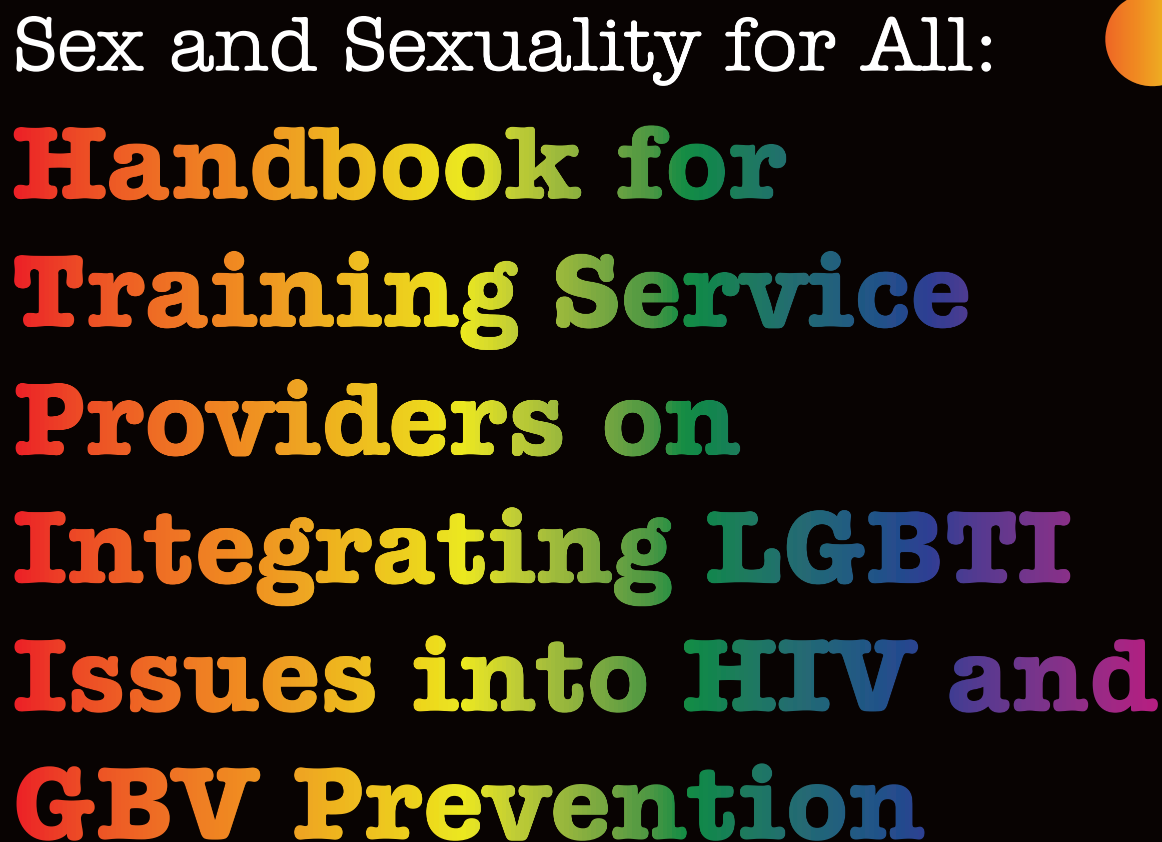
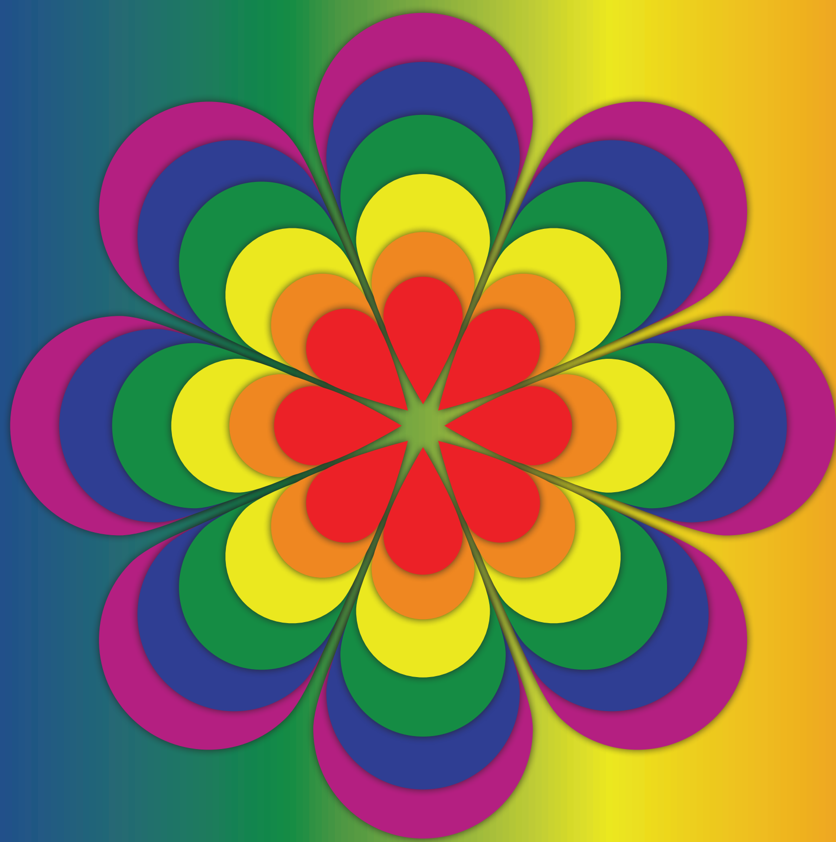


Sex and Sexuality for All: Handbook for Training Service Providers on Integrating LGBTI Issues into HIV and GBV Prevention

TOOLKIT

"HIV & Gender-Based Violence Prevention for LGBTI People: Advocating a Rights-Based Prevention Approach!"

SAfAIDS
Southern Africa HIV and AIDS Information Dissemination Service



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Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), conducted a rapid baseline in eight countries in southern Africa, and drawing information needs; from a total of 67 representatives from LGBTI, service providers and community groups; on the integrating of LGBTI issues into HIV & GBV prevention activities. The information gathered through this baseline informed the shaping of the contents of this Toolkit.

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Definition of Terms

These are common terms used throughout this handbook. It is important to define from the outset what all the terms mean, so that we are all on the same page of understanding.

AIDS

Acquired Immune Deficiency Syndrome, a disease in which there is a severe loss of the body's cellular immunity, greatly lowering resistance to infection and malignancy. The cause is a virus (the human immunodeficiency virus, or HIV) which is transmitted in blood and in sexual fluids.

Androgyny

Not having clear masculine or feminine physical characteristics or appearance.

Asexual

Lack of (interest in and desire for sex) sexual attraction.

Bisexual

A sexual orientation and identity. Bisexual people have an attraction to people of the same and opposite sex on various levels (emotionally, physically, intellectually, spiritually, and sexually). Not necessarily at the same time and not necessarily an equal amount of attraction.

Cisgender

Cisgender people are those whose gender identity matches their sex at birth e.g. a cisman would be a person who is born male and presents himself as masculine and a ciswoman is a person who is born female and presents herself as feminine. The Latin prefix *cis* stands for 'on the same side,' while the prefix *trans* stands for 'on the opposite side.' This has a more positive connotation than 'normal' or 'non-transgender.'

Coming out

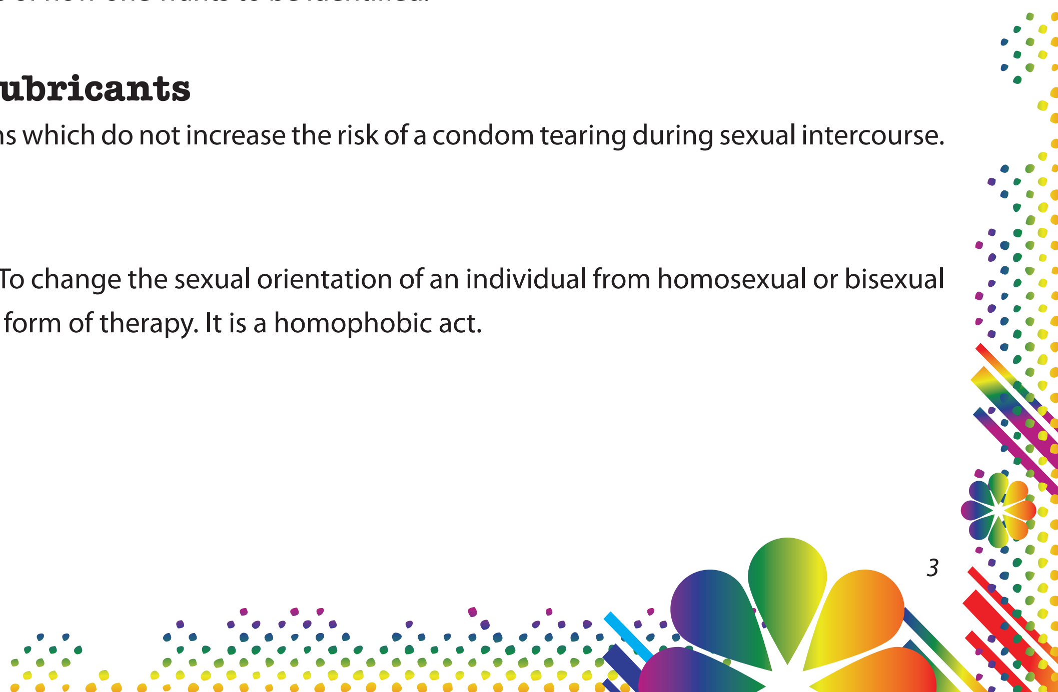
A term describing the complex process where an individual realises they are not heterosexual and the process of resolving related conflicts due to heteronormativity (where heterosexuality is being internalised and viewed as the norm). Coming out is a process of how one wants to be identified.

Condom-compatible lubricants

Water and silicon based lubrications which do not increase the risk of a condom tearing during sexual intercourse.

Conversion therapy

Also known as reparative therapy. To change the sexual orientation of an individual from homosexual or bisexual to heterosexual through a specific form of therapy. It is a homophobic act.



Dental dams

A latex sheath (square) that serves as a barrier of protection against the transmission of sexually transmitted infections (STIs) during oral sex or tribadism (where genitals rub directly against each other).

Discrimination

The unjust or prejudicial treatment of different categories of people on the grounds of race, age, sex, sexual orientation, gender and gender identity and presentation.

Female condom (Femidom or Woman's condom)

A device that is used during sexual intercourse as a barrier contraceptive and to reduce the risk of sexually transmitted infections.

FTM/Trans man

A transman, or female-to-male, starts his life with a female body, but his gender identity is male. Always use male pronouns in reference.

Gay

A male - same sexual identity and orientation. Attraction between two males on various levels (emotionally, physically, intellectually, spiritually, and sexually).

Gender

Socially constructed characteristics assigned that may vary according to the times and the society or group one belongs to, and which are learned or assigned to women and men. It is a broader concept than the mere biological differences between men and women, and includes masculine and feminine traits. Unequal power is afforded to males.

Gender-based violence

GBV encompasses various forms of violence directed at women, because they are women, and men, because they are men, depending on the expectations of each in a given community. For LGBTI people the violence is directed towards them because of their challenging notions of sexuality and gender identity and presentation.

Gender dysphoria

The medical diagnosis for someone who experiences a disconnection between their assigned and preferred gender. Some transgender people disagree with the categorisation of gender dysphoria as a medical condition because it relies on an understanding of what "normal" gender is.

Gender identity

Refers to a person's persistent and consistent sense of being male, female or androgynous. An internalised representation of gender roles and an awareness from infancy which is reinforced during adolescence.

Genderqueer

An umbrella term for gender identities other than man and woman that are outside of the gender binary (male and female) and heteronormativity. Genderqueer people may think of themselves as both man and woman (bigender), neither man nor woman (agender), moving between genders (genderfluid), and/or third gendered.

Gender role

Socially constructed or learned behaviors that condition activities, tasks, and responsibilities viewed within a given society as "masculine" or "feminine".

Hegemonic masculinity

This is the 'normative' ideal of masculinity to which men are supposed to aim. It is not necessarily the most prevalent, but rather the most socially endorsed. It is supported by the heteronormative model.

Heteronormative

A social construct that views all human beings as either male or female with the associated behaviour and gender roles assigned, both in sex and gender, and that sexual and romantic thoughts and relations are normal only between people of opposite sexes and all other behaviour is viewed as "abnormal".

Heteronormative model

The typical heteronormative family consisting of a father (male bodied person), mother (female bodied person) and offspring.

Heterosexual / Straight

Attraction between two people of the opposite sex on various levels (emotionally, physically, intellectually, spiritually, and sexually) where the sex of the attracted person is the key to the attraction.

Homophobia

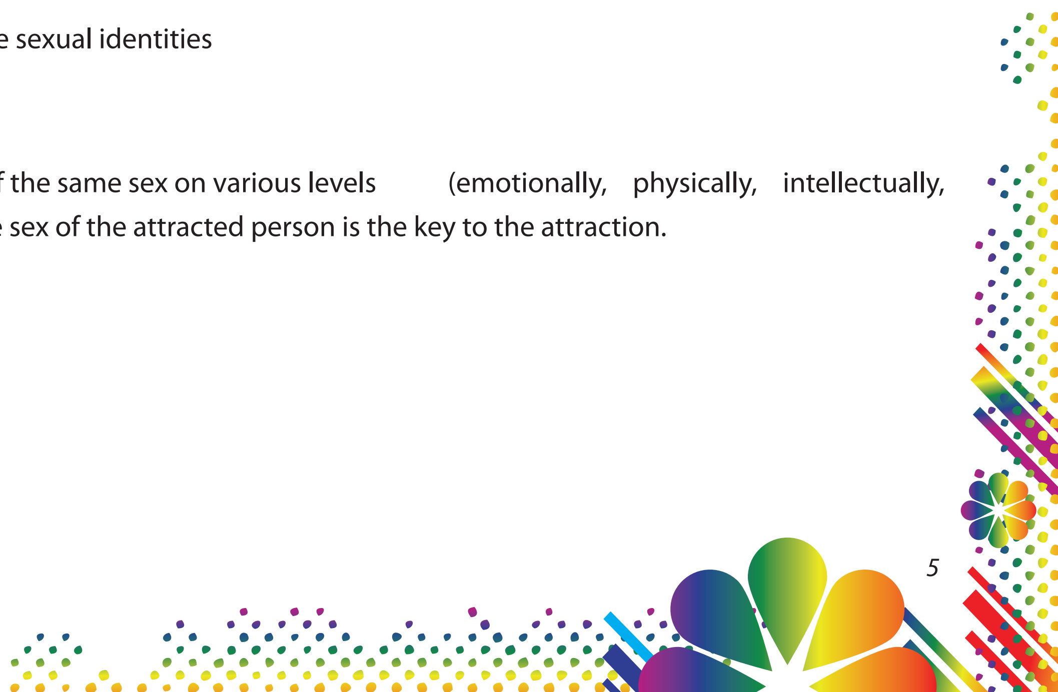
Irrational fear of homosexual feelings, thoughts, behaviours, or people and an undervaluing of homosexual identities resulting in prejudice, discrimination and bias against homosexual individuals.

Homo-prejudice

Prejudice against people of diverse sexual identities

Homosexual

Attraction between two people of the same sex on various levels (emotionally, physically, intellectually, spiritually, and sexually) where the sex of the attracted person is the key to the attraction.



Human rights

The basic rights and freedoms that all people are entitled to regardless of nationality, sex, age, nationality or ethnic origin, race, religion, language, or other status. The other status refers to e.g. a person's HIV status. Sexual orientation and gender identity are also basic human rights.

HIV

Human Immunodeficiency Virus, a retrovirus that causes AIDS by infecting helper T cells of the immune system. The most common serotype, HIV-1, is distributed worldwide, while HIV-2 is primarily confined to West Africa. It is one of many sexually transmitted infections.

Internalised homophobia

When a homosexual individual internalises (make it their own) the shame and hatred projected onto gays and lesbians by a homophobic society.

Intersex

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

Lesbian

A female sexual identity and orientation which is an attraction between two females on various levels (emotionally, physically, intellectually, spiritually, and sexually).

MTF / Trans woman

A transwoman, or male-to-female, starts her life with a male body, but her gender identity is female. Always use female pronouns in reference.

MSM

Men who have sex with men. A sexual practice irrespective of sexual orientation or gender identity. An MSM can be hetero-, bi-,homosexual or trans. This term is more technical and is not necessarily an identity.

Patriarchy

A system of society or government in which the father or eldest male is head of the family and descent is traced through the male line. The wives / females are viewed as dependant. Roles assigned to men are considered superior and valued above females' roles. Patriarchy forms the basis of discrimination against minorities like LGBTI people.

Serodiscordant couples

Refers to an intimate couple where one partner is HIV positive and the other HIV negative.

Service providers

In this handbook, service providers refer to anyone who could come into contact with sexual minorities accessing services for prevention, treatment and care. This could include nurses, doctors, counsellors providing voluntary counselling and testing (VCT) and HIV counselling and testing (HCT) or supportive services. It also includes the management staff responsible for designing and monitoring the services. It could also include those who provide an indirect service, e.g. secretary, whom the LGBTI client will have contact with.

Sex

A biological construct of a human being. *"What's in the pants?"* Male genitals - penis, testes, testosterone and genetic make-up and females – breasts, vagina, oestrogen, progesterone and genetic make-up.

Sexuality

How people experience and express themselves as sexual beings, within the concepts of biological sex, gender identity and presentation, attractions and practices. Culture and religion have a huge impact on how individuals see themselves as sexual beings, especially within relations of power.

Sexual fluidity

Sexuality varying across time and situation, particularly for women. Fluidity offers a more inclusive definition than the more limiting conventional labels we have become accustomed to using to define sexual identity. Sexual fluidity, quite simply, means situation-dependent flexibility in women's sexual responsiveness. This flexibility makes it possible for some women to experience desires for either men or women under certain circumstances, regardless of their overall sexual orientation. In other words, though women - like men - appear to be born with distinct sexual orientations, these orientations do not provide the last word on their sexual attractions and experiences.

Sexual identity

The overall sexual self identity which includes how the person identifies as male, female, masculine, feminine, or some combination, and the person's sexual orientation.

