people.

Prevention	Treatment and Care	Psychosocial Support
<ul style="list-style-type: none"> ● Male and female condoms & water-based lubricants. ● HTC and ART initiation ● TB Screening (Including for PLHIV) ● Presumptive STI screening (triple site screening) ● Targeted IEC (through peers, mobile phones, internet, etc.) ● PEP and PrEP ● Cervical cancer screening & female sexual health education ● Family planning (all methods except permanent, which can be done through referral) ● Voluntary medical male circumcision & male sexual health education ● Anal & prostate cancer screening ● HPV vaccinations (SW and MSM) 	<ul style="list-style-type: none"> ● Diagnosis and treatment of opportunistic infection/TB (Including PLHIV) ● Vaccination, diagnosis and treatment of viral hepatitis ● Antiretroviral therapy (ART) ● STI treatment ● Cryotherapy for genital warts 	<ul style="list-style-type: none"> ● Mental health services, counselling & care ● Legal advice & support ● Establishment of KP peer support groups and networks at clinic sites and in communities
<p>By referral (to partners or larger public facility):</p> <ul style="list-style-type: none"> ● Management of severe ART failure. ● Harm reduction services, including sterile needles/syringes. ● Overdose management, medically assisted treatment. ● Drug detoxification & drug dependence treatment. ● Relapse prevention including socio-economic and related reintegration services. ● Services for the sexual partners of MSM (female, transgender, male) including family planning. 		
<p>Cross Cutting Elements:</p> <ul style="list-style-type: none"> ● Key population-friendly outreach and decentralised drop-in centres and clinics ● Case management ● Peer education ● Prevention of violence 	<ul style="list-style-type: none"> ● Life skills training ● IEC ● Crisis response and management ● Peer counselling and individual and small group interventions 	

Value Clarification Exercise 8: Risk Reduction Role Plays ±30 minutes

This activity contains several role plays designed to make participants think about which risk reduction strategies they would suggest for their key population clients in a variety of situations.

- Divide the participants into pairs or small groups and assign each pair or group one of the case studies below.
- Instruct each pair or group to role play the case study with one participant acting as the counsellor and one participant acting as the client.
- Instruct the participants to use risk-reduction counselling to find an appropriate risk reduction plan for the client in each case study. (Alternatively, the case studies can be used as case studies for the larger group spread throughout the module.)

Give participants some time to work through each case study. For each case study, address the following questions:

- *What are the key risk behaviours of the client?*
- *What strategies would you create to help each client reduce their risk?*
- *How would you prevent the client from feeling judged?*
- *What types of language would you use when speaking with the client?*

Discussion: Ask each group to present their strategy for their case study. Allow other groups to pose questions. As the facilitator, you may also point out strategies you feel are particularly appropriate.

Summarise key findings: After all the groups have presented, highlight important aspects of the strategies, especially highlighting that no single strategy is appropriate for all clients.

Case study 1

Luke is a 24-year-old gay male from Bulawayo. He is in a relationship with his boyfriend Temba. When they have sex, Luke only enjoys being the receptive partner, but Temba enjoys both the insertive and receptive roles. They do not use condoms when they have sex with each other. Because Luke does not enjoy taking the insertive role, the two have agreed that Temba may find partners outside of their relationship to have sex with when he wants to bottom. Temba does not have an emotional attachment to these third parties. He reports that he almost always uses condoms with his casual partners.

Case study 2

Rosaria is an eighteen year-old girl who is unemployed. Recently she has been hanging out at the local football field with a group of boys who smoke *mbanje* and occasionally other drugs when they can afford them. She had never tried drugs and didn't like to smoke but when a new dealer arrived one day, he encouraged her to try some cocaine. The drug made her forget all her problems and made her feel really self-confident. She ended up having unprotected sex with the dealer, for which he paid her with some more cocaine. She is afraid she will get HIV but she doesn't want to stop having sex with the dealer as she wants more cocaine.

Case study 3

Adam is an 45-year-old gay male who lives in Chitungwiza. Adam is also living with HIV. He has been in a long-term relationship with his HIV-negative partner, Tonderai, for many years. When they have sex, they often take turns being the penetrative and receptive partner. Because they know that Adam is living with HIV, they have always used condoms every time they have sex. Recently however, Tonderai has been pressuring Adam to forego condom use because he likes the added sense of intimacy associated with having sex without a condom. Adam continues to insist on using condoms when they have sex, but the issue has begun to cause problems in their relationship.

Case study 4

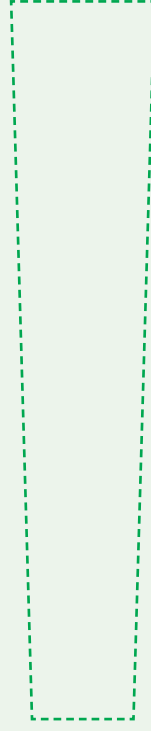
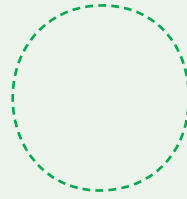
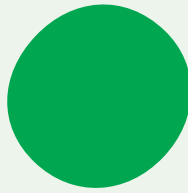
Tinashe is 27 years old and identifies as gay. He has come into your clinic for an HIV test, which he gets every six months. During the pre-counselling session, he tells you that he recently ended a serious relationship with his boyfriend. Following the break up, he fell into a deep depression and often visited bars and drank heavily. Many times, he found a man to have sex with. He tells you that he usually uses condoms, but that sometimes there were no condoms available, so he had unprotected sex. He also has difficulty finding lubricants to use. Other times, he has been too intoxicated to remember.

Case study 5

Adolfo is 25 years old and was thrown out of home by his parents, who are strong born-again Christians, when he was 15. He stayed with the parents of a friend for a while but eventually ended up living on the streets. When he was begging at the shops one day, a man offered him food and when they went to his house, they had sex. The man paid him and offered to put Adolfo in touch with other men who would pay him for sex. Since then, Adolfo earns a good living as a sex worker and has his own place, but often his clients don't want to use condoms.

Case study 6

Tatiana is 24 years old and is a transwoman in the process of social transitioning. She is not on hormone treatment. She has come into your clinic because of a rectal tear. During the pre-counselling session, she tells you that she recently lost her job because she decided to wear a dress to work and asked to be called Tatiana (she had previously been called Titan). As a result, she found herself with no way of earning a living except sex work. On examination, you find significant scarring and damage to the anus. Tatiana admits that a client had raped her without using a condom, when he discovered she was a trans woman.



MODULE SIX:

Promoting Mental Health

Introduction

Key population members can experience chronic high levels of mental distress and related challenges as a result of rejection, isolation and marginalisation. Research suggests that key population members, especially gay men and other MSM and transgender people, are at increased risk for major depression, bipolar disorder, and generalised anxiety disorder, likely as a result of the stigma, discrimination and homophobia they commonly experience. Sustained stress can also lead to key population members turning to drugs and alcohol to cope with their problems and even to contemplate suicide, while use of drugs themselves can lead to or aggravate mental illness.

This module provides a review of common challenges key population members face from a mental health perspective and the factors that drive those challenges. It also provides basic guidance for how healthcare providers can better support their clients to care for their mental health.

Learning Objectives

After completing this module participants will be able to:

1. Understand the factors that fuel negative mental health outcomes among key population groups.
2. Describe common mental health issues faced by key populations.
3. Describe basic strategies for approaching mental health with key population groups.

