Youth Friendly Services Training Manual

A Facilitator's Guide

for training health care providers to deliver optimal care to Lesbian, Gay, Bisexual and Transgendered Persons

Youth Friendly Services
Adolescent and Young Adult Health & Wellness Unit
Ministry of Health
Guyana

Revised December 2010

Ministry of Health in collaboration with the United States Agency for International Development (USAID)

Contents

Acknowledgements

I would especially like to thank the Ministry of Health Adolescent, Youth Health and Wellness Unit Youth Friendly Services Department for commissioning me to compile this facilitator's guide. This assignment provided me with much useful insight into the issues surrounding sexuality and sexual orientation.

Special thanks are extended to the following Ministry of Health staff for their excellent support:

- Ms. Yumiko Texidor, Coordinator, Adolescent Health Unit, MoH
- Ms Reyana Mckenzie, Co-Coordinator, Adolescent Health Unit, MoH

I would like to acknowledge the significant contribution of representatives of the Society Against Sexual Orientation Discrimination, SASOD, and the Guyana Rainbow Association (Guybow) for participating in the focus group discussion. The focus group offered an opportunity to validate themes emerging from the literature review and identify health care concerns, and barriers and facilitators for accessing health care among members of the LGBT community in Guyana.

Dereck Springer, MPH
Consultant

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
BBSS	Biological Behavioural Surveillance Survey
FSW	Female Sex Workers
GUYBOW	Guyana Rainbow Association
HIV	Human Immuno-deficiency Virus
LGBT	Lesbian, Gay, Bisexual, Transgendered
MSM	Men who have sex with men
MoH	Ministry of Health
PLHIV	People Living with HIV
SASOD	Society Against Sexual Orientation Discrimination
STI	Sexually Transmitted Infections
VCT	Voluntary Counselling & Testing
WSM	Women who have sex with woman

Introduction

In Guyana there are a growing number of men who has sex with men (MSM), women who have sex with women (WSW) and individuals who engage in sex with both men and women and some reported cases of transgendered people. A review of the literature suggests that there is a paucity of data in relation to the health of lesbian, gay, bisexual and transgendered (LGBT) people in Guyana. Significantly, the review also found the there has been no specific study done to determine the health needs of lesbian, gay, bisexual and transgendered people in Guyana.

The 2005 Biological Behavioural Surveillance Survey (BBSS) provided data on the sexual health of gay men but was limited both in scope and geographical representation. The survey reported an HIV prevalence of 21.2 percent among MSM in the capital city, Georgetown. The Terborg (2006) study, which sought to determine the 'Perceptions and Behaviour Regarding HIV and AIDS Prevention and Care among Female Sex Workers (FSW) and Men who have Sex with Men (MSM), was limited to MSM and had an HIV and STI bias. The Terborg study found that while MSM have access to STI and HIV related services such as knowledge, condoms, early treatment of STI, and HIV testing, there were many who complained about the quality of the services, particularly public health services. Long and inconvenient waiting hours, lack of confidentiality, limited pre-test counselling and inadequate post-test counselling, lack of informed consent, the prejudiced attitude of health workers and their lack of adequate communication skills, were some of the issues listed. MSM living with HIV stressed the double burden of stigma and discrimination. First they suffer stigma and discrimination based on their sexual lifestyles and second because they are HIV positive.

Sub-populations forced to keep their behavior and identities secret because of personal prejudice, stigma and discrimination are less likely to access vital health care, including lifesaving information about HIV and STI prevention. The Terborg study observed that community health care workers are not sensitive to the needs of MSM thus exposing them to further ridicule and humiliation. The **S**ociety **A**gainst **S**exual **O**rientation **D**iscrimination (SASOD), a Guyanese-based NGO which is committed to eradicating discrimination on the grounds of sexual orientation, in its March

8, 2008 online response to the UNGASS Guyana Country Progress Report 2006-2007 expounded on the observations highlighted in the Terborg study. SASOD opined that the approach to health promotion targeting vulnerable sub-populations of gay, bisexual and other men who have sex with men (MSM) is still based on narrow, technical public-health strategies of outreach and referral to "friendly" services. SASOD recommended that the programmatic response needs to be holistic by improving the quality of client services across the board through training to mitigate same-gender and HIV-related stigma by addressing homophobia among health care workers. SASOD posited that once services become and are know to be client-friendly, there will be less need to invest in "targeting MSM" as Gay, Lesbian, Bisexual and Transgendered (GLBT) communities in Guyana would gain confidence that the public health system does not house homophobic prejudices and allow discriminatory practices.

Although the findings of the Terborg study are limited to the MSM population, there is anecdotal evidence that LGBT people in Guyana experience discrimination when seeking health care. In light of the prevailing situation the Ministry of Health's Youth Friendly Services, identified as a priority, the development of a manual for the training of health care providers to ensure that they provide optimal clinical and non-clinical services in a non stigmatized and non discriminatory manner to lesbian gay, bisexual, and transgendered people seeking services at their youth friendly centres and beyond.

About this Guide

This facilitator's guide outlines the key activities and background information needed for the training of clinical and non clinical health care providers responsible for delivering youth friendly services to sub-populations including lesbian, gay, bisexual, and transgendered people. The guide is laid out in four chapters;

1. Exploring Values and Diversity;
2. Exploring the Complexity of Sexual Orientation;
3. Communication Skills for Optimal Health Care;
4. Sexual Health of Men Who Have Sex with Men and Gay Men
5. Theory to Practice

The facilitator's guide provides training activities design to guide the facilitator on how to stimulate critical thinking and encourage interaction among the participants. The activities will lead the facilitator and participants to examine their deeply held views about sexual orientation and sexual behaviour. The facilitator will engage participants in a process of defining sexual orientation and examining its complexities.

Participants will develop and in some cases deepen their understanding of the terms "lesbian", 'gay", "bisexual", and "transgender". By engaging in the activities participants will appreciate that assumptions can lead to stereotypes and unfair judgments about individuals and groups and how stereotypes and biases affect our lives. Participants will explore sexual health of gay men and other men who have sex with men. They will be introduced to gender neutral language required for communicating with LGBT people seeking health care services and will have an opportunity to practice using gender sensitive language during role play. To ensure realism it is recommended that as much as possible members of the GLBT community should be recruited to play themselves during the role play activity.

As implied this document is a guide and facilitators must feel free to adapt the content through the use of other relevant activities. This facilitator's

guide is a working document which should be revised as needs and contexts change.

About this Training

Duration
The training is designed to take place over five days.

Organisation of the Training
The training guide is comprised of 21 activities which build upon each other, therefore it is recommended that the sequence be maintained as much as possible.

Learning objectives, suggested materials, facilitator's instructions, and where applicable relevant background reading materials comprise each activity. Additionally participants' handouts are provided in the appendix section.

Each activity is structured and presented in the following manner:

- Learning Objectives
- Suggested Materials
- Facilitator's Instructions
- Background Reading Materials (where relevant)

Training Outline

Day 1

08:30 Hours	Registration
09:00 Hours	Welcome
09:05 Hours	Introductions
09:15 Hours	Overview of Training Objectives
09:20 Hours	Ground Rules
09:30 Hours	Identifying our Values
10:30 Hours	BREAK
10:45 Hours	Exploring Diversity
12:00 Hours	LUNCH
13:00 Hours	Respecting Diversity
14:30 Hours	BREAK
14:45 Hours	Exploring the Complexity of Sexual Orientation – Straight Talk
16:00 Hours	Departure

Day 2

09:00 Hours Reflection

09:30 Hours Exploring the Complexity of Sexual Orientation – The Fish Bowl

10:30 Hours BREAK

10:45 Hours Exploring the Complexity of Sexual Orientation – The Fish Bowl Cont'd

12:00 Hours LUNCH

13:00 Hours Respecting Others' Sexual Orientation

14:30 Hours BREAK

14:45 Hours Communication Skills

16:00 Hours Departure

Day 3

09:00 Hours	Reflection
09:30 Hours	Communication Skills – Sharpening our Vocabulary
10:30 Hours	BREAK
10:45 Hours	Guide to Taking Sexual History
12:00 Hours	LUNCH
13:00 Hours	Recognising Depression and Risks for Suicide
13:45 Hours	Guidelines for Coming Out
14:30 Hours	BREAK
14:45 Hours	Theory to Practice

Health Care Concerns of LGBT People (Group Work)

Guidelines for Dealing with Male Rape or Sexual Assault

16:00 Hours	Departure

Day 4

08:30 Hours	What is Sexual Health?
09:00 Hours	Transmission of STIs and HIV
09:45 Hours	Brainstorming Knowledge of STIS
10:45 Hours	BREAK
11:00 Hours	Prevention of STIs and HIV
12:00 Hours	LUNCH
13:00 Hours	Vulnerability and Risk Taking
14:30 Hours	BREAK
14:45 Hours	Reducing Vulnerability to STIs and HIV
16:15 Hours	Departure

Day 5

09:00 Hours	Reflection
09:30 Hours	Theory to Practice Role Play in triads
10:30 Hours	BREAK
10:45 Hours	Role Play in triads
12:00 Hours	LUNCH
13:00 Hours	Role Play in triads
14:30 Hours	BREAK
14:45 Hours	Questions and Answers

Members of the LGBT community field questions from participants

15: 30 Hours	Workshop Evaluation
15:50 Hours	Closing Remarks
16:00 Hours	Departure

Training Health Care Providers to Deliver Optimal Care to LGBT People Workshop Evaluation

1. Please rate the workshop as a whole by circling your answer.

Poor……Excellent

1 2 3 4 5 6 7 8 9 10

2. Please rate the following items by circling your answer.

Course content:

Poor……Excellent

1 2 3 4 5 6 7 8 9 10

Quality of Instruction:

Poor……Excellent

1 2 3 4 5 6 7 8 9 10

Group Work /Activity during Sessions:

Poor……Excellent

1 2 3 4 5 6 7 8 9 10

Achievement of Workshop Objectives:

Poor… ……Excellent

1 2 3 4 5 6 7 8 9 10

Overall Level of Satisfaction:

Poor……Excellent

1 2 3 4 5 6 7 8 9 10

3. What other topics should be included in future workshops subject?

_____

_____

_____

4. Which concepts or ideas presented in the workshop did you find particularly useful or helpful?

5. Has the workshop inspired you to change or think differently in relation to LGBT people? Please explain.

6. Which sessions were most relevant to your work? Why?

7. On which topics would you have preferred additional time?

8. Who would benefit most from this training?

9. Action Plan: Please list three things you plan to do in the next 6 months to apply the knowledge and skills gained from this workshop

Thank you for your feedback.

Chapter 1

Exploring Values and Diversity

"Live by your personal code of values to get the most out of life. Life is fulfilling and free of stress when we live in accordance to our own personal values"

Jerry Lopper

This chapter aims to:

- Enable participants to identify and express their values;
- Increase participants' understanding of how values represent themselves in everyday life;
- Facilitate participants' understanding of and respect for diversity.

Activity 1: Identifying our Values

Times: 60 Minutes

Objectives

- Define values;
- Help participants understand where they learn their values;
- Enable participants to identify their values.

Materials

- Flip chart
- Markers
- Masking Tape

Facilitator's Instructions

Step 1 *Facilitator first divides a flip chart into three columns. He/she begins discussion by asking participants to define values. Facilitator records participants responses in column one.*

Step 2 *Asks participants to identify where they learn their values - who teaches them values? Record their responses in column two.*

Step 3 *Finally, asks participants to identify specific values they hold. Record their responses in column three.*

What are values?	Where do you learn your values?	What values do you hold?
Values are deeply held beliefs about what is good, right, and appropriate. Values are deep-seated and remain constant over time.	We accumulate our values from childhood based on teachings and observations of our parents, teachers, and religious leaders, other	Record values stated

	influential and powerful people and culture.	

Facilitator's Instructions Cont'd

Facilitator concludes the activity with some summary thoughts and impresses on the participants the idea that when an individual acts in accordance with his/her values, he/she is becoming a person of character, irrespective of who he/she is.

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Activity 2: Exploring Diversity

Time: 75 Minutes

Objectives

- Enable participants to explore the diversity of the group;
- Allow participants to begin to break down some of the stereotypes and assumptions they hold.

Materials

- Activity Guide only

Facilitator's Instructions

Facilitator says that it is important to start this activity by establishing common ground for the activity. We live in a diverse world. In this activity we will explore the diversity among us by thinking about our values, our backgrounds, our teachers, and our experiences. We might even discover that this group that might seem alike is much more diverse than any of you would assume.

This activity will involve labeling and personalizing some of this diversity. This personalization (relating to self) might prove uncomfortable at times. Eventually, however, it might empower us to break down some of the stereotypes and assumptions that we, as a product of our cultures, experience, and life, hold.