Sexual minority

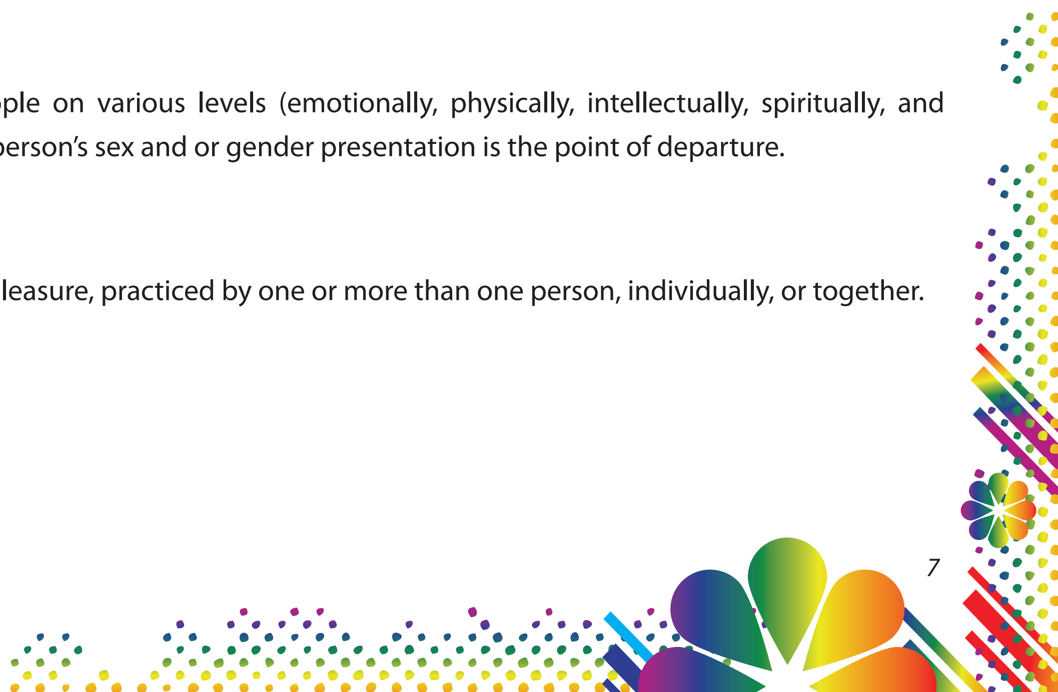
A group whose sexual identity, orientation or practices differ from the majority of the surrounding society.

Sexual orientation

Attraction between any two people on various levels (emotionally, physically, intellectually, spiritually, and sexually). Attraction to the other person's sex and or gender presentation is the point of departure.

Sexual practices

All behaviour that creates sexual pleasure, practiced by one or more than one person, individually, or together.



Stigma

This is when a certain individual, with certain characteristics, e.g. HIV positive individual or trans woman, is rejected by their community or society because of that characteristic which might be considered as "abnormal". These individuals' lives might be at risk, possibly being threatened and abused.

Transgender

An umbrella term which is often used to describe a wide range of identities and experiences, including transsexuals, FTMs, MTFs, transvestites, cross-dressers, drag queens and kings, two-spirits, gender-queers, and many more

Transphobia

The irrational fear of, and/or hostility towards people who are transgender or who otherwise transgress traditional gender norms. Because our culture is often very transphobic, transgender people can often have internalised transphobia and experience feelings of insignificance and self-prejudice.

Transsexual

A transgender person in the process of seeking or undergoing some form of medical treatment to bring their body and gender identity into closer alignment. Not all transgender people undergo reassignment surgery.

Transitioning

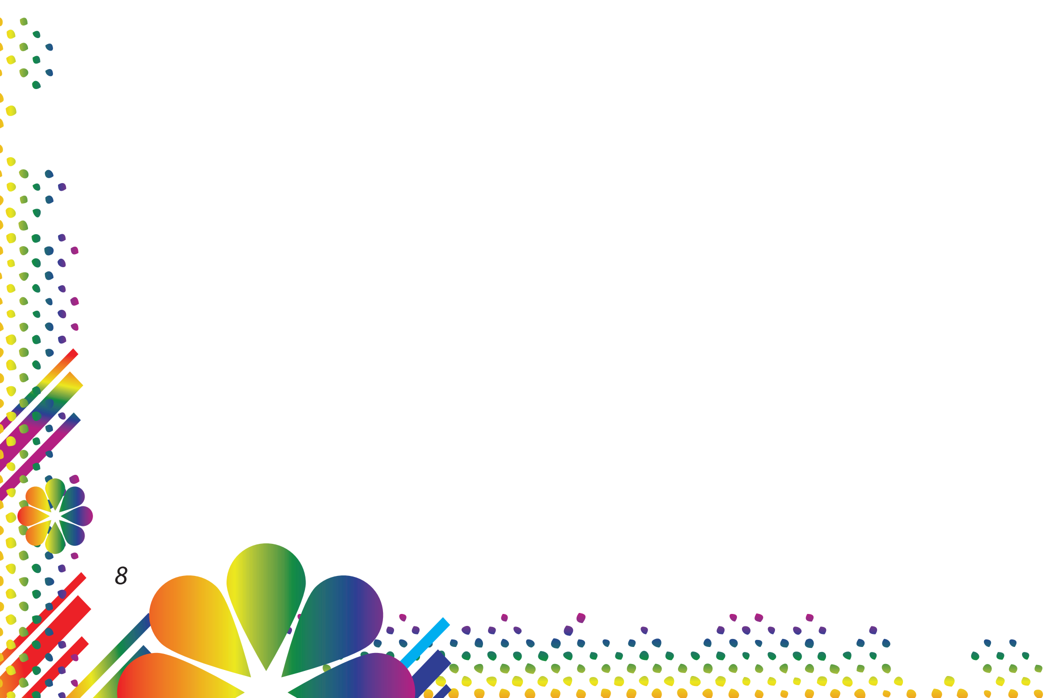
The process of changing one's gender presentation to align with one's internal sense of one's gender. For transgender people this may sometimes include sexual reassignment surgery, but not always. It could include hormonal therapy.

Transvestite

An individual who dresses in the clothing of the opposite sex for a variety of reasons and who has no desire to change or modify their body

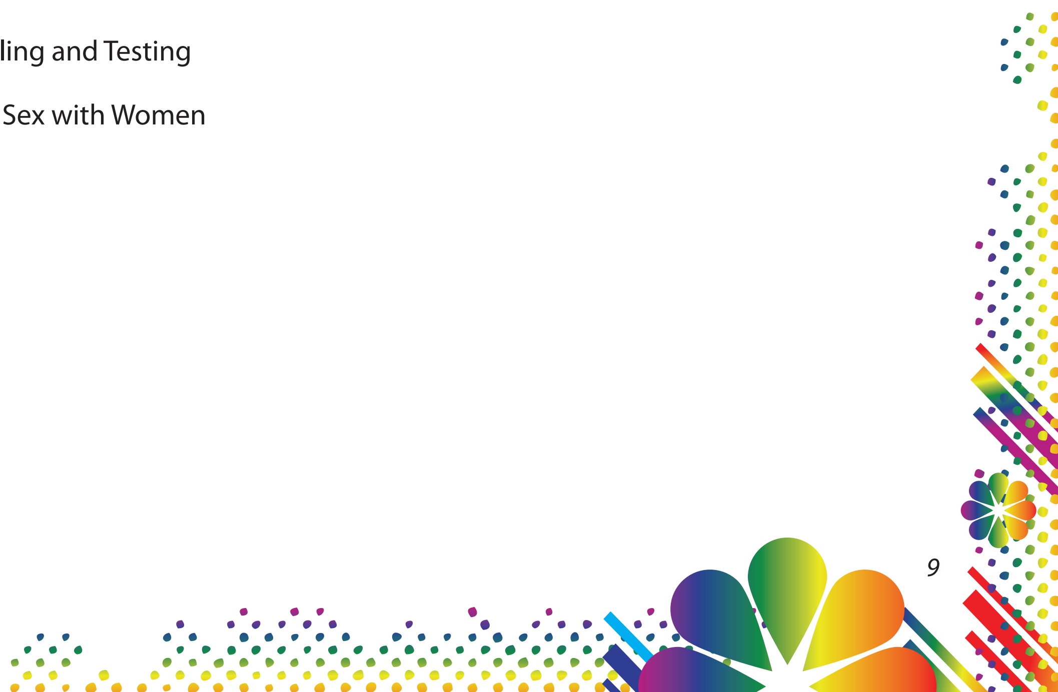
WSW

Women who have sex with women. A sexual practice irrespective of sexual orientation or gender identity. A WSW can be hetero-, bi- or homosexual. This term is more technical and is not necessarily an identity.



Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretrovirals
SW	Sex Worker
FTM	Female to Male Transsexual
GBV	Gender Based Violence
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
MARP	Most At Risk Population
MTF	Male to Female Transsexual
MSM	Men who have Sex with Men
MSP	Minimum Service Package
MSW	Male Sex Workers
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
SOGI	Sexual Orientation and Gender Identity
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TG	Transgender
VCT	Voluntary Counselling and Testing
WSW	Women who have Sex with Women



1. Introduction – Getting Started

Purpose of this Handbook

This handbook has been designed to assist individuals in understanding human sexuality through a rights based approach. This approach includes human rights, as well as sexual and reproductive health and rights. This handbook provides a means by which to disseminate information pertaining to African sexualities, human sexuality and sexual minorities, specifically on how sexual orientation relates to and interconnects with HIV and gender based violence. The activities outlined in this manual explore the different concepts and constructs of sexuality through an active and experiential learning approach.

This approach focuses on:

- building a strong advocacy base among service providers, NGOs and civil society stakeholders and LGBTI individuals themselves
- addressing the demand and supply of LGBTI-friendly HIV and GBV prevention services and information in a timely, just, non-discriminatory and non-judgmental manner
- encouraging the provision of correct information and quality services
- encouraging participatory processes and engaging LGBTI persons in the development of programmes for, with and by them, and building knowledge of one's own sexuality and understanding sexuality in general
- understanding HIV and GBV prevention in general, and in the context of the experiences of LGBTI people and their specific prevention needs
- advocating a rights-based approach to HIV and GBV prevention for LGBTI people

Using the Handbook for Capacity Strengthening

This handbook can be used for capacity strengthening (training) of service providers, NGOs and CBOs (civil society partners) and LGBTI individuals
The training will:

- build knowledge and skills on LGBTI sexuality and related issues;
- build knowledge and skills on specific HIV and gender-based violence prevention needs of LGBTI; and
- build and strengthen advocacy skills to ensure that prevention information and quality service provision is availed to LGBTI within a rights-based approach in our communities

This is a training of trainers handbook and those who are equipped with the information laid out in this handbook are expected to become trainers and conduct further workshops (employing the SAfAIDS Cascade Model of Training) with their peers and partners in their respective constituencies.

During the workshop, trainers will be confronted with their own attitudes on sexualities and preferences. It is important that these issues are explored and discussed in an understanding and affirmative environment. This process of understanding the self will enhance the development of insight into the world of sexual minorities. The activities will help the participants to feel more comfortable in talking about a theme that is often not talked about, assisting with the building of good quality group facilitation.

Who Should Use This Handbook?

This handbook can be used in conjunction with other capacity building strategies and tools in the field of HIV and GBV. It will be relevant for use by all organisations offering support services to people living with HIV, young people and people of sexual minorities. It will also be relevant for training LGBTI people. The innovative use of this guide by facilitators would also make this handbook useful for a wider audience. Participants may come from a wide range of experiences and organisations. They might include:

- Staff of community based organisations, or community members who are well-positioned to train others
- Trainers of CBOs and NGOs and other bodies in civil society
- Individuals who are actively involved in HIV, sexual and reproductive health and GBV related work in their communities and who have training/facilitation experience
- Staff and members of organisations working with LGBTI individuals
- Peer educators
- Service providers
- This handbook can also be used in a classroom by life skills teachers (taking into consideration the age of the learners and should be conducted creatively and modified if needed)

What Can You Expect from this Handbook?

This handbook presents information on human sexuality, sexual minorities and challenges experienced by sexual minorities, including the intersections between sexual minorities and their vulnerability to HIV and gender based violence. Various activities will be introduced to facilitate learning and develop insight. Participants who take part in training from this handbook will achieve three main objectives:

- They will have a better understanding of human sexuality
- They will have a better understanding of the challenges experienced by sexual minorities, especially in relation to HIV and GBV prevention and mitigation
- They will be able to use the information to offer sensitive and ethical services to people of sexual minorities

For facilitators to lead the way in achieving these objectives, they need a deep understanding of the following from this material:

- the meaning of concepts pertaining to sexuality and sexual minorities
- the specific health and wellbeing challenges experienced by people of sexual minorities
- the linkages between failure to provide inclusive, affirmative services and LGBTI individuals' risk of HIV transmission and acquisition, and of experiencing gender based violence
- the concept of implementation of a rights-based approach for sexual minorities

Structure of the Handbook

The material in this handbook is designed to be used in a group learning environment, for instance in workshops and sensitisation trainings for HIV and GBV programmers and community based organisations (CBOs). Facilitators should be aware of, and innovative in working out new or different ways in which they can use and share the content in this handbook. The more the content in this handbook is shared in a professional way, the more the facilitator will be able to convey it with comfort.

- The content in this handbook is designed to be covered during the course of two days, and can be incorporated into other forms of sensitisation trainings, for instance when doing sexual and reproductive health and rights capacity building sessions
- Each training day will be almost eight hours long (all breaks included)
- Learning objectives are provided at the beginning of each section
- Content for discussion is provided in the Facilitators Guide – this is not intended to be read out to the participants – it provides a guide and a prompt for the facilitator on what each section aims to achieve
- At the end of each section time is dedicated for 'wrapping up'

To get the most out of this handbook, facilitators should make sure that they are familiar with all the content in the toolkit before they begin the training. Teach backs should form part of the initial and ongoing training to achieve a level of comfort for teaching the content of the handbook before attempting to train others. Talking and training about sexuality is often a daunting task, even if you are a very experienced trainer. Often participants project their insecurities about the subject to the trainers. Be aware that this is not a personal attack on you, but part of the process of learning and gaining a better understanding about sexual minorities. It is preferred that you would have reflected on and understand beliefs about your own sexuality and that of others, especially sexual minorities, before you attempt to facilitate a workshop of this nature.

Try and anticipate the kind of questions (refer to FAQ's in the LGBTI folder) or discussions that might arise during the training and prepare your responses in advance. Special attention must also be given to the practical aspects of the training – ensuring that learning objectives are met, and that sessions are completed within the given time.

2. Characteristics, Knowledge and Skills of a Successful Sexuality Facilitator

The importance of the role of the facilitator in group learning cannot be overemphasised, especially in a sensitive field like sexuality. With the leadership of the facilitator, the group moves through a process of understanding the nature of human sexuality, LGBTI and intersections with HIV and gender based violence, identifying challenges and possible solutions and starting the process of strategising and planning appropriate actions and responses. This is especially important for this training as one of the key aims is that participants are sensitised and come away from the training with practical ideas and ways in which they can integrate LGBTI affirmative services into their programmes.

Personal Characteristics of Good Facilitators

While aspects of our personality make us who we are, there are certain characteristics that facilitators can strengthen to help them excel in training in this field. These include:

- Focusing on assisting adults to learn through self discovery
- Ability to make learning happen
- Guiding participants to the learning destination *with* them, but not as one of them
- Being able to recognise and accept own biases and make a conscious effort to remain neutral in the workshop environment
- Respecting and enjoying interaction with diverse groups of people
- Inspiring the trust of others
- Creating and sustaining a safe and comfortable learning environment
- Being enthusiastic and motivated for the subject of human sexuality
- Creating opportunities for learners to share their own experiences
- Being able to anticipate obstacles to learning and being able to remove them
- Presenting with sensitivity and understanding of cultures, gender, sexual orientation and HIV status
- Respecting other's views, being non-confrontational and remaining open-minded and interacting with others in a friendly and honest manner.

Facilitators should have a solid understanding of:

- The need to address LGBTI rights and the empowerment of LGBTI people to assist in addressing HIV and GBV in their communities
- Their own attitudes and perceptions relating to the rights of sexual minorities, their SRHR and the rights of PLHIV
- How their past experiences, families and environments have influenced these perceptions and ideas and how this could influence their ability to effectively facilitate the training
- Their personal limitations in terms of knowledge and experience, and willingness to ask for help when it is needed.

Facilitator Knowledge

A certain level of knowledge on sexuality, sexual minorities, HIV and AIDS, GBV and SRHR provides the best background for facilitators of this training.
Make sure you are familiar with:

- Stereotyping, the meaning and reasoning behind it, as well as the impact it has on the provision of sensitive, affirmative and inclusive services to sexual minorities
- The different concepts of human sexuality, including sex as a biological concept, gender as a social construct, sexual orientation and sexual practices and the links between them
- The differences between sexual identity and sexual practices and the impact of misunderstanding these on service delivery
- The health and wellbeing challenges experienced by individuals within LGBTI communities
- The human and sexual and reproductive health and rights of sexual minorities
- How homophobia, homo-prejudice, patriarchy and heteronormativity impact society at large negatively
- The identity development and coming out processes of individuals within sexual minorities
- Barriers to providing sensitive, affirmative and inclusive services to people of sexual minorities
- LGBTI and the link with HIV
- LGBTI and the link with GBV

Facilitator Skills

An effective facilitator will create an enabling and encouraging environment for participants to share ideas, opinions and experiences to achieve the common goal of understanding the challenges experienced by sexual minorities. All participants will get the most out of the training.

To achieve this, the facilitator should be able to:

- Get the group acquainted and encourage everyone to participate
- Encourage participants to ask those questions they always wanted to ask, but were afraid to
- Create an environment that is tolerant and acknowledges diversity
- Understand how each particular group will interact
- Manage situations where conflict arises
- Encourage the group to work together
- Lead the group through processes to reach a level of understanding and consensus in discussions
- Take feedback and provide a summary of each session to wrap up.

Top Tips for Facilitators

Planning for Training

- Make sure you understand topics and are familiar with the terms involved
- Plan in advance how you can bring in your experience
- Find out about your participants, which organisations they are from, what their experience is
- Know the situation regarding LGBTI challenges and rights in your area. This will include laws, national policies, statistics on LGBTI, HIV and GBV (if available)
- The first few times you conduct the training it might help you to go through a 'rehearsal' of what you plan to cover in each session
- The night before the first day of the training, familiarise yourself with the participants' names so that you can quickly begin to refer to them by their names during the training
- Ensure that the group consist of a maximum of 25 participants, from a variety of backgrounds, including LGBTI individuals themselves
- Ensure that you have a co-facilitator to assist with the process and flow of the training, especially when participants tend to project their uncomfortable feelings unto the facilitator/s

Practical Considerations

- Make sure the venue is big enough
- Try to ensure that you can avoid noise and other distractions
- Create a comfortable learning environment, make sure there are enough seats, and that windows are open for ventilation
- Check beforehand that you have all the equipment you will need – flip charts, markers, handouts (enough copies for each participant, with extras)
- Ensure that the room is arranged in a U-shape. This enables close interaction with all participants
- Make sure that you have prepared, and have name tags for participants and facilitators

Conducting Training

- Dress appropriately, avoiding tight clothing and any noisy jewellery that could be distracting
- Be confident, open and friendly with the group
- Introduce yourself and explain a bit about your background
- Don't make eye contact for too long as this can be intimidating for some people
- Make sure you speak slowly enough and loudly enough for everyone to hear and understand you
- Make sure you write legibly on the flipchart or board that you use
- Stay within the allocated time for each section, and make sure you give participants enough time to ask questions, share their experience and raise their views
- If you notice that some participants are dominating the discussion, and others are more reserved, try to bring balance to the discussion and hear everyone's contribution
- Bear in mind that adults learn best in situations where they can share their experiences, and apply information to their real life context
- Be aware of when you are 'losing' your audience. If your attention is waning, take a short break to let people walk around, use an energiser, or break early for teas or lunches
- Always be aware of your audience, and do not make remarks that could be offensive

- Try to avoid talking about personal experience that may be sensitive or upsetting. This is particularly relevant because of the subject of the training. Encourage participants to share experiences but to avoid revealing anything they are not comfortable with.