Resources

Time: This module needs a minimum of 1 hour and 30 minutes to complete.

Flip chart and pens, Participant Handbook.

Module Activities

Knowledge Session: ±50 minutes

Part A: Factors Leading to Poor Mental Health Outcomes among Key Population Members

- Many key population members demonstrate resilience – the ability to end up healthy human beings despite facing severe discrimination and marginalisation; but others present with mental health challenges.
- Social discrimination is a key factor leading to poor mental health outcomes across all key population groups. This discrimination is well documented in settings all around the world, regardless of the cultural, social, political, economic, or legal environment.
- Discrimination manifests in many ways, including personal hardships like harassment, ridicule, rejection, or violence, and also higher-level structural factors like discriminatory policies or straight forward human rights violations.

1. Criminalisation

Beyond violating basic rights, criminalisation has made key population members more vulnerable to poor health outcomes, reduced their access to health services and created inequities in access to and affordability of essentials like housing and work. Repealing laws that criminalise sex work, drug use and same-sex behaviour is an important step towards combating prejudice against key populations. However, it must also be accompanied by work at the grassroots level to address societal attitudes.

Other consequences of criminalisation of sex work, drug use and same-sex sexual behaviour include:

- Under representation of key population members in the development and implementation of policies and programmes.
- Lowered client participation in and discouragement of staff from working in programmes for key populations.
- Lack of research and resources concerning key populations.
- Discuss some of the following statistics. HIV prevalence is taking root in three 'key' groups. It is:
 - 28 times higher among people who inject drugs.
 - 12 times higher among sex workers.
 - 49 times higher among transgender women than in the rest of the adult population.
- Ask the group to read the article on Stigma and Discrimination in their Participant Handbooks.

2. Reparative Therapies

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

3. Family Rejection

Research correlates family rejection with negative health outcomes among lesbian, gay, bisexual, and transgender (LGBT) people. Young LGBT adults who experience high levels of family rejection during adolescence are eight times more likely to attempt suicide, six times more likely to report high levels of depression, three times more likely to use drugs and report unprotected sexual intercourse, than peers who report no or low levels of family rejection. It is important that healthcare providers are aware of these issues and probe to better understand an individual's circumstances.

In situations where a family member has difficulty accepting someone's sexual orientation, healthcare providers should refer them to an appropriate support organisation for help. And provide positive sexuality education (see the glossary in the Participant Handbook for an understanding of this term). If possible, connect the family member experiencing the difficulty to local resources that can help them accept their family member without feeling guilt, shame, prejudice or judgment.

Sex workers face a similar taboo and the strain of hiding their source of income, while lying to family and loved ones can also take a physical and mental toll.



Part B: Common Mental Health Issues for Key Population Members

Due in no small part to experiences of marginalisation and discrimination, key population members are vulnerable to a variety of mental health issues. The harassment and discrimination experienced contribute significantly to anxiety and are linked to depression and other mental health disorders. The following section is intended to give healthcare providers a broad overview of the mental health issues common in many key population groups.

NB: This module does not provide guidance on how to make a clinical diagnosis around any mental health illness. However the Ultra Quick Screening Tool and the Shona Symptom Tool in the Participant Handbook may help.

It is hoped that the resources mentioned will help healthcare providers increase their knowledge and sensitivity to mental health problems in order to make referrals when necessary.

Anxiety

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

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

Depression

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

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



Suicide

Research suggests that LGBT adolescents attempt suicide at higher rates when compared with their heterosexual peers. The strongest risk factor for suicide is a history of previous attempts. As previously noted, LGBT individuals who experienced family rejection were eight times more likely to attempt suicide. Family connectedness, caring adults, and school safety all serve as protective factors from suicide for LGBT individuals.

Current suicide risk assessment tools do not provide the necessary guidance for mental healthcare professionals to tailor assessments for key population members due to the unique and very aggressive stressors in their environments. However, healthcare providers must take the possibility of suicide seriously and should be familiar with local and national resources available in their own community or country context. They should have a list of mental health professionals who are trained to handle suicide-related mental health concerns. In addition to what may be locally available, additional resources are included at the end of this module.

HIV-related Stress Disorder

While key populations living with HIV often experience dual stigma associated both with HIV and with social and cultural marginalisation, those living with HIV may also experience specific instances over the course of the illness that cause physical harm or additional psychological stress. Life-threatening illness is recognised as a stressor that can lead to a post traumatic stress response. However, rather than shame, humiliation, or guilt, this response is primarily associated with a sense of fear and helplessness. Some instances associated with HIV that can cause this response are:

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

Sexual Problems

Sexual problems may be common. These may include issues related to:

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

Additional sexual problems for some key populations are related to anal sex, HIV and sexually transmitted infections, erectile dysfunction, difficulty in ejaculation and lack of sex drive or interest in sex.

Though not always the case, these problems may arise or persist longer in the presence of mental health issues like depression or psychological stress. Sexual dysfunction, in turn, can impact overall psychological well-being and lead to significant stress within relationships. Where available, referral to psychological or specialised services may be necessary. If psychological distress is the cause of the sexual problem, then addressing the distress will likely solve the sexual problem.

Eating Disorders

The connection between physical health and body image is fundamental. How we feel about our bodies affects how we treat them, particularly with regard to what we choose to eat. Studies have found a relationship between body image dissatisfaction and dietary lifestyle – overeating, over-exercising – and the development of eating disorders. With few exceptions, studies have found that many vulnerable population members are significantly more likely to develop eating disorders and have higher rates of dissatisfaction with their bodies as compared with others.

Physical and Sexual Violence

Physical and sexual violence against vulnerable population members remains a neglected area in clinical science research and practice around the world. The following are a few points about sexual violence targeted against vulnerable population members:

- Sex workers and men CAN be raped or sexually coerced; at home, the workplace, school, on the streets, in the military, in prisons, and in police custody.
- Rates of domestic violence amongst vulnerable populations are similar to general domestic violence rates; many have suffered traumatic or abusive sexual experiences in childhood.
- Key population members who have suffered violence may be unwilling to speak openly about it because of shame, fear, or guilt. These crimes may also not be reported because of the negative attitudes and indifference of law enforcement officials.
- Local resources to support key population members who experience sexual violence are scarce.

Exercise (±40 minutes): Using the Ultra Quick Screening Tool (by facility or network, if referral partners are also present):

Ask participants to review the tool in Module 5 of their Training Handbooks. Then ask the group to think how they could use this in their health facility. Let them discuss and consider the following questions:

- How do we really feel about mental health issues generally? Do we feel different when it is the mental health of a client who is a member of a key population? If so, say why.
- How do we currently deal with clients with mental health issues? Is this adequate?
- What changes would be needed for our facility to use this tool?
- Is it only medical staff who can use these tools or can others at the facility help? If yes, how?

Participants should also be made aware of The Friendship Bench programme, which runs at several clinics within Harare and makes use of the Shona Symptoms Questionnaire to assess mental health issues. A copy of this questionnaire is included in the Participant Handbook.

Facilitator's Feedback.

Encourage the group to reflect and share experiences amongst themselves. Before closing, share the following points if they have not already been made:

- Homosexuality is NOT a mental disorder; any information to this effect in current training curricula is wrong!
- Experiencing stigma and discrimination, including from healthcare providers, puts members of vulnerable populations at higher risk of developing a mental disorder; in a healthcare setting the attitude and behaviour of the most senior people at the facility is key.