This exercise is fairly simple. I will ask that all of you gather on one side of the room and face towards its center. I will call out specific categories/labels/ descriptions, and ask that all of those to whom this applies, walk to the other side of the room. For example, I might request that anyone with glasses please cross the room. If this describes you and you feel comfortable acknowledging it, you would walk to this side of the room (indicate).

Once there you would turn and face the crowd you just left. Get in touch with your feelings and think about those people on both sides of the room – then return to the side you started from. After a few seconds, I will continue with a new category. A number of categories will be called out. Remember, cross the room if the category applies.

Remember, ***there is no pressure to cross the room*** *if you don't feel comfortable doing so.* ***You*** *will need to make that decision.*

At the conclusion *of the activity, we will discuss what we felt and what we learned. There may be times when this activity makes you feel slightly uncomfortable. I would urge you to lean into that discomfort since it may mean that you are about to gain an important learning or insight.*

However, if the discomfort becomes intense, you may ***stop participating*** *at any time. No questions will be asked and we will* ***respect your decision****. We would, however, encourage you to* ***remain*** *in the room as an observer.*

The facilitator begins the activity by asking questions from the following list:

- Anyone who has visited another country . . .cross the room
- Anyone who has never flown. . .
- Anyone who owns your own car. . .

- Anyone who does not believe in God. . .
- Anyone who is a person of mixed race. . .
- Anyone who feels that he/she knows very little about his/her cultural heritage. . .

Remember, walk across the room only if you feel comfortable identifying yourself this way.

- Anyone who is the oldest in the family. . .
- Anyone who is the youngest in the family . . .
- Anyone who is an only child. . .
- Anyone who is adopted. . .

- Anyone who sometimes has low self-confidence. . .
- Anyone who sometimes feels lonely. . .
- Anyone whose natural parents have divorced. . .
- Anyone who has had a parent who passed away. . .

- Anyone who believes it is alright for someone to have a date of the same gender at a social event. . .
- Anyone who has a family member who is gay, lesbian, bisexual, or transgendered. . .
- Anyone who is choosing to abstain from sex until marriage. . .
- Anyone who has experienced the effects of alcoholism in the family. .

- Anyone who has experienced the effects of drug addiction in the family. . .
- Anyone who has a friend or relative who attempted suicide. . .
- Anyone who has not yet crossed the line. . .

Facilitator invites participants to form a circle

Facilitator leads a discussion about the activity; as much as possible focus on values.

- What did you learn?
- What kind of feelings did you have as you participated?
- How did you feel when there were very few of you on one side of the room?
- Did you find yourself making judgments of others?
- Through this activity, intentionally or not, did you share your values?
- Through this activity, intentionally or not, do you think that you learned about the values of others?

- If this activity is about values, then how do we use this experience to remove the stereotype (label)?
- How do values represent themselves in everyday life?
- Are there times in life when values are ignored?
- What is the result when values are ignored, forgotten or trashed about?

"We are not our labels"
Eckhart Tolle - A New Earth

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Activity 3: Respecting Diversity

Time: 90 Minutes

Objectives

- Help participants become aware of the many ways in which individuals show both respect and disrespect towards each other;
- Enable participants to adopt a value for treating people respectfully;
- Help participants to learn to appreciate people's differences rather than fear them.

Materials

- Flip Chart
- Markers
- Masking tape

Facilitator's instructions

Facilitator asks participants to respond to the following questions:

*1. **Agree** or **disagree:** It's okay to insult or make fun of people as long as they don't hear it.*

2. What are some common signs of disrespect that you see in your place of work? How do you feel about that?

3. What do you dislike most about the way people treat each other at your place of work? Why do you feel that way?

4. Is there a difference between a put-down and an insult? What's the difference?

5. Do you have to like a person in order to be respectful, or can you be respectful to someone even if you don't particularly care for him or her?

6. Do you think there is discrimination at your place of work? How is it expressed? How does that make you feel?

7. Have you, personally, ever experienced discrimination or some other type of prejudice? What happened? How did it make you feel?

8. Do you think people are afraid of differences sometimes? Can you give some examples? Why do you think that's true?

9. Is it harder to respect someone who is very different from us? Why?

10. What are the benefits of having friends who are different from us?

11. Have you ever learned something new about a different culture from a friend?

12. Is it ever okay to treat another person with disrespect?

13. What are the benefits of treating people with respect?

At the end of the exercise the facilitator emphasizes that everyone wants to be treated with respect. You and everyone in your life want to be accepted, considered as individuals, treated politely, allowed some privacy, and judged on their own merits. Respect is earned and deserved when you learn how to respect others.

To be respectful, you must recognize and understand other people's beliefs, and accept individual differences without prejudice. Don't insist that everyone like you; simply treat others as they wish to be treated and expect them to do the same for you. When you are respectful, you value and encourage others. You must help other people find value in themselves. You will become respected when you act with respect towards others. Respect is never demanded.

"If you judge people you have no time to love them"

Mother Teresa

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Chapter 2

Exploring the Complexity of Sexual Orientation

"Truly straight people do not — cannot — make a choice about their sexual orientation, just as gay people don't, and can't, choose. People who are comfortable in their own sexual persona are not threatened by the way the sexuality of others is expressed"

Jon Ponder

This chapter aims to:

- Illustrate the difficulty in defining rigid and consistent categories of sexual orientation;
- Fill the information gap that exists regarding sexual orientation in recognition of the lack of knowledge in this area;
- Uncover misconceptions and stereotypes in relation to sexual orientation.
- Enable participants to explore their own feelings, beliefs, and values regarding sexual orientation.
- Expose participants to other people's points of view, attitudes, and values.

Activity 4: "Straight Talk"

Time: 75 Minutes

Objective

Enable participants to explore heterosexuality.

Materials

- Activity Guide only

Facilitator's Instructions

Facilitator asks participants the following questions:

1. What is heterosexuality? (Define)

2. How can you tell if someone is heterosexual ('straight')?

3. What causes heterosexuality?

4. Is it possible that heterosexuality stems from neurotic fear of others of the same sex?

5. The media seems to portray straights as preoccupied with (genital) sex. Do you think this is so?

6. Do you think straights flaunt their sexuality? If so, why?

7. Do you believe it is sinful for straights to engage in sexual behavior other than vaginal/penile intercourse for procreation?

8. In a straight couple, who takes the dominant role and who takes the passive role?

9. If 50% of married couples get divorced, why is it so difficult for straights to stay in long-term relationships?

10. Considering the consequences of overpopulation, is it feasible that the human race could survive if everyone were heterosexual?

11. Since 99% of reported rapists are heterosexual, why are straights so sexually aggressive?
12. A disproportionate majority of child molesters are heterosexual. Therefore, do you consider it safe to expose children to heterosexual teachers, scout leaders, coaches, etc?
13. What would you do if a straight person of the other sex tried to force him/herself on you?
14. When did you choose your sexual orientation?
15. Did one of your teachers have a significant influence on your sexual orientation?
16. How easy would it be for you to change your sexual orientation starting right now?
17. Techniques have been developed which might enable you to change your sexual orientation if you wished to. Would you consider intensive psychotherapy?
18. What have been your reactions to answering these questions? What feelings have you experienced? Why?

"What do we live for if not to make life less difficult for each other?"
George Eliot

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Activity 5: The Fish Bowl

Time: 90 Minutes

Objectives

- Enable participants to address issues of rights related to sexuality, including sexual orientation;
- Help participants develop self-confidence to express their own opinion on these issues;
- Promote tolerance and empathy.

Materials

- 3 chairs
- 2 facilitators
- Space for participants to move about
- Flip charts and markers
- Small slips of papers and pens
- A small box or a hat
- Copies of Handout 1: *Exploring Sexual Orientations,* for participants

Preparation

Facilitator please note that the aim of this activity is to allow participants to reflect on their own sexuality and the norms of their society and to encourage them to have the self-confidence to express their own point of view while being tolerant of people who hold different views. The aim is not to convince people of one point of view or another, nor to come to a consensus decision.

Before running the activity it is important to reflect on your own values and beliefs about what is right for yourself, your families and for others and to remember that these values will be reflected in everything you do and say,

and what you don't do or say. It is crucial that you acknowledge your own values and prejudice and understand the origins of those values in order that the participants may also develop insights into the origins of their own values.

It is a good idea to start off with two facilitators as conversationalists. for example, one of you may start by saying, "Have you heard, about the pregnant man?" The other might reply, "Yes, I saw him speaking about it on Oprah". In this way you imply that the conversation is about a real person and not a theoretical debate. It also helps open up a discussion about what people know about other sexual orientations and their attitudes to those.

Facilitator's Instructions

Facilitator hand out slips of paper and asks participants to write down any questions they have about sexual orientation in general, and to put their papers in the hat/box. The questions should be anonymous.

Facilitator explains that this activity is about exploring attitudes to sexuality and in particular to sexual orientation. Everyone is free to express opinions that may be conventional or unconventional, controversial or which challenge the norms of their society. People may present points of view with which they agree, or with which they disagree with without fear of ridicule or contempt. Offensive or hurtful comments, which are directed at individuals in the group, are not allowed.

Participants are given a few minutes to write their questions on the slips of paper. Facilitator passes around the hat or small box and asks participants to place their questions into it.

Facilitator then places three chairs in a half-circle in front of the group; these are for the three conversationalists who are in the "fish-bowl"; one facilitator and two participants. The rest of the group are observers.

Facilitator invites two volunteers to join him/her in a conversation in the "fish bowl". Facilitator then explains that if at any point someone else would like to join the conversation then they may do so, but as there is only room for three fish in the bowl at any one time, someone will have to step out. Someone who wishes to join the conversation should come forward and

gently tap one of the "conversationalists" on the shoulder. These two people exchange seats and the original "conversationalist becomes an observer.

Facilitator then asks a volunteer to pick up a question from the box/hat and start discussing it. Let the discussion run until people have exhausted the topic and points are being repeated. Facilitator leaves the conversation. Hopefully one of the observers will quickly replace you, thus enabling you to leave the discussion to the participants. However, you should continue to participate as an observer so that you maintain the possibility of taking another turn as a conversationalist. This leaves open the possibility for you to discretely manipulate the discussion either to open up different avenues of debate or to tactfully remove a participant who is not keeping to the rules.

If you wish to, you can introduce a rule that any particular point of view can only be raised once. This prevents the discussion focusing on only a few aspects of the topic and helps to discourage repetition of popular prejudices.

Facilitator asks for three volunteers to discuss another question and start another round of conversations under the same rules as before.

Participants discuss as many questions as possible within the time allotted. Before you finally go on to the debriefing and evaluation, take a ***short break*** *to allow time for people to come out of the "fish-bowl". This is especially important if the discussion has been heated and controversial.*

Debriefing and Evaluation of Activity

- Start with a brief review of how people felt being both inside and outside the "fish-bowl". Then talk about the different views that were expressed, and finally discuss what people learnt from the activity:
- Was anyone shocked or surprised by some points of view expressed? Which ones? Why?
- In your community, how open-minded are people generally about sexuality?
- Are some groups more open than others? Why?
- What forces mould how our sexuality develops?

- Where do people get their values about sexuality from?
- Do participants' attitudes about sexuality differ from those of their parents and grandparents?
- If so, in what ways do they differ? Why?

Background Information for Facilitator

It is recommended that you prepare yourselves by reading the background information below. Some frequently asked questions and issues include:

- What is homosexuality?
- What are the differences between heterosexual, gay, lesbian, bisexual and transgendered people?
- Is homosexuality (same-sex attracted) an illness?
- How do people become gay or lesbian?
- In some countries (e.g., Sweden same-sex attracted relationship is accepted and persons with different sexual orientations can get married while in others it is punishable by death.

Sexual orientation is one of the four components of sexuality and is distinguished by an emotional, romantic, sexual or affectionate attraction to individuals of a particular sex.

The three other components of sexuality are **biological sex** (whether we are born as a male or female), **gender identity** (the psychological sense of being male or female) and **social gender role** (the extent to which people conform to what is regarded in our society as feminine and masculine behaviour).

Three sexual orientations are commonly recognised:

Heterosexual, attraction to individuals of the other sex;

Homosexual, attraction to individuals of one's own sex (same-sex attracted); Women with a same sex orientation are usually referred to as **lesbian** and **men** with a same sex orientation are usually referred to as **gay**;

Bisexual is used to describe the capacity for emotional, romantic and/or physical attraction to more than one gender. That capacity for attraction may or may not manifest itself in terms of sexual interaction; or

Transgender is the state of one's "gender identity" (self-identification as male, female, both or neither) not matching one's "assigned gender" (identification by others as male or female based on physical/genetic sex). "Transgender" does not imply any specific form of sexual orientation; transgender people may identify as heterosexual, homosexual, bisexual. "Transgendered" refers to the individual. For example, "I am a male **transgendered** person who chooses to present female".