Facilitator Tools in This Handbook

In addition to the general tools and tips given above, this guideline also contains some specific tools to help the facilitator.

Wrap Up

Wrap up sections give bulleted lists of key points for the facilitator to run through before moving on to the next section.

These boxes give tips for successful facilitation.

3. Introduction and Background

Sylvia Tamale explains in *African Sexualities, A Reader* that many of us have done a great deal of learning by the time we grow into adults. Most of this learning took place through cramming and drilling and not by looking at the content in a critical manner. Informally, at home, children were often not allowed to question adults. Both the formal and informal learning systems allowed only for learning in dualisms and absolute truths (for example male and female, wrong and right, moral and immoral, good and bad), impeding reflective and critical thinking. This process of learning makes it very difficult for an adult to "unlearn" negative concepts and stereotyped information.

> *"Most of us passively absorb the assumptions and perspectives of the dominant view and many of us have a visceral negative reaction to the concept of sexuality. Unlearning literally requires us to discard our old eyes and acquire a new set of eyes with which to see the world. It requires us to jettison assumptions and prejudices that are so deep-seated and internalised that they have become normal and appear to be natural".*
>
> **- Sylvia Tamale,** *African Sexualities, A Reader***, 2011.**

In Africa, people are dying, not only because of the various forms of violence, poverty, illness (in particular AIDS), but also due to ignorance. Knowledge which is applied correctly can change the lives of many and in this case, the lives of LGBTI individuals as well as services providers.

SAfAIDS conducted a Rapid Baseline Study in July 2011. Except for a few experts in the LGBTI field, most respondents to the survey, including both LGBTI individuals and service providers, expressed the need for both information and training around the needs of LGBTI communities in relation to HIV and GBV prevention, mitigation and appropriate service provision.

The biggest challenges in LGBTI affirmative and ethical services seem to be ignorance, lack of information and fundamentalist religious beliefs. In the African countries where homosexuality is still criminalised, these laws seem to be the biggest reason for high incidences of homophobia and experience of discriminatory services.

It seems as if, in South Africa specifically, HIV and GBV services are not provided in a sensitive and LGBTI affirmative and accommodating manner. LGBTI services are reportedly provided mostly by the government at government clinics and police stations. In other African countries, it seems that LGBTI people experience discrimination from a wide range of service providers, and that lowering discrimination will not change until discriminatory laws are amended and abolished.

The most important of all needs is most probably the need for a product that completely integrates the concept of "human sexuality", avoids alienating other sexual orientations and identities, and explains the more complex areas of being transgendered and/or intersex.

Most respondents to the baseline survey reiterated the importance of sensitisation training for service providers. Sensitisation would be provided to the administrator/secretary at the front desk, to the person in charge of providing the service. To facilitate this process, role play sessions and interacting with a rich diversity of LGBTI facilitators should be included in training, looking for the common "humanness" and linking LGBTI rights to broader human rights struggles.

> *"Neither the existence of national laws, nor the prevalence of custom can ever justify the abuse, attacks, torture and indeed killings that gay, lesbian, bisexual, and transgender persons are subjected to because of who they are or are perceived to be. Because of the stigma attached to issues surrounding sexual orientation and gender identity, violence against LGBT persons is frequently unreported, undocumented and goes ultimately unpunished. Rarely does it provoke public debate and outrage. This shameful silence is the ultimate rejection of the fundamental principle of universality of rights."*
>
> **-Louise Arbour, Former UN High Commissioner for Human Rights**

No longer can the health needs and the rights of LGBTI people be ignored and violated.

Let's talk about it – and learn from each other!

4. The 'How-To' LGBTI Integration Into HIV and GBV Prevention

Day One: Human Sexuality

Session One: Introduction to the Training

Time: 45 minutes

Aim of the Session

This session aims to introduce the training and give the facilitator/s the opportunity to get the group comfortable talking to each other and working together, asking questions and sharing experiences.

Learning Objective

By the end of the session participants will:

- Have a good understanding of the aims of the training and how it will be conducted
- Get to meet the facilitators and each other

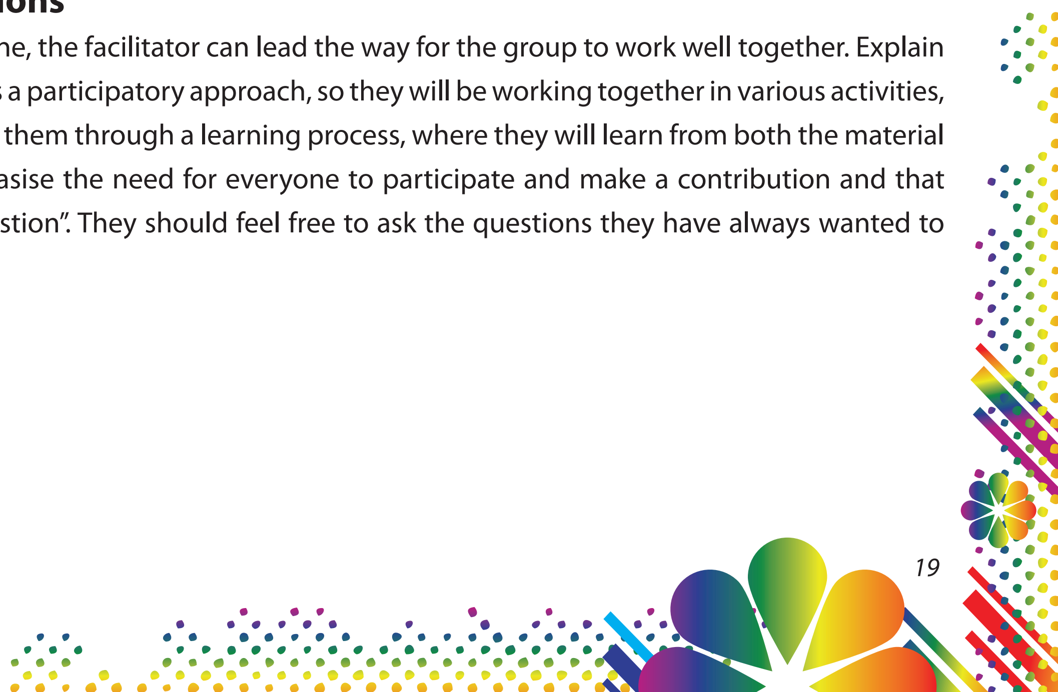
Registration and Welcome

Greet each participant as they enter the room. Allow all participants to complete the registration form and/or or attendance register. Provide a name tag or label for them to write their own name on it. If opportunity allows, pronounce each participants name to ensure correctness.

Once all participants have arrived, proceed with a formal welcome. If several participants seem to be running late, explain to the group that a few extra minutes will be granted in order for all participants to be present. Facilitators can then introduce themselves and the workshop and highlight the aim and importance of the training.

Icebreaker and Introductions

By setting an open and friendly tone, the facilitator can lead the way for the group to work well together. Explain to the group that the training takes a participatory approach, so they will be working together in various activities, which have been designed to take them through a learning process, where they will learn from both the material as well as from each other. Emphasise the need for everyone to participate and make a contribution and that there is nothing like a "stupid question". They should feel free to ask the questions they have always wanted to ask, but were too afraid to do so.



Introduce the icebreaker to enable all to get to know each other.

Icebreaker

The Name Game
Everyone sits around in a circle or U-shape. Each person says his/her name and one characteristic that describes him/her that starts with the first letter of his/her name. For example, Candy might say "Cocky Candy" or "Candy Cane." Have the next person repeat the last name-characteristic combination and then add his/her own. Keep going until the last person has had an opportunity. There are a number of introductory session examples and icebreakers available. As a facilitator you can use your own discretion on what activities could be appropriate to use.

Making Expectations Clear

It is important that the participants are clear about their expectations from the outset, so that they can feel a sense of achievement from what they get out of the training and also so that they can identify further training and information needs. Give the group a couple of minutes to identify their expectations. Each participant is requested to share one expectation with the group, which is recorded on a flipchart. This will be displayed in the training room for the duration of the training.

Clarify if there are any expectations that will not be met during this training.

Use this opportunity to explain that at the beginning of day 2, the previous days' sessions will be recapped, and all outstanding questions will be dealt with.

Ground Rules

Although this training is designed for participation and sharing of experiences, it is important that participants agree on how they are going to work together as a group. Ask the group to brainstorm ground rules that they theink will be important for achieving their objectives. Record these on a flip chart and display them in a prominent position in the training room. Some things that can be mentioned if they don't come up:

- Any personal information or experience shared by members of the group should remain confidential
- All participants should give their full co-operation and participation
- Participants should respect each others' opinions

Participants should not start separate conversations while group discussion is going on

Introduction to Training

To introduce participants to the content of the training, paraphrase the information contained in the background of this handbook and the need for sensitising various service providers to the health needs of LGBTI people.

Session Two: Stereotype Experiential Exercise

Time: 60 minutes

It is important not to mention to the group what the name of the exercise is up front, in order for them to be able to understand what the intention of the exercise is about. Rather call it an "exercise about identity".

Aim of the Session

This session aims to ensure that the participants have a good understanding of the concept of stereotyping and how it negatively impacts their own behaviour and ultimately, if strongly believed and internalised, service delivery to sexual minorities.

Learning Objectives

- To create a safe space for participants to freely express how they feel about themselves and others who use stereotyping while trying to make sense of the world.
- To connect different kinds of stereotyping around sexual orientation, race and gender.
- To understand that stereotyping has the same source and outcomes.
- To provide background information about stereotyping and the consequences of stigma and discrimination due to generalising.

Materials Needed

- Flipchart
- Flipchart paper
- Flipchart pens
- A scribe

Preparation

Facilitator (preferably a co-facilitator) should write out the words below, depending on the needs of the participants, in the middle of a flip chart paper, but remember to keep it covered or hidden from the participants:

- Man
- Woman
- Black person
- White person
- Gay man
- Lesbian woman
- MSM
- WSW
- HIV positive person

Use a combination of the words above. Always use 'lesbian' and 'gay' but be sure to write somewhere in the middle of the exercise, not first or last.

Suggested Process for Facilitation

Instructions to the group

Start of the session by saying: "A word will appear on the paper".
"When I say the word, you say any word or meaning that you think yourself or society attaches to the word. It could be positive or negative."

One facilitator calls out a word, the other one writes down the responses. Write down all the answers/associations for each word on a piece of flip chart paper. Be aware that this happens quite fast, so keep up! Be aware not to restrict the responses in any way.

Write in any language that participants use, do not translate. Use two to three minutes per word/ category. Also ask people to add any words or labels they know or have heard, in relation to 'lesbian' and 'gay'.

Say 'Stop' after two or three minutes. There is no need to exhaust each category. The facilitator who was writing then turns to the next word on the flip chart paper. Continue: "When I say (for example) 'black person', you say…" (or continue with another word on the list). Continue until you have discussed all the words. The association exercise should take about 15 minutes.

Discussion

Put all the flip chart papers on the floor, within the U-shape. Tell people to stand in a circle and look at them (if you are training a small group). If the group consists of 20 or more participants, they can stay seated in the U-shape.

Facilitate a group discussion about the nature of stereotyping (without saying the word stereotyping at first).

First ask about participants' feelings when they see themselves described in a certain way.

Make it personal by asking questions like:

- "Are you ***this woman*** described here?"
- "How does it make you feel to see the black (or white) person described like this?"

Try to get the participants to a point where they themselves say the word - ***stereotype***. Otherwise ask what the words on the papers are. If there is no answer, ask participants if they have heard of **'stereotyping'**. Explain the term if it is unknown, but usually there will be people who know. Ask them to explain the word to the other participants.

Encourage further discussion by asking questions like:

- "Why do you think stereotyping happens?
- "What is the function of it?"

Stereotyping is a natural process. It is way to structure the world and the way that human beings position themselves in the world. Individuals also get classified into categories because of a fear of the "other" and a fear of the unknown.

You can then focus on discussing coping strategies to stereotyping. Some people change negative stereotypes into positive ones, others ignore the negative ones and only look at the positive stereotypes, etc. Draw on the fact sheet for further reflections in the plenary session.

Finally, zoom in on lesbian and gay stereotypes, and make the connection with the others. Discuss that exactly the same stereotyping happens to lesbian and gay people as happens to other groups. Stress the fact that sometimes it happens more often to lesbian and gay people because they are most likely to be in the minority in any given group. As all others, they internalise what the "world" says about them. Emphasise that THE lesbian and THE gay do not exist in the same way that THE woman or THE black person do not exist. Ask your audience if they agree and how they feel about it.

This activity demonstrates how quick and easy it is to give other people a label, but how uncomfortable it is to be labelled oneself, especially with very derogatory names.

The discussion should focus on the feelings that this exercise evoked in the participants, which are often quite strong. This activity also highlights how much we operate out of stereotypes, and in particular how strong the stereotyping, especially of gender, often is. The discussion should focus around the validity of these stereotypes, checking them out in reality, as well as where they come from. The point needs to be made that stereotyping often has little basis in reality, and that it comes out of prejudice and is closely linked to labelling.

Underline the idea that stereotyping is often unhelpful, and that it can also have a very negative impact on the way people are treated and on interpersonal relationships. Also make the links between stereotypes and power relations in society.

Wrap up

It is natural to stereotype, we all do it in one way or another, but it hurts the self, and others, in the process. We should all be aware of how we stereotype others, and try our best to change that for the positive.

End off by saying something along the line of:

> *"Even though we stereotype to make sense of our world, from today, we should* ***never, ever assume****.This is the beginning. We know we cannot fit people into a box. How boring would life be if we could fit all people into the same box? Our alphabet, with only 26 letters, is too small to describe human beings in totality. Although these words are not necessarily something that is known in your own language, that doesn't mean that the people described doesn't exist. There may be an assumption that because there is no word for it in (for example) seTswana, it doesn't exist.*

What this training covers is nothing new. Maybe some things will be new, but mostly we all know what we are talking about here. Now we are taking the puzzle apart, then we are going to put it back together again.

Session Three: The Binaries & The Boxes

Time: Two hours

Aim of the Session

This session aims to introduce the four different components of human sexuality in order for participants to be able to link sex, gender, sexual orientation and sexual practices.

Learning Objectives

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

- Understand the difference between sex, gender, sexual orientation and sexual practices
- Share their past experiences with LGBTI clients / patients / relatives / colleagues /media etc.
- Share their own knowledge of human sexuality
- Understand the terminology used with regard to LGBTI people
- Begin to understand the health challenges experienced by LGBTI people

Component One: Sex as a Biological Concept

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

Materials Needed

- Flipchart
- Flip chart paper
- Flip chart pens
- Handout: **Human Sexuality –** The Grid to be handed out on completion of Day 1
- Binaries & Boxes Powerpoint Presentation
- What Do You See? Powerpoint Presentation

Preparation

The facilitator divides a flip chart paper into four quadrants. You can also make use of the Binaries & Boxes Power Point Presentation if technology allows for it. Make sure you know how the Binaries & Boxes Power Point Presentation actually works.

This specific activity starts in the top left corner, the first quadrant. Only the word **"SEX"** is written on the top of the first quadrant (for now). Place the flipchart where everyone can see it.

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

Suggested Process

Instructions to the Group

Inform participants that information written on the flip chart will be shared step by step and repeated often.

- The information is going to be unpacked, step by step
- This, (SEX) is the first part of the puzzle that we will unravel..
- By the end of this session on Human Sexuality, the puzzle will be put together again.

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

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

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

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

Continue the discussion by asking: **"How do you know what sex somebody is?"**
Look in the pants - male has penis, female has vagina. Biological sex is about *what's in the pants*, as well as the hormonal and genetic makeup which indicates a person as being biologically male or biologically female.

Then, ask if the group knows of any other biological sex? Probe them by asking them what they have heard from the media. Write down the word **"INTERSEX".**

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

Explain the word Intersex.

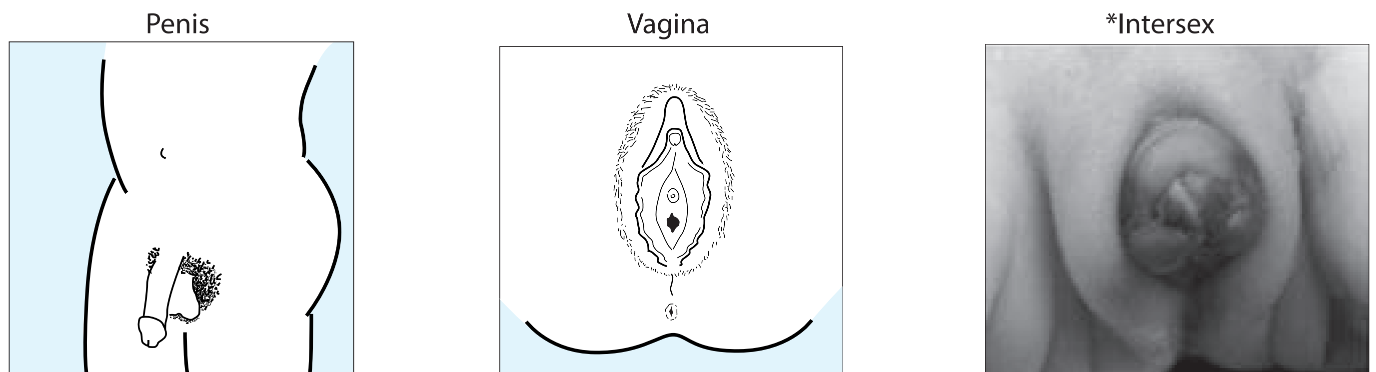
We don't exactly know what an intersex person has in their pants, but it is not important. However, it is important to know that they exist. Intersex people used to be called hermaphrodite, but it is an offensive and inappropriate term, politically incorrect and we should refrain from using the word. In some cases the genitals are not clear at birth; in some cases individuals discover much later life that they are intersex. There are very many different ways intersex can manifest. Refer (with respect) to a well known South African athlete, Caster Semenya who has (according to media reports) a vagina and internal testes. Testes produce male hormones, testosterone, resulting in masculine features.

Another example is that of the case of a woman who wanted to have a baby in her late 20's and found that she did not have an uterus, another type of intersex.

Explain that many years ago; even maybe today, when a baby was born intersex, the doctor would urge the parents to actually choose the sex of their baby. The genitals would then be surgically modified to fit into the chosen sex binary. Cases were reported where the choice of the sex of the baby was that of a boy and where, later in life, at about puberty, the boy would develop breasts.

These days parents are referred to endocrinologists. A choice is not made immediately, but the child is allowed to grow up without any "corrective" surgery and supported to make their own choice in terms of sex and gender identity. Having an intersex child can be very traumatic for parents. According to Intersex SA, one in 500 babies in Africa is born intersex today. It is a very sensitive issue and clients should be referred to the correct health care providers for assistance with various challenges.

Because of stereotypes, we look for a penis or a vagina.



Explain to the group that this information is just the tip of the iceberg, and that they should read more on the topic.