MODULE SEVEN:

Taking a Sexual History

Introduction

Healthcare providers play a central role in the prevention and treatment of health conditions that affect members of key populations, particularly HIV. Experts recognise that health promotion occurs largely at the individual level and is effectively facilitated by meaningful health assessments and behaviour modification techniques. However, members of key populations are less likely than others to receive adequate assessment, treatment, and prevention of health problems.

Health facilities that are able to effectively assess the risks their clients face are better able to promote their overall health, including HIV prevention and supporting adherence to treatment.

This module provides an in-depth discussion of how to take a comprehensive sexual history for all clients in light of what we have learned in Module Two about sexual practices. It stresses the importance of confidentiality when taking a sexual history, presents the barriers to sexual history taking, as well as how to overcome them. It then discusses key communication issues when taking the sexual history, giving specific questions to ask during the course of the sexual history interview.

Learning Objectives

After completing this module, participants will be able to:

1. Take a comprehensive sexual history sensitively.
2. Describe the various steps of health assessment.
3. Assess the health status of sexual partners.

Resources

Time: This module needs a minimum of 2 hours to complete.

Flip chart and pens, Participant Handbook.

An Important Note on Confidentiality Before You Start!

Confidentiality is critical to all provider-client relationships. This is true not only for key population members, but for ALL clients. However, confidentiality gains special significance when working with vulnerable key population members. Many KPs do not disclose their sexuality or sexual behaviour to their healthcare provider because doing so could result in harassment, blackmail, violence, or even imprisonment.

Providers should discuss confidentiality and its limits with their clients. Assuring them that any information provided during a session will not be shared without their express permission may help alleviate any fears or concerns they may have.

Clients who fear the negative consequences of disclosure are less likely to engage productively in counselling and less likely to receive the full benefits of the session. Assuring clients that their privacy and confidentiality will be respected should be a priority of each session.

Everyone at a health facility needs to respect confidentiality; not just the medical staff.

Knowledge Session: ±45 minutes

Barriers to Sexual History Taking

Taking a complete and accurate sexual history is critical to providing appropriate care but key population members are often reluctant to volunteer their true sexual history to a provider whom they perceive to be judgmental. There are many barriers to taking a sexual history.

Provider barriers

- Lack of experience or discomfort with asking relevant questions.
- Discomfort, or inability to respond to issues that arise.
- Homophobia and anger towards sex workers and drug users.
- Inability to understand consensual same-sex sexual behaviour between adults as a normal expression of sexuality.
- Inability to understand sex work or drug use
- Making false assumptions regarding sexual behaviour and the level of risk of key population members.
- Uncertainty on how to help a client feel comfortable, particularly with regard to key population members and sexual orientation or practices.
- Lack of time.

Client Barriers

- Embarrassment or shame.
- Perceived stigma from a healthcare provider.
- Lack of awareness on sexual health issues.
- Differences between doctor and client: age, gender, skin colour, appearance, ethnicity, national origin, sexuality, culture, wealth, social class, sexual orientation.



Steps to Address These Barriers

Most of the barriers presented above can be overcome by planning ahead and becoming educated about clients and how to take their sexual history. Though it is common to feel uncomfortable discussing matters of sexuality with clients, most service providers already possess the skills necessary to do so. Over time and with practice, providers will feel more comfortable and discussing sexuality will become easier. Though each individual will develop their own personal style, here are a few tips relating to sexual history taking and communication.

- Develop a policy that shows when to initiate a sexual risk assessment.
- Determine how sexual risk assessments will be integrated into the clients' overall care.
- An important issue is the extra time needed. You may want to have set times for KP groups (at the start or end of each day or specific days in a week, or at times when you know the facility is not as busy).
- Identify specific questions to ask.

- Develop a plan for how to respond to information that might surface.
- Train staff on how to perform a sexual risk assessment.

Key Communication Issues

Providers might feel that clients will be surprised by questions about sexual health but most clients actually welcome them. Providers should simply begin by preparing the client so they are aware that these types of questions are to come. Providers should also:

- Develop rapport with the client while being sensitive to concerns about confidentiality and assuring the client that they can speak freely without fear of judgment.
- Explain the importance of taking a sexual history. Providers should advise the client to be open during the interview because these questions will help the provider give optimal care, even though the questions may be sensitive.
- Never assume the client is either heterosexual or homosexual, a sex worker or drug user.
- Use terms like they or them, partner, rather than husband or wife, to avoid assuming the sex of clients' sexual or emotional partners.

Underscore that the interview is part of routine care, emphasising confidentiality and the desire to provide quality care. A few key issues are:

- **Avoid making assumptions:** Assumptions based on gender, age, marital status, disability or other characteristics are not necessarily correct. For example, a male client who is married to a woman may not be sexually monogamous with their spouse and does not necessarily have sex with only women.
- **Be nonjudgmental, direct, and specific:** Doing so with questions about sexual behaviour is a good way to normalise the behaviour and make the client comfortable. Providers should cultivate self-awareness of their own judgments and how these affect their work so that they can leave their judgments at the door. They should also be aware of their non-verbal communication to avoid coming across as judgmental.
- **Ask open-ended questions:** Questions that require more than a yes or no answer help to open the dialogue between the provider and client, encouraging a more complete history.

Examples of statements to introduce the sexual history and reinforce confidentiality include:

“As I do with all of my clients, in order to provide you with the best possible care, I am going to ask you several straight forward questions related to your current and past sexual activity. I will also ask questions about drug and alcohol use.”

“Everything we discuss is strictly confidential and will stay between you and me.”

“I take a sexual and alcohol/ drug use history with all of my clients as part of their health assessment. This is important in order to provide optimal care. I know that these subjects are very personal. Please be confident that I will not divulge this information to anyone.”

1. Ask about experience with condom use and other prevention modalities

As appropriate, providers should ask clients about the frequency and consistency with which they use condoms and the circumstances surrounding their condom use. Some clients may never use condoms or may use them differently with casual partners than with regular partners. They may use condoms only for certain types of sexual act, such as anal intercourse but not oral sex. It may be best to ask an open-ended question since clients may provide more information this way. One way to ask for information about condom use is:

“Tell me about your experience with condom use”

2. Ask about known HIV and STI status of the client and of their sexual partners

Providers should ask about the client’s HIV and other STI status and that of their sexual partners. Example questions to ask for information about HIV or other STI status include:

“Have you ever been tested for HIV?”

“What about your sexual partners?”

If yes, *“When were you last tested for HIV? What was your last result?”* If No *“What are the reasons you have not been tested for HIV? Do you have any concerns regarding HIV testing?”*

“Have you been tested for STIs?”

If yes, *“When were you last tested for STIs. What was the result?”* If No *“What are the reasons you haven’t been tested for STIs?” “Do you have any concerns about STI testing?”*

3. Ask about drug and alcohol use

Key population members, like others, use drugs and alcohol for any number of reasons. Literature suggests that key population members use drugs and alcohol as a mechanism for coping with stigma and homophobia. In the context of sexual history taking, providers should ask about drug use in a nonjudgmental and non-stigmatising manner. Providers should not assume that reported drug use automatically means sexual risk behaviour or dependence.

Example questions to ask for information about drug and alcohol use include:

“Tell me about your alcohol use?”

“What has your experience with drugs been?”

4. Summarise the client’s response to questions. This assures the client that the provider is listening and helps clarify any misunderstandings.