"Drag Queen" in the local culture refers to a male who, by and large, identifies as his birth-designated sex, but who plays at or performs as the opposite gender. He is a cross dresser who periodically adorns himself in women's clothes and appears boldly on the streets mainly at nights. He is seen as an entertainer.

What causes a person to have a particular sexual orientation?
How a particular sexual orientation develops in any individual is not well understood by scientists. Various theories provide different explanations for what determines a person's sexual orientation, including genetic and biological factors and life experiences during early childhood. Despite much research there is no proven explanation of how sexual orientation is determined. However, many scientists share the view that for most people sexual orientation is shaped during the first few years of life through complex interactions of genetic, biological, psychological and social factors.

Despite what some people claim, there is no evidence that society's greater acceptance of homosexuality results in more people having a homosexual sexual orientation. The greater numbers of people identifying as homosexual are a result of fewer people fighting their homosexual feelings while attempting to live heterosexual lives.

Is Sexual Orientation a Choice?

No. For most people, sexual orientation emerges in early childhood or adolescence without any prior sexual experience. Some people report trying very hard over many years to change their sexual orientation from homosexual to heterosexual, with no success. For these reasons, psychologists do not consider sexual orientation for most people to be a conscious choice that can be voluntarily changed. People don't choose their

sexual orientation; they can of course choose the kind of a life they want to live.

"If God, as they say, is homophobic, I wouldn't worship that God,"
Archbishop Desmond Tutu

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Activity 6: Respecting Others' Sexual Orientation

Time: 90 Minutes

Objective

- To enable participants to examine their feelings, thoughts and actions in relation to people who are lesbians, gays, bisexuals, and transgendered.

Materials

- Activity Guide only

Facilitator's Instructions

Facilitator says let's examine our likely reaction to the situations below. Facilitator then asks participants the following questions:

a) How would you react if you learnt that your child is lesbian, gay, or bisexual or transgendered?

b) How would you react if you learnt that your co-worker is lesbian, gay, or bisexual or transgendered?

c) How would you react if you believed that the person you are counseling is lesbian, gay, bisexual or transgendered?

d) How would you react if you learnt during the session that the person you are counseling is lesbian, gay, bisexual or transgendered?

e) How would you react if you believed that the person you are attending to is lesbian, gay, bisexual transgendered?

f) How would you react if you learnt while attending to someone that he/she is lesbian, gay, bisexual or transgendered?

g) How would you react if you learnt that your best friend with a lesbian, gay, bisexual or transgendered person?

h) How would you react if you learnt that an influential person in your life is lesbian, gay, bisexual or a transgendered person?

i) How would you react if you learnt that the person you are in a relationship with reveals he/she was a lesbian, gay, bisexual or transgendered person?

At the end of the activity the facilitator asks the following questions to help participants clarify their values in relation to others.

A) What have you learnt about yourself as a result of this activity?

b) Have your feelings and thoughts regarding sexual orientation changed as a result of this exercise? Please give reasons for your answers.

c) Would you like people to respect your values in relation to sexual orientation? If yes, how would you like them to demonstrate that they respect your values?

d) Do you respect the right of other persons to express their sexual orientation if it is different to yours? If yes, how can you demonstrate that you respect theirs.

In closing the facilitator shares that as participants are entitled to their values and to be respected for their sexual orientation so do others. This is especially important in their capacity as health care providers since they are expected to provide optimal care in a non judgmental and non discriminatory manner to patients/clients with different values and lifestyles.

Participants must therefore learn to deal with their own areas of discomfort, lest they communicate negative messages to their patients/clients without realizing it.

"I believe that it takes a lot of courage no matter where you are to come out and say you are gay"

Oprah Winfrey

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Chapter 3

Communication Skills for Optimal Health Care

"The basic building block of good communications is the feeling that every human being is unique and of value"

Unknown Author

This chapter aims to:

- Create an awareness that good communication skills are necessary for delivering optimal care;
- Facilitate participants' awareness of the verbal and non verbal communication that act as barriers to individuals' access to health care;
- Reduce the heterosexual bias in language when referring to lesbian, gay, bisexual and transgendered people;
- Provide participants with knowledge and skills to conduct patient/client interviews and take sexual histories of LGBT people.

Effective communication offers more than just good manners or being nice.

Effective communication enables us to be better heath care providers.

Effective communication improves patient care and disease outcome.

Activity 7: Communication Skills

Time: 75 Minutes

Objectives

- Help participants identify the four basic parts in the communication process;
- Facilitate participants' understanding of the two basic modes of communication;
- Enable participants to recognize the barriers to effective communication.

Materials

- Flip chart
- Markers
- Masking Tape

Facilitator's Instructions

*Facilitator begins by saying to participants that the human communication process consists of **four basic parts**. Facilitator then asks participants to identify the four parts. Facilitator notes the responses and summarized as follows:*

The human communication process consists of four basic parts:

1. <u>The sender of the message</u>; the sender starts the process;

<u>2. The message;</u> the message is the body of information the sender wishes to transmit to the receiver;

<u>3. The receiver of the message</u>; the receiver is the individual intended to receive the message;

4. <u>Feedback</u>; feedback is the response given by the receiver to the message. Feedback, at times, is used to validate whether effective communication has taken place.

Facilitator's Instructions Cont'd

*Facilitator asks participants to identify the **two basic modes of communication.***

Facilitator acknowledges responses and states that:

***Verbal communication** involves the use of words.*

*He/she then asks participants to explain their understanding of **non verbal communication** and provide examples of the various forms.*

Facilitators notes participants' responses and summarises. Nonverbal communication, on the other hand, does not involve the use of words. For example:

Dress, Gestures, Facial expressions, Eye contact, Tone of voice, Pauses and Silence

Facilitator points out that even though there are two forms of communication, both the verbal and the nonverbal are inseparable in the total communication process.

Conscious awareness of this fact is extremely important because your professional effectiveness is highly dependent upon successful communication.

Facilitator's Instructions

Facilitator says now let us examine barriers to effective communication Ineffective communication occurs when obstacles or barriers are present.

Facilitator asks participants to brainstorm the various barriers to effective communication and records their responses on flip chart.

The facilitator then works with participants to group the responses under three main categories on a flip chart.

Physiological Barriers	**Physical Barriers**	**Psychosocial Barriers**
Result from some kind of sensory dysfunction on the part of either the sender or the receiver. Such things as hearing impairments, speech defects, and even vision problems influence the effectiveness of communication.	Consist of elements in the environment (such as noise) that contribute to the development of physiological barriers (such as the inability to hear).	Are usually the result of one's inaccurate perception of self or others; the presence of some defense mechanism employed to cope with some form of threatening anxiety; or the existence of factors such as age, education, culture, language, nationality, or a combination of socioeconomic factors.

Facilitator's Instructions

Facilitator encourages a discussion around the barriers identified and highlights the following:

<u>Psychosocial barriers</u> are the most difficult to identify and the most common cause of communication failure or breakdown. A person's true feelings are often communicated more accurately through nonverbal communication than through verbal communication.

Facilitator ends the discussion by emphasizing that participants who are aware of their verbal and non verbal communication and the impact that these have on their patients/clients are more likely to improve the quality of health care they provide to them.

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Activity 8: Sharpening our Vocabulary

Time: 90 Minutes

Objectives

- Expose participants to the preferred vocabulary when referring to lesbians, gays, bisexuals and transgendered people and their sexual behaviours.
- Reduce the heterosexual bias in language when referring to lesbian, gay, bisexual and transgendered people.

Materials

- Flip chart
- Markers
- Masking Tape
- Copies of Handout 3: *Problematic versus Preferred Examples*, for participants

Facilitator's Instructions

Facilitator informs participants that the next activity is about word association. Facilitator explains that he/she will write a word related to sexual orientation and sexual behavior and participants are invited to share

what words come to mind. A few words are provided here for the facilitator's use however, the facilitators should feel free to include others.

1) *Homosexual*
2) *Heterosexual*
3) *Lesbian*
4) *Gay*
5) *Oral Sex*
6) *Anal sex*

Facilitator records participants' responses to each of the words he/she provides.

Facilitator then explains that it is important when referring to lesbian, gay, bisexual and transgendered persons that participants use gender neutral language such as partner rather than husband, wife, boyfriend, girlfriend since these words suggest that the health care provider has made an assumption that the patient/client is heterosexual. When such assumptions are made it is difficult for a lesbian, gay, bisexual or transgendered person to share their sexual orientations with the provider, thus, receive the most accurate and optimal care.

Additionally, the use of words such as homosexuality has been associated in the past with deviance, mental illness and criminal behavior, and these negative stereotypes may be perpetuated by bias.

The Committee on Lesbian and Gay Concerns American Psychological Association, points out that problem occur in language concerning lesbians, gay men, and bisexual and transgendered people when language is too vague or concepts are poorly defined.

The Committee also believes that there is need to reduce heterosexual bias and increase the visibility of lesbians, gay men, bisexual, and transgendered people since they often feel ignored by the general media which take the heterosexual orientation of their readers for granted. It is within this context that the Committee offers a guide (below) to aid us in improving our vocabulary in relation to sexual orientation and sexual behaviour.

*Facilitator shares the **problematic** for each of the sections below and request participants to suggest the **preferred** terms. Facilitator shares the **comment** for each of the sections and encourages a discussion around the issues identified.*

Problematic Versus Preferred Examples

Issues of Designation: Ambiguity of Referent

1. **PROBLEMATIC**: Sexual **preference**
   PREFERRED: Sexual **orientation**

Comment: Avoids the implication of voluntary choice that may not be appropriate.

2. **PROBLEMATIC**: The sample consisted of 200 **adolescent homosexuals**
   PREFERRED: The sample consisted of 200 **gay male adolescents**
   The sample consisted of 100 **gay male** and 100 **lesbian** adolescents

Comment: Avoids use of "homosexual" and specifies gender of subjects.

3. **PROBLEMATIC**: None of the subjects were **homosexual or bisexual**.
   PREFERRED: None of the subjects were **lesbians, gay men, or bisexual people**
   All of the subjects were **heterosexual**

Comment: Avoids use of "homosexual" and increases the visibility of lesbians, gay men or bisexual people.

4. **PROBLEMATIC**: Manuscript title: "Gay relationships in the 1990s"
   PREFERRED: Manuscript title: "Gay male relationships in the 1990s"

Comment: Specifies gender of gay persons before the term gay is used to describe women and men; avoids invisibility of lesbians.

5. **PROBLEMATIC**: Subjects were asked about their **homosexuality**.
   PREFERRED: Subjects were asked about the **experience of being a lesbian or a gay man**.

Comment: Changes sentence construction to avoid use of the term "homosexuality".

6. **PROBLEMATIC**: The women reported **lesbian sexual fantasies**.
   PREFERRED: The women reported **female-female sexual fantasies**.

Comment: Avoids confusion of lesbian orientation and specifies sexual behaviors.

7. **PROBLEMATIC**: The two **bisexual** subjects had engaged in both **gay and heterosexual sexual encounters** in the past year.
   PREFERRED: The two **bisexual** subjects had engaged in both **male-male** and **male-female sexual encounters** in the past year.

Comment: Avoids confusing sexual orientation (bisexual) with specific sexual behaviors.

8. **PROBLEMATIC**: The male dogs were **bisexual**.
   PREFERRED: The male dogs were observed to engage in both **male-male and male-female sexual behavior**.

Comment: Increases specificity; does not use sexual orientation terms with animal species.

9. **PROBLEMATIC**: It was the subjects' **sex**, not their sexual orientation that affected number of friendships.

PREFERRED: It was subjects' **gender**, not their sexual orientation that affected number of friendships.

Comment: Avoids confusing gender with sexual activity.

Problems of Designation: Stereotyping

10. **PROBLEMATIC**: **Homosexual** abuse of children.
    PREFERRED: **Sexual** abuse of male children **by adult men**.

Comment: Does not imply sexual orientation of participants; does not imply that gay men are rapists.

Problems of Evaluation: Ambiguity of Reference

11. **PROBLEMATIC**: Questionnaire item: Have you ever engaged in sexual intercourse?
    PREFERRED: Questionnaire item: Have you ever engaged in penile/vaginal intercourse?

Comment: States precisely if penile/vaginal intercourse is the purpose of the item.

PREFERRED: Have you ever engaged in sexual activity?

Comment: Avoids assumption of heterosexual orientation if sexual activity is the purpose of the item.

Problems of Evaluation: Stereotyping

12 **ROBLEMATIC**: AIDS education must extend beyond the gay male population into the **general population**.
PREFERRED: AIDS education must not focus only on selected groups.

Comment: Does not refer to gay men as set apart from the general population.

13. **PROBLEMATIC**: Psychologists who work with **special populations** (e.g., **lesbians**, **drug abusers**, **survivors of sexual abuse**) need extra training.
    PREFERRED: Psychologists who work with **minority populations** (e.g., **Latinos**, **lesbians**, **Black women**, **older women**) need extra training.

Comment: Avoids equating lesbians with pathology.