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

End this session with a statement, for example something along the lines of "Intersexuality challenges the notion that there are only two sexes. But who knows there may be even more than just male, female and intersex."

Check with the group if all the information is understood so far.

Component Two: Gender as a Social Construct

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

Materials Needed

- The flip chart used for component one

Preparation

This specific activity starts in the top right corner, the second quadrant. Only the word **"GENDER"** is written on the top of the second quadrant e.g.:

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

Suggested Process

Instructions to the Group

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

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

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

The following two terms should be identified and written up on the flip chart:

- Masculine
- Feminine

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

Continue with a discussion on gender expectations, an example can be used of what is represented in the media, e.g. the well known beer advertisement of *"Real men don't drink pink drinks, Dave"*. This advertisement reinforces the stereotypical masculine male model, in a very subtle way. So who only drinks pink drinks? Stereotypically, women? What about those women who prefer to drink a strong beer? Are men not real men when they drink pink drinks? Elicit a discussion around these notions.

Perhaps ask the question: "What are some of the social expectations for men and women respectively?" "What is the impact of these social expectations for men and women's health, intimate relationships, relationships with your children?"

Some behaviour/roles are perceived to be masculine, like drinking too much, and are accepted by society, even if it hurts or is pathological in nature. If a woman portrays masculine behaviour, e.g. being dynamic, what is the perception of that woman? That she is a bitch? That she wants to be a man? As soon as a person is boxed or stereotyped, there is a danger of being discriminated against.

The facilitator can make use of examples that they feel comfortable with. Further examples - Female jobs - administration, teachers, nurses, housewives, counsellors. Male jobs - engineers, directors, doctors, preachers.

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

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

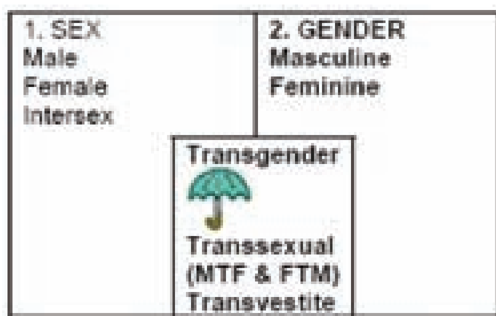
Another example: What happens at a baby shower, girls get pink, and boys get blue. Who decided that blue was a 'boy colour' and pink a 'girl colour'?

Human beings are born with a sex, *not* with a gender. Gender is what human beings are "taught", what is expected of male bodied people and female bodied people.

The irony is that for a human being to be whole, they need both masculine and feminine characteristics. A man has to be in touch with his feminine side and a woman with her masculine side; our masculine and feminine characteristics should be in balance in the self. When there is no balance, it may cause power imbalances which can lead to different forms of abuse, of the self, or a partner.

Repeat what has already been covered: Sex, Gender.

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



Ask the participants if they know the difference between the two words. A transvestite is a cross dresser, in most of the cases, a male who has the need, for various reasons, to wear female clothes, underwear, make up etc. It is not related to who they are attracted to.

Although women can wear men's clothing, (and some men in Africa wear dresses), men as cross dressers are, sadly, not accepted by society.

Transvestites are most of the time heterosexual. Often cross-dressing men, those who like to wear women's underwear or wear women's clothes; would wonder if they are actually gay? ***Transgender has nothing to do with sexual orientation.*** It is because of the myth that gay men want to be women that even heterosexual transvestites themselves will question their own sexual orientation, although they are well aware of whom they feel attracted to sexually.

Some gay men will wear women's clothes too and are commonly known as **drag queens**.

Transsexuals, on the other hand, are people who transition, or are in the process of transitioning, from one sex to another.

Example: A child is born, there is a penis, and there is the assumption that he is a boy. When brought up, the person follows a masculine gender role, but feels uncomfortable with the self as a man, and feels more comfortable in feminine role, and being a woman. ***<u>She</u>*** **feels *trapped* in the wrong body**. Remember to use the current pronoun.

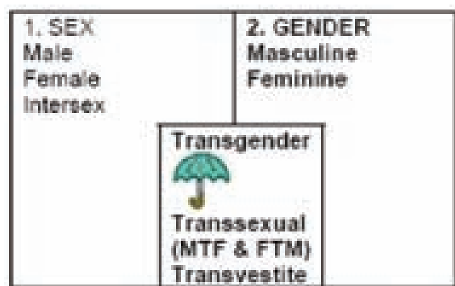
VERY IMPORTANT! Again! It is important that participants understand that gender identity and sexual orientation are not the same***, although they share the same experiences of prejudice and discrimination.*** It is about the relation of the person with themselves, their gender identity, not whom they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

Gender identity: This refers to how someone feels about themselves in the world as a woman or a man, i.e. a person's sense of themselves as male or female. While most people's gender matches their biological sex, this is not always the case, and for instance, someone may be born biologically male, yet have a female gender identity

Continue by further explaining the complexity of transgenderism, where people who feel they cannot identify with their sex organs (for instance feels like a woman inside but has a man's body or the other way around). Some will try to change their bodies, through hormones and/or sex change operations or gender reassignment surgery. Not all transsexual people are the same. A transsexual person can be of any sexual orientation. A man, married to a woman, felt trapped in the wrong body, had a sex change operation to become a woman and remained married to the same woman. This has an impact on their sexual orientation, a lesbian woman trapped in a man's body. This will be discussed after this component.

Fa'afafine are biological males who have a strong feminine gender orientation, which the Samoan parents recognise quite early in childhood, and then raise them as female children or rather 'third gender' children. They grow up as Fa'afafines, which is a gender category/identity altogether different from men and women, and so they have their distinct gender roles specific to them, different from both men and women. It is something which is not discouraged in the traditional fa'asamoa (Samoan society). http://en.wikipedia.org/wiki/Fa%27afafine

Terms used: **MTF** (male to female) or **FTM** (female to male), with or without gender reassignment surgery.



Check with the group if it is all understood so far. Mention that we are now moving to the third part of the puzzle.

Component Three: Sexual Orientation

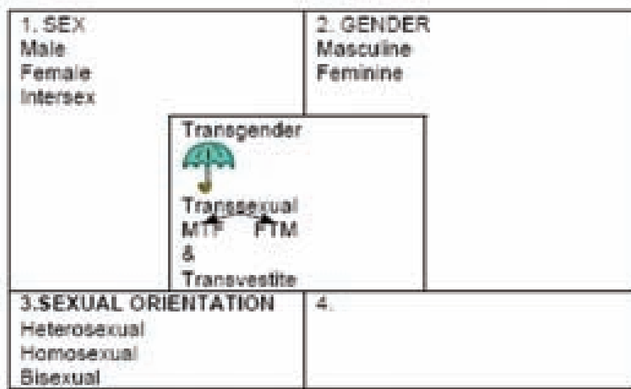
Although a separate discussion from components one, two and four, this activity should not be seen as a separate entity. All four components make up the puzzle of human sexuality.

Materials Needed

- The flip chart used for discussing components one and two

Preparation

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



Suggested Process

Instructions to the group

Ask what the word "Sexual Orientation" means. Participants can either also write it down as part of an individual reflective process, pairing with the person next to them or in group work.

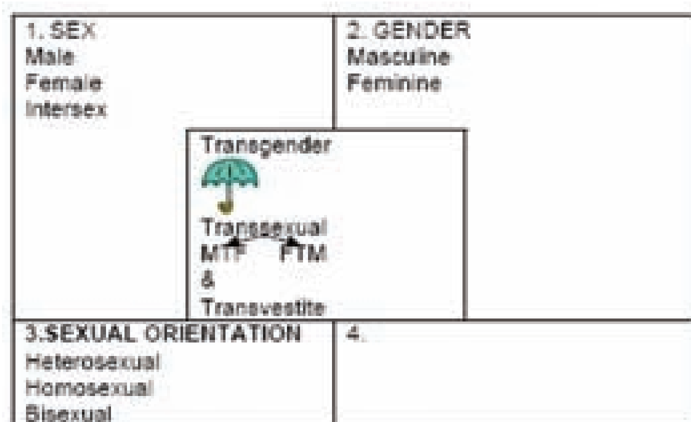
Do not give the answer immediately, allow people to think a bit.

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

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

Definition of a sexual orientation: Sexual orientation is about attraction and feelings. Attraction has many levels - sexually, physically, intellectually, emotionally and spiritually. **Thus, it is not only about sex!**

Now start to write down the different sexual orientations.

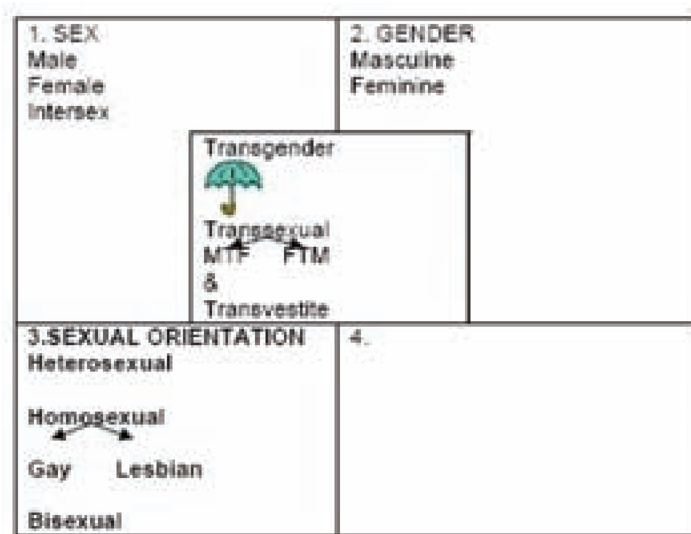


Heterosexual (straight). 'Hetero' means opposite, therefore heterosexual people are attracted to the opposite sex; a man attracted to women, or woman attracted to men. This attraction is sexually, emotionally, intellectually, physically and spiritually.

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

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

Write it down next to the term homosexual:



Although being gay or lesbian is an identity, there are some women who do not like to be called a lesbian, because the word is offensive to them. They prefer to be called a gay woman, although the term 'gay' was originally used to refer to feelings of being "carefree", "happy", or "bright and showy"; it had also come to acquire some connotations

of "immorality" as early as 1637 and today refers to a homosexual man (http://www.etymonline.com/index.php?term=gay.) The "label" is not important, what is important is that the person feels comfortable within their own identity.

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

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

For many years, people thought that homosexuality should be cured or fixed, especially if we listen to the horrid stories of trauma that some LGBTI people have experienced. But the irony is that homosexuality cannot be cured or fixed, because it is not a disease or illness, but a natural expression of human sexualities, there is nothing to fix or cure.

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

In 1973, in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), homosexuality was removed as a mental illness. Almost 40 years later and some professionals and lay people still look for a cause, like they would do with sickness. There is no cause for hetero or homo orientation. Statistically, one in every 10 people is lesbian or gay, according to the Kinsey study from the 1950s.

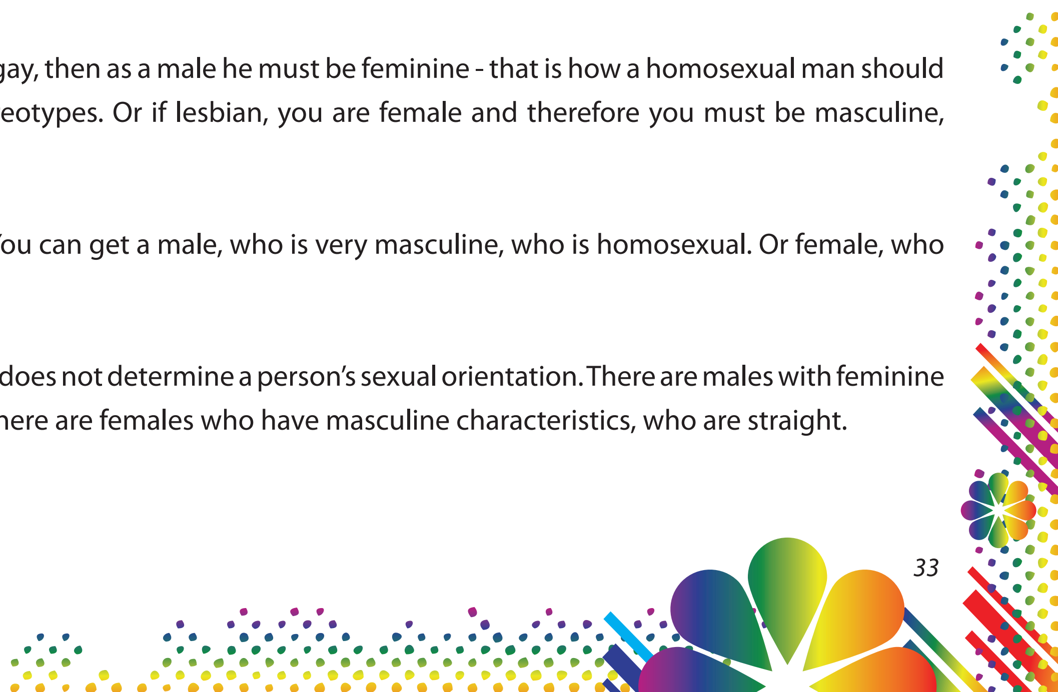
Sexual orientation is not a choice. Usually participants want to talk about the 'Nature versus Nurture' debate. Unfortunately, there is no clear answer. Maybe because there is nothing wrong with the homosexual person. It is natural to look for a cause for a problem / illness, but if nothing is the matter, why the need to look for a cause?

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

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

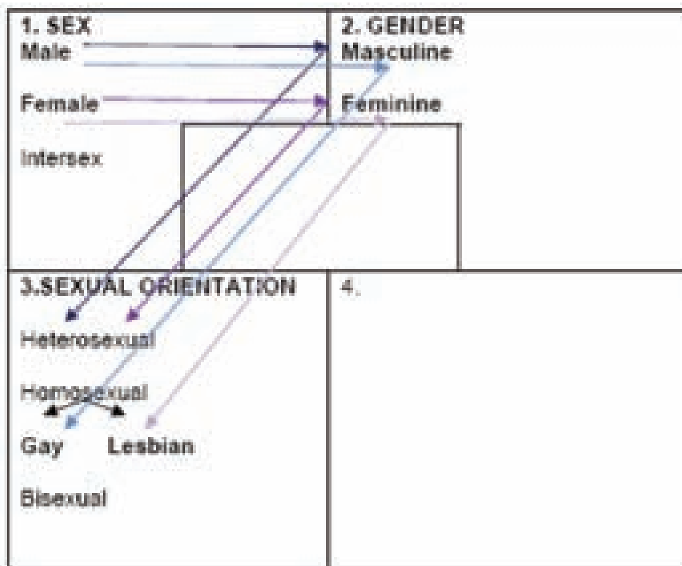
It does not always work like that. You can get a male, who is very masculine, who is homosexual. Or female, who is very feminine, and homosexual.

Behaviour (masculine or feminine) does not determine a person's sexual orientation. There are males with feminine characteristics, who are straight. There are females who have masculine characteristics, who are straight.



Sex does not inform gender, nor does it inform sexual orientation.

At this stage, start to make the links on the flipchart, by using examples of different people in terms of sex, gender and sexual orientation. Use a pen. You can use yourself as an example, or with their permission, a participant or two.



Mention that the pieces of the puzzle are getting together.

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

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

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

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

Another example: **A man, a dad, sits next to you, he has problems. You assume he is married, maybe he is but he also confides in you that he also has sex with men on the side, you cringe - client lost. Do not let your own judgment and belief systems interfere with your job.**
If you let a person, your client, tell you more about their intimate lives, and if you react in a non-judgemental manner, you will be surprised at how much you learn.

Discuss the meaning of understanding important discriminatory concepts. Let's have a look at the terms **heterosexism** or **homoprejudice**: Look at the -ism, think of racism - when one race acts as if it is better than all the other races and severe discrimination follows. What was the impact of racism and apartheid on South Africa? How did racism play out in practice? Where proper health services availed to black people? Can you remember the signs on the South African clinics which proclaimed "Whites" and "Blacks", and how the services to the latter were always of a sub-standard nature, and provided at the back of the building? People were abused, gross humans rights violations and even murder were perpetrated on people. Remember those times?

Heterosexism means when heterosexuality is seen as the only sexual orientation, better than other orientations. Important to know is that most of us are from heterosexual behaviour, from a heterosexual sexual act. (Some might be from artificial insemination). However we are not all heterosexually identified people.

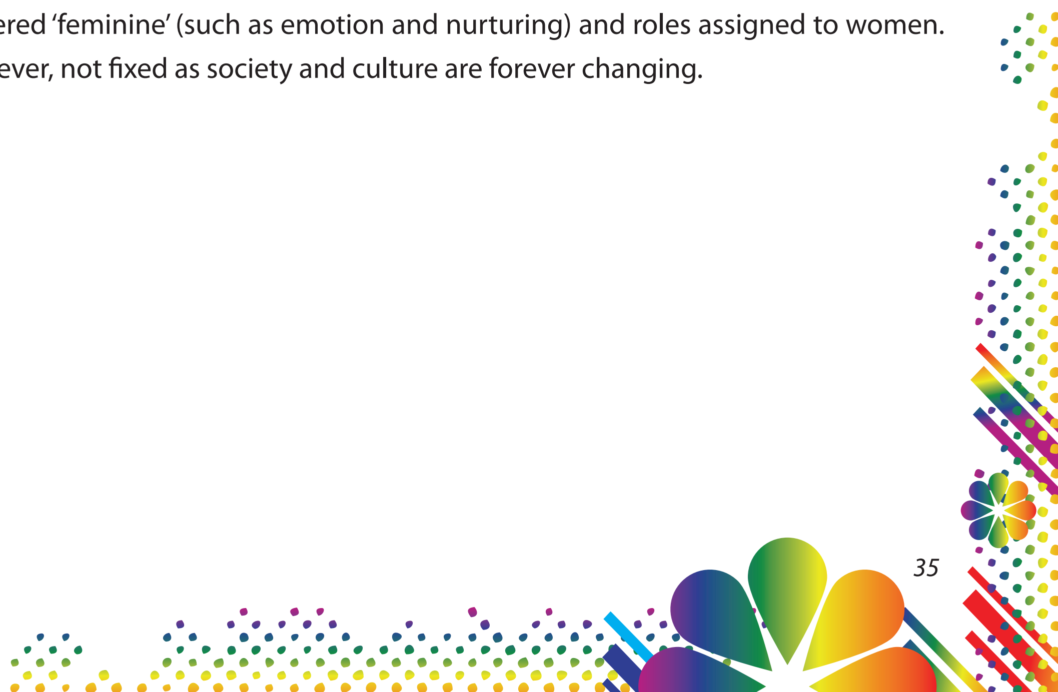
Again, a lot of people assume that everybody is heterosexual. **Heteronormativity** - the belief that only heterosexuality is "normal" or accepted. Because most people, including homosexuals, look at the world through a heteronormative lens, they assume and even expect same sex partners in relationships to have male/female roles. They expect the one to be more masculine and the other to be more feminine. This comes from the **heteronormative model**, which looks at life with the following picture in mind:

A daddy, a mommy, 2.4 kids (average in South Africa), the dog, the cat and the picket fence (or barbed wire nowadays) and if they are fortunate, the MPV (multi purpose vehicle)…

Another way of looking at it – ***"looking at life through the eye of the penis!"***

Yes, sadly, even most gay and lesbian individuals and couples try to fit within the stereotyped gender expectations. Remember the discussion on how stereotypes are internalised in the first session? Example: two masculine gay men in a relationship confuses people. Often people want to who is the *"wife"* and who is the *"husband"* in a homosexual relationship. Some gay man refer to their partner as "my wife", because the other partner is more effeminate. Even though people joke about it, unfortunately such statements negatively validate the acceptance of negative stereotypes about gender roles and homosexual people.