5. Ending the interview: By the end of the interview, the client may have questions or concerns that they were not ready to discuss earlier. Providers should give the client an opportunity to voice these concerns.

“What other things about your sexual health and sexual practices would you like to discuss today?”

Exercise: Taking a Sexual History (±75 minutes)

- This activity helps participants practice and feel more comfortable asking questions relating to sex and sexuality to their clients. Participants should refer to their Training Handbook for this exercise.
- Ask participants to form pairs or groups. Medical and other staff who will be taking the sexual history can be paired with other staff who would not, such as administrative staff, maintenance or security staff, who can act as the clients.
- Then, either using an existing sexual history taking tool or one that the participants create, ask them to role play the questions they would ask to elicit information from their clients when taking a sexual history.
- Have participants go through each of the parts in the above section. Take turns being the provider and the patient.
- Try changing the personalities of the patient. Try one who is reluctant to divulge information versus one who provides a lot of detail of sexual exploits. Compare participants' questions to the examples given earlier.

Facilitator's Feedback

- Afterwards, facilitate a brief discussion about any difficulties participants encountered and how they felt while taking the sexual history. Discuss any specific aspects to follow up specifically when taking the sexual history of a vulnerable population member.
- Summarise the key points elicited during the discussion for the group.

MODULE EIGHT:

Clinical Care for HIV and STIs

Introduction

Clinical care for HIV and STIs need not take a different form from that of any other client attending our clinics. However, members of key populations have been under-served or ignored in the delivery of health information and care for quite some time and it is therefore worth making sure that they are provided with inclusive and non-judgmental care. Though gaps remain, the HIV epidemic has led to epidemiological data on this group becoming increasingly available. For HIV-negative patients, an STI diagnosis is both a marker for possible high-risk activity and a potential co-factor for HIV acquisition. Members of key populations have been shown to be, on average, more likely to be infected with HIV or certain STIs than their peers, in nearly every nation where data is available

This module covers generally recommended steps for STI testing and treatment. It also focuses on HIV, before discussing HIV testing and treatment. It covers the benefits of early treatment, considerations for initiating antiretroviral therapy (ART), and treatment as prevention (TasP). The module closes with a discussion of HIV co-infection with two other serious infections: tuberculosis and hepatitis.

Learning Objectives

After completing this module, participants will:

1. List signs and symptoms of well-known STIs and corresponding treatment recommendations as they are relevant to key population groups.
2. Understand the relationship between STIs and HIV infection, including HIV-related co-infection with tuberculosis (TB) and hepatitis.
3. Describe the main steps involved and reasons for carrying out a triple site physical assessment.

Resources

Time: This module needs a minimum of 2 hours to complete.

Flip chart and pens, Training Handbook

Module Activities

Knowledge session: ±60 minutes

Sexually transmitted infections: When a pathogen infects a sex organ or the reproductive system and the infection is transmitted from one person to another (usually through sexual methods) it is termed a sexually transmitted infection.

- Most STIs spread through bodily fluids such as semen, pre-ejaculate fluid, or blood, or through direct contact such as touching skin to a sore.
- STIs vary widely and include viruses, bacteria, parasites, protozoa and fungi; they may present with or without symptoms.
- Because STIs are often asymptomatic, healthcare providers should test clients for STIs regularly.
- Clients should also test when entering into new sexual partnerships, both to ensure the client's health and to avoid transmitting an infection to their partner.
- The table starting on page 55 provides an overview of common STIs across key population groups.

Recommended Steps for STI Testing for Key Populations

This is a fairly technical session but all staff can benefit from it so make sure everyone is involved. Have non medical staff sit with medical staff so that they can explain difficult or medical terms.

- Healthcare providers should assess the STI risk of all sexually active clients, and especially those identified as members of vulnerable populations following the sexual history taking.
- A triple site assessment of all sexually active clients is also recommended (refer to the Training Handbook).

The following is suggested:

1. Interview the client and conduct a culturally sensitive sexual history (as per module 6).
 2. Identify risk of STI exposure.
 3. Assess alcohol use history and drug use and assess if it is relevant to client's sexual health (as per module 8).
 4. Assess underlying social and psychological challenges (as per module 4).
 5. Ask the client if they are experiencing any STI symptoms and ask about specific symptoms consistent with the presence of an STI. Keep in mind that the client may be asymptomatic. Common symptoms include dysuria, urethral discharge, pain, skin rash, and ano-rectal pruritis.
- In addition to HIV, STIs pose a serious public health concern for the whole community, key population members and their partners and clients. This is in part because the presence of an STI increases an individual's susceptibility to HIV acquisition. For example, in MSM, a history of two rectal STI infections has been associated with an 8-fold increased risk of acquiring HIV.

Recent research has shown that in this region, transgender women are more likely than heterosexual MSM to test positive for HIV, as well as to report experiences of stigma, depressive symptoms, and condomless sex².

² <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002422>

Compounding this, STIs are difficult to detect, diagnose, and treat, especially in resource-limited settings. This module provides an in-depth discussion of HIV and other STIs.

- It discusses STIs common in key populations and the importance of testing for STIs.
- Service providers should always emphasise to clients the need to have their sex partners tested and treated, should an STI be identified.
- On completing the sexual history, it is strongly recommended that ALL sexually active clients receive a triple site assessment, with the aim of establishing a less stigmatising approach towards members of key populations.
- Triple site examination involves a visual inspection of the mouth and throat, the vagina/ penile areas and the rectum.
- Depending on the sexual history/ risk assessment and the results of the visual inspection, specific diagnostic tests can then be carried out. Refer to the Training Handbook for a detailed list of what a full triple site assessment entails.

6. Consistently provide the following recommended clinical STI prevention services:

Testing (at least annually) for:

- STI signs (visual inspection of the skin, mouth, genital, and anal area).
- HIV infection if HIV negative or not tested within the previous year.
- Syphilis, with a confirmatory test to establish whether it is recent untreated syphilis, partially treated syphilis, or whether the client is manifesting a slow serologic response to appropriate prior therapy.
- Urethral *N. gonorrhoeae* (GC) and *C. trachomatis* (CT) in men who have had insertive intercourse.
- Rectal *N. gonorrhoeae* and *C. trachomatis* in men and women who have had receptive anal intercourse.
- Pharyngeal *N. gonorrhoeae* and *C. trachomatis* in men who have had receptive oral sex.
- Vaccinate against HAV and HBV for all sex workers, transgender people, gay men and other MSM in whom a previous infection or vaccination cannot be documented.
- Consider screening for other STIs: Lymphogranuloma venereum (LGV): consider LGV in diagnosis of compatible syndromes (proctitis and proctocolitis) and perform tests to diagnose chlamydia.
- Check for Herpes simplex virus (HSV)
- Check for Human papillomavirus (HPV).

Screen all sexually active members of vulnerable populations annually. Clients at higher risk (such as those with multiple partners or those who engage in anal intercourse without a condom with anonymous partners) should be screened every three to six months.

Exercise: Triple Site Screening For Sexually Active Clients (oral/ genital and rectal, and for pharyngeal gonorrhoea) ±60 minutes

Diagnostic Tests

Throat Swabs (if indicated)

- Gonorrhoea (GC) and culture and sensitivity (C&S) throat swabs are indicated for: men who have sex with men (MSM) who have had receptive oral sex (with or without symptoms) clients who have had receptive oral sex with a partner who has ano-genital gonorrhoea, others determined to be at potential higher risk (e.g. clients who are involved in sex work, transgender persons) and at the discretion of the nurse
- GC/CT nucleic acid amplification test (NAAT) is indicated for clients determined to be at potential higher risk (e.g. clients who are involved in sex work, MSM) and at the discretion of the nurse.