14. **PROBLEMATIC**: Women's **sexual partners** should use condoms.
    PREFERRED: Women's **male sexual partners** should use condoms.

Comment: Avoids assumption of heterosexuality

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Activity 9: Guide to Taking a Sexual History

Time: 75 Minutes

Objectives

- Facilitate participants' understanding of the importance of creating a safe atmosphere when taking a sexual history;
- Help participants understand the importance of confidentiality in taking a sexual history;
- Explore how a health care provider's use of language can either facilitate or hinder the taking of a sexual history;
- Indentify common stereotypes to avoid making when taking a sexual history with LGBT patients/clients.

Materials

- Copies of the Handout 3*: Issues to Consider When Taking a Sexual History*, for participants

Facilitator's Instructions

Facilitator explains to participants that any person who walks into their clinic/centre could self-identify as gay, lesbian, or bisexual and/or have a history of relationships with members of the same sex.

Similarly, they may have been born another gender to the one they now adopt. You have better chance to create trust with the LGBT patient/client during the initial interview.Ensure that questions you ask are open-ended and apply to all patients/clients.

Facilitator reviews with participants the guide to history taking below.

Summary Points; Issues to consider when taking a sexual history

- Create a Welcoming and safe atmosphere
- Confidentiality
- Use inclusive language
- Evaluate sexual risk
- Identify the patient's/client's concerns
- Common Assumptions Not to Make in Taking a Sexual History

Issues to Consider When a Taking Sexual History

Creating a Welcoming and Safe Atmosphere

In general, creating a safe environment for taking a sexual history is similar in LGBT and heterosexual patients/clients. In all such situations, the health care provider strives to be open minded, nonjudgmental, patient, tactful, respectful and provides assurances that privacy and confidentiality will be maintained.

It is useful, however, to keep in mind that many LGBT people may approach a health care provider interview with greater anxiety and guardedness than their heterosexual counterparts. Their anxieties may stem from past experiences with providers who were critically judgmental or they may anticipate a critical or judgmental response by projecting their own "internalized homophobia" or transphobia (discrimination transgendered people). These patients/clients may need additional time and encouragement to reveal their true concerns.

As with any patient/client, the provider's non-judgmental attitude will help bring out honest and relevant information. Such an attitude is conveyed to the patient/client both verbally and non-verbally through body posture and room set up. A relaxed stance and not conducting an interview from behind a

desk can be beneficial. Techniques such as open-ended questions, verbal mirroring of the patient's/client's own language, use of non-judgmental language, attention to heterosexist assumptions and avoidance of stereotyping can all lead to greater success in obtaining a more accurate sexual history.

Confidentiality

Confidentiality is the cornerstone of all provider-patient/client relationships and assurances of confidentiality are crucial to taking a sexual history. This is done by assuring a patient/client that any information provided will *not* be shared with others. In cases where complete confidentiality cannot be assured, a provider should clarify the limits of confidentiality from the onset and respect the patient's/client's decision as to how much sexual history he/she is willing to reveal.

Special caution needs to be taken when working with children, adolescents and young adults who may not have shared their concerns about sexual orientation or gender identity with their parents. Children and adolescents are particularly unlikely to share their intimate feelings with providers unless their wishes and sensitivities are recognized.

Use of Inclusive Language

When taking a sexual history, the provider's task is aided by using inclusive terms and language. Inclusive language should not make assumptions about a patient's/client's sexual identity or sexual behavior, particularly in situations where patients/clients do not volunteer such information. One way to do this is to have intake forms and questionnaires that do not make heterosexual assumptions.

Such inclusive language also conveys to the LGBT patient/client that the provider is potentially open to hearing about his or her sexual identity and relationships. The accuracy and completeness of the details requested will reflect the patient's/client's level of comfort with the process.

Evaluating Sexual Risk

Sexual history should explore the patient's/client's knowledge of both high risk and safer sex behaviors. The following are important to keep in mind:

- Anti-homosexual attitudes and stigma can contribute to a patient's/client's lack of information about what constitutes risky sexual behavior and may contribute to a patient's/client's inability or unwillingness to use safer sex practices. For example, internalized homophobia has been found to be associated with increased problematic substance use and riskier sexual practices (Meyer 2003).
- Depression, anxiety, psychosis (irrational or disturbed thinking), mental retardation and other psychiatric disorders can contribute to inconsistent use or even complete neglect of safer sex precautions.
- A patient/client may lack or have inaccurate knowledge about HIV and other sexually transmitted infections. Providing a patient/client with up-to-date information about STI can be a useful part of taking a sexual history.
- In general, giving advice or telling patients/clients what they should or should not do may not lead to behavioral change. Exploring the motivations behind patient/clients choices, the accuracy of their information, and their capacity for self-care can help patients/clients think through risk-benefit scenarios.

Identifying the Patient's/Client's Concerns

When taking a sexual history, it is important to assess its relevance to the patient's/client's presenting complaint (i.e., an LGBT patient/client being seen for congestive heart failure) or whether some aspect of the patient's /client's sexual activity or identity represents a source of concern to the patient and therefore warrants clinical attention. In both situations, the information gathered may be critical to the development of a reasonable treatment plan. Avoid the appearance that you are 'minding the patient/client's business".

However, the patient's/client's major focus of concern should always be uppermost in the provider's mind and guide how the interview proceeds and how much detail is required in the sexual history.

Common Assumptions Not to Make in Taking a Sexual History

- Don't assume patients/clients are heterosexual just because they haven't said otherwise.
- Don't assume LGBT patients/clients do not have children.
- Don't assume that self-identified gay men do not have sex with women or that lesbians never have sex with men.
- Don't assume that early same-sex erotic feelings are merely a passing phase, and therefore not to be taken seriously.
- Avoid conceptualizing gender identity confusion as an immediate need to establish a male or female gender identity.
- Avoid common stereotypes: that all gay men are promiscuous or that all lesbian couples experience "bed death" (likened to heterosexuals who stop having sex after being in a relationship for a long time) - individuals are unique in their sexual behavior.
- Don't assume that domestic violence does not occur in LGBT couples.

Chapter 4

Sexual Health of Gay Men and Other Men Who Have Sex with Men

Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. ~World Health Organization, 1948

This chapter aims to:

- Introduce participants to the health care concerns of lesbian, gay, bisexual and transgendered people;
- Help participants understand the issue of 'coming out';
- Help participants to identify the signs of depression and suicide risks;
- Provide participants with guidelines for referral;
- Provide participants with the opportunity to practice effective provider-patient/client communication through role play.

Activity 10: What is Sexual Health

Time: 30 Minutes

Objective

- To ensure that participants have an understanding that sexual health includes physical, emotional, intellectual and social aspects of well-being.

Materials

- Flip chart
- Markers

Facilitator's Instructions

1. Ask the participants to think about what sexual health means to them personally. Write the response on flip chart paper. For example:

- healthy ways of having sex
- healthy functioning of sexual organs
- not having sexually transmitted infections (STIs)
- knowledge and practice of safer sex
- knowledge of sexual organs

- experiencing sexual pleasure
- mental peace about sex and sexuality
- positive attitude about sexuality

2) Ask the group how they would define sexual health?

3) Record participants' responses and facilitate a discussion.

4) Share with participants that WHO *defines* ***sexual health*** *as the integration of physical, emotional, intellectual and social aspects of sexuality in a way that positively enriches and promotes personality, communication and love.*

5) Conclude by telling participants that sexual health is important to men because research has shown that men generally seek health services late or not at all and this can have serious consequences for their sexual health.

Notes for Facilitator:
Facilitator should have a good understanding of the various aspects of sexual health and how these might impact on vulnerability to STIs and HIV.

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Activity 11: Transmission of STIs and HIV

Time: 45 Minutes

Objective

To ensure that participants understand the major means of transmission of STIs and HIV.

Materials

- Flip chart
- Markers

Facilitator's Instructions

1) Ask the whole group to brainstorm all of the sexual acts performed among gay men and other MSM. Make a list on flip chart.

2) Ask participants to identify all the sexual acts between two men that can lead to HIV and STI transmission. In addition to the exchange of body

fluids ensure that the group includes different types of direct contact with the skin, sore or parasite.

3) Facilitate a discussion about the level of risk associated with each sexual act. Include which MSM sexual partner is at greater risk for infection.

3) Invite questions for clarification. How big is the gap between the "reality" of risk and people's "perceptions" of risk? Where do we get our information from? How can we improve access to accurate, appropriate and timely sexual health information? What factors affect the level of risk? What can we learn from this about the factors that might increase vulnerability?

4) Conclude by summarising the basic facts about HIV transmission.

Notes for Facilitator:
Discussion should be generated in a way that is sex positive. During the brainstorm, you may need to add any suggestions of your own, if you think that important risk behaviours have been missed by the group.

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Activity 12: Brainstorming Knowledge of STI

Time: 60 Minutes

Objective

To review participants' knowledge of STIs including HIV.

Materials

- Flip chart
- Markers

Facilitator's Instructions

1) Having just discussed the sexual routes of transmission of HIV and STIs with the group, ask them now to identify the names of STIs they are aware of. Guide discussion to which STIs are common amongst MSM and gay men

and ensure that discussion refers to anal and oral sex. What STIs are associated with which sexual behaviours?

2) Beforehand prepare two sets of cards or flip charts. One set will have the name of the STI on it. The other will have the symptoms of the STI. Arrange the cards or flip charts with the names of the STIs on it so that all the participants can clearly see them. It might be helpful to stick them on the wall. Ensure that there is adequate space beside them so that participants can match up the symptoms for each STI.

3) Ask each participant to take one or more cards or flip charts with a list of symptoms and match it with the appropriate STI. The card or flip chart with the symptoms on it should be placed to the right of the card or flip chart with the STI name on it. The facilitator should provide clarification where necessary – ensure that the difference between HIV and AIDS is understood.

Notes for Facilitator

See list of STIs and their signs and symptoms in Handout .. in the Appendix.

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Activity 13: Prevention of STIs and HIV

Time: 60 Minutes

Objective

To ensure that participants understand the major means of prevention of STIs and HIV.

Materials

- Flip chart
- Markers
- Male condoms
- Lubricants

- Dildo
- Flip chart flip chart of different sexual acts from Activity 11.
- Blindfold

Facilitator's Instructions
Prevention

1) Refer back to the different sexual acts between MSM and ask participants to list ways of preventing the transmission of HIV and STIs.

2) Explore issues about non-penetrative sex, use of condoms, reducing numbers of partners, HIV testing as a prevention tool and not having sex (e.g. how realistic is it to ask people not to have sex?). What other sexual practices are considered safer sex?

3) What is the role of the condom in safer sex? Invite one person to demonstrate correct use of a condom using dildo or substitute.

4) Repeat the above exercise with one person blindfolded.

5) Discuss ways in which to ensure the condom will remain effective.
• Avoid tearing the package with your teeth or a sharp object
• Check the date of expiry
• Do not keep condoms in the back pocket where they risk being damaged from being sat on regularly

6) Discuss use of water-based lubricant as a part of efficient condom use especially for anal sex.

Notes for Facilitator
Discussion should be generated in a way that is sex positive. This activity usually brings up a lot of questions and concerns that people have about how HIV and STIs are prevented. Make sure that you are comfortable with the basic facts of transmission and prevention. Remember that there is still a lot of research being carried out on HIV and that there is still much that we do not know. It is OK to say that you do not know an answer to a particular question as long as you make a commitment to try to find out.

Ensure that there is identification of
• non-penetrative sex -
• use of condoms - note need for lubricants for anal sex

Generate discussion about the possibility of achieving these forms of safer sex
• the extent to which negotiating safe sex is realistic and what it means – negotiated safety

In discussion of reduction of number of partners be sure to be clear that this only reduces risk in a mathematical sense - it does not remove risk - only sex where there is no exchange of bodily fluids removes risk.

In discussion of abstinence be sure to discuss realism of this choice and reinforce sex positive message.

Activity 14: Vulnerability and Risk Taking

Time: 90 Minutes

Objectives

1. To explore the vulnerability of MSM and gay men to STIs and HIV as it relates to a number of economic and social issues.
2. To explore risk taking as it pertains to particular sexual behaviours and raises issue of vulnerability of female partners of men who have sex with men and gay men.

Materials

- Flip chart
- Markers
- Scenarios (provided below)

Facilitator's Instructions

1) Ask the participants to break into three small groups. Each group will receive a different role-play scenario related to vulnerability and risk taking among MSM and gay men. Ask each group to consider the scenario they are given. Make sure all scenarios are used. The group should discuss the dynamics of the situation and the vulnerability and/or risk taking of the characters related to STIs and HIV transmission.

Note: A copy of these role play scenarios appears in the Appendix. It can be photocopied and then cut in three for distribution to the three groups.

