

KEY POPULATIONS SENSITISATION & COMPETENCY DEVELOPMENT



TOOLKIT



health

Department:
Health
REPUBLIC OF SOUTH AFRICA





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NATIONAL DEPARTMENT OF HEALTH

KEY POPULATIONS SENSITISATION AND COMPETENCY DEVELOPMENT

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1. Sensitisation Training for the Department of Correctional Services: Prevention health system strengthening programme, developed by SA Partners (SA Partners, 2017)
2. Dignity, Diversity and Policing: Trainer Manual (South African Police Services and COC Netherlands, 2017)
3. HEALTH4ALL: Training health workers for the provision of quality, stigma-free HIV services for key populations (LINKAGES, 2013)
4. Health Care Provision for men who have sex with men, sex workers, and people who use drugs: An introductory manual for health workers in South Africa (Desmond Tutu HIV Foundation, 2013).

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Introduction

More than seven million people in the Republic of South Africa are currently living with HIV.¹ Despite the fact that South Africa is home to the largest global antiretroviral treatment programme, HIV prevalence remains high at 19 per cent.² Prevalence varies markedly between populations and key populations experience a disproportionate burden of HIV due to barriers to accessing services. These barriers include stigma, discrimination and criminalisation that leads to unsafe behaviours. South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022 (NSP) characterises key populations as gay men and other men who have sex with men; sex workers; people in prisons and other closed settings; transgender people; and people who use drugs.

Key populations uptake of HIV services is dependent upon quality, as well as actual and perceived stigma and discrimination on the part of health providers.³ While recognising the critical role played by targeted HIV prevention and treatment initiatives, primary healthcare services for key populations in South Africa remain inadequate. Key populations are not receiving services due to pervasive stigma, discrimination, and disapproving attitudes from both clinical and support staff at primary healthcare facilities. Insufficient training on key populations for health workers have left providers ill-equipped to address the health needs of key groups and perpetuates stigmatising and discriminating practices.⁴

There is also a need for clinicians to develop the knowledge and skills necessary to conduct a comprehensive risk assessment for members of key populations. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), "failure to provide adequate HIV services for key groups, such as gay men and other men who have sex with men, people in prison, people who inject drugs, sex workers and transgender people, threatens the global progress of the HIV response".³

Individuals at increased risk of acquiring HIV in South Africa are not obtaining the services they need. The World Health Organization (WHO) has called for the implementation of strategies and activities that aim to improve uptake, availability, quality, and effectiveness of HIV interventions for key populations through improvement and maintenance of provider attitudes, knowledge, and skills. "Healthcare workers should be given the necessary resources, training, and support to provide services to key populations. At the same time, healthcare providers should be held accountable when they fail to meet standards based on professional ethics and internationally agreed human rights principles."⁴

The NSP is the guiding document for the Department of Health's approach to epidemic control, provides strategic direction regarding HIV prevention, care, and treatment initiatives to curb the epidemic, and promotes the department's mission of a long and healthy life for all South Africans. Goal Three of the NSP is to reach all key and vulnerable populations with customised and targeted interventions, including capacity-building programmes to improve the skills of health providers to address the needs of key and vulnerable populations, and strengthen their ability to deliver services in a compassionate, non-discriminatory manner.⁵

The purpose of the Key Populations Sensitisation and Competency Development Toolkit is to increase demand and supply of key population-friendly HIV prevention, care, and treatment service, to improve primary care health outcomes and achieve UNAIDS 95-95-95 targets.

The toolkit will:

- Sensitise clinical and support staff at primary care and community level on issues related to stigma and discrimination as they relate to five key populations:
 - Sex workers
 - Gay men and other men who have sex with men
 - Transgender people
 - People who use drugs
- People in prisons and other closed settings Provide health workers with the knowledge and skills necessary to perform a comprehensive and sensitive risk assessment of key population members.
- Provide health workers at facility level with the tools and resources necessary to treat, care for, and refer key population members to appropriate services.

How to use this toolkit

The multimodal Key Populations Sensitisation and Competency Development Toolkit provides health educators, trainers, mentors, and managers with a variety of interactive learning activities that may be used in the classroom, the workplace, or for independent study. The story-based approach provides the opportunity to learn from the lived experiences of individual key population members from a variety of sociocultural backgrounds in South Africa. Toolkit activities are based upon evidence-based adult learning principles. Learning materials may therefore be accessed as needed, depending on the learner's knowledge and skill gaps. Materials need not be accessed in order. The toolkit includes the following resources:

- Classroom training sessions
 - Lesson plans and session workbooks for facilitators
 - Session workbooks for participants
- Case studies
- Job aids
- Resources

Acronyms

ANC	Antenatal care
ARV	Antiretroviral drugs: Medication used to inhibit HIV at specific phases of its life cycle
ART	Antiretroviral therapy
CDC	Centers for Disease Control
DOT	Directly observed treatment/therapy
ECP	Emergency contraception pills
EPOA	Enhanced peer outreach approach
HCT	HIV counselling and testing
HBV	Hepatitis B
HCV	Hepatitis C
HIV	Human immunodeficiency virus: A retrovirus that causes AIDS by infecting helper T cells of the immune system
HPV	Human papillomavirus
HSV	Herpes simplex virus
HTS	HIV testing services
I-TECH	International Training and Education Centre for Health
LGBTI	Abbreviation for 'lesbian, gay, bisexual, transgender, intersex'
NSP	National Strategic Plan for HIV, TB and STIs 2017-2022
OST	Opioid substitution therapy
PDSA	Plan, do, study, act
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PICT	Provider initiated counselling and testing
PrEP	Pre-exposure prophylaxis: Combinations of antiretroviral medications used by HIV-negative individuals to lower their risk of becoming HIV positive if they are exposed to the virus
PHC	Primary healthcare
QI	Quality improvement
SANAC	South African National AIDS Council
SAPS	South African Police Service
SNS	Social networking service
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VMMC	Voluntary medical male circumcision
WHO	World Health Organization

MODULE 1: Overview of key populations

The learning objectives for Module 1 will be covered in the following sessions:

Session 1 – Key populations defined

- Define key populations
- List the five key population groups
- Explain why key populations are at increased risk of HIV acquisition and transmission

Session 2 – Human rights

- Describe the legal and human rights of key populations and persons who are HIV positive
- Recognise that a human rights approach in health facilities increases access to tailored services
- Discuss personal experiences with human rights violations and identify specific strategies to increase the enforcement of human rights in the future

Session 3 – Stigma and discrimination

- Define and understand stereotypes
- Define and understand stigma
- Define and understand discrimination
- Consider the impact of our own biases and discriminatory behaviours

Session 4 – Violence and abuse

- Define violence and abuse
- Consider the types of violence and abuse that occur in health facilities
- Identify strategies to build healthy relationships
- Discuss what to do when you witness violence or abuse in a health facility

LESSON PLAN

SESSION 1 – Defining KEY POPULATIONS

Learning objectives

At the end of this session, participants should be able to:

- Define key populations
- List the five key population groups
- Explain why key populations are at increased risk of HIV acquisition and transmission

Session overview

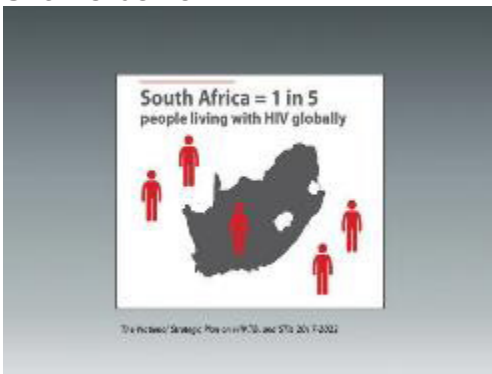
Content	Activity	Materials
Learning objectives and background	Key populations defined	Slides 27-28
Defining key populations	Large group discussion, fill in the blanks	Slides 29-31
Determinants of health affecting key populations and intersectionality	Large group discussion	Slides 32-33
Welcome to programme and purpose of the toolkit	Video	Slides 34-35
Closing	Questions and answers	Slide 36

Indicates a workbook prompt.

Show slide 27

READ Learning objectives for the session.

Show slide 28



SAY: More than seven million people in South Africa are currently living with HIV. Though South Africa has the largest antiretroviral treatment programme in the world, HIV prevalence remains high at 19 per cent. Certain groups experience a disproportionate (higher) burden of HIV due to barriers to accessing services. These groups are called key populations.

For example, HIV prevalence among the approximately 150 000 female sex workers in South Africa ranges from 48 per cent to 72 per cent, compared to 14.4 per cent among adult women in the general population. There is higher HIV prevalence (28 per cent) among the 1.2 million men who have sex with men, the 67 000 people who inject drugs (14 per cent), and inmates (23 per cent).

Show slide 29

Key populations are at
increased ___ of _____
___ HIV, because of barriers
to accessing health
services that leads to
_____.



SAY: Please take a moment to consider the missing words here. When you have them, you can fill the missing words in your workbook.

ASK participants for the missing words. When participants respond correctly, CLICK to the next slide to reveal the missing words (allow three to four attempts).

Show slide 30

Key populations are at increased risk of exposure to HIV, because of barriers to accessing health services that leads to unsafe behaviours



SAY: Key populations are defined groups who, due to higher-risk behaviours, are at increased risk of HIV.

ASK: What are “higher-risk” behaviours? Elicit replies. Highlight the following, if not mentioned:

- Unprotected sex
- Multiple sexual partners
- Sharing of needles or equipment

SAY: Groups such as adolescents, orphans, and migrants are considered vulnerable populations, meaning that they are vulnerable to HIV in certain situations or contexts. So these populations are not affected by HIV uniformly across all countries and epidemics. This toolkit does not specifically address vulnerable populations, but much of the guidance can apply to them as well.

Show slide 31 (animated)

5 Key Populations

1. Sex workers
2. Gay men and other men who have sex with men
3. Transgender people
4. People who use and inject drugs
5. People in prisons and other closed settings



NOTE This slide is animated. Once participants answer the question below, CLICK to reveal the five key populations.

ASK volunteers to name the five groups. When sufficient time has passed, CLICK to reveal answers on slide.

SAY: The NSP 2017-2022 defines key populations for South Africa as:

1. Gay men and other men who have sex with men
2. People who use and inject drugs
3. Transgender people
4. People in prisons and other closed settings
5. Sex workers

Show slide 32

Determinants of Health Affecting Key Populations

Biological	Social and cultural (Non-Biological)	Behavioural
<ul style="list-style-type: none"> Anatomy STIs Acute HIV infection <ul style="list-style-type: none"> (e.g. newly/ recently infected) Viral hepatitis TB 	<ul style="list-style-type: none"> Stigma, discrimination Policy/legal issues Poverty and economic hardship Violence Power imbalance Family and social support etc. 	<ul style="list-style-type: none"> Condom use PrEP use Contraceptive use Substance use Unsafe sexual practices Risk perception Lack of health literacy

SAY: We already know that key populations are at increased risk of exposure to HIV, TB and STIs.

- All key populations experience high levels of stigma, discrimination, violence and other rights abuses, which create barriers to access healthcare and other essential services
- These not only affect their overall wellbeing, health, and rights, but also impact their decision-making power and opportunities to seek and adhere to HIV, TB and STI treatment
- Realities, risks and needs are further influenced by discriminatory laws, policies and practices affecting their ability to make informed choices about all aspects of their lives

EXPLAIN that factors influencing HIV vulnerability can be grouped into three main categories: biological factors, social/non-biological factors, and behavioral factors.

- Biological factors.** It is easier for HIV to be transmitted through condomless anal sex than through condomless vaginal sex, as the rectum is more susceptible to tearing during sex. Also, in penile-vaginal heterosexual intercourse, the risk is higher for the woman because of vaginal anatomy than for the man. A person's anatomy (combined with specific sexual activities) can influence the likelihood of HIV infection. If a person has another sexually transmitted infection (STI), that can increase the likelihood that they will contract HIV.

There is a particularly high risk of HIV when having sex with a person who has recently become infected. The viral load at this point in HIV infection is very high, and a person can be more likely to be unaware of their HIV status.

- Social/cultural factors.** Many HIV prevention campaigns often only talk about the risks of heterosexual sex, and there is little appropriate information available to men who have sex with men, sex workers, transgender women, and people who use drugs, which can give them the false impression that they are not at risk.

Sex workers may find it difficult to persuade their clients to use condoms, or may be offered more money to have unprotected sex, increasing the risk of exposure to HIV. In some instances, HIV programmes target female sex workers, but none target male or transgender sex workers.

Where anti-retroviral drugs (ARVs) are widely available, a climate of optimism about the effectiveness of this treatment may lead some HIV-positive people to take more risks related to sex (such as not using condoms).

Dependence on one's family for emotional, economic and educational support often deters young men in particular from disclosing their HIV status, which makes it difficult to access them with services designed for men who have sex with men.

Men who have sex with men and transgender women are more likely to experience depression due to social isolation and disconnectedness from health systems, which can make it harder to cope with aspects of HIV such as adherence to medication.

- Behavioral factors.** Certain behaviours increase the risk of becoming infected with HIV. For example, having multiple sex partners, not using condoms consistently, having sex while under the influence of drugs or alcohol, etc.

Alcohol and drugs are a common part of socializing in some communities. Drink and drugs can make it more likely that people will have condomless sex and a higher number of sexual partners.

Some types of drug use (such as injecting drugs and using non-sterile needles) increases the likelihood of transmitting HIV. Smoking crack cocaine, marijuana, etc. do not put a person at risk for getting HIV; however, they may affect decision-making or unsafe behaviour.

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Intersectionality

- * Intersectionality: social determinants, power dynamics and structural factors intersect to **disadvantage key population groups** based on their characteristics and contexts.
- * Key population groups often overlap:
 - Some groups (men who have sex with men, people who use drugs, transgender people, sex workers) are more likely to be **homeless** due to stigma and discrimination
 - People (women and men who have sex with men, transgender women, and/or homeless people of all ages) may also be engaging in **sex work**
 - People in any of these groups may engage in **drug use**, etc.
- * Young people (10-24 years) who fall into key population groups experience increased vulnerability to HIV exposure.



EMPHASISE that many key population groups overlap, and you can never assume to know the full story of what is happening in a client's life by appearances.

EXPLAIN Intersectionality is an approach to understanding and responding to the multiple social factors that intersect in dynamic ways to privilege or disadvantage people depending on their characteristics and contexts. It is used as a framework to improve health equity by identifying and addressing the social determinants, power relations and structural factors that drive health inequity.

Source: WHO, 2014. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1

Show slide 34



SAY: Meet Steve, human rights activist and co-chair of the South African National AIDS Council.

Show slide 35



PLAY Video clip #1: My name is Steve

Show slide 36



ASK if there are any questions before moving on to the next session.

THANK participants for their attention!

LESSON PLAN

SESSION 2 – human rights

Learning objectives

At the end of this session, participants should be able to:

- Describe the legal and human rights of key populations and persons who are HIV positive
- Recognize that a human rights approach in health facilities increases access to tailored services
- Discuss personal experiences with human rights violations and identify specific strategies to increase the enforcement of human rights in the future

Session overview

Content	Activity	Materials
Learning objectives	Large group discussion	Slide 39
Defining human rights	Video and group discussion	Slide 40
The right to health	Large group discussion	Slides 41
Providing appropriate health services	Large group discussion Reflection and group exercise	Slides 42-44
Closing	Questions and answers	Slides 45

Indicates a workbook prompt.

Show slide 39

Session 2 Learning objectives

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

- Describe the legal and human rights of key populations and persons who are HIV positive
- Recognise that a human rights approach in health facilities increases access to tailored services
- Discuss personal experiences with human rights violations and identify specific strategies to increase the enforcement of human rights in the future



SAY: This section defines and discusses strategies to identify and address human rights violations in health facilities. Participants will discuss strategies for a non-violent response when rights are violated. Participants will also talk about past experiences with human rights violations.

Show slide 40

What are human rights?

- All human beings are born free and equal in dignity and rights.
- They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

SAY All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

PLAY video.

Show slide 41

The Right to Health

- Everyone has the right to the highest attainable level of physical and mental health
- Health rights are closely linked to other socio-economic rights (e.g., access to sufficient food and water, social security, adequate housing and a clean environment).
- All people at all times have the right to access services and commodities to prevent exposure to and transmission of HIV, TB and STIs, as well as to treatment, care and support services



ADD: This means that no health worker has the right to discriminate against any client seeking prevention care or treatment.

Stigma is a well-documented global barrier to health-seeking behaviour, engagement in care, and adherence to treatment across a range of health conditions. Stigma, enables different forms of discrimination that ultimately deny the individual/group full social acceptance, reduce the individuals' opportunities, and fuel social inequalities. Stigma influences population health outcomes by worsening, undermining, or interfering with several processes, including social relationships, resource availability, stress, and psychological and behavioral responses, exacerbating poor health.

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Appropriate Health Services

- **Available:** health system infrastructure is in place, with adequately trained medical staff
- **Accessible:** everyone can access services without discrimination, regardless of who they are or where they live. They also should be affordable (and/or free) and comprehensive
- **Acceptable:** services are respectful, non-discriminatory and afford equal treatment for all; providers respect and protect peoples' rights (e.g., confidentiality and consent)
- **Relevant:** address specific needs of key population groups such as hormones, methadone, and sterile injecting equipment
- **Good quality:** services adequately respond to what is needed and ensure the good quality of such services



SAY: The right to health means that services need to be available, accessible, acceptable, relevant and of good quality.

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Can you think of an example of a human rights violation against key population member(s)?"

Examples might include:

- Human dignity violations
- Life threatening situations
- Violations of freedom or security
- Violations of health care
- Violations related to a person's needs for food, water and social security
- Verbal abuse, insults, sarcasm
- Physical violence, hitting or being hit
- Sexual assault
- Theft or vandalism

ASK participants to take five minutes to silently think about a personal experience with a human rights violation, for example a time when...

- Your rights were abused or violated
- You abused or violated someone else's rights
- You witnessed someone else's rights being violated but did not intervene

Then ASK: How was this reflection for you? Was it difficult?

LEAD and PARTICIPATE in a group discussion and consider volunteering to describe your experience and how the situation made you feel. After a volunteer presents their example, participate in a discussion that asks:

- "Why did the violation happen?"
- (If the participant violated someone's rights) "Why did you behave the way you did?"
- (If the participant witnessed a violation) "Why didn't you intervene?"
- (To the group) "How would you have behaved in this situation?"
- "What could have been done differently?"
- "Was there any way to prevent the situation from happening?"

LEAD and PARTICIPATE in a large group discussion that includes the following three questions:

1. "What does the word 'tolerance' mean?"
2. "Is it OK to tolerate everything that other people do or say?"
3. "How does tolerance relate to human rights?"