Vaginal Specimens

Vaginal specimens are indicated when any of the following are identified:

- abnormal odour: identified by the client or during physical assessment
- abnormal vaginal discharge: identified by the client or during physical assessment
- vaginal irritation and/or inflammation pH \geq 4.5 • symptoms of pelvic inflammatory disease (PID)
- clients determined to be at potential higher risk (e.g. involved in sex work, street involved or residing in correctional facility)
- pre-upper genital tract instrumentation (e.g. intra uterine device/IUD insertion)

Cervical Specimens

- GC C&S swab if client is symptomatic or a contact to gonorrhoea or others determined to be at potential higher risk (e.g. clients who are involved in sex-work or drug use) and at the discretion of the nurse
- Pap smear if indicated
- HSV PCR swab, if lesion present.

Rectal Swabs, if indicated

- GC C&S for men who have sex with men (MSM) who have had receptive anal sex (with or without symptoms), clients who have had receptive anal sex with a partner who has ano-genital gonorrhoea, others determined to be at potential higher risk (e.g. clients who are involved in sex work or are street involved) at the discretion of the nurse
- NAAT for GC/CT for clients experiencing rectal symptoms
- NAAT for GC/CT for clients determined to be at potential higher risk (e.g. clients who are involved in sex work, MSM) and at the discretion of the nurse. Check with your local lab for availability of this test.

Genital Ulcers or Lesions (peri-anal swab)

- HSV PCR, if lesion present
- Syphilis

Venepuncture:

- Syphilis
- Human Immunodeficiency Virus (HIV)
- Hepatitis A Virus (HAV): consider HAV testing in clients who are not immune AND have at least one of the following: HCV positive, HBV positive (carrier or acute, needle or drug paraphernalia sharing, sex work, MSM, residence in correctional facility (past or present)
- Hepatitis B Virus (HBV) consider HBV testing in clients who are not immune, have not been previously immunised AND have at least one of the following: residence in correctional facility (past or present), HCV reactive active or resolved, HIV positive, needle or drug paraphernalia sharing, sex work, multiple sex partners, sex partner of a person who tests positive for HBV, MSM.
- Hepatitis C Virus (HCV)

Consider HCV testing for clients with the following: needle or drug paraphernalia sharing, sex work; residence in correctional facility (past or present), HBV positive – chronic or acute; HIV positive – co-infection with other STIs where sores and lesions are present, such as Lymphogranuloma Venereum (LGV) and Syphilis (moderate to low risk), longer term partner who tests positive for HCV (low risk).

Also recommended:

- Yearly screening for *C. trachomatis* and *N. gonorrhoea* for all sexually active females aged ≤ 25 years.
- Asymptomatic non-genital Chlamydia/ Gonorrhoea infections contribute to a high burden of infection.
- Screening of sexually active young men should be considered in high prevalence settings (e.g. adolescent clinics, correctional facilities, and STI clinics).
- MSM with relevant exposures should be screened for urethral and rectal CT/ GC, and for pharyngeal gonorrhoea, at least annually. Consider every 3 to 6 months for men at highest risk.

Adapted from the College of Registered Nurses of British Columbia, Canada.

<https://www.crnbc.ca/Standards/CertifiedPractice/Documents/ReproductiveHealth/719STIAssessmentDST.pdf>

The following table gives guidance on treatment of critical STIs.

INFECTION	CAUSATIVE AGENT	SYMPTOMS	Recommended treatment
Chlamydia	<i>Chlamydia trachomatis</i>	Often no symptoms, can be a discharge from the penis, painful urine, swelling of testes. In women this can spread to the fallopian tubes causing pelvic inflammatory disease (PID) Can also infect the rectum of MSM (proctitis) and may include a discharge with bleeding, pain and swelling.	Azithromycin 1 g orally in a single dose OR Doxycycline 100 mg orally twice daily for 7 days
Gonorrhoea	<i>Neisseria gonorrhoeae</i>	Often no symptoms, whitish, yellowish or greenish discharge from penis or vagina, painful and frequent urination (sometimes burning sensation in women, sometimes PID or vaginal bleeding between periods). Rectal infection in both men and women may include discharge, anal itching, soreness, bleeding or painful bowel movements. Pharyngeal infections from unprotected oral sex can cause sore throats.	Ceftriaxone 250 mg in a single intramuscular (IM) dose PLUS Azithromycin 1 g orally in a single dose or doxycycline 100 mg orally twice daily for 7 days If ceftriaxone is unavailable (urethral, rectal, cervical infection): Cefixime 400 mg in a single oral dose PLUS Azithromycin 1 g orally in a single dose or doxycycline 100 mg orally twice daily for 7 days PLUS Test-of-cure in one week
Syphilis	<i>Treponema palladium</i>	A single sore (chancre) first appears and can become multiple sores usually on the outside of the genitals, inside the vagina or anus and even on the lips of the mouth. Secondary phase leads to skin rashes in the mouth vagina and anus and comes with fever, swollen lymph glands, sore throat, hair loss, headaches, weight loss, muscle aches and fatigue. In the latent phase can last for 10 to 30 years. Untreated it can lead to blindness, dementia and death.	(Primary) Benzathine penicillin G 2.4 million units IM in a single dose (Secondary) Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at one-week intervals. (Latent) Early latent syphilis: Benzathine penicillin G 2.4 million units IM in a single dose. Late latent syphilis or latent syphilis of unknown duration: Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals.

INFECTION	CAUSATIVE AGENT	SYMPTOMS	Recommended treatment
Hepatitis A	<i>Hepatitis A virus (HAV)</i>	Loss of appetite, malaise, fatigue, nausea and vomiting, abdominal pain, enlarged liver, dark urine, jaundice rash and arthritis symptoms.	Usually requires only supportive care with rest, abstaining from alcohol, and coping with nausea until the body eliminates the virus. Hospitalisation might be necessary for clients who become dehydrated because of nausea and vomiting and is critical for clients with signs or symptoms of acute liver failure. Medications that might cause liver damage or are metabolised by the liver should be used with caution among persons with HAV.
Hepatitis B	<i>Hepatitis B virus (HBV)</i>	Loss of appetite, malaise, fatigue, nausea and vomiting, abdominal pain, dark urine, jaundice rash and arthritis and may result liver cancer.	No specific therapy is available for persons with acute HBV; treatment is supportive. Persons with chronic HBV infection should be referred for evaluation to a physician experienced in the management of chronic liver disease. Certain therapeutic agents for the treatment of chronic hepatitis B, including some ARVs, can achieve sustained suppression of HBV replication and remission of liver disease in some persons.
Hepatitis C	<i>Hepatitis C virus (HCV)</i>	Often no symptoms, but can be loss of appetite, malaise, fatigue, nausea and vomiting, abdominal pain, enlarged liver, dark urine, jaundice rash and arthritis and if chronic, cirrhosis, liver disease and possibly death.	Persons found to have HCV should be evaluated for the presence of active infection, presence or development of chronic liver disease, and possible treatment. Combination therapy with pegylated interferon and ribavirin is the treatment of choice for people with chronic HCV. However, those newly infected may be cured with relatively short course treatment with specific antiretroviral medicines. Healthcare providers should consult with specialists knowledgeable about management of HCV infection.