In many societies, including most in Africa, men are considered superior to women and their roles are dominant. In these so-called ***patriarchal, heteronormative, heterosexist*** societies, males, 'masculine' characteristics (such as rationality and competitiveness) and roles assigned to men are considered superior and valued above females' roles, those characteristics considered 'feminine' (such as emotion and nurturing) and roles assigned to women. Gender and gender roles are, however, not fixed as society and culture are forever changing.



Component Four: Sexual Practices

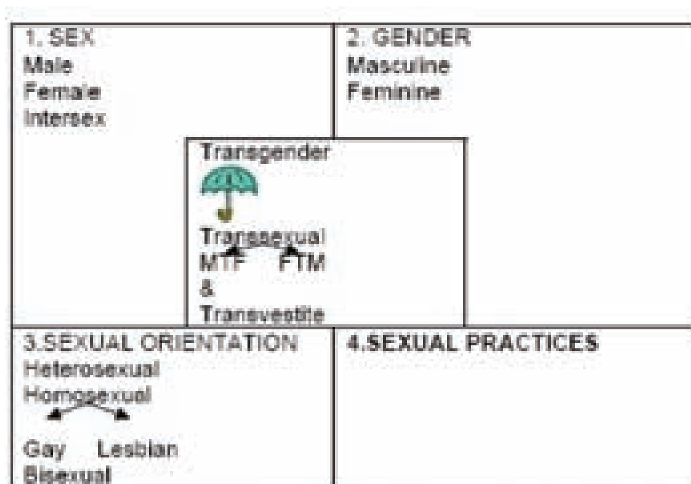
Although a separate discussion from components one, two and three, this activity should not be seen as a separate entity. All four components make up the puzzle of human sexuality.

Materials Needed

- The flip chart used for components one, two and three

Preparation

This specific activity starts in the lower right corner, the fourth quadrant. Only the word **"SEXUAL PRACTICES"** is written on the top of the fourth quadrant, for example:



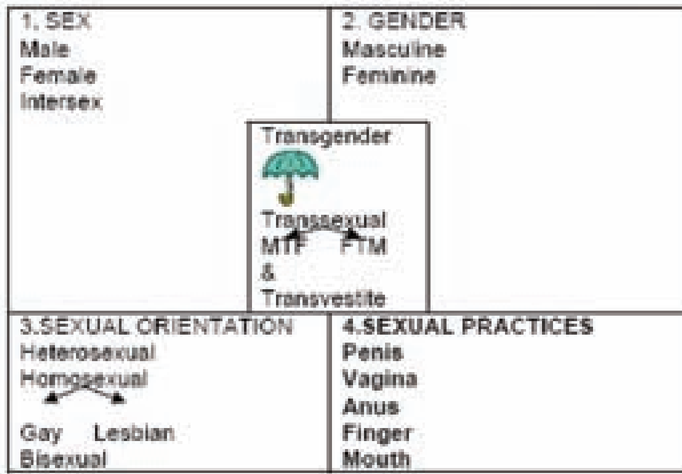
Instructions to the Group

Now we move into the most exciting part of the training! This is the last part of the puzzle that we are putting together.

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

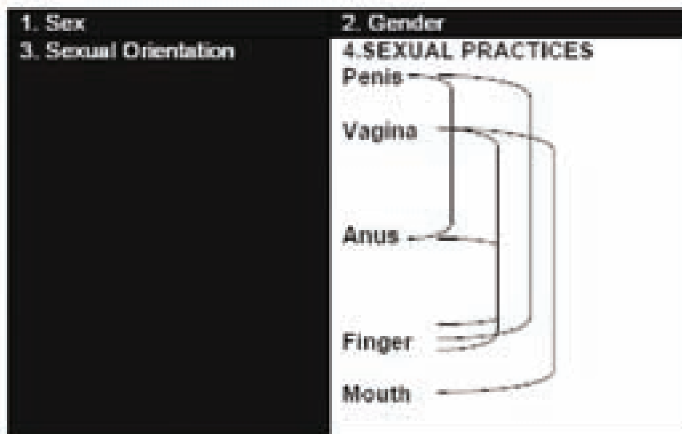
Examples:

Penis
Vagina or vulva
Anus
Fingers
Mouths



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

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



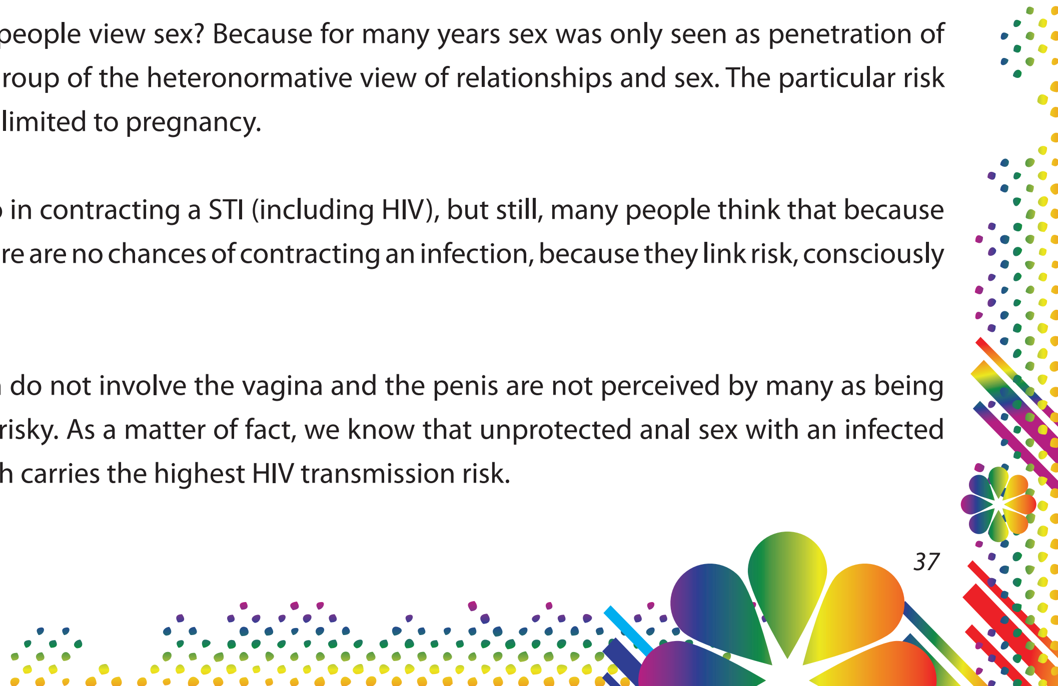
Now, ask them if you mentioned who the body parts belonged to? What the sex of the two (or three or more) people was? The answer is NO! Thus it is all possible.

And it is all seen as sex. Ask the group if they agree.

Why is it important to know how people view sex? Because for many years sex was only seen as penetration of vagina by the penis. Remind the group of the heteronormative view of relationships and sex. The particular risk linked to that kind of practice was limited to pregnancy.

Nowadays we know the risk is also in contracting a STI (including HIV), but still, many people think that because there is no vagina in the sex act, there are no chances of contracting an infection, because they link risk, consciously or unconsciously, with pregnancy.

Therefore, any sex practices which do not involve the vagina and the penis are not perceived by many as being sex, and they are considered non-risky. As a matter of fact, we know that unprotected anal sex with an infected partner is the sexual practice which carries the highest HIV transmission risk.



Let's talk about **MSM** (men who have sex with men) and **WSW** (women who have sex with women). People who have sex with those of the same sex are doing so for a variety of reasons other than as an expression of their sexual orientation or identity. Some people may regularly have sex with others of the same sex without seeing themselves as lesbian or gay (whether due to cultural, religious or personal reasons). Others may temporarily do so due to circumstances, such as being confined to a facility (i.e. a prison, mines) or a period of separation from the opposite sex (i.e. during military training or operations).

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

How people perceive anal sex differs. You can refer to the Durex Sexual Health and Wellbeing Study. The inside of the anus is a very sensitive place, like the inside of the mouth. Because it can be easily hurt and damaged, it is highly suggestible to a sexually transmitted infection. Inside the anus is a gland which is called the prostrate. For most men, the prostrate is a very pleasurable spot when stimulated, no matter what their sexual orientation is. Even if you look at the Durex study results, some homosexual men do not prefer anal sex. Some lesbian women prefer anal sex. Below are reported percentages of how men and women experience anal sex according to the results of the Durex study.

- Anal sex - giving (8% hetero female, 19% hetero male, 72% homo male, 10% homo female)
- Anal sex – receiving (18% hetero female, 11% hetero male, 67% homo male, 15% homo female) 11% of heterosexual men reported that they like receiving penetrative anal sex from their female partners
- Oral sex - giving (56% hetero female, 58% hetero male, 83% homo male, 77% homo female)
- Oral sex - receiving (55% hetero female, 56% hetero male, 81% homo male, 74% homo female)

Discuss the issue of guilt and the shame associated with certain sexual practices, e.g. the "anal taboo". Because of that, some people take part in hidden and risky sexual activities. A heterosexual man might feel too shy to ask his wife or girlfriend to perform anal sex on him, he might try to find the sexual satisfaction he needs somewhere else, often putting himself and his male and female partner(s) at risk. Originally anal sex was seen as a gay sexual practice. We are aware of more and more women who include anal sex, both giving and receiving, in their sexual repertoire.

A challenge arises when trying to identify an MSM. You cannot say an MSM is 1.8 m tall, has a beard, and wears only blue shirts. Out of experience we know that MSM are not easily identified and would not necessary disclose to service providers, hence would end up not receiving services unique to their needs. Not all MSM see the sexual practices they have with other men as sex, for example anal penetration without a condom and water-based lubrication. They might assume that, since there is no vagina, and no chance for pregnancy, what they are practicing is not sex, but rather 'just playing around with the boys'! The reality is that they are engaging in high risk sex and are vulnerable to HIV transmission, without even being aware of it.

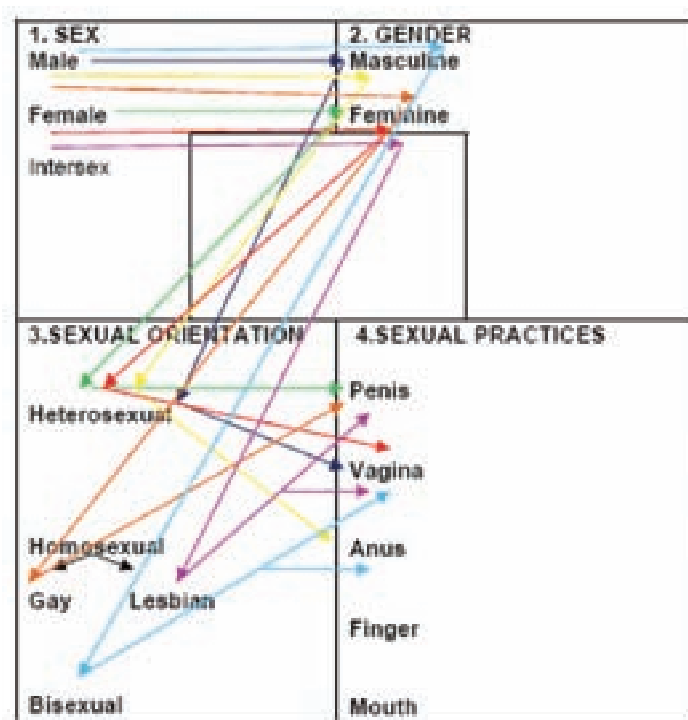
VERY IMPORTANT: Men who engage in anal intercourse, irrespective of whether this is insertive (TOP), receptive (BOTTOM) or both (VERSATILE) and whether it is with men or with women, or both, must be informed that HIV can pass through the delicate mucosal membrane of the rectum. For this reason, receptive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

Don't assume people know what sex is all about. Again, ***never ever assume***.
When talking about responsible and safer sex strategies with a client, never assume the sexual practices they may be indulging in. The message must be all encompassing. For example, when giving safer sex messaging to lesbian women say something like, "Here is a safer sex pack, use condoms on toys or when you have sex with men etc. Act as if it is the most natural thing in the world for you to talk about." When speaking to men, try something along the lines of "Here is a condom, use it when you have sex with a male or female partner, anal or otherwise."

A closing statement could be: ***"Who we have sex with is not important, how safely we have sex with others – that is what is important!"***

Wrap up

Link up all the possibilities with colour pens by:



Link various options of a human being and their sexuality on the flipchart with different colour pens. The following can be examples:

Biological male – married (to a woman) with children, with masculine gender presentation – identifies as heterosexual – is a practicing MSM (has anal sex, giving or receiving, by visiting men only sex clubs once a month).

Biological male – married (to a woman), with a bit of a feminine gender presentation – identifies as bisexual – has mostly vaginal sex, never had sex with a man (and chooses not to) but has sexual fantasies about the same sex, currently NOT a practicing MSM.

Biological male – divorced, masculine gender presentation – identifies as heterosexual – has anal sex with and receives oral sex from a man (he is in prison for the next 10 years).
Biological female – married (to a man) with a masculine gender presentation – identifies as heterosexual – and has vaginal sex.
Biological female – with feminine gender presentation – identifies as a lesbian – has sexual fantasies about the opposite sex.
Biological female – with a masculine gender presentation – prefer to be a FTM – identifies as bisexual – receives anal sex.
Biological female – married (to a man) with feminine gender presentation – identifies as heterosexual – practices WSW (through threesomes with her husband present).

In conclusion:

- People may or may not express their sexual orientation in their behaviours, sexually or otherwise. ***YOU CAN NEVER ASSUME ANOTHER PERSON'S SEXUAL ORIENTATION.***
- Some people may regularly have sex with others of the same sex, without seeing themselves as lesbian or gay (whether due to cultural, religious or personal reasons).
- Gender presentation has got nothing to do with being lesbian or gay. Most lesbian women consider themselves as women and similarly, most gay men consider themselves to be men.
- Being transsexual has got nothing to do with being lesbian or gay. Transsexual people can be heterosexual, lesbian, gay or bisexual.
- Being transvestite has nothing to do with sexual orientation. Transvestites can be heterosexual, gay or bisexual.
- Intersex is a biological variant and NOT a sexual orientation, nor does it refer to sexual behaviour.
- Having a penis does not make you a man, having breasts does not make you a mother, being heterosexual does not make you "normal".
- Our language is too limited to fully describe a human being's sexuality and sexual expression.

Session Four: Identity Development and Coming Out

Time: 60 minutes

Aim of the Session

To allow participants to personally experience revealing or keeping a secret; and allow for reflection on the relevance of such an experience in this workshop.

Learning Objectives

- To understand the process of a person's identity development
- To share knowledge and experiences of own identity development
- To demystify an LGBT person's coming out experience
- To allow participants to make the connection with the experiences of lesbian and gay people regarding revealing or keeping their sexual orientation a secret

- To provide information about the identity development of lesbian and gay people and the potential impact of a lesbian or gay sexual orientation on someone's life
- To provide information about coming out as a lifelong process
- To understand the challenges LGBT people and MSM / WSW have when disclosing

Materials Needed

- None necessary for this session, group activity and discussion
- On completion of the session, refer to the Lesbian and Bisexual Women's and the Gay and Bisexual Men's Booklets for "Tips on Coming Out".

Preparation

Ensure that the training room / space can accommodate all participants standing in two rows, looking at each other, with about two meters of space available between them.

Suggested Process

Give the following instructions:
Tell the participants to stand up and, if required, put chairs aside or go outside.
Let the participants all stand on one side of the room/space. Tell them that they are going to do an exercise about revealing and keeping secrets. Make sure you stress the fact that it is allowed to hide the truth; if a participant does not want to be honest, they don't have to.

"I am going to give instructions now. If it applies to you, take two steps forward. While you walk take a look and see who else is walking with you and who stays behind. On my command, "walk back", you may walk back to join the group that stayed behind. Again, remember if you don't want to be honest, you don't have to take two steps forward; you can simply stay put." Also, ask the participants not to over analyse the question, but to make a decision to walk or not as soon as the question is posed. Refrain from answering any questions while the questioning is proceeding.

If LGBT individuals are included in this activity, please note that this activity can also stimulate intense emotions of either memories of coming out, and fear of not and it's important to have a co-facilitator who would deal with those who might become emotional and step out of the activity.

Say the following sentences (and give participants the time to walk, wait a few seconds before giving the "walk back" command:
Everyone who is wearing pants, walk.
Everyone with brown eyes, walk.
Everyone who lives in a township, walk.
Everyone who has a child, walk.
Everyone who does not have a partner, walk.
Everyone who feels overweight, walk.
Everyone who has ever cheated on a partner, walk.
Everyone who had an abortion or helped someone get an abortion, walk.
Everyone who has ever, even once, had unsafe sex, walk.
Everyone who has ever had an HIV test, walk.
Everyone who has regular unsafe sex, walk.
Everyone who has been threatened or beaten by an intimate partner, walk.
Everyone who has threatened or beaten an intimate partner, walk.
Everyone who has ever, even once, felt attracted to someone of the same sex, walk.
Everyone who has ever, even once, had sex with someone of the same sex, walk
You can add or delete statements, make them safer or more daring according to the group. Don't be nervous to say the most daring sentences - everybody is allowed to hide the truth! Stop this exercise after 10 minutes and ask everyone to return to their seats in the plenary.

Group Discussion

Have a feedback discussion without offering any information about the content of the group discussion. Before moving on to the lesbian and gay-specific content, ask participants what they thought of the exercise,

- how it made them feel?
- what kind of thoughts went through their minds while doing the exercise?

For those who have walked alone at times, how did it feel?
If someone wants to share a personal remark, allow for that. If it is not already mentioned, ask the participants what the connection is between the exercise and lesbian and gay people. Emphasise that lesbians and gays often live with a secret, and many keep this secret for a long time. Telling someone the secret or disclosing their sexual orientation could for some be life threatening, however also remember that it's a human right not to disclose as some people choose to. Telling someone that you are gay or lesbian is called **coming out**. Ask if people have heard of this term, if they know what it means or what they think it means.

Explanation of the Coming Out Process

Before this exercise write up key points for discussion on a flipchart, and refer to these while you speak. Give the stages of development as a lesbian or gay person, including the moment of coming out. Explain what coming out means: to acknowledge to yourself and others that you are lesbian, gay or bisexual. Explain the essence of coming out: how it is a lifelong process and not a once off event. Emphasise that although a lot of lesbian and gay people come out in their late teens, there is no specific age for coming out. Also stress that some people never come out, because it is too dangerous or for other reasons. Coming out is a choice, not a must!