2) Ask each group to prepare to act out the scenario with two members playing the roles. They should provide an ending which results in unsafe sex. Inform the groups that they only have 10 minutes to present the role play. They should keep their preparations general to enact the situation described. The dialogue should be simple. Avoid having the groups spend too long scripting dialogue. Monitor the groups to ensure that the instructions and time frame are understood.

3) Participants return to the large group and the scenarios are briefly enacted. Ensure that participants stick to the time frame.

4) Facilitate discussion about the issues involved and the probability of the outcomes. What were some of the factors affecting the character's vulnerability? Which of these were examples of individual factors (referring to aspects of an individual's life) and which are social factors (referring to aspects of family, institutions, etc)? What was the relative importance of individual factors as compared to social causes of vulnerability? What examples were there of risk taking?

Note:
The "risk taking" will he determined by the participants in how they choose to enact the unsafe sexual encounters.

Examples of individual contexts affecting vulnerability:
• Levels of knowledge about safer sex
• Perceptions of personal risk

• Attitudes about oneself (sense of self worth/self esteem)
• Power
• History of sexual abuse

Examples of social contexts affecting vulnerability:
• Norms about relations between men and women (and how this can be projected onto male partners)
• Social attitudes towards sexuality and MSM/gay men (homophobia)
• Economic conditions (unemployment, poverty)
• Racism
• Accessibility of HIV and STI prevention education and relevant services
• Lack of safe spaces where safer sex can be practiced
• Political and legal climate

5) Ask participants to consider the notion of risk taking. How do they understand the term? How is it different from vulnerability? How is it related?

Generally speaking, **risk taking** is associated with personal choice regarding sexual behaviour.

Vulnerability is associated with social conditions, institutional structures or personal experiences/histories that may affect sexual behaviour. It is not always clear that risk taking can be easily differentiated from vulnerability. People have, based on their experiences and social situation, different perceptions about what choices they can make about sexual behaviour. Social and individual factors limit choices available to people or reduce people's ability or willingness to make safe choices. Understanding the range of factors that affect people's vulnerability to becoming infected with HIV or a STI is vital in order to design effective HIV prevention services.

Role Play Scenarios:

Scenario 1
Gavin is 19, and male sex worker who works mainly on the streets at night. He is not very proud of his work but feels he has no choice because he has no other professional skill or training. He is completely out of money this

day. Cedric is 37, a businessman who is married but sometimes looks for sex with men and will pay for it when he has to. Cedric is not very comfortable with his sexuality and can be rough. Gavin is not physically very strong. Cedric knows about STIs and HIV but assumes this does not really relate to him. He doesn't enjoy using condoms. Tonight he is a bit unhappy. Cedric visits the street and meets Gavin - he wants him badly.

Scenario 2

Anthony and Imtiaz are in their early twenties, graduating from university and in love. Anthony is happy with his sexuality but is very private about it. Imitaz is very confused. Recently the pressure has increased from Imitaz's family for him to marry. In a fight with his father he told him he thought that he was a homosexual and his father threw him out of the house. Imitaz went and had a few drinks and now has gone to Anthony's house. He is in his room and wants to have sex to wash away the fight with his father. He doesn't want to use a condom because he wants Anthony to prove his love for him. He gets a bit noisy from time to time and Anthony is worried about his family hearing what is going on.

Scenario 3.

Andy and Sheema are newly married. Andy prefers sex with men but he likes and respects Sheema and is happy to marry and raise a family. Soon after the marriage he learns that an old partner of his has tested HIV positive. Andy has never had an HIV test. He knows he may have been exposed to HIV. Sheema is very keen to start a family and enjoy her new married life. Sex had been going well since the marriage but suddenly has stopped. She is very strong willed and determined that things should get moving again!

Notes for Facilitator:

Issues that the facilitator should ensure are raised include the link between:

• economic status and vulnerability and risk, (Scenarios 1 & 3) violence and vulnerability and risk, (Scenarios 1 & 2)

• confusion about sexual identity and emotional security and vulnerability and risk (Scenarios 1, 2 & 3)

• impact of family pressure, expectations and vulnerability and risk (Scenarios 2 & 3)

• the vulnerability of female partners of men who have sex with men (Scenario 1 & 3)

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Activity 15: Reducing Vulnerability to STIs and HIV

Time: 60 Minutes

Objectives

1. To ensure that MSM and gay issues are appropriately integrated into programmes that promote sexual health through awareness raising, provision of information and education, encouraging safer sexual behaviour and condom promotion.

Materials

- Flip chart
- Markers
- Scenarios from Activity 14

Facilitator's Instructions

1) Put the following two questions on flip chart paper. Ask the participants to get up and put their responses on different pieces of flip chart paper.

• What do MSM need to help them to reduce vulnerability and risk taking in relation to STIs and HIV?

Discuss: Referring to the previous exercise, what were the needs of the different MSM/gay male characters? What did they need to know about their bodies, HIV/STI transmission, etc.?
• How do you deliver these services?

Discuss: What strategies could be used? How can we increase access to services? What limitations are there to various strategies/services? What are the limitations of the NGO's role? Where else can MSM/gay men go for assistance?

2) Ask the group as a whole to brainstorm two lists - one that lists as many possible components of effective programmes that help people reduce their vulnerability to HIV/STIs and risk taking (see list below) and another list of activities/approaches which are often used but which we know are ineffective in really helping people reduce vulnerability and risk (see list below). The groups should also identify if any of the elements listed are of particular relevance or importance in relation to sexual health of MSM and gay men. Have the group refer back to the flip charts from **Activity 14** to ensure that different strategies are identified to address all the causes of vulnerability and risk taking identified. Emphasise how the NGO's and health workers involvement and services can assist in decreasing vulnerability and risk taking?

Facilitate a guided discussion on any issues – with increasing focus on issues particularly relevant to sexual health of MSM and gay men. Encourage the group to draw their own conclusions.

Optional, if time permits:

4) Reintroduce the role plays from Activity 14. Ask five participants to volunteer to represent the MSM/gay male characters in Activity 14. Ask five additional participants to volunteer to portray NGO workers who would then identify and act out different ways of addressing the situation with one of the MSM/gay men resulting in a positive outcome (e.g. telephone counselling, community outreach, one-on-one counselling, education campaign, etc.).

Ensure that a diversity of different strategies and services are addressed. You should address:
• building negotiation skills to talk about sex and safety (all scenarios)
• where realistic and possible, building capacity to say no (all scenarios)

5) Ask the groups to quickly enact the role plays with different NGO interventions.

6) Facilitate a discussion about the following:
• What does this suggest about the kinds of strategies that might be effective in responding to vulnerability? How can NGO's services (education, etc.) assist in decreasing vulnerability and risk taking? To what extent do people have "choice" about behaviour?

Notes for Facilitator:
The discussion should be introducing general issues and not trying to produce a detailed design for programmes.

Effective approaches should be including things like:
• provision of explicit sex positive information about behaviour, transmission and prevention-that includes information relevant to MSM and gay men
• counselling
• non-discriminatory statements about sex, sexual preference and gender.
• a mix of public information, inter-personal activities, counselling, high quality STI care, availability and accessibility of good quality condoms & lubricant
• inclusion of people affected by STI and HIV in developing responses
• addressing issues related to gender inequality, poverty & mobility
• sensitive and strong policy leadership from government
• partnership between government, community,

• building skills in negotiating sex when possible
• working on specific issues concerning young gay men and their self esteem.
• peer based approaches where appropriate
• incorporating a component of training and income generation

Ineffective programming could include:
• using primarily fear based approaches without any context
• blaming anyone
• dictating behaviour – saying "no" – "don't"
• concentrating only on an individual responsibility to change behavior without paying attention to factors that limit choice or capacity to do this
• promoting condoms but not having good quality condoms available, affordable and accessible
• speaking in generalities about sexual behaviour - not being explicit and direct
• advocating sexual abstinence/no sex
• not involving MSM and gay men

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Chapter 5

Theory to Practice

"*Civility in health care begins with effective communication, driven by respect and empathy for the patient,*"

Dr. Michael Woods

This chapter aims to:

- Introduce participants to the health care concerns of lesbian, gay, bisexual and transgendered people;
- Help participants understand the issue of 'coming out';
- Help participants to identify the signs of depression and suicide risks;
- Provide participants with guidelines for referral;
- Provide participants with the opportunity to practice effective provider-patient/client communication through role play.

Additionally, through role play participants will demonstrate being respectful, valuing the diversity of patients/clients, offering services in their language and in a culturally competent manner, and acknowledging the unique barriers to accessing services experienced by members of the LGBT community.

Activity 16: Health Care Concerns of LGBT People

Time: 60 Minutes

Objective

- Identify health care concerns of LGBT People.

Materials

- Flip chart
- Markers
- Masking tape

Facilitator's Instructions

Facilitator divides participants into the four groups below.
Group 1: Health care concerns of lesbians
Group 2: Health care concerns of gay men
Group 3: Health care concerns of bisexual people
Group 4: Health care concerns of transgendered people

Facilitator requests that each group selects a facilitator to lead the brainstorm session, a scribe and a presenter and informs them that 15 minutes are allotted for discussion.

Facilitator calls time up and invites groups to present. Facilitator adds any missing needs to the lists.

Facilitator makes reference to the concerns identified for each of the four groups and points out that while there are some similarities, there are noticeable differences.

Facilitator advises that health care providers must take these differences into consideration when dealing with individuals from the LGBT community.

In ending the activity the facilitator reminds participants that while we all belong to groups where we have a number of things in common, as individuals we have different concerns.

The implication is that LGBT must not be lumped into one group when their health care concerns are being addressed.

Lesbians' Health Care Concerns

Research found that many professionals within the health care system maintain a position that lesbian health is synonymous with women's health, secure in their belief that it is unnecessary to identify women as lesbian or bisexual within a consultation. Discussions with lesbians in Guyana suggest that they are concerned with issues related to:

- Safe sexual practices, including cervical cytology screening;
- Reproductive health and parenting;

- Psychological support to deal with alcoholism, drug abuse, and tobacco use, cope in the face of stigma and discrimination and with suicidal thoughts and actions;
- Empowerment to disclose to significant others in their lives;
- Ageing in relation to issues such as menopause.

Gay Men's Health Care Concerns

There is increasing evidence that gay men demonstrate distinctive health needs besides HIV since findings suggest greater vulnerability for poor health among gay men in many areas.

Discussions with gay men in Guyana suggest that they are concerned with issues related to:

- Psychological support to deal with their identity, denial of their true sexuality, depression, alcoholism and drug abuse; cope in the face of stigma and discrimination and with suicidal thoughts and actions;
- Sexual health, including anal and oral sex, hygiene, HIV and STI;
- Relationship dynamics as it relates to domestic violence, stress involving issues/pressures to fulfill heterosexual expectations of marriage and fatherhood.

Bisexual Men and Women's Health Care Concerns

Research shows that many bisexuals have negative experiences with health care providers whether it is because they are afraid to come out to their providers, or because their providers give them improper or incomplete information. Discussions with the LGBT people in Guyana suggest that bisexual men and women are concerned with issues relating to:

- Psychological support to deal with their identity, denial of their true sexuality, depression, alcoholism and drug abuse; cope in the face of stigma and discrimination and with suicidal thoughts and actions;
- Conflict with identity leading to violence;
- Sexual health, including anal and oral sex, hygiene, HIV and STI;
- Relationship dynamics as it relates to being in a relationship with someone with multiple partners;
- Risks associated with STI transmission;

- How to present themselves to the health care facility to have their health needs addressed;
- Eliminating barriers to accessing health care.

Transgendered People's Health Care Concerns

Transgendered people's health issues are beginning to come to the attention of many health practitioners and researchers. Discussions with transgendered people in Guyana suggest that they are concerned with issues relating to:

- Barriers accessing healthcare in a non-discriminatory environment;
- Communicating their health care needs to providers;
- Building the capacity of health care provider to recognize the present needs of those who are transitioning from one identity to another or those who are already in the preferred identity.
- HIV and STI
- Hormone issues
- Alcohol abuse
- Drug abuse

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Activity 17: Coming Out

Time: 45 Minutes

Objective

Enable participants to understand the issues around 'coming out'.

Materials

Copies of Handout 4: *Guidelines for Coming Out*, for participants.

Facilitator's Instructions

*Facilitator explains that the term **coming out** is used to describe the process of understanding, accepting, and disclosing one's sexual identity. The process is very personal and can happen in different ways for each person.*

Facilitator asks participants to share their understanding of the challenges faced by LGBT people who wish to 'come out'. Facilitator notes the responses and discusses the following:

Coming out to one self

Some people acknowledge their sexual identity during their childhood or teenage years, while others continue to explore their sexual identity much later in life.

One of the first steps in the process of coming out is acknowledging one's own sexual identity. During this process, it can help to think of sexual orientation as a continuum from exclusive attraction to the same sex to exclusive attraction to the opposite sex. People of many sexual orientations have questions about their physical and emotional attractions to others.