INFECTION	CAUSATIVE AGENT	SYMPTOMS	Recommended treatment
Herpes	<i>Herpes simplex virus (HSV-1 (usually oral herpes) and HSV-2 (usually genital herpes)</i>	Tingling, itching, pimples or blisters that crust over and scab like a cut. Symptoms recur every few weeks, months or years. Aggravated by stress.	Acyclovir 400 mg orally three times daily for 7-10 days OR Acyclovir 200 mg orally five times daily for 7-10 days OR Famcyclovir 250 mg orally three times daily for 7-10 days OR Valacyclovir 1 g orally twice daily for 7-10 days
Human Papilloma virus infection	<i>Human Papilloma virus (HPV)</i>	Often no symptoms, genital or anal warts in males and females. Rare but may be warts in the throat (known as recurrent respiratory papillomatosis)	Treatment is directed at the macroscopic or pathologic lesions caused by infection. Subclinical genital HPV infection typically clears spontaneously and antiviral therapy is not recommended. In the absence of lesions, treatment is not recommended for subclinical genital HPV.
Human immune-deficiency virus infections	<i>Human immune-deficiency virus (HIV)</i>	Symptoms of acute infection are often flu-like and include: headaches, swollen glands, sore throat, rash, fatigue, muscle and joint aches and pains, diarrhoea, dry cough, rapid weight loss, recurring fever, night sweats and untreated, opportunistic infections such as pneumonia, even NCDs and cancers.	See National Treatment Guidelines
Lympho-granuloma Venereum (LGV)	<i>Chlamydia trachomatis, serovar L2</i>	This is often a painless sore on the male genitals or in the female genital tract, there can be blood or pus from the rectum, painful bowel movements, groin swelling and redness as well as drainage from inguinal lymph nodes (rarely there is also diarrhoea and lower abdominal pain)	Doxycycline 100 mg orally twice daily for 21 days Alternative recommendation: Erythromycin base 500 mg orally four times daily for 21 days.

Tuberculosis and Co-infection with HIV

Co-infection with TB occurs when an individual is living with both HIV and has either a latent or active TB infection at the same time.

- Globally, TB is the leading cause of death in this population.
- Latent TB infection can usually be treated with one type of medication, whereas an active TB infection might require several concurrently.
- Common first-line TB treatment medications include Isoniazid, Rifampin, Ethambutol, and Pyrazinamide.
- In the case of multi-drug resistant TB (MDR-TB) or extremely drug resistant TB (XDR-TB), second-line medications such as Streptomycin, Kanamycin, Clarithromycin, Amikacin, Capreomycin, or other antibiotics are necessary. These drugs are more expensive, more toxic, less effective, and require a longer course of treatment than first-line drugs.

The WHO has established guidelines for the treatment of TB in people living with HIV. These include:

Antiretroviral Therapy: ART can restore some immune system function, which can mitigate the impact of TB and HIV. **All people living with HIV with an active TB infection should be placed on ART immediately.**

Intensified TB Case Finding: All people living with HIV should be screened regularly for TB. Research on TB case finding shows that the presence of one or more of the following three symptoms – persistent cough, fever, or night sweats – detects the vast majority of active TB cases.

Isoniazid Preventive Therapy: People living with HIV who test positive for a latent TB infection should be put on Isoniazid preventive therapy (IPT) for up to 36 months.

Infection Control for TB: This includes rapid detection of people who are infectious, precautions to reduce airborne transmission in healthcare settings and treatment of those either suspected or confirmed to have active TB.

There are two key challenges for TB treatment in people living with HIV.

- The first is MDR-TB. The likelihood of dying from MDR-TB is high, especially for people living with HIV, unless treatment with appropriately tailored therapy can begin very quickly after infection. Ensuring that clients complete TB treatment with methods such as directly observed therapy short course (DOTS) is, to date, the most effective way to avoid the spread of MDR-TB.
- Second, **clinical management of HIV/TB co-infection is difficult because of the many treatment interactions between medications for HIV and TB.** These interactions can cause many negative health effects such as liver-related illnesses.
- Because key populations are disproportionately affected by HIV and experience greater difficulty in accessing the health system, it is particularly important that efforts be made to integrate TB screening and case finding into the minimum service package for this population. Refer to the Participant Handbook.



MODULE NINE:

Supporting the Needs of Members of Zimbabwe's Key Populations Who Use Drugs and Alcohol

Introduction

Research has shown that people who inject or use drugs are at higher risk of HIV due to reduced capacity and inhibitions and when using drugs. This is why people who inject drugs and people who use drugs are classified as key population groups in Zimbabwe. Research also suggests that other key populations such as sex workers, MSM and transgender people, are more likely to use drugs and alcohol than adults in the general population.

In this training programme, 'drugs' includes both prescription drugs such as Tramadol and Bronchclear, as well as non-prescription drugs that are considered illegal or otherwise 'recreational' in most countries. These higher rates of use can be a reaction to the poverty, homophobia, discrimination, mental health issues or violence that key population members experience because of their lifestyles or sexuality.

In the clinical setting, candid discussions between healthcare providers and clients about the use of drugs and alcohol can be challenging and present various barriers in nearly every context and when serving any given population. This is aggravated because drug use and possession is not only highly stigmatised but also criminalised, with harsh punishments for those caught.

- This module aims to increase healthcare providers' knowledge of alcohol and drugs that are commonly abused. It also discusses the contexts in which drug or alcohol use occurs.
- It aims to increase healthcare providers' sense of comfort in discussing drug- and alcohol-related issues with clients in the clinical setting.
- This module does not aim to provide clinical guidance and training on how to implement specific harm reduction interventions like needle exchange programmes, which are not commonly catered for in Zimbabwe. However it is important that healthcare providers understand their role in advocating for needle exchange programmes, as they play an important role in reducing the spread of HIV and hepatitis, as well as in encouraging injecting drug users to come into the open.
- It is beyond the scope of this module to include information on how to diagnose or treat drug or alcohol dependence. Clients seeking or needing such higher-level interventions are best counselled according to nationally recognised guidelines around drug- and alcohol-related healthcare or referred to qualified allied health professionals.

Learning Objectives

After completing this module, participants will be able to:

1. Describe the reasons for drug and alcohol use among members of key populations.
2. Describe the known patterns of drug and alcohol use among members of key populations.
3. Name the common drugs used by members of vulnerable populations in Zimbabwe.
4. Discuss drug and alcohol use within the clinical setting with members of key populations more comfortably and effectively.

Resources

Time: This module needs a minimum of 2 hours to complete.

Flip chart and pens, Participant Handbook, you may want to show again or for the first time video link/podcast on drug abuse listed in Module 4.

It is important to recognise that an unknown proportion of people, regardless of socio-economic status or education level, use drugs and alcohol globally and do so for any number of reasons.

Many of these individuals go through life using drugs and alcohol either regularly or occasionally without any disruption or negative impact on their social, professional, or physical lives. A proportion of them may even report positive benefits from their use of drugs or alcohol. It is also important to recognise that for others, drug and alcohol use might be problematic every time they use drugs and alcohol, or only under specific circumstances.

For instance, drug and alcohol use may be problematic only when they use a particular drug or type of alcohol, or only when they use an excessive amount. In these cases, they may report that their drug and alcohol use interferes, either at all times or under specific circumstances, with their personal health goals and/or with their goals for security, job, relationships, and family.