Pointers to describe the phases of coming out:
Feelings of being different - internal phase
Confusion, denial - internal phase
Realisation - internal phase
Coming out, telling another - external phase
Discovering a new lifestyle - external phase

Ask the group to apply this information to themselves, other health care providers, teachers etc.
Can they imagine how it works and can they understand why it can be difficult to come out, or to tell a secret? Check understandings around how much time a coming out process can take. A lot of people think it is a short and sudden experience, instead of a process. Emphasise the importance and duration of the process, which can last a lifetime.

Storytelling
If appropriate, facilitators may wish to briefly share their own experiences of coming out with regards to a "secret" in their lives. By giving prompting questions to each other, talk about self disclosure; reflections on how it has been for you and how it impacts on the work that you do. You could also then refer to the info sheet on coming out tips, as a guide.
NB!
It's also important to emphasise that coming out is not always linked to danger or acceptance by society, but a process chosen by those comfortable with their sexual orientation, or don't choose because they are comfortable. Some argue, why are heterosexuals not "coming out"? Because there is a level of self acceptance.

Wrap up

- It is very difficult to share a "secret" or to come out to a health care provider who is known to be judgmental, discriminatory and who doesn't treat clients' information as confidential.
- Coming out is a deeply personal process for a lesbian, gay or bisexual individual.
- Coming out is a choice, a right, not a must.
- Some never tell, they are too afraid of rejection or of being hurt in other ways.
- LGBT individuals should be supported to accept themselves for who they are, before coming out to others.
- The coming out process should be respected and supported by health care providers.
- Coming out is a process, it happens over time and more than once.
- Everyone in the life of the LGBT individual is not informed at once.
- Coming out should not be forced. A person should only come out if they want to, without rushing into it.
- The person to come out first should be carefully chosen.
- Some LGBT individuals will rather come out to someone in another neighbourhood, as there is the fear that someone close to them might gossip and "out" them.

- LGBT individuals should be supported to come out first to someone they trust and to follow their gut feeling regarding who would be the best person, e.g. mother versus father to come out to first.
- When coming out, the response from the loved one or other person could vary. It might be a surprise. If it is parents, they had dreams for and expectations for their child, which they could feel are now shattered.
- The LGBT individual should be prepared for the questioning that might follow. People often have very stereotyped views of lesbian, gay and bisexual people and their lives.
- An individual might choose to keep their sexual orientation a secret, which might at first feel comforting, but living a secret life can also hurt in the long run. That individual should be encouraged to talk to a professional who is LGBT affirmative and totally supportive.

Session Five: Checking Out

Time: 45 minutes

Aim of the Session

To allow participants to share how they feel about the full day of training and intense information sharing.

Learning Objectives

- To reflect on all new information and experiences
- To share experiences of the day with other participants

Materials Needed

- None

Suggested Process

Ask if there is any participant who would like to share their experience of the day. What stood out for participants? What is the one thing, reminder or new learning, they would take with them after the day? Allow a couple of stories. Facilitate the responses.

Then, before thanking the participants for being part of an exciting and productive day of training, do one final "mood check", taking into consideration that participants' level of energy might be low.

Checking Out with One Word
Each participant is requested to say just one word that would explain how they feel at that exact moment, e.g. the facilitator: moved. Allow all participants a minute or two to think and then express themselves.

The facilitator can also check with participants what worked for them during the day and what did not work. It could be facilitation styles, logistics, room temperature, where they are seated etc. Remember, as a facilitator you are there to make the learning experience as positive as possible for participants.

Day Two: LINKING LGBTI SEXUALITY WITH HIV AND GBV: Meeting LGBTI People's Needs in HIV & GBV Prevention

Session One: Checking in and Re-Cap of the Previous Day

Time: 30 minutes

Aim of the Session

This session aims to 'check in' with participants, on what the impact was of the previous day's training, how they feel on the second morning, to re-cap the previous day's sessions and clarify any uncertainties.

Learning Objectives

By the end of the session participants will:

- Be able to express themselves and their experience of the previous day's training
- Be able to ask for clarity, if necessary.

Suggested Process

Ask if there is any participant who would like to share their experience of the previous day, now that they have had a chance to go home and "sleep on it". Was there anything participants did as a result of what they have learned the previous day? Allow for a couple of stories to be shared. Facilitate responses. Then, before introducing the second day's content, use the same ice breaker as the previous afternoon to check participants' levels of energy, excitement and interest for the new day's training.

'Checking In' with One Word
Each participant is requested to say just one word that would explain how they feel at that exact moment, e.g. the facilitator: excited! Allow all participants a minute or two to think and then express themselves.

Session Two: LINKING SEXUALITY WITH HIV & GBV: LGBTI People & HIV Prevention

Time: 90 minutes

Aim of the Session

This session aims to allow participants to explore the specific risks that can impact LGBTI people with regard to HIV.

Learning Objectives

By the end of the session participants will:

- Be able to understand the risk factors with regard to sexual identity, sexual practices and HIV transmission
- Debunk myths around LGBTI people and HIV
- Be able to understand what safe sex messaging for LGBTI people would entail

Materials Needed

- Flip chart paper
- Different colour markers / pens
- Shernoff's Hierarchy of Risk
- "Much More" Booklet
- Lesbian and Bisexual Women's Booklet
- Gay and Bisexual Men's Booklet
- Transgender Booklet
- Handout: **Myths to cut out and give to groups**

Preparation

Divide participants into small groups of maximum five people in a group. Give each group some flip chart paper and markers.

Suggested Process

Explain to the group that you are going to give each group a copy of Shernoff's Hierarchy of Risk. Taking into consideration the previous day's training, list all the possible risks each of the LGBTI individuals might be challenged by with regard to their risk towards HIV transmission. Each group has about 30 minutes to complete this exercise and then allow 30 minutes for feedback and discussion.

TopTip

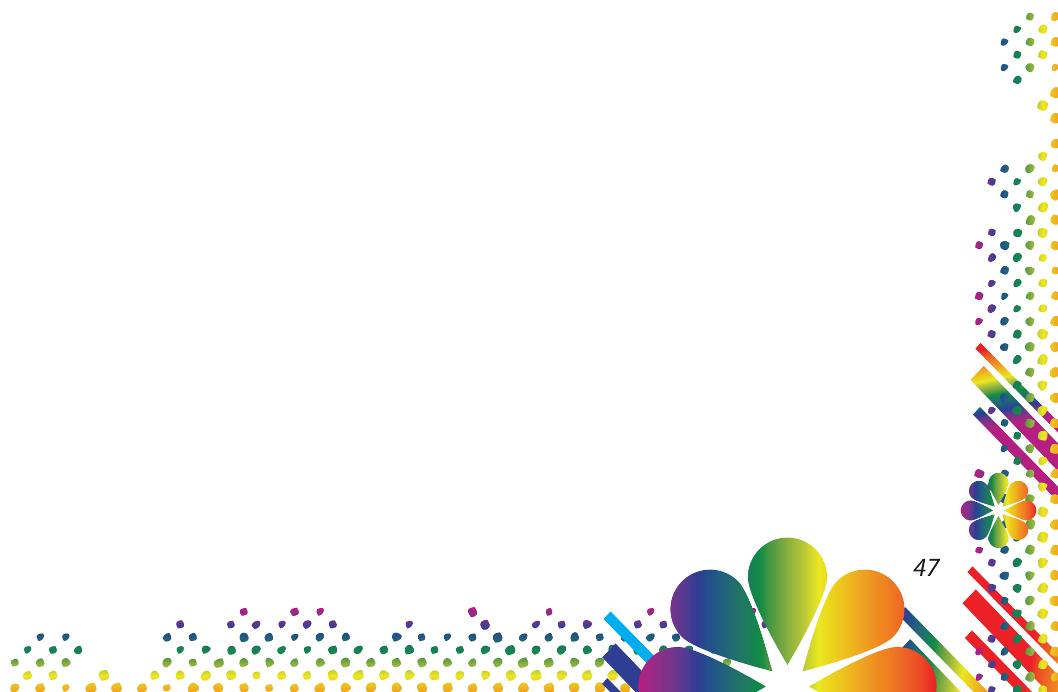
Identifying LGBTI Risk
Examples:

Lesbian	Gay	Bisexual	Transmen	Trans-women	Intersex
No 8. Frottage - vulvas together No 30. Anal intercourse with internal ejaculation without a condom	No 30. Anal intercourse with internal ejaculation without a condom	No 30. Anal intercourse with internal ejaculation without a condom	No 30. Anal intercourse with internal ejaculation without a condom	No 30. Anal intercourse with internal ejaculation without a condom	No 30. Anal intercourse with internal ejaculation without a condom

Note that the highest risk - No. 30, Anal intercourse with internal ejaculation without a condom - is a sexual practice that that could be practiced by any person, no matter their sexual or gender identity.

Following the discussion on LGBTI people and risk, continue with a 60 minute discussion on common myths with regard to LGBTI people and HIV. Write down each myth identified by the group on the flipchart and elicit a discussion within the group.

Make use of the "Much More" Booklet in this toolkit to facilitate the process.
See also the handout of some examples of myths which you could also hand out to different groups to discuss, if you do not want to write them down on a flipchart.



Session Three: LINKING SEXUALITY WITH HIV & GBV: LGBTI People & GBV Prevention

Time: 60 minutes

Aim of the Session

This session aims to allow participants to explore the specific challenges impacting LGBTI people, with regard to gender based violence (GBV).

Learning Objectives

By the end of the session participants will:

- Be able to understand the risk factors with regard to sexual and gender identity and presentation and GBV
- Debunk myths around LGBTI people and GBV
- Link GBV and HIV risk and vulnerability

Materials Needed

- Flip chart paper
- Different colour markers / pens
- Lesbian and Bisexual Women's Booklet
- Gay and Bisexual Men's Booklet
- Transgender Booklet
- Handouts:
- *1. WikiLeaks cables: Ugandan gay rights activist 'mocked' at rights seminar by Karen McVeigh*
- *2. Malawi gay couple who 'married' face harsh prison sentences by David Smith in Johannesburg and Godfrey Mapondera in Blantyre*
- *3. Once again the 'T' in LGBT is silenced by Natacha Kennedy*
- *4. Raped and killed for being a lesbian: South Africa ignores 'corrective' attacks by Annie Kelly*

Preparation

Divide the group into four groups. Give each group some flip chart paper and markers to make notes on for feedback purposes.

Suggested Process

Explain to the groups that you are going to give each group a newspaper article with regard to LGBTI people and GBV. Taking into consideration the training up to this point, discuss the article. How are these newspaper reports indicative of the experiences of African LGBTI people in general? Each group has about 30 minutes to complete this exercise and then allow 30 minutes for feedback and discussion. Discuss the four newspaper articles in the light of GBV that LGBTI people may experience in Africa. Link it with HIV risk and vulnerability for all the players (in the article) involved.

TopTip

GBV and LGBTI Definition
Gender based violence (GBV) includes, but is not limited to, violence against women (VAW), and covers violence against sexual minorities. Gender is understood as the social relationships that shape our understandings, norms and behaviours regarding femininity and masculinity, the cultural conditioning of what is expected of women and men in a given society, and in that sense, GBV could be defined as dealing in sum total with the various elements of the patriarchal ideology: the heteronorm-based violence against LGBT people, the notion of controlling 'others', whose economic independence, sexual freedom and untamed sexuality are viewed as threatening to the male-centred social structure, and therefore criminalised in order to uphold family values and morality. http://www.beyondthebluesky.com/press/pdf/Human%20rights_GBV_HIV%20paper.pdf

Session Four: Designing a Minimum Service Package (MSP) for LGBTI People

Time: 90 minutes

Aim of the Session

This session aims to allow participants to design a specific MSP with regard to HIV and GBV prevention for the LGBTI individuals in their community.

Learning Objectives

By the end of the session participants will:

- Be able to design a Minimum Service Package for LGBTI-affirmative services by making use of the information of the training up to now, as well as tools within the toolkit.

Materials Needed

- Flip chart paper
- Different colour markers / pens
- Handout: **Minimum Service Package (MSP) for HIV and GBV Prevention for Sexual Minorities**

Preparation

Divide the group into small groups of maximum five people in a group. Give each group some flip chart paper and markers and a handout of an MSP example.

Suggested Process

Explain to the groups that you are going to give each group an example of the components of an MSP. Taking into consideration the training up to this point, discuss how an MSP would look like in your community. In other words, embroider on the six components given. Each group has about 60 minutes to complete this exercise and then 30 minutes is allowed for feedback and discussion.

Why is an MSP needed?
No single existing intervention has the ability to stop HIV transmission among sexual minorities.
A successful prevention programme = structural + biomedical + behavioural interventions.
These interventions are supportive of each other, constantly evaluated, and customised to the needs and risks of specific at risk populations.
HIV and GBV prevention programmes should be scientifically accurate, evidence-based, and designed to be responsive to the needs and experiences of local sexual minorities, and to reach them through safe and non-judgmental settings

Session Five: Advocacy for LGBTI Needs in HIV & GBV Prevention

Time: 60 minutes

Aim of the Session

This session aims to allow participants to identify the specific advocacy needs with regard to HIV and GBV prevention for the LGBTI individuals in their community.

Learning Objectives

By the end of the session participants will:

- Be able to identify the specific advocacy needs of LGBTI people by making use of the information gained in the training up to now, as well as from all the different tools within the LGBTI toolkit.
- Be able to implement the identified Advocacy Plan in their community.

Materials Needed

- Flip chart paper
- Different colour markers / pens
- Handout: **Identifying a LGBTI Advocacy Plan**

Preparation
Divide the group into small groups of maximum five people in a group. Give each group some flip chart paper and markers and all appropriate handouts within the toolkit.

Suggested Process
Explain to the groups that each group should work together and design an advocacy plan, taking into consideration the training up to this point, as well as all the tools within the toolkit. Discuss how an Advocacy Plan would look like in their community. Each group has about 30 minutes to complete this exercise and then 30 minutes allowed for feedback and discussion.

Session Six: Closing Remarks and Participants' Post-Course Assessment and Course Evaluation

Time: 45 minutes

Aim of the Session
To allow participants to share how they feel about the full two days of training and intense information sharing and to complete an assessment and evaluation form with regard to their learning and experiences.

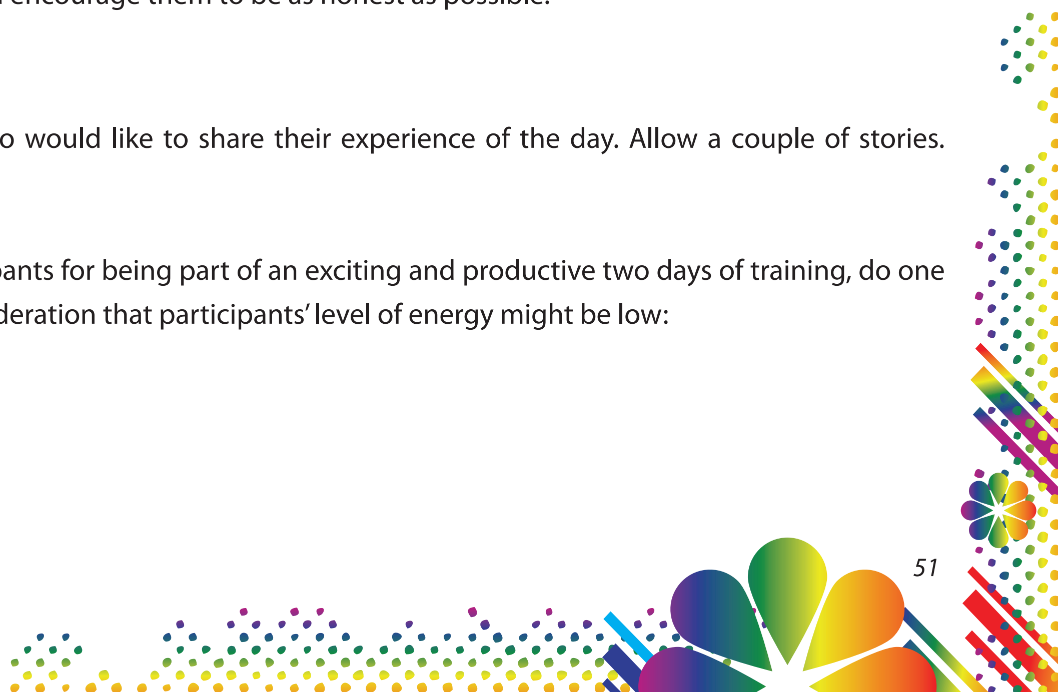
Learning Objectives
- To reflect on all new information gained and experiences
- To share experiences of the day with other participants
- To evaluate the day as the experience is still fresh

Materials Needed
- Participant's post-course assessment and course evaluation for each participant.

Preparation
Hand out all assessment and evaluation forms and give participants about 15 minutes to complete them. Ensure anonymity and confidentiality and encourage them to be as honest as possible.

Suggested Process
Ask if there is any participant who would like to share their experience of the day. Allow a couple of stories. Facilitate the responses.

Then, before thanking the participants for being part of an exciting and productive two days of training, do one final ice-breaker, taking into consideration that participants' level of energy might be low:



TopTip

'Checking Out' with One Word

Each participant is requested to say just one word that would explain how they feel at that exact moment, e.g. the facilitator: inspired. Allow all participants a minute or two to think and then express themselves.

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6. Annexes

Annex 1: Sample: Training Programme Training Programme

Annex 2: Sample: Participants Post-Course Assessment and Course

Annex 3: Handouts

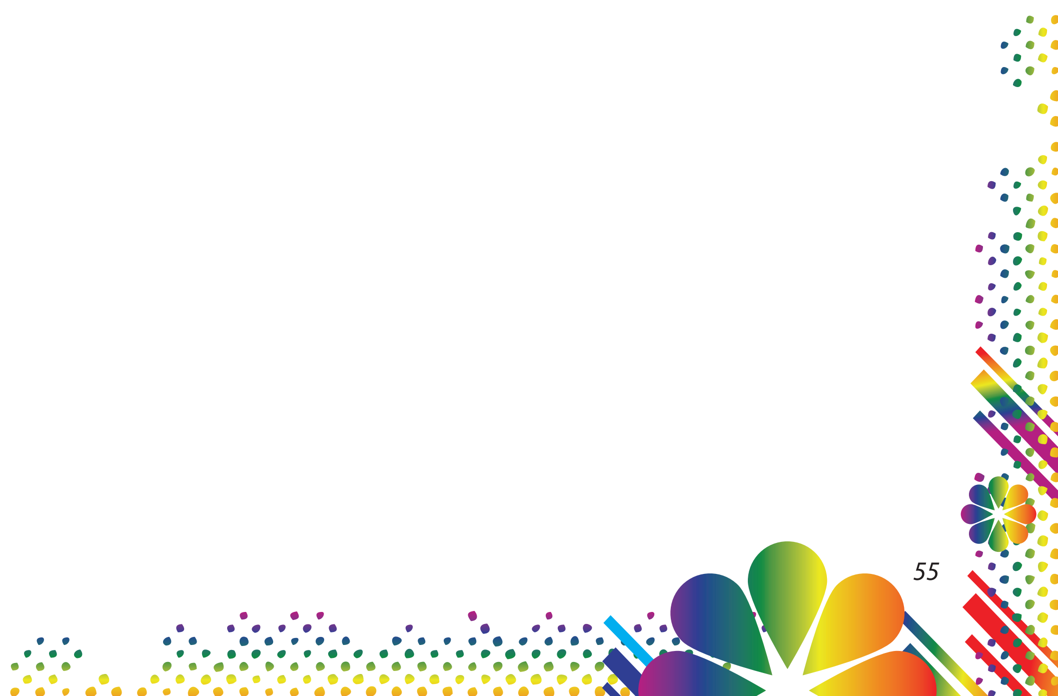
The following handouts can be used by facilitators if needed or when appropriate and as indicated by materials needed.