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Tips for Healthcare Workers

- Make clients aware of the Batho Pele Principles and the Patients Rights Charters
- Provide equal treatment and access to healthcare for all clients, irrespective of who the person is
- Work closely with representatives of key population groups and organisations to enhance service access
- Solicit feedback and suggestions from key populations
- Provide non-judgemental, non-coercive, non-discriminatory, respectful, and dignified treatment for all clients
- Cultivate awareness around rights
- Stigma and discrimination in healthcare settings harm people, violate their rights, and undermine health gains. Question your own biases and moral judgements



EMPHASISE that

1. Each facility should have a suggestion box; suggestions should be reviewed and acted upon
2. Liaise with the community (including LGBTI and other key population groups) on a regular basis so that suggestions are integrated into service provision.
3. Patient Rights Charters and Batho Pele Principles should be visible in all centers.
4. Healthcare workers should be aware of and question their own biases and moral judgements
5. Healthcare workers should be careful to protect the confidentiality and privacy of all clients

Show slide 45



ASK if there are any questions before moving on to the next session.

THANK participants for their attention!

LESSON PLAN

SESSION 3 – Stigma and Discrimination

Learning objectives

At the end of this session, participants should be able to:

- Define and understand stereotypes
- Define and understand stigma
- Define and understand discrimination
- Consider the impact of our own biases and discriminatory behaviours

Session overview

Content	Activity	Materials
Learning objectives	Large group discussion	Slide 47
Stereotypes	Large group discussion, group exercise	Slides 48-50
Defining stigma and discrimination, effects	Large group discussion	Slides 51-54
What can health workers do? Dos and don'ts	Large group discussion	Slides 55-60
Internal or self-stigma and discrimination	Large group discussion	Slide 61
Key points and closing	Questions and Answers	Slides 62-63

Indicates a workbook prompt.

Show slide 47

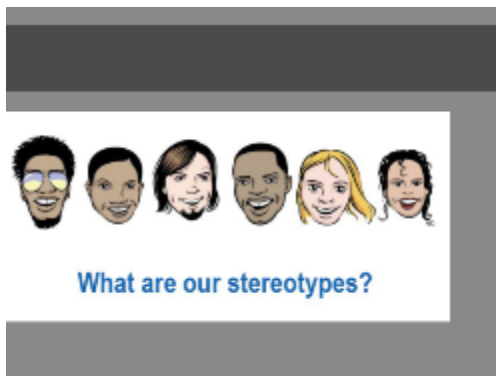
Session 3 Learning objectives

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

- Define and understand stereotypes
- Define and understand stigma
- Define and understand discrimination
- Consider the impact of our own biases and discriminatory behaviours



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Answer these questions:

“Please explain what stereotype means?”

“Why do you think stereotyping happens?”

“What is the function or purpose of a stereotype?”

“Can you recall a time when you were stereotyped?”

Remember these points:

- Stereotyping is a natural process
- Stereotyping is a way to create structure for the world and for one’s position in the world
- Stereotyping is used to exert power over another stigmatised individual or group
- Usually stereotypes cause others to be judged in a very negative way
- Individuals may be stereotyped into categories because of a fear of the other or a fear of the unknown
- Stereotyping often leads to stigma, discrimination, and other hurtful behaviours

Discuss:

- Whether or not the stereotypes are true and where they might originate from
- How stereotyping often has little basis but comes out of prejudice
- Stereotyping is often extremely hurtful and can cause very negative impact
- There are links between stereotypes, power, stigma, discrimination, violence, and abuse in society

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SAY: Stereotypes cause negative impact by limiting the freedoms of those impacted.

Discuss how key populations are stereotyped by society as:

Sex workers: No morals, bad mothers. REALITY: sex work is work and a way to earn

a living

Men who have sex with men: Emotional, promiscuous. REALITY: Men who have sex with men are as diverse in their emotions and behaviours as the general population

Transgender persons: child molesters; drag queens

People who inject drugs: Bring it on themselves; thieves; lazy; must pull themselves together. REALITY: People start to use drugs for different reasons

Inmates: Violent, guilty, antisocial. REALITY: Some inmates are incarcerated for non-violent crimes/are falsely accused and sentenced for crimes they did not commit unlawfully arrested Some inmates regret their criminal actions

These stereotypes apply to all groups of key populations regardless of the reality

Show slide 50



ASK participants to reflect on experiences of being stigmatized and discriminated against and then relate their experiences to that of key population groups. The objectives are to:

- Guide participants to acknowledge their own experiences with stigma
- Help participants to recognize how their experiences relate to the experiences of key populations

ASK participants to take a moment to reflect: What does stigma mean to you?

Quietly, think back to a time when you were treated in any way differently by other people. It could have been a time when you moved into a new area, attended a new school, or lived in an area where you were considered 'different.'

Try to remember details of the experience and what happened. Think about how you were treated differently.

Then ASK if anyone will share their experience with the group.

ASK the volunteer the following questions during the group discussion:

- “How were you treated differently by the others around you?”
- “How did this make you feel?”
- “How did this experience affect you?”
- “What did you learn from this experience?”

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Stigma

Refers to negative beliefs and/or attitudes towards people based on characteristics seen as 'different' to those thought to be 'acceptable' by the norm.

Stigma is a dynamic process of devaluation that significantly discredits an individual in the eyes of others, such as when certain attributes are seized upon within particular cultures or settings and defined as discreditable or unworthy.

- Negative beliefs, attitudes and feelings
- These views are often supported by stereotypes, moral judgement, and prejudice.

SAY: The term stigma is derived from a Greek word meaning a mark or stain, and it refers to negative beliefs and/or attitudes towards people based on characteristics seen as 'different' from those thought to be 'acceptable' by the norm (e.g., sex work, drug use).

Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others, such as when certain attributes are seized upon within particular cultures or settings and defined as discreditable or unworthy.

Stigma results in negative beliefs, attitudes and feelings, which are often supported by stereotypes, moral judgement and prejudice.

Source adapted from UNAIDS 2017. Fast-Track and human rights: Advancing human rights in efforts to accelerate the response to HIV and UNAIDS terminology guidelines, 2015.

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Discrimination

- When people act on stigmatising beliefs
- When a person is treated unjustly or unfairly because of someone's stigmatising beliefs, attitudes and feelings.
- Stigma and discrimination harms people, violates their rights, and undermines health efforts.
- For key populations, stigma and discrimination creates major barriers to access to and use of health services.

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Effects of stigma and discrimination

- Stigma exists and takes two major forms – isolating/avoiding and blaming/shaming;
- Stigma towards key populations has three major causes:
 - fear and lack of understanding of how HIV is transmitted,
 - judgemental attitudes,
 - people's lack of awareness that they stigmatise
- Stigma causes—lack of understanding of marginalised groups and moral judgement of their behaviour;
- Stigma has a number of effects:
 - self-stigma (stigmatised persons accepting the stigma, withdrawing from social contact
 - not accessing health and other services



Stigma refers to the strong negative feelings or significant disapproval that is linked to a specific person, group, or trait. For example, HIV/AIDS stigma often involves judging and

blaming a person for being infected with their disease.

Stigma can be experienced both internally and externally.

Discuss external and internal stigma:

- External stigma results from the actions of others
- Internal stigma is the discriminatory voice inside your own head; it is experienced inwardly by an individual who is being stigmatised
- Internal stigma occurs when those who are stereotyped accept the stereotypes as true and feel devalued
- Self-discrimination is behaviour that arises from internal or self-stigma. It is an act or instance of believing a distinction, stereotype, or stigma

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What can health workers do?

- Stop judgemental attitudes and practices
- Use correct terminology
- Avoid stigmatising language
- Stop stigmatising certain diseases and behaviours



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Stigma DON'Ts

- Never judge any behaviours, sexual orientation, or sexual identity. Definitely not on your own moral or religious beliefs.
- Avoid making assumptions: Assumptions based on gender, age, marital status, disability or other characteristics are against the Constitution and the law.
- Do not ask clients whether they belong to a key population. Address the specific problem the client states.
- Do not satisfy your own curiosity by asking probing and personal questions that do not relate to the client's problem.
- Do not assume because people are members of a key population they automatically practice unsafe sex behaviour (men who have sex with men) or are dependent on drugs (sex workers) or can't be trusted (injectors).



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Examples of health discrimination

Humiliation	Unfriendly or dismissive attitude Assuming a woman who uses drugs is unfit to be a mother
Verbal and emotional abuse	Laughed at, shouted at, called names Moral judgement based on religious beliefs ("holier than thou")
Coercion or involuntary treatment	Not explaining treatment options properly; withholding information
Breach of confidentiality	Discussing client sexual orientation with colleagues
Breach of privacy	Discussing personal information where other people can hear
Lack of free and informed consent	Forcing sex workers to have abortions or undergo sterilisation
Denial of services	Refusing sex workers condoms in larger quantities
Warning	Telling people who inject drugs they are bringing abscesses / accidental overdoses on themselves



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More examples of Discrimination

- A transgender man going to the clinic for reproductive healthcare (e.g., PAP smear) is ridiculed by nurses, denied services and told that these services are only available for 'real' women.
- A woman using drugs goes to the clinic for contraceptives and is told that she should use Depo-Provera, since she can't be trusted to take a pill every day due to her drug habit.
- A sex worker is denied services at a clinic and told by the nurse that this clinic is not for people 'like you'.



Self stigma and discrimination



Know Your Self (NCHADS) www.nchads.org



Internal or self-stigma and self-discrimination

- Internal or self-stigma: "Discriminatory voice inside your own head"
 - Negative thoughts, attitudes, or feelings about oneself because of the label or stigma directed toward you
 - Negative self-belief because of being key population member, "you do not belong in society..."
- Self-discrimination:
 - Behaviour that arises from internal or self-stigma
 - An act or instance of discriminating or of making a distinction



Self-stigma and discrimination

- Fear of being found out and being stigmatised may inhibit key populations and people living with HIV from using public health services.
- May not be able to access information about prevention or feel too embarrassed to access services and less able to take care of health.
- All these factors increase the vulnerability of key populations to acquiring HIV, TB and STIs.



GROUP EXERCISE

Examples of actions	<ul style="list-style-type: none"> • Name calling • Labeling • Gossiping • Making assumptions • Mocking/judging • Rejecting • Excluding • Displaying bias • Discrimination • Prejudice • Physical violence, rape, murder 	EXTERNAL STIGMA
Causes	<ul style="list-style-type: none"> • Fear • Lack of information • Ignorance • Religious beliefs • Cultural beliefs • Perceived difference • Lack of knowledge or understanding • Society norms and expectations • Corruption/inequality 	
Effects	<ul style="list-style-type: none"> • Withdrawal • Lower self-worth • Self-blame • Self-harm • Isolation • Sadness • Anger • Hopelessness • Lack of motivation • Depressive, suicidal thoughts, PTSD 	INTERNAL STIGMA

In society, stigma against key population groups can undermine a person's ability (e.g. people who use drugs or paroled inmate) to reintegrate into society. People who are labelled and stereotyped may internalise the negative association and then behave in ways to confirm the stereotype.

Answer the questions:

“How does external stigma become internal?”

“Think back to the earlier exercise when we reflected on our own experiences with stigma. Let us fill in these columns.”

EXAMPLES/ACTIONS CAUSES EFFECTS

Key points

- It is important to acknowledge and address our own personal stereotypes so that we do not stigmatise or discriminate against others
- Structural, social and self-stigma impact the health and wellbeing of key population groups and its members
- Internal stigma can cause low self-esteem, shame and low moral worth
- Discrimination based on gender and sexual orientation may lead to rape and other forms of sexual violence
- Appropriate support and counselling helps to reduce the negative impact of external and internal stigma



LESSON PLAN

SESSION 4 – VIOLENCE and abuse

Learning objectives

At the end of this session, participants should be able to:

- Define violence and abuse
- Consider the types of violence and abuse that occur in health facilities
- Identify strategies to build healthy relationships
- Discuss what to do when you witness violence or abuse in a health facility

Session overview

Content	Activity	Materials
Learning objectives	Large group discussion	Slide 65
Defining violence and abuse	Large group discussion	Slides 66-67
Violence and abuse of key populations Violence and abuse in health facilities	Group exercise Large group discussion	Slides 68-70
Closing	Questions and answers	Slide 71

Content adapted from (SA Partners, 2017)

Indicates a workbook prompt.

Show slide 65

Learning objectives

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


- Define violence and abuse
- Consider the types of violence and abuse that occur in health facilities
- Identify strategies to build healthy relationships
- Discuss what to do when you witness violence or abuse in a health facility



Defining Violence

The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in *injury, death, psychological harm, maldevelopment, or deprivation*

World Health Organization



Defining Abuse

- Abuse is treating someone or something with cruelty or violence or using something to bad effect or purpose.
- Abuse is the misuse of power through which the perpetrator gains control or advantage of the abused, using and causing physical or psychological harm or inflicting or inciting fear of that harm.
- Abuse prevents people from making free decisions and forces them to behave against their will.



Example: Violence In Correctional Facilities

Violence is a common occurrence in correctional facilities

Violence is often due to inmates' diverse behaviours and needs, their varied criminal and social backgrounds and the correctional facility environment

There are different types of violent attacks in correctional facilities:

- Inmate on inmate
- Warder on inmate
- Inmate on guard
- Self-inflicted

Health workers on inmates



How Violence and Abuse is expressed

Expressive	Spontaneous, impulsive, irrational attack typically carried out when the perpetrator feels provoked / questioned / threatened
Self-inflicted	Driven by mental health disorders, anxiety or depression due to influences such as facility surroundings, harsh treatment, stigma, and discrimination received from others
Instrumental	Premeditated, planned out, calculated and then implemented; more commonly executed as a show of strength and power



Forms of violence and abuse key populations are exposed to

Physical	When someone uses a part of their body or an object to control a person's actions: Homophobic rape or 'gay bashing'
Emotional	When someone says or does something to make a person feel stupid or worthless: Isolation from community and family
Psychological	When someone uses threats and cause fear in a person to gain control: Unethical arrest
Intimidation	When someone uses their power or position to control a person's actions: Letting people who use drugs wait long to punish them Using power to prevent colleagues from reporting stigma
Sexual	When a person is forced to unwillingly take part in sexual activity
Financial	When someone controls an individual's financial resources without the person's consent or misuses those resources
Spiritual	When someone uses their religious beliefs to manipulate, humiliate or coerce another person



During this group exercise, create and act out short skits that portray violent and non-violent incidents in health facilities.

The objectives are to:

- Discuss violence in health facilities
- Develop strategies to promote respect and prevent violence

Participants should divide into four small groups.

For two of the groups: Prepare a brief skit, less than five minutes long, that shows an incident in a health facility that involves violence. The violence can be physical or psychological.

For the other two groups: Prepare a brief skit, less than five minutes long, that shows an incident in a health facility that is based on mutual respect. Show how the people who are involved can handle a conflict without resorting to violence.

For all participants: Be realistic and use examples from your experience. Act out events among key population members and staff, friends, family, or others.

After the first two groups perform, answer the questions:

“Do you have any questions?”

“Why do you think this incident led to violence?”

After the remaining two groups perform their skits about mutual respect, answer:

“Do you have any questions?”

“Why do you think this event was healthy and nonviolent?”

Facilitate a group discussion about the following questions:

- “What are different types of violence in health facilities?”
- “What are the characteristics of a violent incident?”
- Why do people feel powerless to do anything about violence in health? Are they really powerless?
- What are characteristics of healthy and respectful conduct? Were the examples used in the skits realistic? Do you see these situations in your daily lives?
- Is physical and/or sexual violence mostly committed by men against women? Are women equally violent toward men?
- What causes violent relationships in general?
- What causes violent incidents in health facilities?
- Are the causes for violent incidents in health facilities related to or the same as for violent relationships outside of facilities?

- When you witness violence, what do you normally do? What could you do?
- What strategies can we use to build healthy relationships with work colleagues, friends, and sexual partners?

Source: This group exercise was developed by the International Sexuality and HIV Curriculum Working Group as “Activity 13: From Violence to Respect in Intimate Relationships,” in It’s All One Curriculum, Volume 2 Activities Guide available at:

http://www.popcouncil.org/uploads/pdfs/2011PGY_ItsAllOneActivities_en.pdf

Forms of violence and abuse in health facilities

Physical	When health workers deliberately hurts a client when doing an anal examination.
Emotional	Telling inmates they do not deserve health services / treatment Ignoring sex workers or transgender persons when they come to the clinic.
Psychological	When health workers threaten to withhold future treatment: Refusing to treat STIs after repeated infections.
Intimidation	Getting a sex worker to sign consent for an unwanted procedure (sterilisation) when in labour.
Spiritual	Moral judgement based on behaviour: multiple sexual partners; drug use; same sex relationship; incarceration etc. Telling homosexual persons that the bible says they will go to hell.



DISCUSS the different forms of violence that occur in health facilities and review the following key points about violence:

- Health workers may use emotional coercion, psychological force, or manipulation to coerce a person into non-consensual procedures (sterilisation, abortion)
- Health workers can withhold prevention and treatment options from clients (post-exposure prophylaxis (PEP) and other support after rape; contraception options; condom supplies)
- Violence in health facilities is an example of a hate crime or form of gay bashing
- Some key population members are more vulnerable to violence in health facilities, including
 - Young people who know very little about what services they are entitled to
 - Desperate clients who are homeless and lack food, money, and toiletries
 - Clients who are isolated from friends and family (inmates; sex workers; people who use drugs)
 - Clients with low self-esteem who will not confront the abuse (young people or those with severe self-stigma)
 - Inmates who are thought to be ‘pretty’ or ‘good looking’ or look ‘feminine’
 - Clients who are openly gay, lesbian or trans identified
 - Clients with mental health disorders or with disabilities

MODULE 2: Gender and Sex

The learning objectives for Module 2 will be covered in the following sessions:

Session 5 – Sexual orientation and gender identity

- Define and understand the different sexual orientations and gender identities

Session 6 – Safe and unsafe behaviours

- Define different sexual behaviours and assess the associated health risks
- Discuss possible prevention methods to reduce the transmission of HIV and other STIs and other communicable diseases
- Explain why it is important to understand human sexuality and sexual behaviour

Session 7 – Harm reduction and self-care

- Define harm reduction
- Define self-care
- Explain the importance of harm reduction and self-care in working with key populations to improve health outcomes

LESSON PLAN

SESSION 5 – sexual orientation and gender identity

Learning objectives

At the end of this session, participants should be able to:

- Define and understand the different sexual orientations and gender identities

Session overview

Content	Activity	Materials
Learning objectives	Large group discussion	Slides 75-76
Binaries NOT Boxes Anatomical sex Gender	Large group discussion Group exercise	Slides 77-89
Binaries NOT Boxes Sexual orientation Sexual behaviour	Large group discussion Group exercise	Slides 90-95
Conclusion and closing	Questions and answers	Slides 96-97

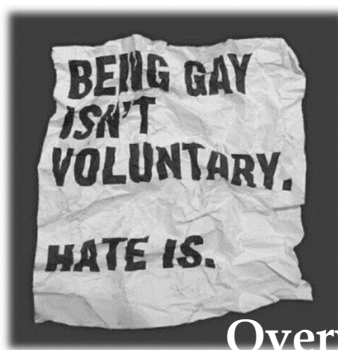
(Content adapted from (SA Partners, 2017)

Indicates a workbook prompt.