Module Activities

Value Clarification Exercise 7: Getting Comfortable Talking About Drugs and Alcohol ±45 minutes

This activity is designed to allow participants to explore their beliefs and attitudes toward substance use. Participants will choose their placement along a continuum of true and false for a variety of statements relating to drug and alcohol use.

- Write or use a computer to print 'True' on a large sheet of paper and tape it to a wall on one end of the training room. Write or print 'False' on a second large sheet of paper and tape it to the opposite wall. Tell the group that you will be standing in the middle of a line that runs across the room.
- One end of the room is the 'True' area and the opposite end of the room the 'False' area.
- In between represents a continuum of responses anywhere between 'True' and 'False'.

Next, read the following statements aloud and ask the participants to move to the point on the line that best represents their views or beliefs. All of the statements are ambiguous. After everyone has moved, ask volunteers from the True, False and Middle groups to support their points of view.

Statements:

- I use drugs.
- It's okay for young people to drink under their parents' guidance.
- It is important for people to be held responsible for things they do when they drink or get high.
- It's okay if my friends drink alcohol.
- It's okay if a friend uses illegal drugs.
- A drug user who works for your organisation should be fired.
- Manufacturers of alcohol should be allowed to advertise their products on TV.

Questions for discussion: After you have completed the above statements, ask each of the questions below for discussion.

1. What did you learn as you participated in this activity?
2. Did anything surprise you? What?
3. Do you believe that some discussion of why people selected their position on the continuum might have brought people together? Why or why not?

Summarise key findings: Depending on how participants respond in this activity, what can you learn about their awareness around drug and alcohol use and their view of drug and alcohol users? If participants appear judgmental or narrow in their views, you may transition the closing conversation about how that would apply to a clinical setting.

Knowledge Session ±45 minutes

The Link Between Drug Use and HIV Transmission

Although the link between non-injection drug use and HIV is not fully understood and may be complex, some studies correlate drug use with higher incidence of HIV infection.

- Drug use may be linked to HIV and hepatitis risk, especially through the sharing of contaminated injection equipment and unprotected sex with a serodiscordant partner while under the influence of these drugs.
- Drug use can lead to high-risk sexual behaviours (including unprotected sex and anal sex) because certain drugs lower sexual inhibition.
- Use of some specific drugs such as cocaine or methamphetamines is associated with interruptions in antiretroviral therapy (ART), which can increase the likelihood of HIV transmission.
- Among sex workers, gay men and other MSM who are being treated for STIs, drug use is linked to a higher likelihood of HIV and hepatitis transmission.

Drugs Commonly Used in Zimbabwe

LIST OF DRUGS	STREET NAME	EFFECTS
Alcohol, including both legal and illegal forms) is a stimulant in small doses and a depressant in larger doses	<i>Kachasu, Maragadu, Musombodhiya, Tegutegu, Zed</i>	Relaxation and happiness (<i>can lead to aggression, heart and liver disease and cancer</i>)
Cannabis is a hallucinogen	<i>Mbanje, Weed, Marijuana</i>	State of relaxation and happiness
Cocaine is a stimulant	<i>Upfu, coke, blow</i>	Extreme happiness, confidence, sexual arousal (<i>but then causes agitation, depression, paranoia and decreased appetite</i>)
Codeine (including cough syrups) is an opiate	BronCleeer, Bronco	Get 'high', get excited and impulsive (<i>but then causes breathing problems, low blood pressure, vomiting</i>)
Crystal Methamphetamine is a stimulant	Meth, crystal, ice	High energy, confidence, invincibility and impulsiveness (<i>but then causes agitation, depression, suicidal tendencies, loss of memory or muscle control</i>)

In the Participant Handbook you will also find a list of symptoms of commonly abused drugs.

This list of warning signs of drug use is also included in the Training Handbook.

Warning Signs Of Commonly Abused Drugs

- Marijuana: Glassy, red eyes; loud talking, inappropriate laughter, followed by sleepiness; loss of interest or motivation.
- Depressants (including Xanax, Valium): Contracted pupils; drunk-like; difficulty concentrating; clumsiness; poor judgment; slurred speech; sleepiness.
- Stimulants (including amphetamines, cocaine, crystal meth): Dilated pupils; hyperactivity; euphoria; irritability; anxiety; excessive talking followed by depression or excessive sleeping at odd times; dry mouth and nose.
- Inhalants (glues, aerosols, vapours): Watery eyes; impaired vision, memory and thought; secretions from the nose or rashes around the nose and mouth. headaches and nausea; appearance of intoxication; drowsiness; poor muscle control; anxiety and irritability.
- Hallucinogens (LSD, PCP): Dilated pupils; bizarre and irrational behaviour including paranoia, aggression, hallucinations; mood swings; detachment from people; absorption with self or other objects, slurred speech; confusion.
- Heroin: Contracted pupils; no response of pupils to light; needle marks; sleeping at unusual times; sweating; vomiting; coughing, sniffing and twitching.

Ask the group to read and discuss the following article (it is also in the Participant Handbook).

Encourage the group to share their experiences of drug use in their facilities as well as the common drugs used in their areas.

**Article adapted from the Zimbabwe Civil Liberties and Drug Network
Newsletter June 2018 Issue. No.%. Volume 1.**

"Cocaine, crack cocaine, meth, codeine, diazepam... it just depends on the kind of high a person is looking for"

This is Crispen. No. That's not his real name. Crispen is a Zimbabwe drug lord based in Harare. He agreed to talk to Khuluma Afrika, on condition of anonymity. Crispen was born in Mbare, a densely populated neighbourhood some 5km outside the city center. Crispen sells all kinds of drugs, except for crystal meth, which he claims is sold out of Highfields, another high-density suburb 12km from the city centre. Zimbabwe's rising drug abuse epidemic is a new phenomenon. Until recently, the only available drugs were marijuana and 'bronco' – a cough syrup manufactured in South Africa. But cocaine has made its way. *"Everyone now wants upfu (mealie meal) – (the street name for cocaine),"* Crispen says. Crispen claims he pushes big volumes. He sells in town, and sends boys to places where large numbers of people gather to party. He also uses sex workers to push drugs to clients. On the street, a gram of cocaine sells for \$80. Other drugs like meth sell for \$50 a gram.

This makes them out of reach for the majority of Zimbabweans. But Crispen has come up with a plan. *"We sell a fix. Like one sniff (cocaine) we make it about \$10,"* he says. A lot of the drugs are manufactured outside of Zimbabwe and then smuggled through the border. It is a lucrative business, which those involved claim is turning them into millionaires.

"Anything with codeine is my prime product. But lately I now move a lot of ephedrine. Even ecstasy pills are now big bucks" Crispen spends most of his day at Bosman station, shipping boxes of prescription medication. His main transporters are bus drivers who hide the boxes in luggage compartments.

Most discussions about drug abuse in Zimbabwe neglect substances like cocaine, heroin and alcohol, traditionally because substance abuse has been limited to marijuana and recently prescription cough medication. But experts contend the 'imported banned substances' problem is bigger and includes drugs traditionally thought to be impossible to find in Zimbabwe and those not thought to be dangerous. *"By far the drug most abused is alcohol due to its ease of acquisition and price. Illicit illegal alcoholic drinks are smuggled into the country, mostly from Mozambique. These are untested and their ingredients are not known. For US 50c, one can purchase a 300ml bottle of these concoctions which are believed to contain toxic, dangerous chemicals like isopropanol, a disinfectant found in mouthwash or skin lotions, or methanol, a solvent found in paints and industrial cleaning fluids"* says Benson Mudiwa, a Zimbabwean medical doctor based in Swaziland.