It is normal to have questions about one's attractions. Simply exploring these questions does not determine if one is gay, lesbian, bisexual, transgendered, or straight. Many persons are confused about their sexual identity. You are not alone.

Coming Out to Other Lesbians and Gay Men

Often, after spending some time getting in touch with one's own feelings, the next step is to come out to others.

- It is usually advisable to come out first to those who are most likely to be supportive.

- LGBT people are a potential natural support system because they have all experienced at least some of the steps in the process of coming out.
- Sharing experiences about being gay, lesbian, bisexual or transgender can help oneself decrease feelings of isolation and shame.
- Furthermore, coming out to other LGBT people can help oneself build a community of people who can then support and assist in coming out to others.
- Many LGBT groups offer a number of helpful resources, including local coming out groups, switchboards, social outlets, and political and cultural activities and organizations. Coming out to other LGBT people does not need to happen quickly.
- Also, choosing to do so does not mean that one must conform to real or presumed expectations of the LGBT community.
- What is most important is that he/she seeks his/her own path through the coming out process and that he/she attends to his/her unique, personal timetable.
- One should not allow oneself to be pressured into anything he/she is not ready for or don't want to do.
- It is important to proceed at his/her own pace, being honest with oneself and taking time to discover who she/he really is.

<u>Coming out to heterosexuals</u>

Perhaps the most difficult step in coming out will be to reveal yourself to heterosexuals. It is at this step that one may feel most likely to encounter negative consequences. Thus it is particularly important to go into this part of the coming out process with open eyes. For example, it will help to understand that some heterosexuals will be shocked or confused initially, and that they may need some time to get used to the idea that you are LGBT. Also, it is possible that some heterosexual family members or friends may reject him/her initially. However, do not consider them as hopeless; many people come around in their own time.

In coming out to others, you must counsel the client to consider the following:

- Think about what he/she wants to say and choose the time and place carefully.

- Be aware of what the other person is going through. The best time you believe for you might not be the best time for someone else.
- One should present him/herself honestly and remind the other person that he/she is the same individual he/she was yesterday.
- Be prepared for an initially negative reaction from some people. Do not forget that it took time for you to come to terms with your sexuality, and that it is important to give others the time they need.
- Have friends lined up to talk with you later about what happened.
- Don't give up hope if you don't initially get the reaction you wanted. Due to inculcated societal prejudices mentioned earlier, some people need more time than others to come to terms with what they have heard.

However, LGBT individuals must consider these issues because of the very real presence of heterosexism, homophobia, and discrimination.

Some people feel more comfortable disclosing their sexual identity to LGBT people or others who will be supportive before they decide to disclose their identities on a broader basis.

Often, people choose to disclose to close friends and family members, depending on their comfort levels.

Some people choose to come out in very public forums. Regardless of the circumstances, the choices surrounding coming out to others require courage and deserve respect.

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Activity 18: Recognising Signs of Depression and Suicide Risks

Time: 45 Minutes

Objective

Enable participants to recognize signs of depression and suicide risks.

Materials

Copies of Handout 5: *Recognising Signs of Depression and Suicide Risk*, for participants.

Facilitator's Instructions

Facilitator explains that many LGBT people experience depression and some even contemplate or commit suicide. These can result from internal conflicts they have experienced while trying to determine who they are. Society's perception of people whose sexual orientations are not heterosexual, as well as the discrimination they experience also contribute to feelings of depression and thoughts of suicide.

It is therefore vital that you know how to recognise signs of depression and suicide risks. Some of you might have the skills to apply this knowledge to counsel the client. Others might need to refer.

Facilitator then leads a discussion about the common signs of depression and suicide risk.

Common signs of depression and suicide risks are:

- change in personality: sad, withdrawn, irritable, anxious, tired, indecisive,
- apathetic (lack of concern/interest)
- change in behaviour: can't concentrate on school, work, routine tasks
- change in sleep pattern: oversleeping, insomnia sleeplessness), sometimes with early waking
- change in eating habits: loss of appetite and weight, or overeating
- loss of interest in friends, sex, hobbies, activities previously enjoyed
- worry about money, illness (real or imaginary)
- fear of losing control, going crazy, harming self or others

- feeling helpless, worthless, "nobody cares", "everyone would be better off without me"
- feeling of overwhelming guilt, shame, self-hatred
- no hope for the future, "it will never get better, I will always feel this way"
- drug or alcohol abuse
- recent loss: through death, divorce, separation, broken relationship, or loss off health, job, money, status, self- confidence, self-esteem
- loss of religious faith
- nightmares
- suicidal impulses, statements, plans, giving away favourite things, previous
- suicide attempts or gestures
- agitation, hyperactivity, restlessness may indicate masked depression

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Activity19: Guidelines for Dealing with Male Rape/Sexual Assault

Time: 45 Minutes

Objective

Enable participants to acknowledge and deal with male rape/sexual assault.

Materials

Copies of Handout 8: *Guidelines for Dealing with Male Rape/Sexual Assault*, for participants.

Facilitator's Instructions
Facilitator explains that male rape is a reality and that men who are raped or sexually assaulted will help to deal with their health and emotional needs. Facilitator engages in an interactive discussion with participants to bring out the following:

What is male sexual assault?

Sexual assault is any unwanted sexual contact. It can be committed by the use of threats or force or when someone takes advantage of circumstances that render a person incapable of giving consent, such as intoxication.

Male sexual assault can include unwanted touching, fondling, or groping of a male's body including the penis, scrotum or buttocks, even through his clothes.

Male rape is any kind of sexual assault that involves forced oral or anal sex, including any amount of penetration of the anus or mouth with a body part or any other object.

Some of the feelings a male survivor may experience

Any survivor of sexual assault may experience the following feelings, but male survivors may experience these feelings in a different way:

- Guilt - as though he is somehow at fault for not preventing the assault because our society promotes the misconception those men should be able to protect themselves at all times.

- Shame - as though being assaulted makes him "dirty," "weak," or less of a "real man."
- Fear - that he may be blamed, judged, laughed at, or not believed.
- Denial - because it is upsetting, he may try not to think about it or talk about it; he may try to hide from his feelings behind alcohol, drugs, and other self-destructive habits.
- Anger - about what happened; this anger may sometimes be misdirected and generalized to target people who remind him of the perpetrator.
- Sadness - feeling depressed, worthless, powerless; withdrawing from friends, family, and usual activities; some victims even consider suicide.

If a male victim became sexually aroused, had an erection, or ejaculated during the sexual assault, he may not believe that he was raped. These are involuntary physiological reactions. They do not mean that the victim wanted to be sexually assaulted, or that the survivor enjoyed the traumatic experience. Just as with women, a sexual response does not mean there was consent.

The experience of sexual assault may affect gay and heterosexual men differently. Counsellors have found that gay men have difficulties in their sexual and emotional relationships with other men and think that the assault occurred because they are gay.

What you should do as a Health Care Provider

If you are unsure, you should:

- Ask the patient when no one else is in the examining room.
- Make direct eye contact and actively listen to the response.
- Ask direct questions in a non-judgmental way
- Avoid technical or medical language.

Begin by first normalizing the topic. For example:

- "I need to ask you some personal questions. Let me explain why."
- Asking these questions can help me care for you better."
- "Since I am your health care provider, we need to have a good partnership."
- I can better understand your health if you would answer some questions about your sexual history."

Next ask the patient/client directly:

- Have you ever been touched sexually against your will or without your consent?
- Have you ever been forced or pressured to have sex?
- Do you feel that you have control over your sexual relationships and will be listened to if you say "no" to having sex?

What if your patient/client says yes?

Validate your patient's/client's response.

- "Thank you for telling me about such a difficult experience."
- "I'm sure that was hard for you to tell me. It is good that you told me."
- "Rape is devastating in many ways. Let's talk about some of the ways you need support."

If your patient/client says "yes"

Medical Needs

- Discuss any injury or trauma the patient/client might have experience
- Conduct examination with patient's/client's permission, if qualified to do so, or refer for evaluation.
- Evaluation of potential sexually transmitted infections and treatment.
- Discussion of HIV counseling and testing.

Emotional Needs

- Support counseling to deal with clients feelings
- Referral for appropriate follow-up counseling, if you are unable to provide. Help & Shelter NGO can provide such assistance.

If your patient/client says "no"

- Offer education and prevention information and provide follow-up at next visit.

If your patient/client is "not sure"

- Evaluate the experience(s) with the patient and provide.
- Education about violence and consent.

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Activity 20: Referral Guidelines

Time: 45 Minutes

Objective

- Provide guidance to providers on when and how to refer patients/clients and what information to provide to the referral agency.

Materials

- Flip chart
- Markers
- Masking tape
- Copies of Activity 13: *Referral Guidelines*, for participants

Facilitator's Instructions

Facilitator asks participants to share how they make referrals and what informs their decision to refer. Facilitator records responses.

Facilitator reminds participants that referral of patients/clients from primary care (health centres) to secondary care (hospitals and NGOs) is an indispensable part of health care practice.

As a provider you must have an awareness and recognition of your limitations and must know when to refer. This means that you must be aware of your knowledge, skills and experience and must be able to determine when what is being required of you by the patient/client is beyond your expertise and experience.

You must take responsibility for finding out the qualification and experience of the person or agency to whom/which you are referring the patient/client. The client will expect you to refer him/her to a reputable person or agency. You must never fail the client in this regard.

It is important that you first seek agreement from the patient/client before you make the necessary referral. You must also inform the client that you will be including personal information about his/her condition and medical history in the referral and seek his/her permission before doing so.

The following are included in the referral:

- Date of referral
- Name, address and phone number of referring provider
- Name, address and Date of Birth of patient/client
- Reason for referral (counselling and/or treatment requested)
- Key details of problem
- Medical history and treatment given
- Relevant social and family history
- Indication of urgency of referral
- Signature and printed name of referring provider
- Must be addressed to the referral agency (Name, designation, Agency, Address, telephone Number

Facilitator's Instructions Cont'd

You can still refer a patient/client who does not give permission to disclose his/her condition and medical history. In this case you should provide the patient/client with the name, designation, agency, address and telephone number of the referral agent or agency.

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Activity21: Role Play in Triads

Time: 120 Minutes

Objective

- Provide participants with the opportunity to practice effective provider-patient/client communication through role play.

Materials

- Copies of **Care Guidelines** for each participant
- Scenario for each participant playing the role of client
- Representatives of the LGBT community; a lesbian, a gay man, a bisexual man or woman and a transgendered person.

Facilitator's Instructions

Facilitator shares with participants that during this section of the training they will spend time working in groups of three (triads). Using health care scenarios, they will role-play provider-patient/client and observe the interaction. The key to this experience is to create an atmosphere where making mistakes is alright and, in fact, desirable. It is best for participants to learn during a role-play. Participants will have an opportunity to combine new knowledge and skills crucial for providing optimal care to LGBT people.

Learning from this experience can reduce ineffective communication during real provider-patient/client interactions. By the end of this activity each participant will have the opportunity to be in the role of provider. (minimum 12 participants)

Participants and facilitator will provide feedback to the provider at the end of each 15-minute session. Participants will provide feedback in plenary to the 'provider' using the ***C.A.R.E.*** *Guidelines below:*

C.A.R.E**.** Guidelines

- **C—C**ommunicate immediately, both verbally and nonverbally, to set the tone of the encounter; show openness, genuine concern, and positive regard for the patient/client.
- **A—A**ppropriate communication behaviors for the patient's/client's age, gender, social position in the family and community, language use and comprehension, and degree of discomfort or distress.
- **R—R**ecognize the patient's/client's experience, efforts, and emotions in an honest, straightforward manner, using statements of concern and empathy, indicating you care about the patient/client and his or her problem.
- **E—E**xpress support and partnership by letting patients/clients know you will work with them to help them get better.

Facilitator's Instructions

Facilitator recommends that participants provide feedback by first identifying what they liked about the provider-patient/client interaction and then stating what they wished the provider could have done differently.

Providing feedback in this manner allows for the provider to receive the feedback without feeling judged.

Example 1: "I liked the way you used statements of concern and empathy".

Example 2; "I wished that you would have done more to express your support by letting the patient/client know you would work with him/her to help him/her get better".

Role Play Scenarios

Scenario 1: Lesbian seeking services

Sheila, 21, presents at the Youth Friendly Centre in her community complaining of feeling depress. She is withdrawn. After some probing she tells you that she believes that she is different. You continue to probe.

Scenario 2: Gay teenage male seeking services
David, 17, presents at the Youth Friendly Centre in his community and tells you that he believes that he is overweight. He says that his desire is to look like a model. You probe.

Scenario 3: Male who have sex with women and men seeking services
Brad, 30, presents at the Health Centre in his community and tells you that he is abusing alcohol. He also tells you that he is married but is having sex with someone else. You probe.