Show slide 75

Learning objectives

- Define and understand the different sexual orientations and gender identities



Divide into 4 groups:

- Group 1 writes all the names and words, in different languages, that refer to a penis
- Group 2 writes all the names and words, in different languages, that refer to a vagina
- Group 3 draws a naked man, from hair to toes, and labels all parts of the man's body that can cause him to become aroused when they are touched
- Group 4 draws a naked woman, from hair to toes, and labels all parts of the woman's body that can cause her to become aroused when they are touched

You have 10 minutes for this exercise. While you are meeting, please select one person to present your work when we reconvene the larger group.

Key point

- When we talk about controversial issues, thoughts or feelings, we can potentially recognise any bias or prejudice



Binaries AND Boxes



Helpful tip

To understand the Binaries NOT Boxes group exercise, please see the recording and slides available at http://www.msgf.org/files/msgf/documents/BinariesBoxes_slidedeck.pdf

SAY: In this session we are going to gain a better understanding of the terms sex, gender, sexual orientations, and sexual practices.

Binaries NOT Boxes



Answer the question:

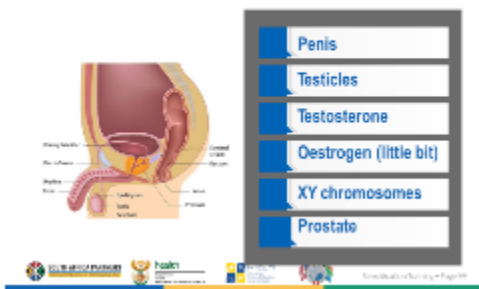
“When I say the word ‘SEX,’ what do you think of?”

“There are many meanings for this small three-letter word. For this exercise, let us think about ‘sex’ as a biological concept or ‘what’s in the pants.’ In most cases, a ‘male’ body has a penis and a ‘female’ body has a vagina.”

Answer the question:

“Are male and female the only possibilities?”

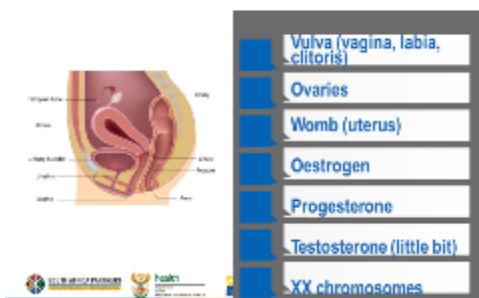
Defining Anatomical Sex: Male



Review the diagram of the male anatomical sex and how it usually contains:

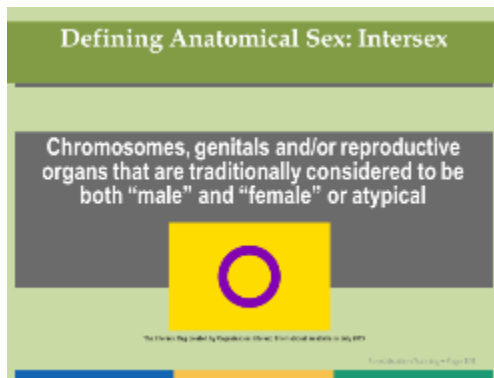
- Penis
- Testicles
- Testosterone
- Oestrogen (a little bit)
- XY chromosomes
- Prostate

Defining Anatomical Sex: Female



Review the diagram of the female anatomical sex and how it usually contains:

- Vulva (vagina, labia, clitoris)
- Ovaries
- Womb (uterus)
- Oestrogen
- Progesterone
- Testosterone (a little bit)
- XX chromosomes



Some people are not born with either a penis or a vagina. Intersex-bodied people are born with a mix of chromosomes, genitals and/or reproductive organs that are traditionally considered to be both 'male' and 'female' or atypical for either.

Intersex challenges the concept that there are only two sexes.

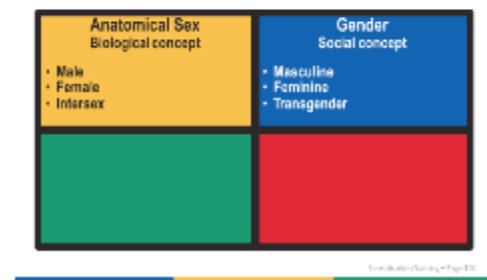
Answer the question:

"Does anyone have any questions about the biological concept of sex and male, female or intersex?"

Helpful tip

The term, 'hermaphrodite', is no longer used to describe intersex people because it is stigmatising and confusing. Hermaphrodite implies that someone has all the organs of males and females—but that is physically not possible.

Binaries NOT Boxes



Answer the question:

"Male, female and intersex describe biological sex. What describes gender?"

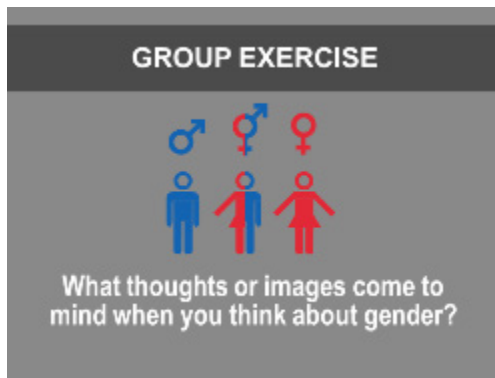
Gender is socially constructed characteristics that are assigned to women and men and varies across different cultures over time. Sex is a biological concept and gender is a social construct.

Participate in a discussion about constructs:

- A construct is an idea, philosophy, or belief that is built for specific purposes
- Gender constructs are expectations based on biology or 'what's in the pants'
- A male-bodied person is expected to behave in certain ways, masculine ways
- A female-bodied person is expected to behave in certain ways, feminine ways

Constructs are thought to be 'normal' but are really related to stereotypes.

Gender is not always divided by male/masculine and female/feminine.



Answer the question:

“What thoughts or images come to mind when you think about gender? What examples of gender constructs can you think of?”

Review three examples of gender constructs:

Gender and cooking

- Who does the cooking at home? (female/feminine)
- Who are the best chefs in the world? (male/masculine)
- Why is there a gender construct that women cook at home but not as world-class chefs?

Food portions

- Some restaurants call a smaller sized steak, a ‘ladies-sized’ steak, and a larger sized steak, a ‘man-sized’ steak
- Why do they use these names instead of just listing the weight of the steak?
- Would a not-so-hungry man ever order a ‘ladies’ steak?
- Would a really hungry woman ever order a ‘mens’ steak?
- What would the possible reaction be of dinner companions? Or of restaurant staff?

Women as nurturing wives and mothers

- How are women treated when they choose not to get married?
- How are women treated when they choose not to bear children?
- How are married mothers treated when they choose to work outside their home?

The following discussion about gender roles is excerpted from Blackstone’s Gender Roles and Society, available at http://digitalcommons.library.umaine.edu/cgi/viewcontent.cgi?article=1000&context=soc_fac_pub

Gender roles are based on society’s constructs of men/masculine and women/feminine and reflect the values and beliefs that are considered to be appropriate.

For example, the traditional feminine gender role suggests that women should be nurturing, stay-home mothers who are not employed outside the home. A masculine gender role suggests that men should be the heads of their households, provide financially for their family and make the important family decisions. Yet alternative perspectives about gender roles are becoming more popular.

Review the following alternative perspectives about male and female gender roles:

Biological perspective:

- Women are naturally drawn toward femininity
- Men are naturally drawn toward masculinity

- Masculine and feminine are equally valued gender roles

Sociological perspective:

- Masculine and feminine roles are learned over time
- Masculine and feminine roles are not necessarily connected to males' and females' biological traits

Feminist perspective:

- Gender roles are not simply ideas about appropriate behaviour for males and females
- Gender roles are strongly linked to different levels of power that males and females hold in society

Because traditional gender roles dominate many parts of society, power imbalances exist between male/masculine and females/feminine. Power imbalances can further stereotypes, stigma, discrimination and potentially abuse and violence.



Answer the question:

"What does 'masculine' mean to you?"

Potential masculine traits include:

Strong

Muscular

Hard

Aggressive

Competitive

Dynamic

Active

Potent

Self-confident

Independent

Rebellious

A leader

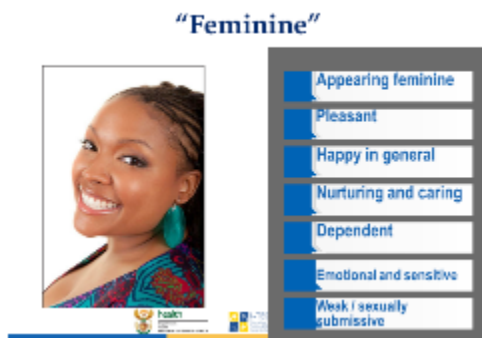
Powerful

Experienced

Loud voice

Bold

Brave
 Honourable
 Hairy
 Manly
 Clumsy
 Tough-skinned
 Non-emotional
 Rational
 Sexually aggressive



Answer the question:

“What does ‘feminine’ mean to you?”

Potential feminine traits include:

Nurturing
 Caring
 Submissive
 Passive
 Innocent
 Sexy
 Flirtatious
 Sexually submissive
 Weak
 Sensitive
 Emotional
 Quiet
 Soft spoken
 Dependent
 Slim
 Soft

Graceful

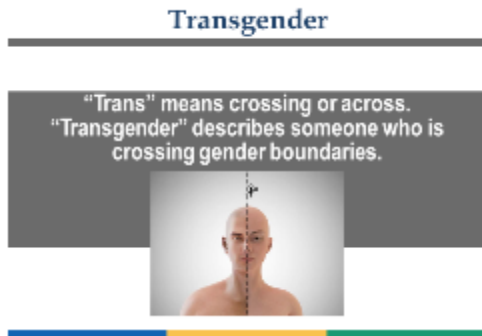
Self-critical

Accepting

Answer the questions:

“Do masculine attributes only apply to men?”

“Do feminine attributes only apply to women?”



Trans means crossing or across. Transgender describes someone who is crossing gender boundaries.

Participate in a discussion that includes the following points:

Cisgender describes when an individual’s gender identity matches their biological sex at birth, for example, a person born female who identifies with the female gender.

Gender non-conforming describes when people do not identify as cisgender but challenge societal expectations of a specific gender.

Transgender describes a wide range of identities and experiences, including transsexuals, transvestites, drag queens and kings, two-spirits, gender-queers and others.

A trans person may transition to cross gender boundaries with or without gender reassignment surgery and hormonal therapy.

Transsexual describes people who wish to or are undergoing gender reassignment therapy to align their bodies to their gender identity:

- Transsexuals may have any sexual orientation
- Transsexuals can transition from male to female, she is a woman
- Transsexuals can transition from female to male, he is a man

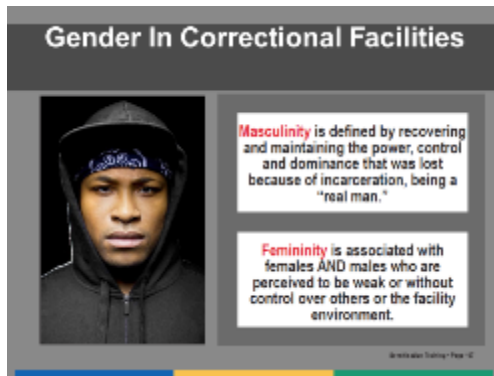
Transvestites enjoy wearing clothing, make up, accessories to cross dress and appear as a different gender that is different from their biological sex

- Transvestites may have any sexual orientation
- Transvestites may cross dress to gain sexual arousal and gratification
- Transvestites may cross dress to gain non-sexual satisfaction
- Transvestites generally self-identify according to their biological sex at birth and have no interest in gender reassignment therapy

There is a societal double standard so that biological women can wear men’s clothing and often be accepted by society while men who wear women’s clothing are generally not accepted in the same way.

Remember that a person’s gender identity does NOT imply their sexual orientation, who they

are attracted to.



Answer the questions:

In a correctional facility, what are masculine gender traits?

In a correctional facility, what are feminine gender traits?

Participate in a group discussion about gender and gender expectations in correctional facilities and answer:

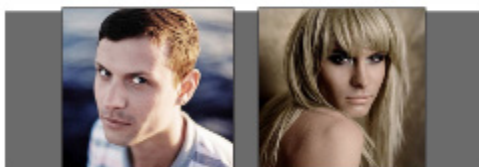
- Why is feminine perceived to be bad?
- What is the impact of hyper-masculinity in a male facility?

In correctional facilities, gender roles can be fluid. For example, male inmates may identify and engage in gender roles that are masculine or feminine. It is also possible for someone to adopt different gender roles at different times.

Answer the questions:

- What does it mean to be 'the man' or 'Ndoda'?
- What does it mean to be the wyfie?
- What could be done to change these expectations?
- Are there words, other than 'wyfie,' that would lessen stigma?

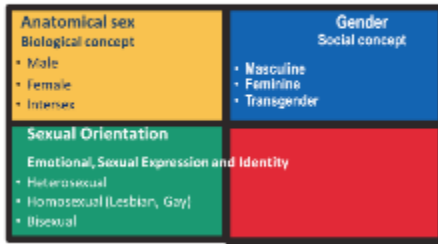
Feminine and Masculine



Helpful tip

These photos are of a biological man with masculine gender and again with feminine gender. Use the photos to explain that all people have masculine and feminine gender traits that can be expressed in different ways at different times.

Binaries NOT Boxes



SAY: We now understand that male, female and intersex describe biological sex. Masculine, feminine and transgender are social concepts to describe gender. Let us talk about the third quadrant, sexual orientation.


Answer the question:

How do you define sexual orientation?

Defining Sexual Orientation

An emotional, physical and sexual attraction to persons of the opposite sex or gender, the same sex or gender, to both sexes or more than one gender.

Also refers to a person's sense of identity based on their attraction, related behaviours and membership in a community of people who share the attraction.




Sexual orientation is an emotional, physical and sexual attraction. These attractions are of a romantic nature, not platonic. A person can be attracted to people of the opposite sex or gender, to people of the same sex or gender, to both sexes or more than one gender.

Sexual orientation also refers to a person's identity and feelings of membership in a community of people who share their attractions.

Different Sexual Orientations

Heterosexual	Someone who seeks romantic relationships with someone of the opposite sex (male with female)
Homosexual	Someone who seeks romantic relationships with someone of the same sex (gay - male with male or lesbian - female with female)
Bisexual	Someone who seeks romantic relationships with someone of the same sex and with the opposite sex



Three sexual orientations include heterosexual, homosexual and bisexual

Participate in a group discussion that includes the following points:

Heterosexual describes people who have romantic, sexual, intellectual and intimate feelings for the opposite biological sex and gender.

- A man attracted to women
- A woman attracted to men
- Sometimes the word 'straight' is used to describe heterosexual individuals or relationships

Homosexual describes people who have romantic, sexual, intellectual and intimate feelings for the same biological sex and gender.

- Gay, a man attracted to men
- Lesbian, a woman attracted to women

Bisexual – describes people who have romantic, sexual, intellectual and intimate feelings for the opposite biological sex and gender and/or the same biological sex or gender.

- A man attracted to men and/or women
- A woman attracted to men and/or women
- Bisexuals do not always experience attraction to men and women at the same time
- Bisexuals are often stereotyped as promiscuous or as people who ‘cannot choose’

It is unclear what determines a person’s sexual orientation.

When people ask, “Where does homosexuality come from?”

The answer is, “From the same place as other sexual orientations”.

This question is often asked because some people mistakenly believe that sexual orientation is a choice or that homosexuality or bisexuality is different, an illness or a sin. In the past, some people also thought that homosexuality should be cured or fixed. These false beliefs were due to ignorance and a lack of information.

Answer the question:

“How do you know another person’s sexual orientation?”

Participate in a group discussion about sexual orientation:

- Biological sex, gender and sexual behaviour are separate and different from sexual orientation
- Men with feminine traits can be heterosexual, homosexual or bisexual
- Women with masculine traits can be heterosexual, homosexual or bisexual
- People of all sexual orientations can have intimate partners of different genders

The Diagnostic and Statistical Manual of Mental Disorders removed homosexuality as a mental illness in 1973 but there is still a bias that happy families include a heterosexual father, mother and offspring. Prejudice, stigma and shame continue to impact homosexuals and bisexuals.

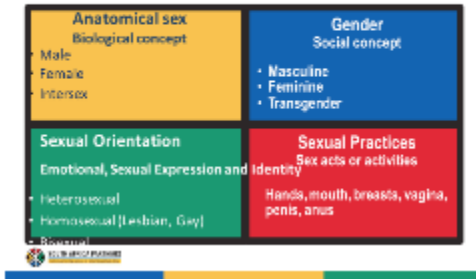
In South Africa, homosexuals and bisexuals are protected by the Constitution but do experience a lot of stigma and discrimination and are vulnerable to sexual violence, including rape.

Remember that sexual orientation is an emotional, physical and sexual attraction, and an identity.

Answer the question:

“Does anyone have any questions about sexual orientation and heterosexuality, homosexuality or bisexuality?”

Binaries NOT Boxes



Let us talk about the final quadrant of Binaries NOT Boxes, sexual practices.

Sexual practices include all sexual acts or activities that people experience with themselves, another person or more than one other person, including desires, fantasies, sexual self-stimulation and sexual acts with various body parts.

Answer the question:

“Who can identify different body parts that people use to experience sexual pleasure?”

Participate in a group discussion about the following questions:

- “Can a vagina and mouth go together?”
- “What about a vagina and penis?”
- “A vagina and hand or finger?”
- “A mouth and a penis?”
- “A mouth and a hand?”
- “A mouth and an anus?”
- “Hands and breasts?”
- “A penis and a hand?”
- “A penis and breasts?”
- “A penis and an anus?”
- “An anus and a hand?”

People of all biological sexes, genders and sexual orientations use many different parts of the body for a variety of sexual practices.

Why is this important to understand? In the past, some people believed that the only sexual practice was the penetration of a penis into a vagina and the only associated health risk was pregnancy. Many people still believe, consciously or unconsciously, that if there is no vaginal intercourse, there is no health risk.

We know this is not true. All sexual practices, including anal intercourse and the other practices we discussed earlier, have health risks including HIV and other sexually transmitted infections.

Defining Sexual Behaviours

- Sexual practices include acts with body parts, sex toys AND desires and fantasies that provide sexual pleasure
- Sexual practices do NOT always match one's sexual orientation. Men who enjoy sex with other men are not always gay. Men who love and are attracted to other men are gay



Sexual practices include acts with body parts, sex toys and desires and fantasies that provide sexual pleasure. People engage in sexual practices for many different reasons.

Participate in a discussion about different reasons why people engage in sexual activities:

- Feelings of pleasure and physical satisfaction
- Sexual desire or attraction towards another person
- To create pleasure and physical satisfaction for a partner
- Money or financial considerations
- Achievement of an advantage from a partner

Sexual practices do not always match one's sexual orientation. It is important not to make assumptions about other people's sexual behaviours and sexual orientations.