The statements below can help providers sharpen their overall interviewing skills sensitively and sensibly. Try them out for yourself. Does this help you improve communication with people who use or inject drugs?

Normalising

“Many people find it difficult to talk about sex and drugs.”

Transparency

“I need to ask you some very specific questions about your drug use in order to better understand your health needs and provide the best possible care”

Asking permission

“Would it be alright if I asked you some questions about your alcohol use?”

Option of now answering question:

“If you are not comfortable answering any of these questions you don’t have to answer them”.

Avoid asking for judgments or opinions:

Don’t say,

“How often do you drink in a week or how many drinks do you have in one sitting?”

Better to ask,

“Do you get drunk? Do you drink often?”

Ask specific instead of general questions:

“Have you ever used mbanje? Have you ever used cocaine?”

A healthcare provider’s role is to support a client to better understand the role of drugs in their life, providing accurate information and taking the necessary steps to reach the client-directed position. It is the service provider’s role to serve, not judge!

Drug and Alcohol Use Screening Tools

While this module does not replace clinical guidance on management of clients' drug use, delivery of harm reduction interventions or clinical guidance around diagnosing abuse and/or dependence, it does include helpful tips for healthcare providers who may be interested in supporting key populations who use drugs and alcohol.

It is ultimately the client's decision to stop, modify or maintain drug use depending on their personal goals. The best method for assessing the way forward is:

1. Identify the client's goals in relationship to drug use.
2. Engage in an open discussion about whether or not the client's current use aligns with where they want to be. The role of the healthcare provider is to motivate the client to talk about their personal goals and come to a clear understanding of where they stand with their goals in relation to their current drug and alcohol use.

Regardless of the outcome of such discussions, healthcare providers should aim to provide accurate information about drugs, including risks of death (e.g. from overdosing) and any relevant local information to help prioritise personal safety and security (e.g. taking possible measures to avoid a drug-related arrest or losing a job).

Providers can effectively screen for drug and alcohol use in a general history taking session when asking lifestyle-related questions such as diet, exercise, or sleep. A single question being used by healthcare professionals in primary care asks clients the following question:

"How many times in the past year have you used illegal drugs or used a prescription medication for non medical reasons?"

A response of at least one time is considered positive for drug use.

Learning Exercise: Sharing Experiences ±30 minutes

Ask participants what they currently do to screen clients for drugs and alcohol. Share experiences in the group. Ask the group to look at the tools summarised in the Participant Handbook. How can they help? Do they need adapting? Discuss.

Approaching Drug Use in the Clinical Setting

As mentioned earlier, drug and alcohol use is a difficult topic for both healthcare providers and their clients. It is therefore important for providers to be sensitive to their own anxiety as well as that of their client, when discussing drug use. Healthcare providers should use appropriate language when asking questions about drug use. Some principles to consider are:

- 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 tell 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 non-confrontational approach when discussing drug use with clients.



MODULE TEN:

Action Planning

Introduction

Change cannot happen from a workshop alone. Planning for change is important. This module provides time for participants to develop Action Plans that document their commitment to initiating positive change in their own practice and in their workplace. This module also takes a practical approach through the inclusion of a site visit to a healthcare facility that is already working well to support key populations.

It is best if participants work with others from the same facility when going through this final module, so they can think together about how to improve their own institutional environment. But each individual should also consider their own actions, and what they can do, even in the absence of wider change in their facility, to make their services more friendly to key population members. Failing to plan is planning to fail!

Learning Objectives

After completing this module, participants will be able to:

- Share a simple, clear plan of action to improve services for key populations at the health facilities where they work.
- Share their experience and gain insights from a field visit to an established KP healthcare site in Zimbabwe.
- Network with health personal with experience of supporting key populations.

Resources

Time: This module needs a minimum of a full day to complete.

Flip chart and pens, Participant Handbook, transport and logistics for a local health facility site visit.

Module Activities

Action Planning: ± 2 hours

Refer participants to the Action Plan Template in their Participant Handbooks, which includes the following headings:

Topic	Objectives	Activities	Time Frame	Inputs	Responsible Person	Expected Outcome	Cost

Participants should work together to think about how to improve the institutional environment where they work. But each individual should also consider what they can do, even in the absence of wider change in their facility, to make their services more friendly to key populations.

- As facilitator, circulate among the groups and provide suggestions during the planning process.
- Encourage participants to think realistically and identify feasible 'small steps that do not have significant cost or resource implications'.
- At the end of the session, groups should present their plans.
- Ideally, there will be ongoing monthly feedback meetings for trained service providers and they should hold each other to account for demonstrating efforts made to implement their Action Plans over time.
- Encourage participants to include regular follow-up in their action plans.

Linking & Learning Session: ± 5 hours (Site Visit)

On the final day, participants should attend a *Sisters with a Voice* clinic or other MoHCC identified and approved site to see the set-up, meet clinical staff, and talk to any key population clients who are waiting for/ exiting services. If possible, a community mobilisation session should be organised for trainees to observe.

After any site visit, make sure to have a de-briefing session with the group. The de-briefing should include discussion about the facility itself, the services and the approaches used, as well as how they felt about the services and approaches and finally, how they can begin to emulate the same where they work.

SOME ISSUES TO CONSIDER IN MAKING THIS TRAINING MORE EFFECTIVE

Clinic Attachments

Participants will benefit greatly from time spent at a healthcare facility experienced in supporting key populations. This could be done on a rotational basis.

- During the attachment, trainees 'shadow' the clinic's programme staff, working and treating key population members.
- A feedback meeting can be held every month with all trained public health nurses, the programme nurses, outreach workers and peer educators.

Meetings are aimed at reflecting on how the programme is going, sharing experiences on working with key population members, as well as members of key population groups sharing their experiences working with the nurses from the public system. This is an extremely valuable part of the programme as it provides service providers with 'hands on' experience in working with a group with whom they have little familiarity; this further helps to reduce stereotypes about key populations and increases their willingness to serve them.

Monthly Lunchtime Meetings

Following training, monthly lunchtime meetings can be arranged to bring the trained nurses together with any local peer educators and nurses from KP project sites to discuss on going progress with implementing Action Plans, whether KPs are starting to come to their facilities and to share experiences and identify solutions to any challenges they face. The peer educators also report any feedback from local KP members about the 'friendliness' of the public health clinic.

Gain support from local stakeholders is critical

Authorities responsible for managing public sector health services need to be on board with the idea of sensitising service providers to better meet KPs' needs.

- The training programme needs approval and support so that staff in local clinics understand that undergoing the training and changing their attitudes are both expected and encouraged from above.
- Before organising any training workshops, it is thus important to engage local health authorities.

Staff turnover can negatively impact sustainability of the training

- Clinic staff often move on, which means that the 'friendliness' of the clinic may decrease in their absence.
- All trained staff should complete the clinic rotation or at least attend monthly follow-up feedback meetings to build momentum for improved services to key populations.
- This challenge can be ameliorated by holding regular training opportunities so new staff can benefit from them, and encouraging attitudinal change within whole facilities, not just individuals.

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