1. Human Sexuality– the grid to hand out on completion of Day 1
2. Minimum Service Package (MSP) for HIV and GBV Prevention of Sexual Minorities
3. Newspaper articles to be used with GBV session
4. Shernoff's Hierarchy of Risk
5. Examples of Myths
6. Identifying a LGBTI Advocacy Plan

Annex 1: Sample: Training Programme

Day 1 – Unpacking Human Sexuality				
1	08h00	Registration & Welcome Tea		60 min
2	09h00	Ice Breaker, Introductions, Expectations & Ground Rules		45 min
3	09h45	Experiential Exercise		60 min
4	10h45	Tea & Body Break		30 min
5	11h15	Human Sexuality Sex as a Biological Concept Gender as Social Construct Sexual Orientation		90 min
6	12h45	LUNCH		60 min
7	13h45	Human Sexuality Continued Sexual Practices		30 min
8	14h15	Identity Development & Coming Out		60 min
9	15h15	Tea & Body Break		30 min
11	15h45	Wrap Up Mood Meter		30 min

Day 2 – Meeting LGBTIs Need in HIV & GBV Prevention				
12	08h00	Morning Tea		30 min
13	08h30	Checking in & Re-Cap of Previous Day		30 min
14	09h00	HIV& Hierarchy of Risk		60 min
15	10h00	Tea & Body Break		30 min
16	10h30	Linking Sexuality with HIV & GBV LGBTI People & HIV Prevention		60 min
17	11h30	Linking Sexuality with HIV & GBV LGBTI People & GBV Prevention		60 min
18	12h30	Designing a MSP (Minimum Service Package) for LGBTI HIV & GBV Prevention (part 1)		30 min
19	13h00	Lunch		60 min
20	14h00	Designing a MSP (Minimum Service Package) for LGBTI HIV & GBV Prevention (part 2)		60 min
21	15h00	Tea & Body Break		30 min
22	15h30	Advocacy for LGBTI Needs in HIV & GBV Prevention		60 min
23	16h30	Closing Remarks Participants' Post-Course Assessment and Course Evaluation		



Annex 2:
Sample: Participants' Post-course Assessment

Date of training:
Place of training:
Trainer/s:

1. Did you find the training beneficial? Explain why or why not:

2. How did the past two day training affect you, both personally and professionally?

3. Which part of the programme did you find most useful and why? Please explain:

4. Which part of today's programme did you find least useful and why? Please explain:

5. Do you find that you can now talk about human sexuality, including issues of sexual minorities with more confidence / ease? Please explain.

6. Please tick which information you are still in need of:							
Lesbian	Gay	Bisexual	Transgender	Intersex	MSM	WSW	Other: please clarify

7. Do you think you might still experience any difficulties / challenges with dealing with any LGBTI clients? Please explain.

___

___

___

8. Do you have any other comments about the training? Please explain:

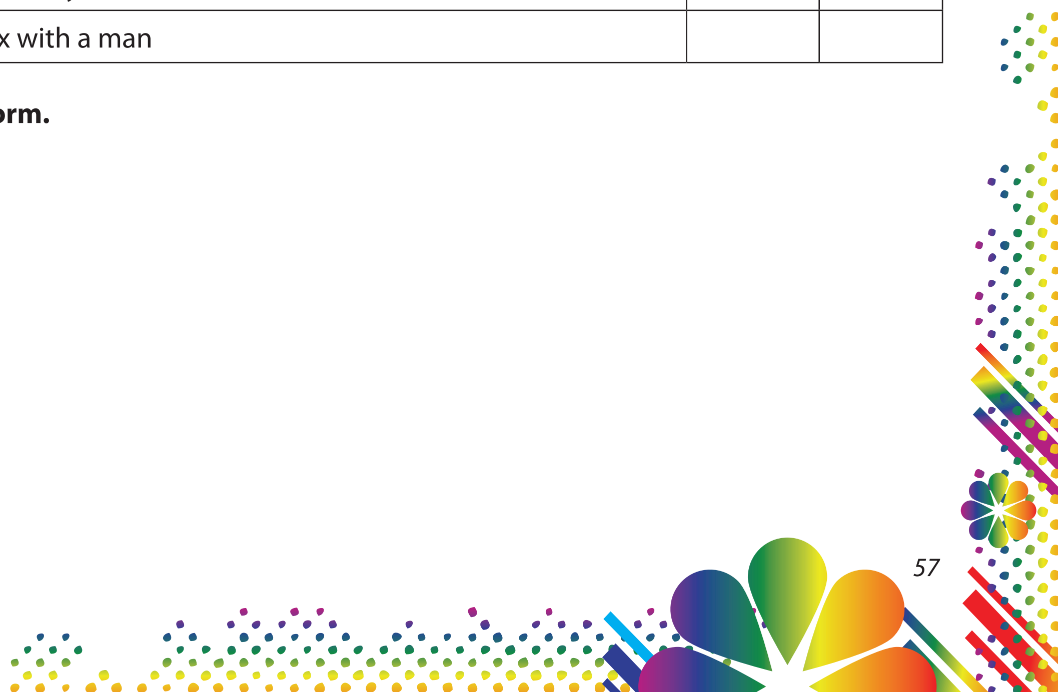
___

___

Let's see if you understand what you have learned the past two days. Please indicate if the following statements are TRUE or FALSE

No	Statement	True	False
1	Intersex and bisexuality are the same		
2	Being homosexual is a choice made by all gay and lesbian people		
3	A lesbian woman can get pregnant		
4	Two HIV + gay men can have sex without risk to either of them		
5	MSM is just an acronym for homosexual men		
6	Bisexuality is not just a temporary phase		
7	Masculine lesbian women want to be men		
8	Transgender people cannot have sex		
9	Transsexuality and homosexuality are not the same		
10	Bisexuals are known to have multiple concurrent partners		
11	All gay men have anal sex		
12	Heterosexual men only have sex with women		
13	Butch lesbians might abuse their partners		
14	Intersex people are born that way		
15	Lesbians will never have sex with a man		

Thank you for completing this form.



Annex 3: Handouts
Human Sexuality – the binaries and boxes grid (2 pages)

SEX – biological concept (what you are born with…)

1. What's in your pants? Including chromosomes and hormones etc
2. Biologically Female?
3. Biologically Male?
4. Intersex is a set of medical diagnoses that feature "congenital anomaly of the reproductive and sexual system." Intersex people are born with chromosomes, external genitalia, and/or internal reproductive systems that are not considered "standard" for either male (penis, testes, and XY chromosomes) or female (ovaries, vagina, uterus, and XX chromosomes).
5. Intersex is a fairly common occurrence. It is estimated that, according to Intersex SA, 1 in 500 babies are born obviously intersex in SA.
6. Intersex people's bodies have historically been, and continue to be, viewed as "social emergencies" by doctors. When discovered at birth in most Western countries, unnecessary cosmetic surgery is performed on the majority of intersex babies to force them to conform to either male or female aesthetic binary standards. These surgeries often require multiple follow-up repair surgeries and are ridden with complications. Obviously, an infant cannot consent to having surgery, and adult intersex people are often haunted by a lifetime of these unnecessary procedures that rob them of their sexual sensations and have long term affects on their ability to feel present and safe in their bodies.

GENDER – social construct (you are NOT born with…)

1.Learned behaviour, culturally and socially determined, sometimes subtle, often not challenged
2.What is feminine or
3. Masculine
4.Certain tasks and behaviours are considered appropriate for a person's biological sex
5. Gender identity: This refers to how someone feels about themselves in the world as a woman or a man, i.e. a person's sense of themselves as male or female. While most people's gender matches their biological sex, this is not always the case, and for instance, someone may be born biologically male, yet have a female gender identity
6. In many societies, including most in Africa, men are considered superior to women and their roles dominant. In these so-called patriarchal, heteronormative, heterosexist societies, males, 'masculine' characteristics [such as rationality and competitiveness] and roles assigned to men are considered superior and valued above females' roles, those characteristics considered 'feminine' [such as emotionality and nurturing] and roles assigned to women. Gender and gender roles are, however, not fixed as society and culture are forever changing.

7. Transgender – umbrella term for transsexuals and transvestites
8. Gender presentation: Most biological males [sex] identify as men [gender] and females identify as women. However, there are people whose gender identity differs from the general pattern.
9. Transsexuals: People whose gender does not match their sex. E.g., a person who is biologically male but feels like a female. Transsexuals often explain being "trapped in the wrong body".
10. MTF or FTM (with or without gender reassignment surgery)
11. Transvestites (cross dressers): The term refers mostly to men, usually heterosexuals, who enjoy wearing female clothes and adopt traditionally female character traits for personal satisfaction. This satisfaction may take the form of sexual arousal and/or gratification, but may just as easily be of a non-sexual nature. Transvestites generally self-identify as men and have no interest in being women.
12. Other labels – gender benders, twinks, bois, androgynous

SEXUAL ORIENTATION – emotional & sexual expression towards others

1. Feelings, attraction (on all levels) and self concept
2. how a person expresses themselves in relation to others, i.e. the lasting (more than two weeks) emotional, romantic, intellectual, sexual or intimate feelings (all levels, psychologically, physically, intellectually, spiritually) they have for individuals of a specific sex
3. Three sexual orientations: heterosexual (straight), challenged by homosexual & bisexual - ALL HUMANS HAVE ONE!
4.Homosexuality – two identities – lesbian or gay
5. A gay man is someone who has romantic, sexual, intellectual and intimate feelings for or a love relationship with another man [or men] and identifies as gay;
6. A lesbian woman is a woman who has romantic, sexual, intellectual and intimate feelings for or a love relationship with another woman [or women] and identifies as lesbian.
7. Bisexual: The ability to have romantic, sexual, intimate feelings for or a love relationship with someone of the same sex and/or with someone of the opposite sex. Note, being bisexual doesn't mean that they will have these feelings at the same time or with an equal amount of attraction to both sexes. Or that these individuals have multiple concurrent partners.
8. Internalised homophobia: The link between heteronormativity, patriarchy (even matriarchy), heterosexism & L(esbian)G(ay)B(isexual)T(ransgendered)'s internalised hatred, shame etc.
9. A transgender individual can have any sexual orientation.

SEXUAL PRACTICES – behavior + meaning

1.MSM (men having sex with men) or WSW (women having sex with women) - These people may have sex with others of the same sex for a variety of reasons other than as an expression of their sexual orientation. Some people may regularly have sex with others of the same sex, without seeing themselves as lesbian or gay (whether due to cultural, religious or personal reasons). Others may temporarily do so due to circumstances, such as being confined to a facility (i.e. a prison) or a period of separation from the opposite sex (i.e. during military training or operations).
2.Some statistics to debunk sex myths(www.durex.com/en-us/sexualwellbeingsurvey):
3.Anal sex - giving (8%hetero female, 19% hetero male, 72% homo male, 10% homo female)
4. Anal sex – receiving (18%hetero female, 11%hetero male, 67%homo male, 15% homo female)
5. Oral sex – giving (56% hetero female, 58% hetero male, 83% homo male, 77% homo female)
6. Oral sex – receiving (55% hetero female, 56% hetero male, 81% homo male, 74% homo female)
7. What is sex? What is the definition of "having sex"? Not all people have the same understanding of what "having sex" means. Never assume that someone is aware that their sexual practice is actually "sex" – this could lead to them withholding important information, that without you (or them) knowing it, possibly putting them at risk.
8. Body parts – all human beings experience sexual pleasure different.
9. Sexual fantasies do not necessarily match / reflect sexual orientation / identity. Often people feel unnecessarily guilty and ashamed of their secret fantasies.

SEX	GENDER
• Biologically female • Biologically male • Intersex	• female and feminine • male and masculine • MTF • FTM • Transvestites
SEXUAL ORIENTATION	**SEXUAL PRACTICES**
• Gay • Lesbian • Bisexual • Heterosexual or straight	• MSM • WSW • Anal sex - giving • Anal sex – receiving • Oral sex • Vaginal sex • Sexual fantasies with same sex • Sexual fantasies with opposite sex

Examples:

Biological male – married (to a woman) with children, with masculine gender presentation – identifies as heterosexual – is a practicing MSM (has anal sex, giving or receiving, by visiting men only sex clubs, once a month)
Biological male – married (to a woman), with a bit of a feminine gender presentation – identifies as bisexual – has mostly vaginal sex, never had sex with a man (and chooses not to) but has sexual fantasies with same sex, currently NOT a practicing MSM
Biological male – divorced, masculine gender presentation – identifies as heterosexual – has anal sex with and receives oral sex from a man (he is in prison for the next 10 years)
Biological female – married (to a man) with a masculine gender presentation – identifies as heterosexual – and has vaginal sex
Biological female – with feminine gender presentation – identifies as a lesbian – has sexual fantasies with the opposite sex
Biological female – with a masculine gender presentation – prefer to be a FTM – identifies as bisexual – receives anal sex
Biological female – married (to a man) with feminine gender presentation – identifies as heterosexual – practices WSW (through threesomes with other women with her husband present)

Minimum Service Package (MSP) for HIV and GBV Prevention of Sexual Minorities

Why is an MSP needed?

No single existing intervention has the ability to stop HIV transmission among sexual minorities. So a combination of interventions is required to ensure that the desired quality of life and outcome is attained by individuals and communities.

A successful prevention programme = structural + biomedical + behavioural interventions. These interventions are supportive of each other, constantly evaluated, and customised to the needs and risks of specific at risk populations.

HIV and GBV prevention programmes should be scientifically accurate, evidence-based, and designed to be responsive to the needs and experiences of local sexual minorities, and to reach them through safe and non-judgmental settings.

The following comprehensive package with its components is suggested:

- Community-based outreach;
- Provision of prevention methods and tools (including condoms and condom-compatible lubricants,)
- Positive prevention for LGBTI people living with HIV
- HIV counselling and testing (HCT);
- Care, support and treatment services
- Targeted information, education and communication and
- Management of sexually transmitted infections (STI)

Community-based outreach

- Dissemination of HIV and GBV risk reduction information and targeted media;
- Distribution of barrier methods, including the female condom (Femidom), dental dams, condoms and condom-compatible lubricants (NO oil-based lubricants);
- Training on correct use of barrier methods;
- Provision of referrals and linkage to HIV testing, other HIV prevention programs, drug and alcohol treatment, mental health care, HIV health care and treatment and GBV prevention and treatment that provide services that are non-discriminatory and responsive to the needs of sexual minorities.
- Referrals to LGBTI affirmative service providers when trauma e.g. rape, is experienced

Provision of prevention methods and tools

(including condoms and condom-compatible lubricants,)

- An increased availability of free condoms has been shown to significantly reduce HIV risk;
- Condom-compatible lubricants reduce risk of condom breakage during sexual intercourse, and include water-based lubricants that are manufactured for use with condoms and do not compromise the integrity of latex condoms or have other harmful effects;
- The availability of barrier methods for WSW including the above as well as the female condom and dental dams.

Positive prevention for LGBTI living with HIV

- Counselling in general specifically for serodiscordant couples
- Inclusion of LGBTI people living with HIV in all interventions

HIV counselling and testing

- Increasing access to HIV testing is critical for reducing the spread of HIV among sexual minorities and their sex partners and facilitating HIV-positive individual's access to appropriate healthcare;
- HIV counselling and testing programmes for sexual minorities should establish strong linkages with other HIV prevention and health service providers and clinics that can deliver appropriate health care and treatment in a manner that is responsive to the needs of HIV-positive sexual minorities and which maintains their confidentiality.

Care, support and treatment services

- Timely access to life-saving health care, antiretroviral treatment and opportunistic infection prophylaxis has very clear and powerful effects on the health and well-being of people diagnosed with HIV;
- Efforts to provide HIV-positive sexual minorities with access to timely and appropriate HIV medical care and ART should form part of a comprehensive HIV strategy
- Comprehensive counselling and trauma debriefing services

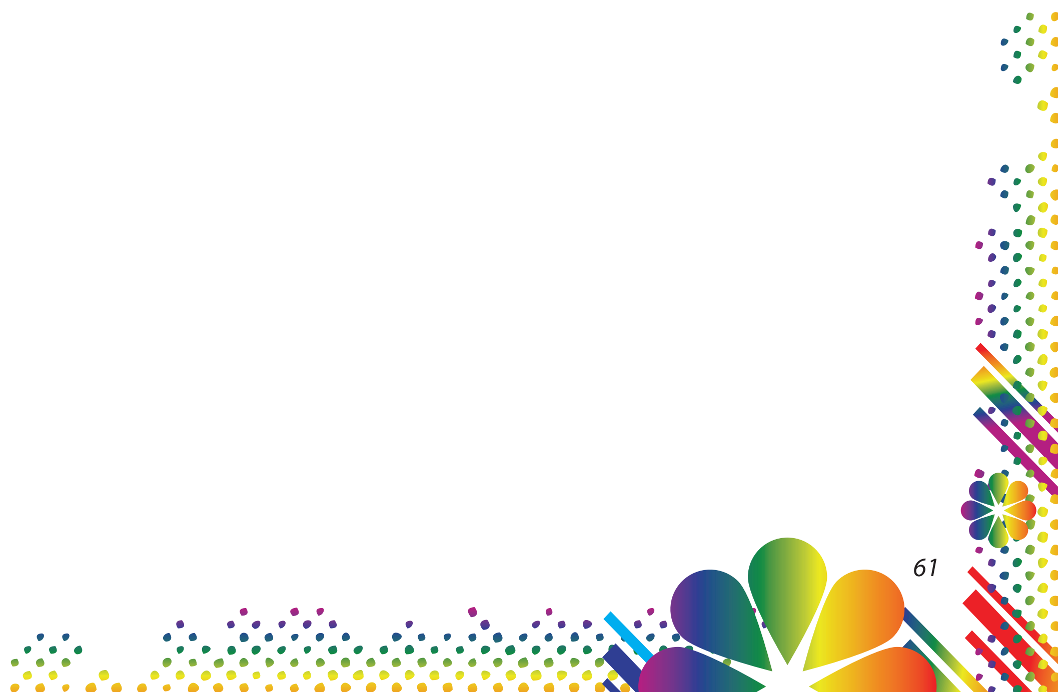
Targeted information, education and communication (IEC)

- Targeted IEC seeks to improve HIV knowledge and awareness; promote beliefs, attitudes, and norms that reduce risk; build skills and self-efficacy; and motivate HIV testing, changes in substance use and sexual practices, and promote other behaviours that reduce HIV and AIDS risk;
- Activities in this category include evidence-based community, small-group, and individual behavioural interventions, peer education, and the development and distribution of targeted media that are used as part of outreach efforts, HIV testing and counselling, behavioural interventions and social marketing campaigns

Management of sexually transmitted infections (STI)

- Other STIs can significantly increase the risk of HIV transmission and acquisition;
- Information and education about the prevention of other STIs should be included as part of a comprehensive package of services;
- The improvement of accessibility to and quality of STI prevention, screening, timely provision of STI results, and STI treatment for sexual minorities is of utmost importance.