DISCUSS the following three real life scenarios to provide examples of how sexual behaviour is not necessarily aligned with sexual orientation:

1. Thembi is biological female with feminine gender. She is happily married to Simphiwe and identifies as heterosexual. While she served her five-year sentence in a correctional facility, she had sex with multiple female inmates. She also had a relationship with a female staff member, whom she had to break up with when she left the facility. She misses her sometimes.
2. Jack is a biological male with a masculine gender. He has been married to Anna for the past 10 years and they have two children. Jack loves his wife and children very much. He identifies as heterosexual. While currently serving his sentence as an inmate in a correctional facility, Jack engages in anal intercourse, both as penetrator and receiver. Sometimes he engages in anal intercourse because he misses sex. Other times he really just enjoys being penetrated by a masculine man. Jack often feels confused about his sexual desires and fantasies but has no one to share his uncertainties with.
3. Lindiwe is a transwoman. Though she has male genitals, she identifies as a woman and has a feminine gender. She is physically beautiful, and people do not notice her male genitals. She identifies as heterosexual and has not had intercourse with anyone since being incarcerated two years ago.

Men who enjoy sex with men are not always gay.

Women who enjoy sex with women are not always lesbian.

People may regularly have sex with others of the same sex, without identifying as lesbian or gay due to cultural, religious, or personal reasons.

People may also adopt sexual behaviors, including anal intercourse, due to temporary circumstances such as being confined to a correctional facility where biological men and women are separated.

Participate in a discussion about the "anal taboo" to include the following key points:

People perceive anal intercourse in different ways.

- Some heterosexual people enjoy anal intercourse
- Some heterosexual women enjoy anal penetration by men

- Some heterosexual men enjoy anal penetration by women (called “pegging”)
- Some but not all homosexual men enjoy anal intercourse
- Some but not all homosexual women enjoy anal intercourse
- Some but not all bisexual people enjoy anal intercourse
- Some people feel guilt or shame about anal intercourse
- Guilt or shame can cause people to engage in secretive sexual behaviour
- Guilt or shame can increase health risks because partners may not use protection

It is important to overcome the ‘anal taboo’ and talk about anal intercourse and prevention strategies. Unprotected anal intercourse is high risk for HIV transmission. When we talk about it, we take the first step towards reducing health risks.

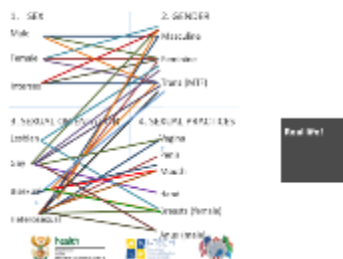


The following few slides are used to facilitate a discussion about the many different ways that the four quadrants of Binaries NOT Boxes work together to describe human sexuality.

Society says that biological males are masculine, heterosexual and prefer vaginal-penile intercourse and biological females are feminine, heterosexual and prefer penile-vaginal intercourse. In reality, we know that human sexuality is more complex.



Binaries NOT Boxes...



LESSON PLAN

SESSION 6 – safe and unsafe sexual behaviour

Learning objectives

At the end of this session, participants should be able to:

- Define harm reduction
- Define self-care
- Explain the importance of harm reduction and self-care in working with key populations to improve health outcomes

Session overview

Content	Activity	Materials
Learning objectives	Large group discussion	Slide 99
HIV risk and sexual behaviour	Large group discussion, fill in the blank	Slides 100-106
Tap framework	Large group discussion	Slide 107
Safer sexual behaviours	Large group discussion	Slide 108
Closing	Questions and answers	Slide 109

(Content adapted from SA Partners, 2017)

Indicates a workbook prompt.

Show slide 99

Session 6 Training objectives

- Define different sexual behaviours and assess the associated health risks
- Discuss possible prevention methods to reduce the transmission of HIV and other STIs and other communicable diseases
- Explain why it is important to understand human sexuality and sexual behaviour



This session provides knowledge, resources and a safe space for discussion to understand sexual behaviours and support prevention. Detailed information is presented to help participants learn about sexual practices, HIV transmission and prevention strategies.

We will now talk about specific sexual behaviours. We will assess the associated health risks and review strategies to lower the transmission of HIV, STIs and other communicable diseases.

HIV risk and behaviour

NOTE: Risky sexual behaviour does not always mean increased risk HIV exposure. Remember that there is only HIV exposure during a risky behaviour if one of the people involved is HIV positive.



Multiple studies demonstrate that key population groups have high rates of HIV and other STIs and viral hepatitis.


Prevention and control are based on the following major strategies:

1. Education and counselling of persons at risk on ways to avoid STIs through safer sexual behaviors and use of recommended combination prevention services
2. Identification of asymptomatic persons and of symptomatic persons unlikely to seek diagnostic and treatment services
3. Effective diagnosis, treatment, and counselling
4. Evaluation, treatment, and counselling of sex partners of persons with HIV and other STIs
5. Availability of male and female condoms and lubricant and information how to use condoms correctly every time you have sex
6. PEP of persons at risk of HIV and hepatitis
7. Voluntary medical male circumcision to protect men against HIV exposure – not a proven prevention strategy for anal sex

The most effective HIV prevention involves biomedical, behavioural and structural strategies.

Condomless sex...

...refers to a sex act which is not protected by male or female condoms. Previously known as unprotected sex, this is now increasingly referred to as condomless sex; this is done to avoid confusion with the protection from pregnancy that is provided by other means of contraception. As oral pre-exposure prophylaxis (PrEP) becomes more widespread (and if topical PrEP is introduced), it is important to be clear about the different methods of protection against HIV and the other consequences of sex, and how those methods might be used or combined (UNAIDS, Terminology Guidelines, 2015).



Sexual Behaviours and Risk



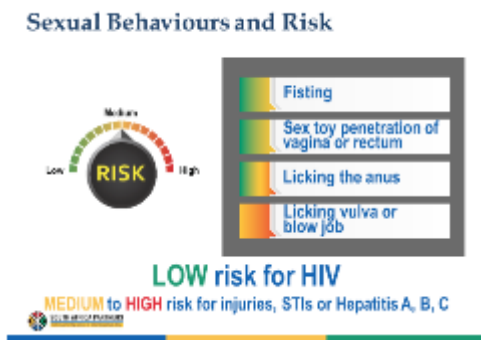
LOW risk for HIV and other STIs



These are sexual behaviours that are LOW risk for the transmission of HIV and STIs:

- Non-penetrative sex, also known as “outercourse,” includes mutual masturbation, kissing, cuddling and thigh sex
- People engage in non-penetrative sex for a variety of reasons, including:
 - Foreplay
 - As a primary or preferred sexual act
 - To preserve virginity
 - As a strategy to prevent pregnancy
 - Fingering the vagina and anus is penetrating sex but is also relatively low risk

While the risk of HIV and STI transmission is generally low with non-penetrative sexual plays, it is important to remember that some STIs including genital herpes, genital warts and pubic lice CAN be transmitted through close genital contact (skin-to-skin) even when there is no penetration.



These penetrating sexual plays may have LOW risk for HIV but MEDIUM or HIGH risks for injuries, STIs or Hepatitis A, B or C:

- Sexual penetration is the insertion of a body part or other object into a body orifice including the vagina, anus or mouth
- Penetrative sex may involve:
 - Penetration of the mouth by a penis (blow job or fellatio)
 - Use of the tongue to penetrate a vagina or vulva (cunnilingus)
 - Use of the tongue to penetrate an anus (anilingus)
 - Use of fingers to penetrate an orifice (fingering)
 - Insertion of an object, such as a dildo, vibrator or other sex toy, into a person’s genital area or anus
 - Double penetration involves simultaneous sexual penetration in the orifices of two partners

Discuss the risks of HIV, STI and hepatitis transmission for the behaviours on the slide.

Sexual Behaviours and Risk



NOTE: When we talk about HIV transmission we must focus on a person's behaviours and not their identity, not their race, gender, age or sexual orientation. For example, unprotected anal sex is the high-risk behaviour and being a man who has sex with another man is not the risk.

Some penetrating sexual plays are HIGH risk for HIV, STI and/or hepatitis transmission:

- Scissoring: a woman having sex with a woman rubs her vulva against her partner's vulva
- Vaginal intercourse: a man inserts his penis into a woman's vagina
- Anal sex or anal intercourse: a penis penetrates another man or woman's anus

Discuss behaviours that can transmit HIV:

- Use of non-sterile syringes and other unsafe means of injection
- Condomless anal, vaginal, and oral sex

Condomless Vaginal Intercourse

The most frequent route of sexual HIV transmission is condomless vaginal intercourse

Women are at greater risk than men of HIV from vaginal intercourse

- Exposed surface area of the vagina is larger than the penis
- Vaginal intercourse causes minute tears in the vaginal lining
- Vaginal lining tissue contains cells that HIV can easily enter
- Semen remains in the vagina for a prolonged period

The most frequent way that HIV is transmitted is condomless vaginal intercourse.

Both men and women are at risk of HIV transmission during unprotected vaginal intercourse. Women are at greater risk because:

- The exposed surface area of the vagina is larger than that of the penis
- Vaginal intercourse causes minute tears in the vaginal lining
- The tissue of the vaginal lining contains certain types of cells that HIV can easily enter
- Semen remains in the vagina for a prolonged period

Discuss the sexual practice of "dry sex".

Dry sex involves removing of vaginal lubrication using herbal aphrodisiacs, household detergents, anti-septics or other materials before having sexual intercourse.

Dry sex increases the risk of HIV and STIs for both partners:

- Drying the vagina removes the natural antiseptic lactobacilli which can combat STIs
- Dry sex increases friction and the risk that a condom will break as a result

- Dry sex may also result in vaginal inflammation, lacerations and/or traumatic lesions which in turn may increase the transmission of STIs

Condomless Anal Intercourse

Condomless anal sex carries a higher risk of HIV transmission than condomless vaginal sex



- Anal intercourse can be practised between men or between men and women.
- Rectal fluid can contain a high concentration of HIV
 - Damage to the lining of the rectum facilitates the transmission of HIV
 - The receptive partner is at greater risk of HIV infection

Anal intercourse can be practiced between men or between men and women.

Unprotected anal intercourse carries a higher risk of sexual HIV transmission than unprotected vaginal intercourse.

When an HIV-negative person has insertive anal sex with an HIV-positive partner, rectal fluid containing HIV can come into contact with the urethra and/or the penis foreskin. Both the urethra and foreskin are vulnerable to HIV infection. Blood does NOT need to be present in the HIV positive partner's rectum.

Discuss strategies for reducing the risk of HIV and STI transmission during anal sex:

- Use lubricants (lube) to minimize rectal inflammation
- Condoms, in combination with lube, are highly effective if used consistently and correctly
- Manage STIs through regular testing and treatment to reduce the viral load in rectal fluid
- Adhere to ART to lower the viral load in blood and rectal fluid
- Post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) are highly effective
- Evidence has not been confirmed but penile circumcision may reduce the risk of HIV infection for men who primarily engage in insertive anal sex

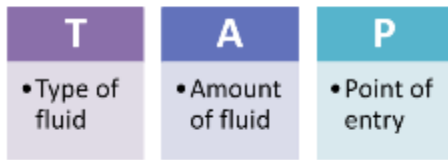
Discuss mucus and rectal fluid:

- Mucus is a slippery secretion produced by certain parts of our body known as the mucous membranes, which are located at the entrances into the body and line the internal passages of many of our organs (mouth, intestines, rectum, vagina, cervix, foreskin and urethra)
- Mucus protects the mucous membranes by trapping bacteria and viruses and preventing them from coming into contact with the membranes
- Mucus contains substances that can, to some extent, kill bacteria and viruses
- For some membranes, mucus also acts as a lubricant that prevents friction and tearing when objects pass through them
- Mucus in the vagina reduces friction during sexual intercourse; mucus in the gastrointestinal tract (including the rectum) helps with the passage of food and faeces; mucus in the rectum also helps

reduce friction during anal intercourse

- Rectal fluid, the mucus that lines the rectum, can contain a high concentration of HIV
- Inflammation in the rectum, caused by STIs or tearing, may increase the amount of HIV in the rectal fluid

The TAP framework



The TAP framework helps us understand the risks of sexual behaviours.

Type of fluid

- The more HIV in the body fluid, the higher the risk of infection
- The concentration of HIV in body fluid depends on many factors including STIs, ART and stage of HIV infection
- More HIV is typically present in the body fluids of newly infected individuals

Amount of fluid

- Exposure to less fluid typically means exposure to less viral load, which lowers risk
- Withdrawal/pulling out the penis during intercourse but before ejaculation reduces the risk for the receptive partner (the bottom)
- For injection drug users, needles cleaned with water reduce blood on or in the syringe

Point of entry

- Different risks are associated with different entry points for HIV
- Having a cut or sore on skin or a membrane can increase the risk of HIV transmission
- STIs, especially those that cause sores or lesions, also increase risk

Use the TAP framework to discuss the risks of kissing, touching HIV-positive blood and being the bottom partner during anal sex.

“What is the risk from kissing?”

“What is the body fluid involved?”

“Is there risk from saliva?”

“What is the risk if a person gets HIV-positive blood on their arm if they have no cuts?”

“What is the type of fluid?”

“Can blood transmit HIV?”

“What is the amount of fluid?” We are not sure; could be a lot, could be a little.

“Is an arm a point of entry?”

“Is there any risk in this case?”

“What is the risk of being the bottom partner in anal sex, without a condom and water-based lubricant?”

“What is the type of fluid?”

“Can semen transmit HIV?”

“What is the amount of fluid?”

NOTE: Remember that HIV transmission requires enough HIV in the body fluid AND a way for the infectious fluid to enter the blood stream. Also remember that, HIV-positive body fluids carry 96 per cent lesser risk if the individual is on ART and adhering to treatment.

Safer sexual behaviours

Risk behaviour	Safer behaviour
Unprotected vaginal sex	Start on PrEP or use condoms and lubricant / spit condoms
Unprotected anal sex	Start on PrEP or use condoms and lubricant / spit condoms
Sexsoring	Wear underwear
Fisting	Use finger condoms – tip from surgical glove Wash hands and check for cuts
Sex toys	Use condoms and lubricant Wash with soapy water
Blowing	Wash nose with soap and water
Blowjob	Use a dental dam or condom every time
Fingering	Low risk
Thigh sex	Low risk
Masturbation	Low risk



LESSON PLAN

SESSION 7 – harm reduction and self-care for people who use or inject drugs

Learning objectives

At the end of this session, participants should be able to:

- Define harm reduction
- Define self-care
- Explain the importance of harm reduction and self-care in working with key populations to improve health outcomes

Session overview

Content	Activity	Materials
Learning objectives	Group discussion	Slide 111
Harm reduction	Large group discussion, fill in the blank	Slides 112-116
Self-care	Large group discussion	Slides 117-119
Closing	Questions and answers	Slide 120

(Content adapted from SA Partners, 2017)

Indicates a workbook prompt.

Show slide 111

Session 7 Learning objectives

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

- Define harm reduction
- Define self-care
- Explain the importance of harm reduction and self-care in working with key populations to improve health outcomes



Harm reduction

Comprehensive package of policies, programmes, and approaches that seeks to reduce the harmful health, social and economic consequences associated with drug use.

Elements include:

- needle and syringe programmes
- opioid substitution therapy
- testing and counselling for HIV, TB and viral hepatitis
- HIV care and ART for people who inject drugs
- prevention of sexual transmission
- outreach



For example, people who inject drugs are vulnerable to blood-borne infections (such as HIV) if they use non-sterile injecting equipment. Therefore, ensuring adequate supplies of sterile needles and syringes is a harm reduction measure that helps to reduce the risk of blood-borne infections.

Harm Reduction - 1

- To reduce harm from drug use, advise clients:
 - That there is treatment to stop drug or alcohol use, but that the decision must be theirs
 - If stopping is not possible, reduce amount/dose and/or frequency of use
 - Avoid injecting drugs, if possible



Harm Reduction - 2

- If clients choose to inject drugs, teach them how to do it safely
 - Obtain sterile needles and syringes from a needle and syringe program, or clean used needles
 - Use bleach to clean needles, syringes, cookers and surfaces
 - Bleach can't be used to clean water or cotton. New sterile water or cotton should be used each time
 - Plan ahead to get high in a safe place, and to have food, water, ARVs, condoms, lube, etc. on hand
 - Dispose of syringes safely after one use in a sharps container or other hard container, away from other people
 - Talk to a health care provider about precautions for taking ARVs alongside specific recreational drugs and/or alcohol



Harm reduction - 3

Additional points to advise/support:

- Avoid solo drug use
- Join a support group
- Overdose prevention
- Be informed about HIV, STIs and other diseases like skin and heart infections
- Practice safer sex



Harm reduction - 3

- Practice safer sex
- Adopt safer injecting practices
 - Avoid solo drug use
 - Use different veins for injection
 - Use clean supplies
 - Safely dispose of used needles in sharps containers
 - Use bleach to clean needles and equipment
 - Use safer injection sites
- Join a support group
- Be informed about HIV, STIs and other diseases



EMPHASISE that people can also overdose or even die from having too many drugs or too much of one drug in their body or from products that may be mixed with the drugs without their knowledge (for example, fentanyl). Advise clients to consider all of the different substances they may have in their body at one time and to learn which may cause unwanted interactions.

Key points

- It is important to be aware of different substances that are commonly used
- Different people use drugs for different reasons
- There are many physical, behavioural, and psychological symptoms of substance use
- Harm reduction strategies are intended to reduce drug-related HIV and disease transmission
- **The objective of harm reduction is not necessarily to stop using**



Self-care...

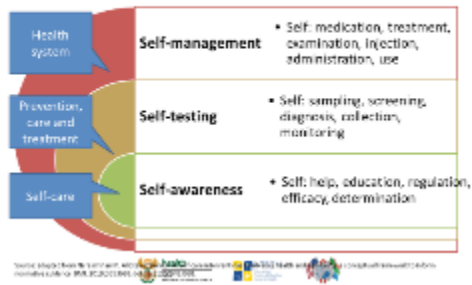
...the ability to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a healthcare provider through:

- health promotion
- disease prevention and control
- self-medication
- providing care to dependent persons
- seeking care if necessary
- and rehabilitation.



Self-care is the ability of individuals, families, and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a healthcare provider. The scope of self-care as described in this definition includes health promotion; disease prevention and control; self-medication; providing care to dependent persons; seeking hospital/specialist/primary care if necessary; and rehabilitation, including palliative care. It includes a range of self-care modes and approaches.

Self-care for key populations



EXPLAIN Self-care interventions have the potential to increase choice, when they are accessible and affordable, and they can also provide more opportunities for individuals to make informed decisions regarding their health and healthcare. Self-care could play an important role to improve health-related outcomes. Self-care also builds upon existing movements, such as task sharing and task shifting, which are powerful strategies to support health systems.