Scenario 4: Female who have sex with men and women seeking services
Brandy, 24, presents at the Health Centre in her community and tells you that she is having irregular periods. She also tells you that she is having sex with someone other than her boyfriend. You probe.

Scenario 5: Female transgendered person seeking services
Shirls, 24, presents at the Youth Friendly Centre in her community and tells you that she is in an abusive relationship. You probe.

Scenario 6: Gay male seeking VCT services
Patrick, 27, presents at the VCT Centre in his community and informs you that he would like to have an HIV test. You begin the history taking.

Scenario 7: Gay male recently raped seeking services
Phil, 16 presents at the Health Centre in his community. He seems distressed, but is hesitant to speak. You begin to probe. He finally shares that he was forced to have sex.

These are only suggested scenarios. The facilitator should feel free to include other scenarios.

"It is the same with sexual orientation. It is a given. I could not have fought against the discrimination of apartheid and not also fight against the discrimination that homosexuals endure, even in our churches and faith groups."

Archbishop Desmond Tutu

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Handout 1: Definitions of Terms Related to Sexual Orientation

Sexual Orientation: The physical and emotional attraction of someone to persons of the opposite sex, same sex, or both sexes – a state of being attracted to anybody. Three forms of sexual orientation are labeled heterosexual, gay/lesbian, and bisexual.

Sexual Behaviour: How someone expresses himself or herself sexually.

Sexual Identity: How an individual presents to the world, i.e. heterosexual identity, gay/lesbian, bisexual identity.

Gender Identity: Someone's sense of being male or female.

Gender Role: Refers to characteristics attached to culturally defined notions of femininity and masculinity.

Heterosexual: Someone who is physically and emotionally attracted to people of the opposite sex.

Homosexual: Someone who is physically and emotionally attracted to people of the same sex. Because the term is associated historically with a medical model of homosexuality, most homosexual people encourage the use of the terms lesbian, gay and bisexual.

Gay: A term for "homosexual". This can refer to both males and females, but is increasingly used to refer to men only.

Lesbian: A female who have sex with other females.

Bisexual: Someone who is attracted physically and emotionally to persons of the same and opposite sex.

Transsexual/Transgendered: Someone whose gender identity is different from her or his biological sex. For example, a biological male who would describe himself as a woman trapped in a man's body.

Cross Dressing: The practice of wearing clothes of the opposite sex which is for erotic enjoyment. Many transvestites are heterosexual men who are often referred to as transvestism (noun, transvestite).

Drag Queen/King: Someone who dresses up in clothing of the opposite gender for fun and entertainment. For example, a gay man who dresses up as a woman to attend a social function is called a "Drag Queen", a woman would be a "Drag King".

Female Impersonator: A man who dresses as a woman to perform professionally in public.

Heterosexism: The belief that heterosexuality is superior to any other form of sexual orientation, the idea of inherent superiority; the assumption that everyone is heterosexual unless otherwise indicated.

Homophobia: Fear and hatred of lesbians, gays and bisexuals (homosexuals), often exhibited as prejudice, discrimination, harassment, and acts of violence.

Internalized Homophobia: The inner feelings of fear or shame felt by lesbian, gay or bisexual people about their sexuality; these are often caused by negative attitudes and/or personal prejudices.

Coming Out:
1. The developmental process through which lesbian, gay and bisexual people recognize their sexual orientation and integrate this knowledge into their personal and social lives.
2. It may also be used to mean disclosure to another person. For example, "I just came out to my parents".

What causes a person to have a particular sexual orientation?
How a particular sexual orientation develops in any individual is not well understood by scientists. Various theories provide different explanations for what determines a person's sexual orientation, including genetic and biological factors and life experiences during early childhood. Despite much research there is no proven explanation of how sexual orientation is determined. However, many scientists share the view that for most people sexual orientation is shaped during the first few years of life through complex interactions of genetic, biological, psychological and social factors.

Despite what some people claim, there is no evidence that society's greater acceptance of homosexuality results in more people having a homosexual sexual orientation. The greater numbers of people identifying as homosexual are a result of fewer people fighting their homosexual feelings while attempting to live heterosexual lives.

Is Sexual Orientation a Choice?

No. For most people, sexual orientation emerges in early adolescence without any prior sexual experience. Some people report trying very hard over many years to change their sexual orientation from homosexual to heterosexual, with no success. For these reasons, psychologists do not consider sexual orientation for most people to be a conscious choice that can be voluntarily changed. People don't choose their sexual orientation; they can of course choose the kind of a life they want to live.

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Handout 2: Problematic Versus Preferred Examples of Gender Neutral Language

1. PROBLEMATIC: Sexual **preference**
PREFERRED: Sexual **orientation**

Comment: Avoids the implication of voluntary choice that may not be appropriate.

2. PROBLEMATIC: The sample consisted of 200 **adolescent homosexuals**
PREFERRED: The sample consisted of 200 **gay male adolescents**
The sample consisted of 100 **gay male** and 100 **lesbian** adolescents

Comment: Avoids use of "homosexual" and specifies gender of subjects.

3. PROBLEMATIC: None of the subjects were **homosexual or bisexual**.
PREFERRED: None of the subjects were **lesbians, gay men, or bisexual persons**
All of the subjects were **heterosexual**

Comment: Avoids use of "homosexual" and increases the visibility of lesbians, gay men or bisexual persons.

4. PROBLEMATIC: Manuscript title: "Gay relationships in the 1990s"
PREFERRED: Manuscript title: "Gay male relationships in the 1990s"

Comment: Specifies gender of gay persons before the term gay is used to describe women and men; avoids invisibility of lesbians.

5. PROBLEMATIC: Subjects were asked about their **homosexuality**.
PREFERRED: Subjects were asked about the **experience of being a lesbian or a gay man**.

Comment: Changes sentence construction to avoid use of the term "homosexuality".

6. PROBLEMATIC: The women reported **lesbian sexual fantasies**.
PREFERRED: The women reported **female-female sexual fantasies**.

Comment: Avoids confusion of lesbian orientation and specifies sexual behaviors.

7. PROBLEMATIC: The two **bisexual** subjects had engaged in both **gay and heterosexual sexual encounters** in the past year.
PREFERRED: The two **bisexual** subjects had engaged in both **male-male** and **male-female sexual encounters** in the past year.

Comment: Avoids confusing sexual orientation (bisexual) with specific sexual behaviors.

8. PROBLEMATIC: The male dogs were **bisexual**.
PREFERRED: The male dogs were observed to engage in both **male-male and male-female sexual behavior**.

Comment: Increases specificity; does not use sexual orientation terms with animal species.

9. PROBLEMATIC: It was the subjects' **sex**, not their sexual orientation that affected number of friendships.
PREFERRED: It was subjects' **gender**, not their sexual orientation that affected number of friendships.

Comment: Avoids confusing gender with sexual activity.

Problems of Designation: Stereotyping

11. **PROBLEMATIC**: **Homosexual** abuse of children.
    PREFERRED: **Sexual** abuse of male children **by adult men**.

Comment: Does not imply sexual orientation of participants; does not imply that gay men are rapists.

Problems of Evaluation: Ambiguity of Reference

12. **PROBLEMATIC**: Questionnaire item: Have you ever engaged in sexual intercourse?
PREFERRED: Questionnaire item: Have you ever engaged in penile/vaginal intercourse?

Comment: States precisely if penile/vaginal intercourse is the purpose of the item.

PREFERRED: Have you ever engaged in sexual activity?

Comment: Avoids assumption of heterosexual orientation if sexual activity is the purpose of the item.

Problems of Evaluation: Stereotyping

13 **ROBLEMATIC**: AIDS education must extend beyond the gay male population into the **general population**.
PREFERRED: AIDS education must not focus only on selected groups.

Comment: Does not refer to gay men as set apart from the general population.

14. PROBLEMATIC: Psychologists who work with **special populations** (e.g., **lesbians**, **drug abusers**, **survivors of sexual abuse**) need extra training.
PREFERRED: Psychologists who work with **minority populations** (e.g., **Latinos**, **lesbians**, **Black women**, **older women**) need extra training.

Comment: Avoids equating lesbians with pathology.

15. PROBLEMATIC: Women's **sexual partners** should use condoms.
PREFERRED: Women's **male sexual partners** should use condoms.

Comment: Avoids assumption of heterosexuality

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Handout 3: Issues to Consider when a Taking Sexual History

Summary Points

- Create a Welcoming and safe atmosphere
- Confidentiality
- Use inclusive language
- Evaluate sexual risk
- Identify the patient's/client's concerns
- Common Assumptions Not to Make in Taking a Sexual History

Creating a Welcoming and Safe Atmosphere

In general, creating a safe environment for taking a sexual history is similar in LGBT and heterosexual patients/clients. In all such situations, the health care provider strives to be open minded, nonjudgmental, patient, tactful, respectful and provides assurances that privacy and confidentiality will be maintained.

It is useful, however, to keep in mind that many LGBT individuals may approach a health care provider interview with greater anxiety and guardedness than their heterosexual counterparts. Their anxieties may stem from past experiences with providers who were critically judgmental or they may anticipate a critical or judgmental response by projecting their own "internalized homophobia" or transphobia (discrimination towards transgendered people). These patients/clients may need additional time and encouragement to reveal their true concerns.

As with any patient/client, the provider's non-judgmental attitude will help bring out honest and relevant information. Such an attitude is conveyed to the patient/client both verbally and non-verbally through body posture and room set up. A relaxed stance and not conducting an interview from behind a desk can be beneficial. Techniques such as open-ended questions, verbal mirroring of the patient's/client's own language, use of non-judgmental

language, attention to heterosexist assumptions and avoidance of stereotyping can all lead to greater success in obtaining a more accurate sexual history.

Confidentiality

Confidentiality is the cornerstone of all provider-patient/client relationships and assurances of confidentiality are crucial to taking a sexual history. This is done by assuring a patient/client that any information provided will not be shared with others. In cases where complete confidentiality cannot be assured, a provider should clarify the limits of confidentiality from the onset and respect the patient's/client's decision as to how much sexual history he/she is willing to reveal.

Special caution needs to be taken when working with children, adolescents and young adults who may not have shared their concerns about sexual orientation or gender identity with their parents. Children and adolescents are particularly unlikely to share their intimate feelings with providers unless their wishes and sensitivities are recognized.

Use of Inclusive Language

When taking a sexual history, the provider's task is aided by using inclusive terms and language. Inclusive language should not make assumptions about a patient's/client's sexual identity or sexual behavior, particularly in situations where patients/clients do not volunteer such information. One way to do this is to have intake forms and questionnaires that do not make heterosexual assumptions.

Such inclusive language also conveys to the LGBT patient/client that the interviewer is potentially open to hearing about his or her sexual identity and relationships. The accuracy and completeness of the details requested will reflect the patient's/client's level of comfort with the process.

Evaluating Sexual Risk

Sexual history should explore the patient's knowledge of both high risk and safer sex behaviors. The following are important to keep in mind:

- Anti-homosexual attitudes and stigma can contribute to a patient's/client's lack of information about what constitutes risky sexual behavior and may contribute to a patient's/client's inability or unwillingness to use safer sex practices. For example, internalized homophobia has been found to be associated with increased problematic substance use and riskier sexual practices (Meyer 2003).
- Depression, anxiety, psychosis, mental retardation and other psychiatric disorders can contribute to inconsistent use or even complete neglect of safer sex precautions.
- A patient/client may lack or have inaccurate knowledge about HIV and other sexually transmitted infections. Providing a patient/client with up-to-date information about STI can be a useful part of taking a sexual history.
- In general, giving advice or telling patients/clients what they should or should not do may not lead to behavioral change. Exploring the motivations behind patient/clients choices, the accuracy of their information, and their capacity for self-care can help patients/clients think through risk-benefit scenarios.

Identifying the Patient's/Client's Concerns

When taking a sexual history, it is important to assess its relevance to the patient's/client's presenting complaint (i.e., an LGBT patient/client being seen for congestive heart failure) or whether some aspect of the patient's /client's sexual activity or identity represents a source of concern to the patient and therefore warrants clinical attention. In both situations, the information gathered may be critical to the development of a reasonable treatment plan. Avoid the appearance that you are 'minding the patient/client's business'.

However, the patient's/client's major focus of concern should always be uppermost in the provider's mind and guide how the interview proceeds and how much detail is required in the sexual history.

Common Assumptions Not to Make in Taking a Sexual History

- Don't assume patients/clients are heterosexual just because they haven't said otherwise.
- Don't assume LGBT patients/clients do not have children.

- Don't assume that self-identified gay men do not have sex with women or that lesbians never have sex with men.
- Don't assume that early same-sex erotic feelings are merely a passing phase, and therefore not to be taken seriously.
- Avoid conceptualizing gender identity confusion as an immediate need to establish a male or female gender identity.
- Avoid common stereotypes: that all gay men are promiscuous or that all lesbian couples experience "bed death" (likened to heterosexuals who stop having sex after being in a relationship for a long time) - individuals are unique in their sexual behavior.
- Don't assume that domestic violence does not occur in LGBT couples.