Adapted from PEPFAR'S Technical Guidance on Comprehensive HIV Prevention, May 2011



Newspaper articles to be used with GBV session on Day 2

1. WikiLeaks cables: Ugandan gay rights activist 'mocked' at rights seminar by Karen McVeigh www. guardian.co.uk, Thursday 17 February 2011

US embassy cable reports on Uganda's rising homophobia, even at a UN-backed human rights meeting attended by activist David Kato, who was later murdered.

Murdered gay rights activist David Kato was mocked at an UN-backed debate on Uganda's antihomosexuality bill, according to a US diplomat in Kampala in a leaked American embassy cable.

The diplomat said Kato, who was bludgeoned to death near his home in the capital, Kampala, last month, delivered a well-written speech against the bill, but his words were almost inaudible due to "his evident nervousness". Throughout his talk a member of the Ugandan Human Rights Commission "openly joked and snickered" with supporters of the bill, the diplomat claimed in the cable.

http://www.guardian.co.uk/world/2011/feb/17/wikileaks-cables-gay rightsuganda?INTCMP=ILCNETTXT3487

Uganda's Rolling Stone Newspaper calls for homosexuals to be hanged.

Here members of the Ugandan gay community demanding to attend David Kato's funeral close to the town of Mataba. (Marc Hofer/AFP/Getty Images)

2. Malawi gay couple who 'married' face harsh prison sentences by David Smith in Johannesburg and Godfrey Mapondera in Blantyre, www. guardian.co.uk, Friday 14 May 2010

Case could become test for emerging gay rights lobby where homosexuality is illegal in 37 African countries. A man whose same-sex "marriage" has become a symbol of the struggle for gay rights in Africa has vowed to become a martyr rather than give in to homophobia, campaigners say. Tiwonge Chimbalanga and his partner Steven Monjeza are facing a possible 14 years in prison with hard labour after becoming the first gay couple in Malawi to declare their commitment in a public ceremony.

A message from Chimbalanga that said: "I love Steven so much. If people or the world cannot give me the chance and freedom to continue living with him as my lover, then I am better off to die here in prison. Freedom without him is useless and meaningless." Monjeza is quoted – who is described as thin and weak with jaundiced eyes – as saying: *"We have come a long way and even if our family and relatives are not happy, I will never stop loving Tiwonge."*

Chimbalanga, 20, and Monjeza, 26, made history when they committed to marriage at a symbolic ceremony – the first same-sex couple to do so in the southern African state, where homosexual acts are illegal.
Two days later, the couple was arrested at their home. Facing taunts and jeers, Chimbalanga, wearing a woman's blouse, and Monjeza appeared in court to answer three charges of unnatural practices between males and

gross indecency. They were denied bail, supposedly for their own safety, and have been forced to endure dire conditions in jail.

http://www.guardian.co.uk/world/2010/may/14/malawi-homosexual-couple-face-prison

Chimbalanga and Monjeza arrested

3. Once again the 'T' in LGBT is silenced by Natacha Kennedy www.guardian.co.uk, Saturday 22 May 2010

The case of the jailed Malawian 'gay' couple is all the worse as one partner has had her transgender identity airbrushed out.

There has rightly been an international outcry in response to the couple's barbaric treatment, but the protest has been against the perceived homophobia of Malawi's law courts. The problem is, however, that one half of this couple does not primarily identify as gay. Tiwonge is most probably transgender but possibly intersex (in many parts of Africa people do not actually have clear vocabulary to express this), and considers herself a woman. Indeed she has lived "as a woman" all her life.

It has been calculated that a transgender woman is murdered somewhere in the world every 53 hours. Given the relative size of the population of transgender women who are "out", and the fact that not all murders of trans women are known or reported, that is equivalent to at least 1.3 million cisgender women being murdered every year. I suspect that if women were being slaughtered on that scale just for their gender it would be huge news, but when it is trans women (and sometimes trans men) being murdered, it is different.

http://www.guardian.co.uk/commentisfree/2010/may/22/malawian-transgenderidentity?INTCMP=ILCNETTXT3487

THE NATION

GAYS ENGAGE

Bail to engaged couple Tiwonge Chimbalanga, 20, and Steven Monjeza, 22, queerty.com

4. Raped and killed for being a lesbian: South Africa ignores 'corrective' attacks by Annie Kelly, www. guardian.co.uk, Thursday 12 March 2009

The partially clothed body of Eudy Simelane, former star of South Africa's acclaimed Banyana Banyana national female football squad, was found in a creek in a park in Kwa Thema, on the outskirts of Johannesburg. Simelane had been gang-raped and brutally beaten before being stabbed 25 times in the face, chest and legs. As well as being one of South Africa's best-known female footballers, Simelane was a voracious equality rights campaigner and one of the first women to live openly as a lesbian in Kwa Thema.
Her brutal murder took place April 2008, and since then a tide of violence against lesbians in South Africa has continued to rise. Human rights campaigners say it is characterised by what they call "corrective rape" committed by men behind the guise of trying to "cure" lesbians of their sexual orientation.

The ferocity and brutality of Simelane's murder sent shockwaves through Kwa Thema, where she was much known and loved for bringing sports fame to the sprawling township.

Her mother, Mally Simelane, said she always feared for her daughter's safety but never imagined her life would be taken in such a way.

> *"I'm scared of these people that they are going to come and kill me too because I don't know what happened," she said. "Why did they do this horrible thing? Because of who she was? She was a sweet lady, she never fought with anyone, but why would they kill her like this? She was stabbed, 25 holes in her. The whole body, even under the feet."*

The Guardian talked to lesbians in townships in Johannesburg and Cape Town who said they were being deliberately targeted for rape and that the threat of violence had become an everyday ordeal.

Research released last year by Triangle, a leading South African gay rights organisation, revealed that a staggering 86% of black lesbians from the Western Cape said they lived in fear of sexual assault. The group says it is dealing with up to 10 new cases of "corrective rape" every week.

Support groups claim an increasingly aggressive and macho political environment is contributing to the inaction of the police over attacks on lesbians and is part of a growing cultural lethargy towards the high levels of gender-based violence in South Africa.

The failure of police to follow up eyewitness statements and continue their investigation into another brutal double rape and murder of lesbian couple Sizakele Sigasa and Salome Massooa in July 2007 has led to the formation of the 07-07-07 campaign, a coalition of human rights and equality groups calling for justice for women targeted in these attacks.

Sigasa and Massooa were tortured, gang raped and shot near their homes in Meadowland, Soweto in July 2007, shortly after being verbally abused outside a bar.

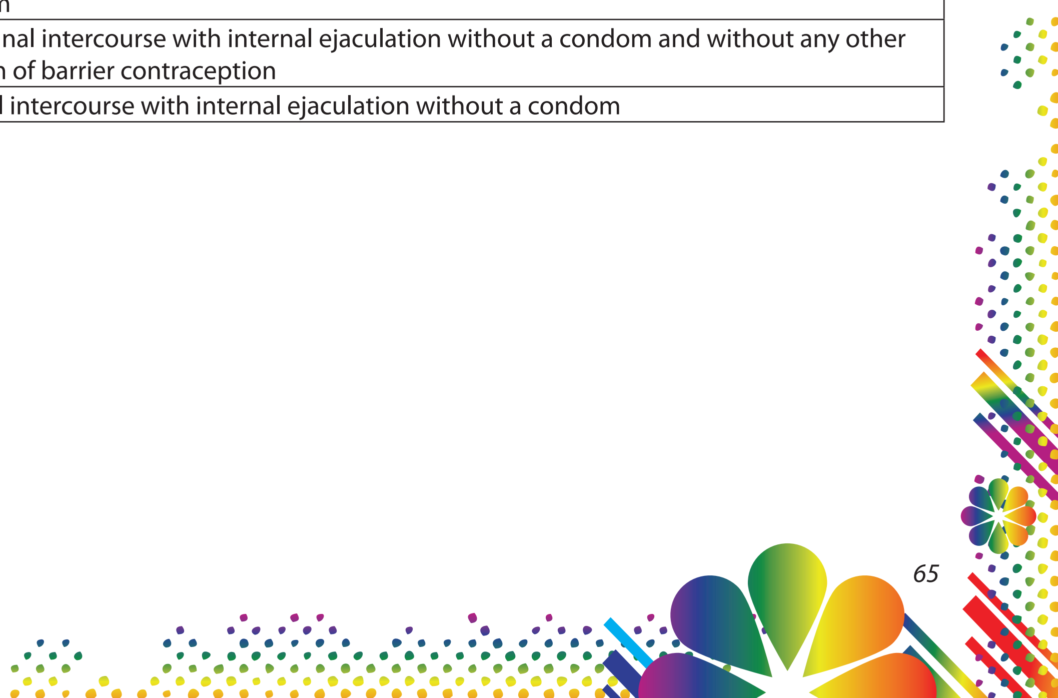
Despite more than 30 reported murders of lesbians in the last decade, Simelane's trial has produced the first conviction, when one man who pleaded guilty to her rape and murder was jailed last month.
On sentencing, the judge said that Simelane's sexual orientation had "no significance" in her killing. The trial of a further three men pleading not guilty to rape, burglary and murder will start in July.

In Soweto and Kwa Thema, women seem unconvinced that Simelane's case will change anything for the better.

> *"Every day you feel like it's a time bomb waiting to go off,"* another lesbian said. *"You don't have freedom of movement; you don't have space to do as you please. You are always scared and your life always feels restricted. As women and as lesbians we need to be very aware that it is a fact of life that we are always in danger."*

http://www.guardian.co.uk/world/2009/mar/12/eudy-simelane-corrective-rape-south-africa

LEVEL OF RISK	RATING	SEXUAL ACTIVITY
Lowest Risk	01	Abstinence
	02	Masturbating alone
	03	Hugging/ Massage/ Dry kissing
	04	Masturbating with another person but not touching one another
	05	Deep wet kissing
	06	Mutual masturbation with only external touching
	07	Mutual masturbation with internal touching using finger cots or condoms
	08	Frottage (rubbing a person for sexual pleasure)
	09	Intercourse between the thighs
	10	Mutual masturbation with ejaculation on, not in partner
	11	Use of sex toys (dildos) with condoms, or that are not shared by partners and that have been properly sterilised between uses
	12	Cunnilingus
	13	Fellatio without a condom, but never putting the head of the penis inside the mouth
	14	Fellatio to orgasm with a condom
	15	Fellatio without a condom putting the head of the penis in the mouth and withdrawing prior to ejaculation
	16	Fellatio without a condom with ejaculation in mouth
	17	Vaginal intercourse with a condom correctly used and spermicidal foam that kills HIV and withdrawing prior to ejaculation
	18	Anal intercourse with a condom correctly used with a lubricant that contains spermicide that kills HIV and withdrawing prior to ejaculation
	19	Vaginal intercourse with internal ejaculation with a condom correctly used and with spermicidal foam that kills HIV
	20	Vaginal intercourse with internal ejaculation with a condom correctly used but with no spermicidal foam
	21	Anal intercourse with internal ejaculation with condom correctly used with spermicide that kills HIV
	22	Brachiovaginal activities (vaginal fisting)
	23	Brachioproctic activities (anal fisting)
	24	Use of sex toys by more than one partner without a condom and that have not been sterilised between uses
	25	Vaginal intercourse using spermicidal foam but without a condom and withdrawing prior to ejaculation
	26	Vaginal intercourse without spermicidal foam and without a condom and withdrawing prior to ejaculation
	27	Anal intercourse with a condom and withdrawing prior to ejaculation
	28	Vaginal intercourse with internal ejaculation without a condom but with spermicidal foam
Highest Risk	29	Vaginal intercourse with internal ejaculation without a condom and without any other form of barrier contraception
	30	Anal intercourse with internal ejaculation without a condom



Myths (Cut out Myths for Individual Handouts)

Myth
LGBTI people do not have a higher risk for HIV transmission than the heterosexual population.

Myth
Lesbians don't have sex; therefore they are not at risk for HIV.

Myth
MSM are gay men who are the receiving partner during anal sex and therefore at high risk for HIV transmission

Myth
Masculine MSM, gay and bisexual men are always the 'top', in other words anal penetrative partner and therefore not at risk for HIV transmission.

Myth
Transgender and intersex people cannot have sex and therefore are not at risk for HIV transmission.

Myth
Two gay men who are both HIV positive can have unprotected anal sex, since they are both positive anyway.

Identifying a LGBTI Advocacy Plan:

1. Tools in Toolkit and Handouts that could be used:

- Know Much More Booklet
- LGBTI Rights Defenders and Protection
- LGBTI African Manifesto
- Sensitisation Training Handbook with various handouts
- Sex Play Packs

2. How to use all the tools:

"Know Much More"

- During discussions at community dialogues
- During discussions with decision makers on various levels
- During SRHR and gender sensitisation trainings
- When compiling IEC materials and protocols to ensure LGBTI sensitive and correct terminology

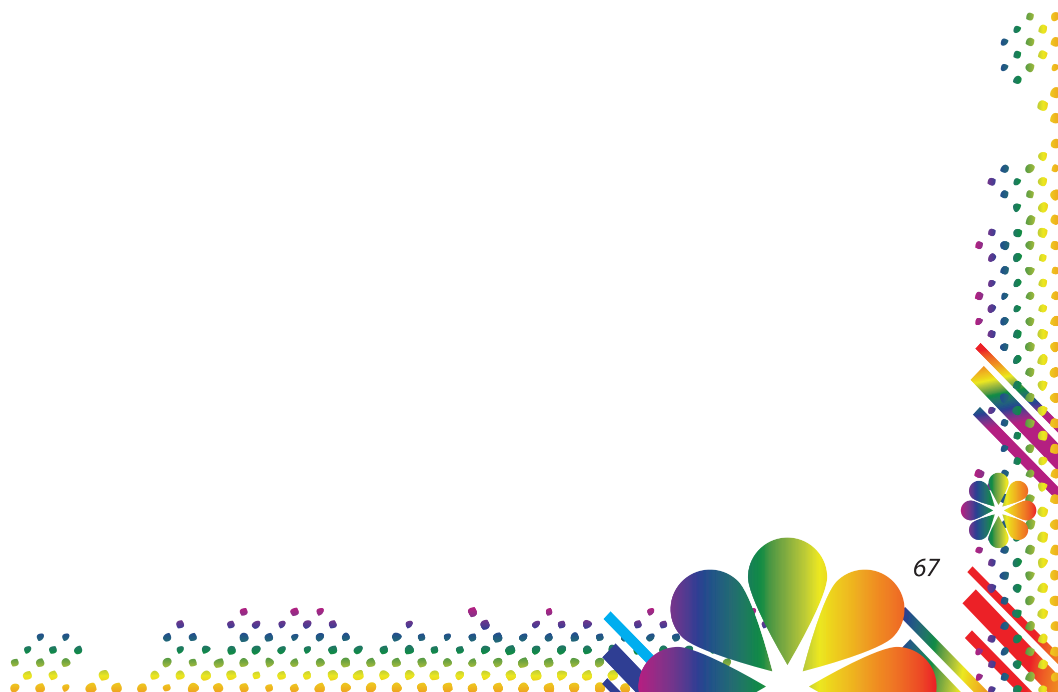
LGBTI Rights, Defenders and Protection

- During discussions at community dialogues and trainings ensuring that LGBTI Rights are seen as having human rights and should be respected and upheld in that way
- During discussions with decision makers on various levels
- During discussions with and training of LGBTI people, ensuring insight into their own rights
- When compiling IEC materials and protocols to ensure LGBTI sensitive and correct terminology

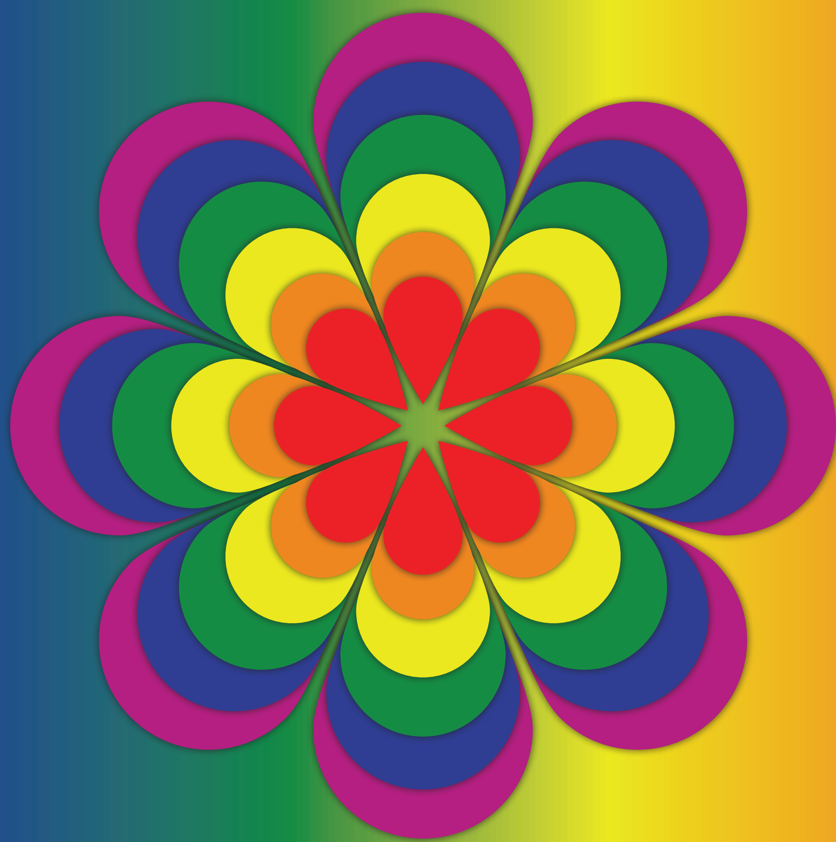
LGBTI African Manifesto
- During discussions at community dialogues to encourage awareness, acknowledgement of LGBTI rights and commitment to protect it
- During discussions with decision makers on various levels to ensure protection of ALL sexual minority rights

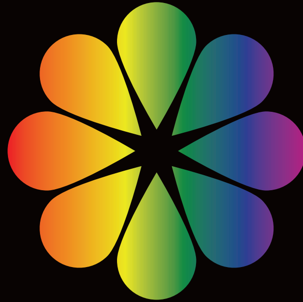
Sensitisation Training Handbook with V-arious Handouts
- Training of Civil Society organizations, Government Institutions, LGBTI groups and other interested parties

Sex Play Packs
- During trainings of health care providers as well as LGBTI's themselves
- During discussions with decision makers on various levels, to introduce the importance of providing specific barrier methods for specific sexual practices,
- To ensure HIV and GBV prevention services offer barrier methods appropriate to various sexual practices, irrespective of sexual or gender identity



Notes





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