We distinguish between three types of self-care:

Self-management

- PrEP and condoms for prevention
- Safer injection practices
- Safer behaviours
- Drug collection or delivery

Self-testing

- HIV self-screening
- Risk self-screening
- Case finding and index testing using key population networks such as the enhanced peer outreach approach or social networking service

Self-awareness

- Peers reach key populations, create demand for services, promote safer behaviours
- Small group interventions
- Social media

Key points

- Self-care is another way to overcome barriers to accessing services for key populations
- Self-care empowers key population members to take responsibility for their own health
- Self-care is a form of task shifting

MODULE 3: Risk Assessment

The learning objectives for Module 3 will be covered in the following sessions:

Session 8 – Risk screening

- Define and understand the different sexual orientations and gender identities

Session 9 – Clinical history taking

- Define different sexual behaviours and assess the associated health risks
- Discuss possible prevention methods to reduce the transmission of HIV and other STIs and other communicable diseases
- Explain why it is important to understand human sexuality and sexual behavior

LESSON PLAN

SESSION 8 – risk screening

Learning objectives

At the end of this session, participants should be able to:

- Define risk assessment
- Describe the importance of risk assessment
- Describe the general intake process performed by administrative staff
- Describe the screening performed by peer educators, lay counsellors and other staff trained to perform screening for HIV, TB, STIs, and mental health

Session overview

Content	Activity	Materials
Learning objectives	Large group discussion	Slide 124
Risk assessment	Large group discussion	Slides 125-131
General intake	Large group discussion	Slides 132-133
Risk screening	Large group discussion	Slides 134-141
Supported referrals are key	Large group discussion	Slide 142
Closing	Questions and answers	Slide 143

Indicates a workbook prompt.

Show slide 124

Session 8 Learning objectives

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

- Define risk assessment
- Describe the importance of risk assessment
- Describe the general intake process performed by administrative staff
- Describe the screening performed by peer educators, lay counsellors and other staff trained to perform screening for HIV, TB, STIs, and mental health

**Risk Assessment**

- Risk assessment is the process of evaluating the probability of acquiring HIV, other STI based on behaviour
- Usually occurs over a series of private, confidential conversations with a client, and often involves the use of screening tools
- Helps health care workers to:
 - Identify clients at risk
 - Ensure that appropriate screenings are conducted
 - Establish strategies to reduce risks and prevent onward infections



Performing sensitive risk assessments for key populations

Tips for performing a risk assessment

Risk assessment quick guide: Things to remember before you begin

Assure confidentiality
<i>"Everything you say to me will remain private and confidential"</i>
Convey routine nature of risk assessment
<i>"I am going to ask you standard questions that I ask all my clients"</i>
Explain that questions may be personal and sensitive
<i>"It may be uncomfortable to discuss these personal and sensitive questions, but they affect your health so I need to ask them."</i>
Use open-ended questions (not yes/no)
<i>"How are you feeling today?" "What can we do for you today?" "What do you know about HIV?"</i>
Reinforce healthy behaviours
<i>"Using condoms most of the time is better than none of the time!" "Adherence is hard; it's great that you took 90% of your pills"</i>

General Intake Needs

- Identify need for urgent or emergency care and direct to an appropriate provider
- Address reason(s) for visit
 - What can we do for you today?
 - Update demographics and contact details
- Identify potential subtexts
 - A client comes in for the common flu, but might have other concerns that could be addressed.
- Client satisfaction survey



General intake

- Identify need for urgent or emergent care. If emergency care is not required continue with risk assessment
- Address reason(s) for visit
 - What can we do for you today?
 - Identify potential subtexts
- E.g. a client comes in for the common flu but has underlying issues that could be identified and addressed
- Do not ask probing questions based on assumptions

Performed during outreach and in the facility by peer educators, lay counsellors, social auxiliary workers and other staff trained to do the screening

2. RISK ASSESSMENT



Risk screening questionnaires

1. HIV risk
2. STI risk
3. TB risk
4. Mental health questionnaire screens for:
 - Alcohol use
 - Depression
 - Anxiety



Please see different risk assessment questionnaires in the resources section of this manual

How to conduct a risk assessment

Risk assessments is an important skill for anyone working in the field of HIV prevention, care, and treatment. Risk assessments helps healthcare workers to identify clients at risk, ensure that appropriate screenings are conducted, and establish risk reduction education topics and strategies.

Effective risk assessments help healthcare workers provide tailored risk reduction counselling to each client that can in turn prevent new infections.

Risk assessments can also help people living with HIV access and adhere to effective treatment.

Risks should be determined during routine history taking with each new client and should be periodically updated during ongoing care.

The following steps outline the basics of how to conduct a risk assessment.

To conduct a comprehensive risk assessment, healthcare workers should be familiar with the specific screening tools and referral mechanisms for their area, to clinical as well as to counselling and support services.

Establishing rapport

For a risk assessment to be effective, the client must feel safe. Take time to build a trust relationship with the client.

- Be non-judgemental
- Do not assume anything about a client's life or behaviour
 - For example, people who identify as homosexual may also have sex with people of the opposite gender; people who identify as heterosexual may also have sex with people of the same sex
 - Reassure the client that everything they share is confidential. You can begin with phrases like:
 - "Everything you say will remain between you and me."
 - "You have a right to privacy and confidentiality that I will respect."
 - "It is my ethical and legal obligation as a healthcare provider to protect your privacy."
- Greet the client and introduce yourself
- Ask about the client's preferred name and pronouns and use them consistently throughout the session. If a client expresses a preference about what terms they prefer, use the client's preference as much as possible
- It is important to accept and respect the self-identification of each individual person
- Do not assume that all people falling into one or more key population groups will have the same preferences, attitudes, beliefs, behaviours, experience, or understanding
- Use specific terms and neutral language:
 - Use "men who have sex with men" or "women who have sex with women" instead of acronyms
 - Avoid words such as faithful/unfaithful, promiscuous, irresponsible, prostitute, and other value-laden terms
 - Avoid presumptive questions
 - Example: "How often do you use drugs?" or "When was the

last time you had sex with someone you just met?”

- Be aware that there are many derogatory, offensive, insulting, and insensitive terms used to talk about key populations found in many different cultures and communities. This type of language should always be avoided in the health facility, whether a client is present or not.
- Convey the routine nature of risk assessments
 - Use language that emphasises that this type of discussion happens with all patients
 - It is important to ensure that your client do not feel like they are being singled out
 - Consider phrases like:
 - “I’m going to ask you some questions that I ask all my clients, because they have a big impact on people’s health.”
 - “The following topics are standard.”
 - “These topics are discussed with all clients.”
- Acknowledge that personal and sensitive information will be assessed
 - Giving the client an introductory notice that you are about to talk about personal topics will help prepare them and may result in them being more open
 - Consider phrases like:
 - “I’m going to ask you about some personal topics. I talk to all my clients about these topics because they affect your health. Many people find it hard to discuss these issues at first.”
 - “The next set of questions cover sensitive information, but they are routinely discussed with all clients at this clinic.”
 - “It may be uncomfortable to discuss some of these topics at first. I talk to all my clients about these issues and am able to provide the best care to those who are open.”
- Confirm with the clients which risk assessments will be formed and the purpose of each questionnaire:
 - HIV risk screening questionnaire – Annex 1
 - STI risk questionnaire – Annex 2
 - Mental health questionnaire – Annex 3
- Reinforce healthy behaviours
 - Praise clients for positive steps they are taking to maintain or improve their health and/or to reduce their risks
 - Do not judge unsafe behaviours

Importance of Risk Assessment

- Unsafe behaviours can put people at risk for HIV, other infections, and adverse health outcomes.
- Effective risk assessment helps health care workers provide targeted care and counselling to each client.
- Targeted risk reduction efforts can help to:
 - Prevent new HIV, TB, STI and other infections
 - Improve health of people living with HIV by encouraging positive health behaviours and effective treatment



NOTE that risk assessments can help people living with HIV, TB, STIs and those practising unsafe behaviours to access effective treatment and identify approaches to avoid spreading HIV infection to other people.

EMPHASISE that HIV prevention efforts directly benefit clients, their families, and communities.

Risk Assessment for Key Populations - 1

Key concerns for key populations groups include:

- Health risk assessment and risk reduction, including discussion of HIV-discordant couples
 - Undetectable = untransmittable, or **U = U**
- Mental health concerns like depression, anxiety, and alcohol use
- Vulnerability to violence and other trauma
- Substance use



EXPLAIN that U = U refers to a campaign explaining how the sexual transmission of HIV can be stopped. When a person is living with HIV and is on effective treatment, it lowers the level of HIV (the viral load) in the blood. This is also medically known as “virally suppressed”. At this stage, HIV cannot be passed on sexually.

Source: <https://www.aidsmap.com/about-hiv/what-does-undetectable-untransmittable-uu-mean>

Risk Assessment for Key Populations - 2

- Safety and comfort at health facilities
- Experiences of stigma and discrimination
- May have limited or no family support; alternative family/community support networks



EXPLAIN that due to a variety of factors, including coping with stigma and discrimination, the areas mentioned on the slide may be over-represented in key population groups. Risk assessments are very sensitive but important with clients from these groups.

When is a risk assessment conducted?

- For new clients, risks related to sexual health and substance use should be determined during history taking.
- For returning patients, risk assessment should be updated periodically during ongoing care.
 - At least once/year, but best more often
 - Combine with HIV testing



Tips for Effective Risk Assessment

- Crucial to establish rapport in order to gain trust and conduct an authentic, effective risk assessment, by:
 - Reassuring the client that everything they share is confidential
 - Explaining why these questions are important
 - Beginning with less threatening or less sensitive topics
 - Using a variety of questioning approaches to get information.
 - Different clients will respond to different styles.
 - Avoiding assumptions about clients and their behaviours.
 - Demonstrating a non-judgmental attitude and approach.



GIVE examples of different types of questioning that a provider might use:

- Open-ended questions.
 - Example: “Tell me about your alcohol use.”
- Close-ended questions.
 - Example: “Do you have sex with men, women, or both?” or “Do you use drugs?”
- Direct questions about specific behaviours.
 - Example: “When would you be uncomfortable using a condom?”
- Exploratory questions.
 - Example: “What do your friends think about using drugs?”
- Normalising questions
 - Example: “Sometimes people have anal intercourse. Have you ever had anal intercourse? or Some of my patients tell me they share their crack pipes. Have you ever shared a pipe?”

Establishing Rapport

- Be non-judgmental and non-directive
- Accept and respect the self-identification and preferences of each individual
 - Ask for and use of client’s preferred name and pronouns
 - No derogatory terms or insults
 - No use of words to describe the client that they would not appreciate or use themselves
- Use respectful language that reflects client’s identity can help to build rapport and trust
- Do NOT refer to people as acronyms
- If you make a mistake, acknowledge it, apologize for it, clarify if needed, and use the client’s preferred name, pronoun, and/or terminology going forward



NOTE some examples:

Some clients may not identify with terms such as “gay” or “men who have sex with men” even though they may engage in same-sex sexual activities. They may be dealing with their own complex identities, or may have internalised stigma/homophobia, and do not want to be called these terms.

Some clients may be transgender but continue to dress in alignment with the sex they were assigned at birth. (For example, a trans woman who continues to dress as a man for safety reasons.) The client’s gender identity should be respected regardless of how they are dressed.

Never be shy to ask the preferred pronoun – which maybe he, she, or they/them.

Mental Health Screening

- Full mental health screening includes questions to identify depression, anxiety, post-traumatic stress disorder (PTSD) and suicidal ideation
 - Requires professional training to conduct
- If you are not trained, ask questions with focus on offering counselling and/or support group referrals, such as:
 - Have you ever received counselling other than HIV related counselling?
 - Are you currently part of a support group?
 - If so, in past, but no longer, why did you decide to stop participating?
 - Would you like to speak to a counsellor and/or participate in support group?



Use the Brief mental health screening questionnaire in the manual to screen for:

- Alcohol use
- Depression
- General anxiety

EMPHASISE that, if possible, referrals for further support should be made to organisations that are focused on the key population group.

Substance Use Screening - 1

- Ask about substance use in a non-judgemental way
 - Prescription, non-prescription medications, alcohol, recreational drugs.
- If positive history of drug use, get more information on safe behaviour.

For example:

 - Tell me about the drugs you use/have used.
 - How do you use drugs (smoke, snort, inject, take pills, etc.)?
 - Do/have you ever injected a drug?
 - What drugs do/did you inject?
 - How do you know if the equipment you use is clean?



EMPHASISE that screening for substance use is particularly important in HIV-infected patients because both alcohol and substance use are risk factors for HIV infection acquisition and transmission. Emphasize that addressing problems associated with substance use can help clients improve adherence to HIV medications and adopt risk-reduction behaviours, such as practicing safer sex.

EXPLAIN that:

- Screening should be conducted when the client does not have alcohol on his/her breath and does not appear to be under the influence of any drug.
- When a person uses one substance, there is an increased likelihood that they may use additional substances. Always ask about additional substances when the client discloses use of a particular substance.
- Clients often minimize or deny alcohol and substance use because of the stigma associated with addiction, or potentially because they are struggling with its use and report what they want to be true.

NOTE that there are some indicators for substance or alcohol use, including:

- History of referrals or participation in substance/alcohol treatment programmes
- Trauma, especially after drinking/substance use
- Legal problems
- Job loss/turnover, downward mobility
- Relationship problems
- History of psychiatric symptoms, especially affective disorders
- History of, or current heavy smoking

Source:

Substance Use Screening in HIV-Infected Patients. New York State Department of Health. 2007. http://www.hivguidelines.org/substance-use/screening-assessment/#tab_0

SAMSHA/ Brown, R. & Saunders, L. CAGE adapted to include drugs. 1991. <http://1.usa.gov/1RZnDAI>

Substance Use Screening - 2

- Ask if the client (or anyone in social network or family) think they may have a substance use problem, now or in the past.
- If client denies substance use, but the provider suspects substance use, continue to inquire about substance use at subsequent visits.
- Refer if needed for a complete assessment.



EMPHASISE that screening for substance use is particularly important in HIV-infected patients because both alcohol and substance use are risk factors for HIV infection acquisition and transmission. Emphasise that addressing problems associated with substance use can help clients improve adherence to HIV medications and adopt risk-reduction behaviours, such as practicing safer sex.

EXPLAIN that:

- Screening should be conducted when the client does not have alcohol on his/her breath and does not appear to be under the influence of any drug.
- When a person uses one substance, there is an increased likelihood that they may use additional substances. Always ask about additional substances when the client discloses use of a particular substance.
- Clients often minimize or deny alcohol and substance use because of the stigma associated with addiction, or potentially because they are struggling with its use and report what they want to be true.

NOTE that there are some indicators for substance or alcohol use, including:

- History of referrals or participation in substance/alcohol treatment programmes
- Trauma, especially after drinking/substance use
- Legal problems
- Job loss, turnover, downward mobility
- Relationship problems
- History of psychiatric symptoms, especially affective disorders
- History of or current heavy smoking

Source:

Substance Use Screening in HIV-Infected Patients. New York State Department of Health. 2007. http://www.hivguidelines.org/substance-use/screening-assessment/#tab_0

SAMSHA/ Brown, R. & Saunders, L. CAGE adapted to include drugs. 1991. <http://1.usa.gov/1RZnDAI>

Substance Use Screening - 3

- If answers indicate daily use or possible abuse, use the following CAGE-AID screening tool for substance use/abuse:
 1. Have you ever felt the need to cut down on your use of alcohol or drugs?
 2. Has anyone annoyed you by criticizing your use of alcohol or drugs?
 3. Have you ever felt guilty because of something you've done while drinking or using drugs?
 4. Have you ever taken a drink or used drugs to steady your nerves or get over a hangover (eye-opener)?
- A total of 2 or more "yes" responses to CAGE-AID may be suggestive of a problem



NOTE that the CAGE-AID tool is designed for clinicians to use as a brief screening. It does not constitute a complete assessment. Providers may wish to refer clients to appropriate services for complete assessment.

Full links to sample screening tools:

- CAGE-AID: <http://www.integration.samhsa.gov/images/res/CAGEAID.pdf>
- NIH/National Institute on Drug Abuse: list of evidence-based resources: <https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools>
- WHO ASSIST screening test: http://www.who.int/substance_abuse/activities/assist/en/
WHO Mental Health Gap Intervention Guide for mental, neurological, and substance use disorders in non-specialised health settings: http://apps.who.int/iris/bitstream/handle/10665/44406/9789241548069_eng.pdf;jsessionid=B58F28C389EB11C2F7B8477A20B-6028F?sequence=1

Source:

Substance Use Screening in HIV-Infected Patients. New York State Department of Health. 2007. http://www.hivguidelines.org/substance-use/screening-assessment/#tab_0

SAMSHA/ Brown, R. & Saunders, L. CAGE adapted to include drugs. 1991. <http://1.usa.gov/1RZnDA>

Violence & Abuse Screening - 1

- Important to assess for violence and abuse at personal, household, and community levels
 - May include domestic violence, gender-based violence, or other types of interpersonal violence
- Always ask these questions in private, and emphasise that these are questions are routine
 - “In light of high levels of sexual and gender-based violence affecting us all, we ask all patients the following questions as part of our assessment.”



Source:

Stanford Medicine. “Domestic Abuse: How to Ask” [webpage]. <http://domesticabuse.stanford.edu/screening/how.html>

Violence & Abuse Screening - 2

- Screening questions include:
 - Do you feel safe at home? Do you feel safe in your community?
 - Does a partner, client or anyone at home, hurt, hit or threaten you?
 - Has a partner, or anyone at home ever hurt, hit or threatened you?
 - Have you been hurt, hit or threatened by anyone outside of your home?
 - Have you ever been physically, sexually, or emotionally abused?



EXPLAIN that “abuse” may not be a word those clients identify with. Some signs of abuse, such as marks on the body from physical harm, are easy to notice. Other forms of abuse may be more difficult to see or understand. Some signs of emotional abuse can be obvious from outside the situation, but a person in that situation may miss them or be unaware that the situation is abusive.

Emotional and mental abuse involves a person acting in a way to control, isolate, or scare somebody else that could include shaming, blaming, humiliation or unpredictable behaviour. The form of abuse may be statements, threats, or actions, and there may be a pattern or regularity to the behaviour.

Sources:

- Stanford Medicine. “Domestic Abuse: How to Ask” [webpage]. <http://domesticabuse.stanford.edu/screening/how.html>
- <https://www.medicalnewstoday.com/articles/325792>

Supported Referrals are Key

- Clients who are experiencing substance abuse, mental health concerns and/or violence may need referral for:
 - Treatment
 - Counselling
 - Psychosocial support
 - Safety planning (such as a shelter or other safe housing)
- Facility should have referral list for these types of services
 - As much as possible, ensure that referrals for members of key population groups are to key population sites.
- If a client seems distressed or expresses concerns for safety, immediately set up an appointment with a (auxiliary) social worker or psychologist.