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Handout 4: Health Care Concerns of LGBT People

Lesbians' Health Care Concerns

Research found that many professionals within the health care system maintain a position that lesbian health is synonymous with women's health, secure in their belief that it is unnecessary to identify women as lesbian or bisexual within a consultation. Discussions with lesbians in Guyana suggest that they are concerned with issues related to:

- Safe sexual practices, including cervical cytology screening;
- Reproductive health and parenting;
- Psychological support to deal with alcoholism, drug abuse, and tobacco use, cope in the face of stigma and discrimination and with suicidal thoughts and actions;
- Empowerment to disclose to significant others in their lives;
- Ageing in relation to issues such as menopause.

Gay Men's Health Care Concerns

There is increasing evidence that gay men demonstrate distinctive health needs besides HIV. Since findings suggest greater vulnerability for poor health among gay men in many areas.

Discussions with gay men in Guyana suggest that they are concerned with issues related to:

- Psychological support to deal their identity, denial of their true sexuality, depression, alcoholism and drug abuse; cope in the face of stigma and discrimination and with suicidal thoughts and actions;
- Sexual health, including anal and oral sex, hygiene, HIV and STI;
- Relationship dynamics as it relates to domestic violence, stress involving issues/pressures to fulfill heterosexual expectations of marriage and fatherhood.

Bisexual Men and Women's Health Care Concerns

Research shows that many bisexuals have negative experiences with health care providers whether it is because they are afraid to come out to their providers, or because their providers give them improper or incomplete information. Discussions with the LGBT people in Guyana suggest that bisexual men and women are concerned with issues relating to:

- Psychological support to deal with their identity, denial of their true sexuality, depression, alcoholism and drug abuse; cope in the face of stigma and discrimination and with suicidal thoughts and actions;
- Conflict with identity leading to violence;
- Sexual health, including anal and oral sex, hygiene, HIV and STI;
- Relationship dynamics as it relates to being in a relationship with someone with multiple partners;
- Risks associated with STI transmission;
- How to present themselves to the health care facility to have their health needs addressed;
- Eliminating barriers to accessing health care.

Transgendered People's Health Care Concerns

Transgendered people's health issues are beginning to come to the attention of many health practitioners and researchers. Discussions with transgendered people in Guyana suggest that they are concerned with issues relating to:

- Eliminating barriers to accessing health care;
- Accessing services in a non discriminatory environment;
- Communicating their health care needs to providers;
- Training of providers to deliver appropriate services to them;
- Building the capacity of health care provider to recognize the present needs of those who are transitioning from one identity to another or those who are already in the preferred identity.
- HIV and STI
- Hormone issues
- Alcohol abuse
- Drug abuse

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Handout 5: Coming Out – Guidelines for Health Care Providers

Coming Out to Other Lesbians and Gay Men

Often, after spending some time getting in touch with one's own feelings, the next step is to come out to others.

- It is usually advisable to come out first to those who are most likely to be supportive.
- LGBT people are a potential natural support system because they have all experienced at least some of the steps in the process of coming out.
- Sharing experiences about being gay, lesbian, bisexual or transgender can help oneself decrease feelings of isolation and shame.
- Furthermore, coming out to other LGBT people can help oneself build a community of people who can then support and assist in coming out to others.
- Many LGBT groups offer a number of helpful resources, including local coming out groups, switchboards, social outlets, and political and cultural activities and organizations. Coming out to other LGBT people does not need to happen quickly.
- Also, choosing to do so does not mean that one must conform to real or presumed expectations of the LGBT community.
- What is most important is that he/she seek his/her own path through the coming out process and that he/she attend to his/her unique, personal timetable.
- One should not allow oneself to be pressured into anything he/she is not ready for or don't want to do.
- It is important to proceed at his/her own pace, being honest with oneself and taking time to discover who she/he really is.

Coming out to heterosexuals

Perhaps the most difficult step in coming out will be to reveal yourself to heterosexuals. It is at this step that one may feel most likely to encounter negative consequences. Thus it is particularly important to go into this part of the coming out process with open eyes. For example, it will help to understand that some heterosexuals will be shocked or confused initially, and that they may need some time to get used to the idea that you are LGBT. Also, it is possible that some heterosexual family members or friends may reject him/her initially. However, do not consider them as hopeless; many people come around in their own time.

In coming out to others, you must counsel the client to consider the following:

- Think about what he/she wants to say and choose the time and place carefully.
- Be aware of what the other person is going through. The best time you believe for you might not be the best time for someone else.
- One should present him/herself honestly and remind the other person that he/she is the same individual he/she was yesterday.
- Be prepared for an initially negative reaction from some people. Do not forget that it took time for you to come to terms with your sexuality, and that it is important to give others the time they need.
- Have friends lined up to talk with you later about what happened.
- Don't give up hope if you don't initially get the reaction you wanted. Due to inculcated societal prejudices mentioned earlier, some people need more time than others to come to terms with what they have heard.

However, LGBT individuals must consider these issues because of the very real presence of heterosexism, homophobia, and discrimination.

Some people feel more comfortable disclosing their sexual identity to LGBT people or others who will be supportive before they decide to disclose their identities on a broader basis.

Often, people choose to disclose to close friends and family members, depending on their comfort levels.

Some people choose to come out in very public forums. Regardless of the circumstances, the choices surrounding coming out to others require courage and deserve respect.

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Handout 6: Recognising Signs of Depression and Suicide Risks

The following are common signs of depression patients/clients at risk for suicide:

- change in personality: sad, withdrawn, irritable, anxious, tired, indecisive,
- apathetic (loss of interest/concern
- change in behaviour: can't concentrate on school, work, routine tasks
- change in sleep pattern: oversleeping, insomnia (sleeplessness), sometimes with early waking
- change in eating habits: loss of appetite and weight, or overeating
- loss of interest in friends, sex, hobbies, activities previously enjoyed
- worry about money, illness (real or imaginary)
- fear of losing control, going crazy, harming self or others
- feeling helpless, worthless, "nobody care", "everyone would be better off
- without me"
- feeling of overwhelming guilt, shame, self-hatred
- no hope for the future, "it will never get better, I will always feel this way"
- drug or alcohol abuse
- recent loss: through death, divorce, separation, broken relationship, or loss off health, job, money, status, self- confidence, self-esteem
- loss of religious faith
- nightmares
- suicidal impulses, statements, plans, giving away favourite things, previous
- suicide attempts or gestures
- agitation, hyperactivity, restlessness may indicate masked depression

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Handout 7: C.A.R.E. Guidelines

C.A.R.E. Guidelines

- ***C*—*C*ommunicate** immediately, both verbally and nonverbally, to set the tone of the encounter; show openness, genuine concern, and positive regard for the patient/client.
- ***A*—Use *A*ppropriate** communication behaviors for the patient's/client's age, gender, social position in the family and community, language use and comprehension, and degree of discomfort or distress.
- **R—R**ecognize the patient's/client's experience, efforts, and emotions in an honest, straightforward manner, using statements of concern and empathy, indicating you care about the patient/client and his or her problem.
- **E—E**xpress support and partnership by letting patients/clients know you will work with them to help them get better.

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Handout 8: Guidelines for Dealing with Male Rape or Sexual Assault

What is male sexual assault?

Sexual assault is any unwanted sexual contact. It can be committed by the use of threats or force or when someone takes advantage of circumstances that render a person incapable of giving consent, such as intoxication.

Male sexual assault can include unwanted touching, fondling, or groping of a male's body including the penis, scrotum or buttocks, even through his clothes.

Male rape is any kind of sexual assault that involves forced oral or anal sex, including any amount of penetration of the anus or mouth with a body part or any other object.

Some of the feelings a male survivor may experience

Any survivor of sexual assault may experience the following feelings, but male survivors may experience these feelings in a different way:

- Guilt - as though he is somehow at fault for not preventing the assault because our society promotes the misconception those men should be able to protect themselves at all times.
- Shame - as though being assaulted makes him "dirty," "weak," or less of a "real man."
- Fear - that he may be blamed, judged, laughed at, or not believed.

- Denial - because it is upsetting, he may try not to think about it or talk about it; he may try to hide from his feelings behind alcohol, drugs, and other self-destructive habits.
- Anger - about what happened; this anger may sometimes be misdirected and generalized to target people who remind him of the perpetrator.
- Sadness - feeling depressed, worthless, powerless; withdrawing from friends, family, and usual activities; some victims even consider suicide.

If a male victim became sexually aroused, had an erection, or ejaculated during the sexual assault, he may not believe that he was raped. These are involuntary physiological reactions. They do not mean that the victim wanted to be sexually assaulted, or that the survivor enjoyed the traumatic experience. Just as with women, a sexual response does not mean there was consent.

The experience of sexual assault may affect gay and heterosexual men differently. Counsellors have found that gay men have difficulties in their sexual and emotional relationships with other men and think that the assault occurred because they are gay.

Heterosexual men often begin to question their sexual identity and are more disturbed by the sexual aspect of the assault than any violence involved.

What you should do as a Health Care Provider

If you are unsure, you should:

- Ask the patient when no one else is in the examining room.
- Make direct eye contact and actively listen to the response.
- Ask direct questions in a non-judgmental way
- Avoid technical or medical language.

Begin by first normalizing the topic. For example:

- "I need to ask you some personal questions. Let me explain why."
- "Asking these questions can help me care for you better."
- "Since I am your health care provider, we need to have a good partnership."
- I can better understand your health if you would answer some questions about your sexual history."

Next ask the patient/client directly:

- Have you ever been touched sexually against your will or without your consent?
- Have you ever been forced or pressured to have sex?
- Do you feel that you have control over your sexual relationships and will be listened to if you say "no" to having sex?

What if your patient/client says yes?

Validate your patient's/client's response.

- "Thank you for telling me about such a difficult experience."
- "I'm sure that was hard for you to tell me. It is good that you told me."
- "Rape is devastating in many ways. Let's talk about some of the ways you need support."

If your patient/client says "yes"

Medical Needs

- Discuss any injury or trauma the patient/client might have experience.
- Conduct examination with patient's/client's permission, if qualified to do so, or refer for evaluation.
- Evaluation of potential sexually transmitted infections and treatment.
- Discussion of HIV counseling and testing.

Emotional Needs

- Support counseling to deal with clients feelings.
- Referral for appropriate follow-up counseling, if you are unable to provide. Help & Shelter NGO can provide such assistance.

If your patient/client says "no"

- Offer education and prevention information and provide follow-up at next visit.

If your patient/client is "not sure"

- Evaluate the experience(s) with the patient and provide.
- Education about violence and consent.

TO A MAN WHO HAS BEEN SEXUALLY ASSAULTED

Adapted from a conversation with a man who had been sexually assaulted and counselled at St. Vincent's Rape Crisis Program

It happened to me too. You're not alone.

I couldn't believe such a think could happen. I thought it was a nightmare. I was sure I'd wake up and it wouldn't be real. I didn't want it to be real.

Why was I picked to be the victim? Was there something about me? The way I look? Walk, act, live? Why me? I couldn't find an answer.

I went over it detail by detail. Was there something I could have done? Could I have fought or stopped it somehow? I thought I was going to die. I didn't want to die.

I thought about it all the time. In the middle of work, dinner, talking I would blank out and remember. I tried to push it out. I worked extra hours, filled every minute, but it always came back. I was afraid I'd go crazy.

I was sure people knew or would find out. I was different. They could look at me and somehow see it on my face. I tried to hide all my feelings all the time so they wouldn't find out. I was so ashamed and completely alone.

I hated being afraid all the time. I didn't feel safe anywhere. I was always bracing for an attack. Feeling like a target. I wondered how women live with such fear. How could they stand it? Did they look at me with the kind of terror I felt? I knew I was losing my mind.

It doesn't have to be that way. You don't have to suffer alone. There are people who can help. People who understand. Others like me who've been there. Don't let this destroy you.

This has nothing to do with your masculinity or sexuality. Rapists are sick people who strike at random. It's not your fault.

You didn't want to die, that's nothing to be ashamed about.

You'll make it. You're not going crazy. You've been badly hurt. Get help for yourself and anyone who's trying to share the burden with you. You deserve it and you need it.

Get help. It will ease the pain. You don't have to go through this alone.

You're stronger than you think you are. It takes a lot of strength to face this. You'll make it. I know. . . because I did.

Handout 9: Information to be included in Referral

The following are included in the referral:

- Date of referral
- Name, address and phone number of referring provider
- Name, address and DOB of patient
- Reason for referral (counselling and/or treatment requested)
- Key details of problem
- Medical history and treatment given
- Relevant social and family history
- Indication of urgency of referral
- Signature and printed name of referring provider
- Must be addressed to the referral agency (Name, designation, Agency, Address, telephone Number