LESSON PLAN

SESSION 9 – clinical history taking

Learning objectives

At the end of this session, participants should be able to:

- Explain the importance of clinical history taking
- Describe the SOAP note-taking process

Session overview

Content	Activity	Materials
Learning objectives	Group exercise	Slide 145
Importance of clinical note taking	Large group discussion	Slide 146
SOAP note-taking process	Large group discussion, fill in the blank	Slides 147-151
Sexual risk assessment	Large group discussion	Slide 152
Use plain language	Video	Slide 153
Key points and closing	Questions and answers	Slides 154-156

Indicates a workbook prompt.

Show slide 145

"If it ain't written down, it didn't happen"

- Good clinical notes are essential in primary care to document changes over time that can be crucial to diagnosis and management.
- Thinking about the note ahead of time can improve the client encounter.
- Notes are legal documents that are taken as the formal, complete record of the consultation.



SOAP

- **S**ubjective – enquire about reason for the visit. Client shares their version of complaint. Ask history. **DO NOT INTERRUPT.**
- **O**bjective – physical examination, observations and measurements. Vitals, labs, x-rays
- **A**ssessment – differential diagnosis and most probable diagnosis. Draw conclusions from S+O
- **P**lan – specific treatment, referral, other support, follow-up visit



The SOAP acronym will improve clinical note taking while maximising the client experience.

Source: <https://www.slideshare.net/ErinLyons/soap-notes-getting-down-and-dirty-with-medical-translation>

Subjective overview

- DO NOT INTERRUPT THE CLIENT
- Client explains their complaint in their own words
- Take note of the reason for the client visit and the issues that they have according to them.
- Also note how severe symptoms are and for how long these have been present
- This summary of complaints will give you the opportunity to detect cues of other concerns the client may have.
- These subjects can be brought up during the Objective part of the consultation.
- Avoid voicing your opinion of what the client says—there's another section for that!



ASK the client to explain their illness, its onset and progress as well as symptoms and concerns in detail.

Subjective: Note the reason the client is visiting and the issues that they are having, according to them. Avoid voicing your opinion of what they are saying—there is another section for that. This summary of complaints will give you the opportunity to detect clues of other concerns the client may have. These subjects can be brought up during the objective part of the consultation.

Objective Medical History

- Include vitals
- Current complaints/symptoms
 - symptoms of acute and chronic HIV infection
 - signs or symptoms of an STI
- Include medical history (past illness, surgery, etc.)
- Family history
- Include current medications. For transgender patients, ask if they are taking any type of hormones to help with gender affirmation (e.g. prescribed medications, contraceptives, or meds purchased online or from an unauthorized shop, etc.)
- Include client's facial expressions and body language
- For people who inject drugs, ask if they are on methadone, as this may interact with PrEP or ART



NOTE: Assess medical history as you would for all patients. Ask the client specific questions to clarify the client's subjective experience and concerns.

Objective: What do you observe? In this section, note the symptoms you can see and anything that you have measured (e.g., weight, vital signs, diagnostic test results, etc.). Do not interpret the data in this section, just record it.

Assessment

- Diagnosis based on conclusions drawn from observations
- Statement of risk the client has
- Reasoning for proposed prevention, care, and treatment plan



Assessment: After you collect and evaluate the subjective and objective information, you will be able to form and notate your assessment of the client's condition. What do you think is going on? Why do you think that? Do you need additional tests (pathology, x-rays etc. to confirm findings)?

Plan

- Include all interventions:
 - Diet / meals
 - Treatments
 - Therapies
 - Education and counselling needs
 - Referrals
 - Follow-up visit



Plan: Map out what is next. What are you recommending the client do, and how often? What will you do? What additional services or support do you need to refer the client for?

Additional note: You might collect some information during an appointment that does not quite belong in one of the SOAP sections. Use the additional note field to jot down those extra details. Some practitioners will use this space to document their clients' goals, questions or expectations.

Source: <https://www.slideshare.net/ErinLyons/soap-notes-getting-down-and-dirty-with-medical-translation>

Plain language terminology

Medical term	Lay term
Abdomen	Stomach, belly
Analgesic	Pain reliever, pain killer
Cardiogenic	Causes stroke
Cardiac	Heart
Haematuria	Blood in the urine
Immunological	How your body fights disease
Metabolise	Break down
Neurological	In the brain
Renal	Kidney
Respiration	Breathing
Thrombus	Blood clot



Always use plain language for medical terminology in client discussions. It is essential that clients understand exactly what you have done, what is wrong with them (and what not), and how will the problem be treated.

Medical history

- Begin with less threatening or less sensitive topics (e.g., general questions about person and medical history).
- Use the types of words the client is using.
- This creates a stronger sense of understanding and connectedness.
- Ask for clarification if you are unsure of a term or wording used by the client.
- Explain why personal questions are important.
- Use a variety of questioning approaches to get information. Different clients will respond to different styles. Some of these approaches include:
 - Open-ended questions. Example: "Tell me about your alcohol use."
 - Close-ended questions. Example: "Do you have sex with men, women, or both?" or "Do you use drugs?"
 - Direct questions about specific behaviours. Example: "When would you be uncomfortable using a

- condom?”
- Exploratory questions. Example: “What do your friends think about using drugs?”
 - Normalising questions. Example: “Sometimes people enjoy anal intercourse. Have you ever had anal intercourse?” or “Some of my clients tell me they share their crack pipes. Have you ever shared a pipe?”
- Remain neutral when hearing sensitive information:
- Maintain neutral body language
 - Smiling or relaxed mouth
 - Nodding
 - Relaxed arms and legs
 - Making eye contact
- Avoid cold and judgemental body language:
- Looking away
 - Rolling eyes
 - Crossed arms and legs
 - Strong gestures or sudden movements in response to client
 - Focus on risk reduction
- After learning about a client, the next step is to help reduce risk and improve health.
- Remember that success is defined as risk reduction.
- Abstinence-only messages are not effective or appropriate.
- Goals for clients should be achievable and realistic.
- Affirm concerns:
- Clients may express concern in response to disclosing sensitive information
 - To help ease this concern, provide the client with affirmation of their concerns:
 - “I’m glad you told me this.”
 - “I know it isn’t easy to talk about this, and I appreciate your honesty.”
 - “I understand why you may be concerned, but let me see how I can help you with that.”
- Be prepared for what you might hear.
- Ask your clients to explain anything you do not understand.
- Assess for symptoms of acute and chronic HIV infection, signs, or symptoms consistent with a sexually transmitted infection, plans related to pregnancy and childbearing and for trauma and abuse in all clients with or at risk for HIV, TB or hepatitis.
- Current complaints/symptoms.
- Chronic conditions/medications.
- History (past conditions, medications, surgery).
- Family history.
- Tobacco, alcohol, drug use.
- Vaccinations

- For transgender clients, in addition to standard questions asked of all clients, remember to ask if they are taking any type of hormones to help with gender affirmation. These might include prescribed medications, contraceptive pills, medications purchased online or from an unauthorised shop, etc.
- Give clear and consistent messages.
- After getting to know clients, provide them with messages on:
 - Risk-reduction behaviours
 - Use of additional health services
- Messages can also be called goals because they:
 - Require a client to take action
 - Require the healthcare provider to follow up

Sexual History

- Initial sexual health questions
 - Are you currently sexually active? When did you last have sex?
- Follow up with detailed questions covering the “5 Ps”:
 - Partners
 - Practices
 - Protection include condoms and PrEP
 - Past STI history
 - Pregnancy / Parenting
- Requires the provider to understand the different risks associated with a variety of sexual behaviours



1. Sexual history

a. Initial sexual health assessment questions

- Are you currently sexually active?
- When did you last have sex?

b. Follow up initial questions with detailed sexual history questions covering the five P's (partners, practices, protection, past history of STIs, and pregnancy). Remember, direct and non-judgemental questions are best.

- Partners** (number of partners, gender of partners)
 - How many sexual partners have you had in the last three months?
 - How many sexual partners have you had in the last year?
 - Are your sex partners men, women, or both?
 - What do you know about your partner(s)' past sexual activities?
- Practices** (e.g., type of sex – vagina, anal, oral, and/or sex toys)
 - I am going to be more explicit about the kind of sex you have had over the last 12 months to better understand if you are at risk for sexually transmitted infections.
 - What kind of sexual contact do you have or have you had?
 - Do you have oral sex? Vaginal sex? Anal sex?
 - Vaginal sex/penis in vagina?
 - Anal sex/penis in anus?
 - If yes, ask: During anal sex, are you the top (insertive partner), the bottom (receptive partner), or both?

- Oral sex/mouth on penis, vagina, or anus?
- Do you use any sex toys?

Protection (use of condoms, etc.)

- Do you and your partner(s) do anything to protect against sexually transmitted infections? What do you do?
- Would you say you use condoms all the time, some of the time, or never?
- When do you use condoms?
- What do you do when you think you have an STI?
 - Probe for more information as needed.

Past STI history

- Have you ever been diagnosed with a sexually transmitted infection?
 - If yes: When was the diagnosis? How were you treated? Were your partner(s) also treated? Have you had any recurring symptoms?
- Have you ever been tested for HIV or other STIs? Would you like to be tested?
- To your knowledge, has your current or former partner(s) ever been diagnosed or treated for an STI?

Pregnancy (plans, contraception, etc.)

Based on information already collected in the sexual history, you may determine that the client is at risk of becoming pregnant or fathering a child. Ask gender-appropriate questions.

- Are you currently trying to conceive a child/father a child?
- Are you concerned about getting pregnant/getting your partner pregnant?
- Are you using any contraception or practicing any form of birth control?
- Would you like any additional information about birth control?

2. Substance use screening

General questions

- What over-the-counter medications are you taking?
- How often do you use alcohol? What about tobacco?
- Have you ever used/are you currently using drugs from a non-medical source?

If there is a positive history of drug use, get more information:

- Tell me about the drugs you use/have used?
- How do you use drugs (smoke, snort, inject, take pills, etc.)?
- Do you, or have you ever injected a drug?
- What drugs do/did you inject?
- How do you know if the equipment you use is clean?

- Tell me about the last time you had sex when you were high?

If answers to above indicate daily use or possible abuse, then use the following CAGE-AID screening tool for substance use/abuse:

- Have you ever felt the need to cut down on your use of alcohol or drugs?
- Has anyone annoyed you by criticising your use of alcohol or drugs?
- Have you ever felt guilty because of something you've done while drinking or using drugs?
- Have you ever taken a drink or used drugs to steady your nerves or get over a hangover (eye-opener)?

A total of two or more 'yes' responses to CAGE-AID may suggest a problem

3. Mental health screening

A full mental health screening would include questions to identify depression, anxiety, post-traumatic stress disorder (PTSD) and suicidal ideation, however these require professional training to conduct. Those without professional mental health screening training may ask a few questions with the focus on offering counselling and/or support group referrals, such as:

- Have you ever received counselling other than HIV-related counselling?
- Are you currently part of a support group?
 - If so, in the past but no longer, why did you decide to stop participating?
- Would you like to speak to a counsellor and/or participate in a support group?

4. Violence and abuse screening

Always ask about experiences of violence and abuse at a personal, household and community level. Introduce the topic with a statement similar to this: "In light of high levels of sexual and gender-based violence affecting us all, we ask all clients the following questions as part of our assessment."

- Do you feel safe at home? Do you feel safe in your community?
- Does a partner, or anyone at home, hurt, hit or threaten you?
- Has a partner, or anyone at home ever hurt, hit or threatened you?
- Have you been hurt, hit or threatened by anyone outside of your home?
- Have you ever been physically, sexually, or emotionally abused?

If you feel comfortable, you could also screen clients for violent behaviour.

- Have you lost your temper to the point where you would hurt someone?
- Have you hit or slapped someone? ...What about grabbing and shaking?

It is important to ensure adequate referral, if needed, to counselling and support services dealing specifically with sexual and gender-based violence.

Key Points - 1

- Risk assessments help health care workers:
 - Identify patients at risk of exposure to illness and harm
 - Ensure that appropriate screenings are conducted
 - Establish strategies to reduce risks and prevent new infections
- Establishing rapport is essential to building the trust necessary to conduct an effective and sensitive risk assessment
- Risk assessment includes screening for health risks, unsafe behaviours, substance and alcohol use, common mental health disorders, and violence
- Important to ensure access to appropriate referrals and ways to support the client to access referral services



Key Points - 2

- Establishing rapport is essential to building the trust necessary to conduct an effective and sensitive risk assessment
- Risk assessments:
 - Stick to the questions on the questionnaire
 - Do not ask questions out of curiosity
 - Avoid negative facial expressions and body language
 - Don't judge
 - Be open-minded
- Risk assessment includes screening for health risks, unsafe behaviours, substance and alcohol use, common mental health disorders, and violence
- Important to ensure access to appropriate referrals and ways to support the client to access referral services



SUMMARISE session with key points.

ASK if there are any questions before closing session.

THANK everyone for their active participation.

MODULE 4: POPULATION-SPECIFIC CONSIDERATIONS

The learning objectives for Module 4 will be covered in the following sessions:

Session 10 – Sex workers

- Define the term “sex worker”
- Identify at least two barriers sex workers face when seeking health services
- Describe at least two barriers to condom acquisition and use among sex workers
- List at least three healthcare and screening needs of sex workers
- Describe PrEP eligibility criteria for sex workers
- State at least four risk assessment questions to ask sex workers

Session 11 – Gay men and other men who have sex with men

- Explain the difference between the terms “gay/homosexual” and “men who have sex with men”
- Identify at least two barriers men who have sex with men face when seeking health services
- Define PrEP
- Describe PrEP eligibility criteria for men who have sex with men
- List at least three healthcare and screening needs of men who have sex with men
- State at least four risk assessment questions to ask men who have sex with men

Session 12 – Transgender people

- Define the terms “transgender person,” “transgender woman,” and “transgender man”
- Identify at least two barriers transgender people face when seeking health services
- Describe at least two physical changes that may occur when a transgender woman takes hormone therapy
- State at least four risk assessment questions to ask transgender women regarding sexual and reproductive health
- State at least two risk assessment questions to ask transgender women regarding harm reduction

Session 13 – People who use and inject drugs

- List at least three common health complications among people who inject drugs
- Describe at least two barriers people who inject drugs face when seeking health services
- Identify at least three signs or symptoms of opioid withdrawal
- Identify three signs of opioid overdose
- Explain the association between opioid substitution therapy and ART adherence
- State at least four risk assessment questions to ask people who inject drugs regarding harm reduction

Session 14 – People in prisons and other closed settings

- Define the terms “prisons and other closed settings”
- Identify at least two barriers people in prisons and other closed settings face when seeking health services
- Describe at least two barriers to condom acquisition and consistent condom use among people in prisons and other closed settings
- List at least three healthcare and screening needs of people in prisons and other closed settings
- State at least four risk assessment questions to ask people in prisons and other closed settings

LESSON PLAN

SESSION 10 — sex workers

Learning objectives

At the end of this session, participants should be able to:

- Define the term “sex worker”
- Identify at least two barriers sex workers face when seeking health services
- Describe at least two barriers to condom acquisition and consistent use among sex workers
- List at least three healthcare and screening needs of sex workers
- Define PrEP
- Describe PrEP eligibility criteria for sex workers
- State at least four risk assessment questions to ask sex workers

Session overview

Content	Activity	Materials
Learning objectives	Large group discussion	Slide 161
Introduction Defining sex worker	Video Fill in the blank exercise	Slides 162-164
Barriers to care	Video Group exercise	Slides 165-166
HIV risk Prevention Condoms PrEP	Videos Mini lecture Small group discussion	Slides 167-171
Screening Violence STIs Mental health	Large group discussion	Slide 172
Risk assessment	Ask and respond activity Video	Slide 173
Key points and closing	Start/Stop/Continue Questions and answers	Slides 175-177

Indicates a workbook prompt.

Opener

Show slide 161

Session 10 Learning Objectives

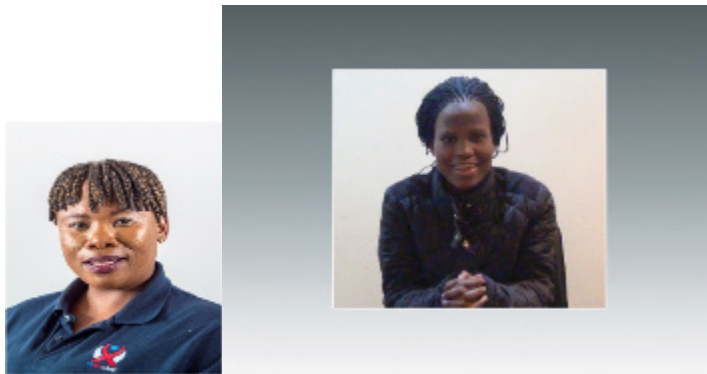
By the end of this session participants should be able to:

- Define the term “sex worker”
- Identify at least two barriers sex workers face when seeking health services
- Describe at least two barriers to condom acquisition and use among sex workers
- List at least three health care and screening needs of sex workers
- Describe PrEP eligibility criteria for sex workers
- State at least four risk assessment questions to ask sex workers





Show slide 162



SAY: Meet Sisanda, a sex worker from Eastland in Limpopo.

Show video clip #1 (slide 163): I'm Sisanda

SAY: We will hear more from Sisanda in her own words, but first let's take a few moments to talk about sex workers.

Show slide #164

A sex worker is a _____ adult over the age of 18 who receives _____ or goods in exchange for sexual services.

SAY: Please fill in the missing words in your workbook.

Invite participants to share the words they have entered.

SAY: A sex worker is a consenting adult over the age of 18 who receives money or goods in exchange for sexual services. The term “sex worker” is preferred over “prostitute,” as it is non-judgemental.

(Note: If asked about the age limit, state that children under age 18 are considered children and therefore victims of sexual exploitation).

Children need additional support and should be referred to a social worker for support if it is believed that a client is younger than 18 years. It is important to note that key populations under 18 years must never be refused health services.

ASK: Does Sisanda fit your idea of what a sex worker looks like? The way a sex worker behaves? Why or why not? Please divide yourselves into teams of three to four people each. You will work with these teams for the rest of the session, when we do small group work. Take a few moments to discuss in teams.

After sufficient time has passed, invite one member of each team to report back.

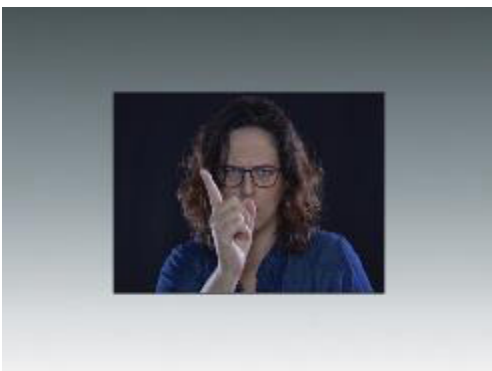
SAY: There are approximately 150 000 sex workers in South Africa, 90 per cent of whom are female.¹⁷ The remaining 10 per cent identify as either male or transgender. Sex workers vary in age, race, and economic background. Sex workers may sell sex regularly or on occasion; some may not identify as sex workers.

Show video clip #2 (slide 165): We end up losing a lot of people

SAY: Sex workers may not seek healthcare due to concerns about poor treatment by staff, or fear of being arrested. Once at the clinic, a sex worker may be stigmatised or denied care for a health complaint because of a staff member’s belief that she “brought it on herself”.

Barriers

Show slide 166



Instruct participants to discuss the following scenario in pairs (you may use breakout rooms for this or LEAD a group discussion).

SAY: The operational manager says, “This facility is for community members. Sex workers are not welcome here”.

ASK: How do you respond? Make sure that each participant has the opportunity to respond aloud.

After sufficient time has passed, INVITE a volunteer to demonstrate how s/he would respond. If judgmental or stigmatising language is used, invite the volunteer to rephrase.

HIGHLIGHT the following, if not mentioned:

- The Constitution of the Republic of South Africa guarantees access to healthcare services for all.
- Sex workers may live within the facility catchment area.
- HIV prevalence among sex workers in South Africa is among the highest in the world.
- Sex worker clients often have other sex partners, and may therefore bring HIV and STIs into the general population.

Show slide 167: HIV risk



Show video clip #3 (slide 168): Condoms as evidence

PLAY Video clip #3: Condoms as evidence

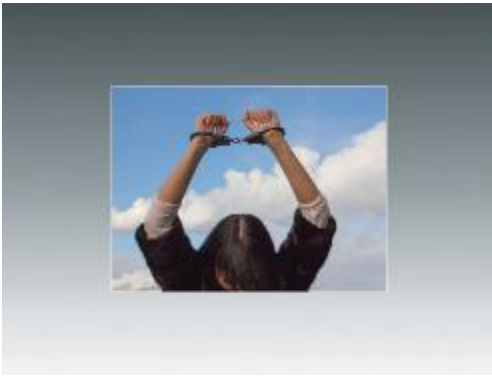
SAY: HIV prevalence among sex workers and sex worker clients is about 10 to 20 times higher than among the general population in sub-Saharan Africa.

ASK: Why may sex workers find it difficult to access and use condoms?

Elicit replies.

SAY: An unequal balance of power between sex workers and clients may make it difficult for sex workers to insist on condom use. A client's offer of extra payment for unprotected sex may also serve as a barrier to condom usage among sex workers.

Show slide 169: Condom usage



SAY: Police officers may treat the fact that a person is carrying condoms as “evidence” that s/he is a sex worker and arrest him or her. This discourages sex workers from carrying condoms, which in turn increases the chances of unprotected sex. Because sex work is criminalised, it is also difficult for a sex worker to report sexual assault and abuse.

SAY: Let’s review what we have covered so far. Please take the next two minutes to note a few key points in your workbook.

After two minutes have passed,

ASK: What is PrEP?

Elicit replies.

Show slide 170: PrEP



PrEP

SAY: PrEP stands for pre-exposure prophylaxis. It is a daily regimen of ARVs (Tenofovir Disoproxil Fumarate and Emtricitabine) that may be taken by HIV-negative people to prevent HIV infection. Concerns about drug resistance or behavioural risk-taking whilst taking PrEP are not supported by evidence. In order to be eligible for PrEP, a sex worker must be/have:

- At least 18 years old
- Confirmed HIV negative
- Creatinine Clearance <60ml/min
- No contraindications for the use of TDF/FTC

- No symptoms of acute viral infection

Show video clip #4 (slide 171): PrEP

Ask participants to get back into their teams. Assign one of the following questions to each team to discuss as a small group. After sufficient time has passed, invite one member of each team to report back.

An antenatal care client who is a sex worker says, “I want to take PrEP to protect myself and my baby against HIV”. How do you respond? Correct reply: PrEP is contraindicated for use in pregnancy and whilst breast-feeding by the South African Health Products Regulatory Authority. Encourage the client to use condoms to protect herself from HIV and STIs.

A client asks, “Is it safe for me to take PrEP while I am on birth control?” How do you respond? Correct reply: Standard hormonal contraception does not affect PrEP effectiveness, nor does PrEP affect contraceptive effectiveness.

A client who is a sex worker has just tested negative for HIV. Your colleague says, “Don’t offer PrEP to that woman; she’s probably in the window period”. How do you respond? Correct reply: Some individuals are at ongoing risk for HIV and may always fall within the window period. Eligible sex workers should be offered PrEP, as all people at risk of acquiring HIV have much to gain from taking it.²⁰

For more information about PrEP, refer to the “Resources” section of your workbook.

Show slide 172: Screening needs



ASK: True or false: Sex workers cannot be raped? Correct reply: False.

SAY: Sex workers often experience violence, including sexual assault. Violence increases the likelihood of future risky sexual behaviour, including lack of condom use. Sex workers who have been sexually assaulted should be offered clinical services, including HIV and STI post-exposure prophylaxis, and emergency contraception, if indicated. For more information about clinical care for survivors of sexual assault, REFER to the “Resources” section of your workbook.

ASK: What healthcare and screening needs may sex workers have, in addition to screening for HIV and violence?

HIGHLIGHT the following, if not mentioned:

- STI screening and treatment
- Cervical cancer screening
- Contraception
- Mother-to-child transmission services, if HIV+ and pregnant or lactating
- Mental health screening (depression and anxiety)

SAY: All sex workers who present at the clinic should be assessed for risks associated with HIV and STIs, including violence. When conducting a risk assessment with a sex worker, focus on sexual behaviour and practices, rather than his or her occupation.

Show slide 173

Risk Assessment



SELECT two participants. ASSIGN one as “health worker” and one as “sex worker”.

INVITE the two participants to demonstrate how to ask and answer one risk assessment question.

After the question has been asked and answered appropriately, INVITE the next two participants to demonstrate asking and answering one risk assessment question.

CONTINUE until all participants have had the chance to ask and answer at least one question.

Highlight the following questions, if not mentioned:

Clinical history questions

Tell me a bit more about your sexual partners?

What types of sex do they prefer? Prompt for violence and abuse.

Have you ever had any STIs? If yes, enquire whether they know which.

When were you last tested for STIs?

Has your partner(s) ever been diagnosed with any STIs?

How do you protect yourself from STIs?

How often do you protect yourself against HIV and STI exposure?

Do you use alcohol or any drugs when you have sex?

Do you use contraception?

Is there any chance you may be pregnant?

Have you experienced abuse from an intimate partner?

Instruct participants to return to their seats and write down at least four risk assessment questions in their workbooks.

SAY: Before we conclude the session, let's hear some parting words from Sisanda.

Show video clip #5 (slide 174): I'm from the sex work industry

Show slide 175

Start / Stop / Continue



SAY: Please take the final few moments to identify one thing that you will start, stop, and continue to do when interacting with sex workers at the facility, by writing it down in the "Start/Stop/Continue" section of your workbook.

Invite participants to share what they have written with the group at large, or, if preferred, in pairs.

Key Points (slide 176)

ASK participants to share some of the key points they've written in their workbooks for the session.

LEAD discussion so that participants may clarify or correct the key points, as needed.

HIGHLIGHT the following, if not mentioned:

Sex work is work, like any other job someone gets paid for.

A sex worker is a consenting adult over the age of 18 who receives money or goods in exchange for sexual services.

Sex workers may not seek healthcare due to concerns about poor treatment by staff.

Because sex work is criminalised, it is also difficult for a sex worker to report sexual assault and abuse.

Once at the clinic, a sex worker may be stigmatised or denied care for a health complaint because of a staff member's belief that he/she "brought it on herself".

An unequal balance of power between sex workers and clients may make it difficult for sex workers to insist on condom use. A client's offer of extra payment for condomless sex may serve as a barrier to consistent condom use .

Sex workers must be provided with the number of condoms they request without being judged.

Sex workers must not be judged for reporting to the clinic with repeated STIs.

Some law enforcement officials consider finding condoms in a woman's bag as evidence that they are doing sex work. This can also be an additional barrier to consistent condom use.

Sex worker clients often have other sex partners which may be at risk of exposure to HIV.

In addition to screening for HIV and STIs, sex workers should be screened for cervical cancer, contraception needs, MTCT services if HIV-positive, mental health screening, and screening for violence and trauma.

Sex workers vary in age, race, and economic background. Sex workers may sell sex regularly or on occasion; some may not identify as sex workers.

Risk assessment questions should focus on unsafe behaviours and practices, rather than his or her occupation or appearance.

LESSON PLAN

Healthcare and screening needs

Sex workers:

PARTICIPANT WORKBOOK

Objectives

At the end of this session participants should be able to:

Define the term “sex worker”.

Identify at least two barriers sex workers face when seeking health services.

Describe at least two barriers to condom acquisition and consistent condom use among sex workers.

List at least three healthcare and screening needs of sex workers.

Define PrEP.

Describe PrEP eligibility criteria for sex workers.

State at least four risk assessment questions to ask sex workers.

Instructions: fill in the words that are missing from the slide.

A sex worker is a _____ adult over the age of 18 who receives _____ or goods in exchange for sexual services.

Instructions: please note a few key points that we have covered so far.

-
-
-

Instructions: Your team will be assigned one of the following questions to discuss. After your discussion, one member of

each team will be invited to report back to the larger group.

An antenatal care (ANC) client who is a sex worker says, “I want to take PrEP to protect myself and my baby against HIV”. How do you respond?

A client asks, “Is it safe for me to take PrEP while I am on birth control?” How do you respond?

A client who is a sex worker has just tested negative for HIV. Your colleague says, “Don’t offer PrEP to that woman; she’s probably in the window period”. How do you respond?

Instructions: after the risk assessment activity, please return to your seat and write down at least four risk assessment questions.

- 1.
- 2.
- 3.
- 4.

Start/Stop/Continue


Instructions: Please take the final few moments to identify one thing that you will start, stop, and continue to do when interacting with sex workers at the facility, by writing it down here.

|

will start
to...

I will
stop...

I will continue to...

5.  CASE STUDY | SISANDA



Sex worker

Experience with health workers

Sisanda is a 47-year-old woman from Eastland in Limpopo. She moved to Johannesburg with her friends when she was 16, as they had heard it was “a place of gold”. They did not find it. She became a sex worker and soon learned she was HIV positive. She knows a lot of sex workers do not access health services because they are afraid of being judged, or that people in the community will find out what kind of work they do. Sisanda believes she must be responsible for her own health and became a peer navigator to help others do the same.

How can we, as health workers, do better ourselves, and also teach others to treat sex workers better? Possible answers:

Healthcare workers have a professional responsibility to treat all clients with dignity and respect. Training is required for all staff to sensitise them to the specific medical and psychosocial needs of sex workers. It is not appropriate to ask unnecessary questions about “why” people choose this work or lecture sex workers about the need to

stop what they are doing.

Modelling non-judgemental, compassionate verbal and non-verbal communication skills is an important way to demonstrate positive interactions with sex workers.

Sisanda knows that a lot of sex workers do not want to access health services because they are afraid of being judged for their work or that people from the community will find out what work they do. When she was a peer navigator, her job was to help people who had received a referral letter link to a facility within 24 hours of receiving the referral. She was sitting with a client in the waiting room of a clinic when a clerk started shouting at a lady in front of them and many people in the clinic: “Last week you were here with the same sickness! Is this person that you are sleeping with not using a condom?” The lady left without accessing services.

What are some of the reasons why sex workers would be fearful?

Possible answers:

Sex work is illegal; they are afraid the nurse would call the police

Health workers would gossip about them if they found out that they were sex workers

Health workers ask them a lot of questions that they do not need the answers to, e.g. who is the father?

Community members who know them might recognise them at the clinic

If that lady or a sex worker was pregnant, what are the health implications of the clerk's behaviour could have on the woman? On her baby?

Possible answers:

Without antenatal care, pregnant women are at risk for maternal complications such as pre-eclampsia.

HIV testing should be done regularly during pregnancy and by not returning to the clinic, she is at risk for not knowing her HIV status and if positive, not starting ART to prevent HIV transmission to her baby.

ANC visits include monitoring and education about the importance of nutrition for mother and baby.

ANC monitoring can identify potential abnormalities early in the course of the pregnancy and provide medication and/or treatment if possible.

How can health workers make the clinic experience more comfortable for sex workers?

Possible answers:

The clinic environment should be welcoming to all clients starting with the guards and receptionist and continuing throughout each area including laboratory and pharmacy. Welcoming staff are those who greet clients, smile and take time to answer even a simple question such as "which door to see the counsellor"?

Some clinics with a large number of sex workers in their community, have a dedicated day/time for sex workers.

Training about this key population is critical for all staff. This training includes medical and psychosocial information as well as stigma and discrimina-

tion specific to sex workers.

Condoms as evidence

Sisanda tells us that there are times when she is distributing condoms to her fellow sex workers, they do not want to take the condoms because the police and other law enforcement officials consider carrying condoms in their bags as evidence that they are engaged in sex work. If they do take condoms, they will hide them so that they do not have to carry them in their bag. There are also clients who ask if they can engage in service without using protection. Some expect it and might get angry if a sex worker refuses. Or they might refuse payment after the services were provided. Sisanda asks, “So who is the driver of HIV?” She argues that sex workers are just the passengers in the passenger seat.

How would this treatment impact sex workers’ ability and motivation to advocate for herself both in general, and in terms of her health?

Possible answer:

Unfortunately Sisanda and many other sex workers have a significant safety risk if they question their client especially about money owed. Sex workers are subject to verbal abuse adding to existing feelings of guilt, anger and depression. Sex workers may carry these feelings and how they communicate when they access healthcare. They may be less likely to communicate all of their problems and choose only to talk about the most urgent problem.

How would it impact her ability to advocate for herself?

Possible answer:

When Sisanda and other sex workers are continually verbally or physically abused and living in fear of their own safety, they are less likely to stand up for even their most basic rights. This treatment causes stress which in turn can lead to physical and emotional problems. Over time, the sex worker can feel that he/she “deserves” this type of treatment due to the type of work they are doing. The cycle of being treated poorly, feeling poorly about themselves and engaging in unsafe behaviours repeats over and over again.

How would it impact how she feels about herself?

Possible answer:

Internalised stigma or self-stigmatisation can lead to poor self-worth. Feeling like she is a bad person for what she is doing. Feeling like she deserves whatever poor treatment she receives from people who should be protecting her safety such as police, people that should be providing quality healthcare and even her own family and friends.

What can we, as health workers, do to help educate groups – beyond health workers – to make things safer for sex workers?

Possible answer:

Provide community health education addressing the effects of stigma and discrimination towards any key population groups. Include scenarios that highlight the poor treatment of sex workers in particular and the role the community has in protecting all of their members.

LESSON PLAN

SESSION — 11 Gay Men and other men who have sex with men

Learning objectives

At the end of this session, participants should be able to:

- Explain the difference between the terms “gay/homosexual” and “men who have sex with men”.
- Identify at least two barriers men who have sex with men face when seeking health services.
- Define PrEP.
- Describe PrEP eligibility criteria for men who have sex with men.
- List at least three healthcare and screening needs of men who have sex with men.
- State at least four risk assessment questions to ask men who have sex with men.

Session overview

Content	Activity	Materials
Opener	Men who have sex with men small group discussion	Slides #1-#4
Barriers	Mini lecture	Slide #5-#6
HIV risk Prevention PrEP	Discussion in pairs	Slides #7-#9
Screening HIV/STIs HPV Viral Hepatitis	Mini lecture	Slide #10
Risk assessment	Team activity Return demonstration	Flip chart paper, markers
Closer	Fill in the blank activity	Slides #11-#12 Fill in the blank activity cards

Indicates a workbook prompt.

Opener

Show slide #180

Session 11 Learning Objectives

By the end of this session participants should be able to:

- Explain the difference between the terms “gay/homosexual” and “men who have sex with men”
- Identify at least two barriers men who have sex with men face when seeking health services
- Define PrEP
- Describe PrEP eligibility criteria for men who have sex with men
- List at least three health care and screening needs of men who have sex with men
- State at least four risk assessment questions to ask men who have sex with men



Show slide #181



SAY: Meet Jay, a gay man from Mamelodi, in Tshwane Metro.

Show video clip #1 (slide 182): My name is Jay.

Show slide #183



ASK: What do you know about men who have sex with men?

SAY: Please take a few minutes to discuss the following question in pairs or small teams (you may choose to use breakout rooms briefly, or just ask for volunteers to “raise their hand”).

After sufficient time has passed, invite one member of each team to report back. For each “fact” that is reported about what participants know about men who have sex with men, address whether they are true or false. Do these “facts” really apply to all men who have sex with men? Highlight the following.

ASK: True or false: The terms “men who have sex with men” and “gay” (or homosexual) mean the same thing. Correct reply: False.

SAY: Gay (homosexual) is a sexual identity, whereas men who have sex with men describes a sexual behaviour. Sexual behaviour is not always determined by sexual identity. Men who have sex with men include:

- Men who self-identify as gay and only have sex with other men
- Bisexual men
- Men who self-identify as straight, but have sex with other men

SAY: Many men who have sex with men in South Africa also have female sex partners.

Show video clip #2 (slide 184): It's a sexual behaviour

SAY: Sex between men occurs in every culture and society.⁷ Health workers and support staff should not assume that all male clients are heterosexual, nor have only female partners. Any male who presents at the clinic may be a man who has sex with men, even if he looks and acts masculine.

Barriers

Show slide #185



ASK: What barriers may men who have sex with men face when seeking health services? Elicit replies.

Show video clip #3 (slide 186): Long journey

SAY: Men who have sex with men may avoid or delay seeking health services for fear of being embarrassed, stigmatised or shamed. Upon presenting at the facility, men who have sex with men may be hesitant to volunteer their sexual history to a health worker who is thought to be judgemental. This may result in missed opportunities for sexual health services, including HIV prevention, treatment, and care.

Show video clip #4 (slide 187): Sexual practices are not linked to sexual orientation

SAY: Men who have sex with men are more likely to be infected with HIV than the general population.⁸ The increased risk may be due to a number of factors, including the barriers we have just discussed. It is also related to sexual behaviour.

ASK: Why, as Jay says, does condomless receptive anal sex

carry the highest HIV risk? Elicit replies. If judgemental language is used, invite participants to rephrase.

Show slide #188



Say: The HIV virus can pass through delicate rectal mucosal membranes. Use of condoms and lubricant during anal sex reduces HIV risk. Some men who have sex with men engage in unsafe practices — such as the use of oil-based lubricants — because they lack awareness of and access to water-based lubricants.

Instruct participants to find a partner nearby and discuss the following question (you may use breakout rooms for this or lead a group discussion).

ASK: A male client who has sex with men asks, “What can I do to protect myself from HIV?” How do you respond?

After sufficient time has passed, invite volunteers to report back.

HIGHLIGHT the following, if not mentioned:

- Condomise
 - Female (or internal) condoms may also be used for anal intercourse
- Always use water-based lubricant (oil-based lubricant may damage condoms)
- Limit the number of concurrent (at the same time) sexual partnerships
- Screen for HIV and STIs regularly
- Take PrEP

Note: If voluntary medical male circumcision (VMMC) is mentioned, inform participants that research has shown a protective effect of VMMC for vaginal, but not anal, sex.

Show slide # 189: PrEP



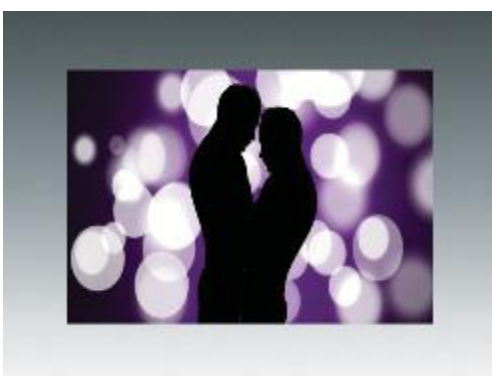
ASK: What is PrEP? Elicit replies.

SAY: PrEP stands for pre-exposure prophylaxis. It is a daily regimen of ARVs (Tenofovir Disoproxil Fumarate and Emtricitabine) that may be taken by HIV-negative people to prevent HIV infection. Concerns about drug resistance or behavioural risk-taking whilst taking PrEP are not supported by evidence. In order to be eligible for PrEP, a man who has sex with men must be/have:

- 18 years old or older
- Confirmed HIV negative
- Creatinine Clearance <60ml/min
- No contraindications for the use of TDF/FTC
- No symptoms of acute viral infection

For more information about PrEP, refer to the “Resources” section of your workbook.

Show slide #190: Screening



SAY: In addition to HIV, men who have sex with men are at risk of other infections, and should therefore be screened for the following:

STIs, including syphilis and HPV

- Anal, penile, and oropharyngeal cancers are associated with HPV.

Viral hepatitis

- Hepatitis A, B, and C.
- Men who have sex with men and who engage in high-risk behaviours, such as injection drug use (including anabolic steroids) are at increased risk of hepatitis C infection.

SAY: Let's review what we have covered so far. Please take the next two minutes to note a few key points in your workbook. After two minutes have passed, invite one participant from each group to share one key point from the session thus far. Highlight the following, if not mentioned:

Some men who have sex with men do not identify as gay.

Men who have sex with men are at increased risk of HIV infection.

Men who have sex with men may avoid or delay seeking health services due to fear of stigma or judgement.

PrEP is one way for men who have sex with men to reduce their risk of exposure to HIV infection.

Men who have sex with men should be screened for STIs, in addition to HIV.

Risk assessment exercise (in-person training exercise)

SAY: All men who have sex with men who present at the clinic should be assessed for risks associated with HIV and STIs, including syphilis and hepatitis. When conducting a risk assessment with a gay man or other man who has sex with men, the clinician should focus on sexual behaviour and practices relevant to HIV and STI risk, rather than sexual identity.

Provide each team with flip chart paper and markers. Instruct each team to:

Write down one risk assessment question for gay men or other men who have sex with men.

Post flip chart paper on the wall.

Shift to another team's area.

Review the posted question and revise as needed (if stigmatising or judgemental language has been used).

Add one more risk assessment question for gay men or other men who have sex with men.

Shift to another team's area.

Continue until all teams have reviewed and added to each other's questions.

Invite one member of each team to present the questions on their piece of paper. Highlight the following questions, if not mentioned:

Are you having sex?

Are you currently taking PrEP. If not, ask when were you last tested for HIV infection?

Do you use a condom (and lubricant) every time you have sex?

How many sex partners have you had in the past year?

Who are you having sex with (men, women, both)?

What types of sex are you having (probe for insertive and/or receptive sex)?

Do you exchange sex for money, drugs, or a place to stay?

What STIs have you had in the past, if any?

When were you last tested for STIs?

Has your partner(s) ever been diagnosed with any STIs?

How do you protect yourself from STIs?

How often do you use condoms? Lube?

Do you use alcohol or any drugs when you have sex?

SAY: For more information, see the “Health4Men guidelines for taking a sexual history” job aid in the “Resources” section of your workbook. Now that we have our list of risk assessment questions, let’s practice.

Instruct participants to divide into pairs and then ask each other four risk assessment questions relevant to men who have sex with men. Ensure that each participant has the opportunity to ask and answer questions. After sufficient time has passed, invite volunteers to demonstrate risk assessment questioning for the group at large. Highlight appropriate, relevant, and non-judgmental questions.

SAY: Before we conclude the session, let’s hear some parting words from Jay.

Show video clip #5 (slide #191): Equal treatment

SAY: Please take a few moments to write down two key points from the session in your workbook.

Show slide #192



SAY: Let's review what we have covered during this session. Please turn to the Fill in the blank activity page of your worksheet.

CLICK to the next slide to go through the activity with participants.

Show slide #193

Fill in the Blank - 1

1. Sexual _____ is not always determined by sexual _____.
2. Many men who have sex with men also have _____ sex partners.
3. Men who have sex with men may avoid or delay seeking _____ for fear of being _____.
4. To reduce HIV risk, people who engage in anal sex should condomise, and use _____ lubricant.



SAY: Each sentence has a blank. The words needed to fill in the blanks are located on cards in the toolkit, (which in person may be spread on the table/floor in front of you). Your task is to locate the cards that contain the information missing from your worksheets.

After a few minutes have passed, ASK participants to volunteer answers for each question. The answers are revealed on the next slide.

Show slide #194

Fill in the Blank - 1

1. Sexual **behaviour** is not always determined by sexual **identity**.
2. Many men who have sex with men also have **female** sex partners.
3. Men who have sex with men may avoid or delay seeking **health services** for fear of being **stigmatised**.
4. To reduce HIV risk, people who engage in anal sex should condomise, and use **water-based** lubricant.



Show slide #195

Fill in the Blank - 2

5. PrEP is a daily regimen that may be taken to _____ HIV infection.
6. To be eligible for PrEP, an individual must be confirmed _____.
7. In addition to HIV, men who have sex with men should be screened for STIs, including _____ and _____.
8. When conducting a risk assessment with a man who has sex with men, the _____ should focus on sexual behaviours and _____, rather than sexual identity.



SAY: Each sentence has a blank. The words needed to fill in the blanks are located on cards in the toolkit, (which in person may be spread on the table/floor in front of you). Your task is to locate the cards that contain the information missing from your worksheets.

After a few minutes have passed, ASK participants to volunteer answers for each question. The answers are revealed on the next slide.

Show slide #196

Fill in the Blank - 2

5. PrEP is a daily regimen that may be taken to **prevent** HIV infection.
6. To be eligible for PrEP, an individual must be confirmed **HIV negative**.
7. In addition to HIV, men who have sex with men should be screened for STIs, including **syphilis** and **HPV**.
8. When conducting a risk assessment with a man who has sex with men, the **clinician** should focus on sexual behaviours and **practices**, rather than sexual identity.



Fill in the blanks (in-person training exercise)

Advance preparation: Cards to print and cut out for in-person training activity

Behaviour

Identity

Female	Health services
Stigmatised	Water-based
PrEP	Prevent
HIV-negative	Syphilis
HPV	Clinician
Practices	Oil-based
Assumptions	HIV-positive

SAY: Let's review what we have covered during this session. Please turn to the Fill in the Blank Activity page of your worksheet. Each sentence has one or two blanks. The words needed to fill in the blanks are located on cards on the table/floor in front of you. Your task is to locate the cards that contain the information missing from your worksheets.

After five minutes have passed, review the worksheet with the group. Correct errors.

Fill in the blank activity

1. Sexual behaviour is not always determined by sexual identity.
2. Many men who have sex with men in South Africa also have female sex partners.
3. Men who have sex with men may avoid or delay seeking health services for fear of being stigmatised.
4. To reduce HIV risk, people who engage in anal sex should condomise and use water-based lubricant.
5. PrEP is a daily regimen that may be taken to prevent HIV infection.
6. In order to be eligible for PrEP, an individual must be confirmed HIV negative.
7. In addition to HIV, men who have sex with men should be screened for STIs, including syphilis and HPV.
8. When conducting a risk assessment with a man who has sex with men, the clinician should focus on sexual behaviours and practices, rather than sexual identity.

Key points

“Men who have sex with men” refers to a behaviour, not an identity.

When men who have sex with men sense judgement, resistance, or discomfort during a clinic visit, they may choose not to answer questions honestly in order to protect themselves. This kind of interaction represents a primary barrier to receiving quality care.

Men who have sex with men may avoid or delay seeking health services for fear of being embarrassed, stigmatised or shamed. These barriers contribute to the higher risk of HIV exposure among men who have sex with men.

Healthcare workers must learn to cultivate an attitude of openness and treat everyone with dignity and respect – especially those who are different from them.

Men who have sex with men are at highest risk for HIV when they engage in condomless receptive anal sex because the HIV virus can pass through delicate rectal mucosal membranes.

Men who have sex with men can protect themselves from HIV by using condoms and water-based lubricants, limiting the number of concurrent sexual partners, screening for HIV and STIs regularly, and taking PrEP.

PrEP stands for pre-exposure prophylaxis and may be taken by HIV-negative people to prevent HIV infection.

Risk assessment questions should focus on sexual behaviour and practices, rather than sexual identity.

LESSON PLAN

Healthcare and screening needs

Gay men and other men who have sex with men:

PARTICIPANT WORKBOOK

Objectives

At the end of this session participants should be able to:

Explain the difference between the terms “gay/homosexual” and “men who have sex with men”.

Identify at least two barriers men who have sex with men face when seeking health services.

Define PrEP.

Describe PrEP eligibility criteria for men who have sex with men.

List at least three healthcare and screening needs of men who have sex with men.

State at least four risk assessment questions to ask gay men and other men who have sex with men.

Slide 3

What do you know about men who have sex with men?

Discuss the following question in teams:

True or false: The terms men who have sex with men and gay (or homosexual) mean the same thing.

True False

Turn to a person nearby and discuss the following question:

A man who has sex with men asks, "What can I do to protect myself from HIV?"
How do you respond?

Fill in the blank activity

Instructions: Each sentence has at least one blank space that should be filled in with a word or phrase. Those words or phrases are located on cards on the table/floor in front of you. Your task is to locate the cards that contain the information missing from your worksheets.

1. Sexual_____is not always determined by sexual_____

2. Many men who have sex with men in South Africa also have_____sex partners.

3. Men who have sex with men may avoid or delay seeking_____for fear of being_____.

4. To reduce HIV risk, people who engage in anal sex should condomise and use_____lubricant.

5. PrEP is a daily regimen that may be taken to _____
 HIV infection.

6. In order to be eligible for PrEP, a man who has sex with men must be confirmed
 _____.

7. In addition to HIV, men who have sex with men should be screened for STIs,
 including _____ and _____.

8. When conducting a risk assessment with a man who has sex with men, the
 _____ should focus on sexual behaviours and
 _____, rather than sexual identity.


Key points

-

-

-

-

6.  CASE STUDY | JAY



Men who have sex with men

Identity

Jay is a 32-year-old man who works as an outreach worker with gay youth. He says that as young as age eight or nine, he knew he was gay. His pastor, who he describes as

being extremely influential in his life, gave a sermon about how people in the LGBTI community were bad and were going

to hell. This led to him feeling a lot of self-hatred and depression. He bargained with God

to change his feelings,
tried

to date women, and
experienced inter-
nalised homopho-
bia throughout his
teenage years.

SAY: Jay acquired an STI.

How might his feelings of shame affect his
ability or motivation to see a provider and get
treatment? Possible answers:

- Stigma, discrimination and feelings of shame, guilt and other mental health issues can lead to excessive worry about contracting an STI and therefore obsessing over possible symptoms that may or may not be present and frequently seeking care.
- These feelings can also lead Jay to ignoring symptoms or trying to treat them with herbs or non-prescription medications which can lead to worsening of symptoms and transmitting STIs.
- Another potential problem for healthcare providers is if Jay or any gay man or woman does not feel safe or comfortable communicating their feelings or reporting all of their symptoms, as this could result in the wrong treatment prescribed or missing an important medical condition.

Behaviour vs. identity

Jay says, “Men who have sex with men can be heterosexual, bisexual, homosexual. It is a sexual behaviour. People have sex for different reasons.” He says that it is a problem when health providers think that they just need to help “the gays” because men who have sex with men may be homosexual, bisexual, or heterosexual.

Why might it be a problem, from a healthcare worker standpoint, to try to group all men who have sex with men as gays? Possible answers:

- The role of the healthcare worker is to provide quality care without judgement, free from stigma and discrimination. Labelling and/or assuming a person is gay is problematic as it will lead the healthcare worker to the belief that the client is only having sex with men. This could limit the prevention, care, and treatment that a man who has sex with men and his partners may need.
- Healthcare workers must be comfortable asking about and discussing sexual behaviours with clients using open-ended, non-judgemental questions and provide culturally competent, comprehensive healthcare.

How might this impact treatment efforts? Possible answers:

- Healthcare workers who are not comfortable asking explicit questions about sexual activities may be missing levels of STI risk for the client and his/her partner(s).
- The correct syndromic approach must be followed when a client complains of symptoms and by labelling a man as a man who only has sex with men and assuming he only has sex with men, the healthcare worker will miss an important part of STI care, which is partner notification.

Why may people have sex with people of the same sex, even if they do not identify as gay or lesbian?

- They are locked up together
- They get money out of it
- They want to experiment
- Because they enjoy it
- Because they have had one too many drinks

Jay also talks about how fear and shame affect people's behaviours in terms of how they care for their health.

What are some ways that shame and fear might affect people's behaviours in terms of how they care for their health?

- People delay seeking treatment for a long time because of fear of judgement or of having a serious condition.
- They may be less likely to use protection because they feel guilt and shame about anal sex (for example).

What are the impacts of these decisions?

- By the time they go for healthcare, their health may already be compromised.
- Regarding not using protection: They are more likely to acquire an STI.

LESSON PLAN

SESSION 12 – Transgender people

Learning objectives

At the end of this session, participants should be able to:

- Define the terms “transgender person,” “transgender man” and “transgender woman”.
- Identify at least two barriers transgender people face when seeking health services.
- Describe at least two physical changes that may occur when a transgender person takes hormone therapy.
- State at least four risk assessment questions to ask transgender people regarding sexual and reproductive health.
- State at least two risk assessment questions to ask transgender people regarding harm reduction.

Session overview

Content	Activity	Materials
Learning objectives	Large group discussion	Slide 201
Introduction Defining transgender	VideoFill in the blank exercise	Slide 202-204
Barriers to care Stigma and discrimination	Video	Slide 205
Transitioning	Large group discussion	Slide 206
Hormone therapy Surgery	Mini lecture	
HIV risk Seeking care	Small group discussion	Slides 207-209
Risk assessment	Question rephrase activity Question practice in pairs	Slides 210-212
More on Letisha’s experience	Videos, discussion	Slides 213-215
Key points and closing	True or false activity Questions and answers	Slides 216-221

Indicates a workbook prompt.

Opener

Show slide 201

Session 12 Learning Objectives

By the end of this session participants should be able to:

- Define the terms “transgender person,” “transgender woman,” and “transgender man”
- Identify at least two barriers transgender people face when seeking health services
- Describe at least two physical changes that may occur when a transgender woman takes hormone therapy?
- State at least four risk assessment questions to ask transgender women regarding sexual and reproductive health
- State at least two risk assessment questions to ask transgender women regarding harm reduction



Show slide 202



SAY: Meet Letisha, a transgender woman from KwaZulu-Natal.

Show video clip #1 (slide #2): My name is Letisha

SAY: We will hear more from Letisha in her own words, but first, let us take a few moments to discuss transgender people.

Divide participants into small teams. Instruct participants to discuss what they know about transgender people, and what they would like to know. After sufficient time has passed, invite one member of each team to report back. Note responses on flip chart paper.

SAY: We will do our best to address the questions that you have raised by the end of the session. Let us begin...

A transgender person is an individual whose gender _____ differs from what is typically associated with the sex assigned to that person at _____.

Show slide #3

SAY: Please take a moment to fill in the missing words in your workbook.

Invite participants to share the words they have entered.

SAY: A transgender person is an individual whose gender identity differs from what is typically associated with the sex assigned to that person at birth. A transgender woman is a person who identifies as female and was assigned as male at birth. A transgender man is a person who identifies as male and was assigned as female at birth. Transgender people may identify as gay, lesbian, bi-sexual, or straight.

Show video clip # 2 (slide #4): I am a trans woman

SAY: Transgender people may avoid seeking primary healthcare services at the facility due to fear of discrimination or stigma, or unease about the physical examination. It is important for clinicians to build rapport, and to clearly explain reasons for asking explicit questions and performing various parts of the examination.

Show slide #5 Hormone therapy



SAY: Some transgender people live as their chosen gender without surgery or medication. Others have surgery or take hormone therapy such as oestrogens, androgen-blockers or testosterone to align their appearance with their gender identities. Lack of access to health services leads some transgender people to use unsafe hormones not prescribed for the purpose.

ASK: True or false: People on ART should not take hormone therapy. Write your answer in your Workbook.

Correct response: False.

SAY: HIV and its treatment are not contraindications to hormone therapy. In fact, providing hormone therapy may improve engagement and retention in HIV care, and therefore help to improve adherence and reduce viral load. For more information about hormone therapy, including dosing and contraindications, please refer to the “Resources” section of your workbook.

ASK: What changes might you expect a transgender woman to have as a result of taking hormone therapy? Write your answer in your Workbook.

Elicit replies. Highlight the following, if not mentioned:

Breast development

Fat redistribution

Reduced muscle mass

Thinned or absent body hair

Thinned or absent facial hair

Softened, thinner skin

Testicles that have decreased in size or retract

Show slide #6 HIV risk



SAY: Transgender people in South Africa are particularly vulnerable to acquiring HIV: globally, the prevalence of HIV is 49 times higher in the transgender community than in the general population.¹⁵

Instruct participants to discuss the following question in teams:

ASK: Why are transgender people at greater risk of acquiring HIV, compared to the general population? After sufficient time has passed, elicit replies from each team. Highlight the following, if not mentioned:

Stigma

Discrimination

Social rejection

Violence and trauma

Insensitivity to/lack of awareness of transgender issues by clinicians

Injecting hormones or other drugs with shared syringes

Condom failure due to reduced swelling (tumescence) related to hormone therapy.

Low PrEP availability and access to combination prevention options

□

SAY: Transgender people may be reluctant to seek HIV prevention and treatment services if they feel they may be stigmatised, embarrassed, or poorly treated by clinical and support staff. Let us listen to Letisha share an experience she had while accessing HIV prevention services.

Show video clip # 3 (slide #7): VMMC

ASK: How would you describe the clinicians' behaviour? Elicit replies.

What might you have done differently? Elicit replies.

Risk and clinical assessment

SAY: As discussed in earlier sessions, risk assessment is a way to identify, analyse, and evaluate health hazards.

In order to conduct an effective clinical assessment, the clinician must obtain an accurate history that includes anatomy-specific sexual behaviour. For instance, transgender people who have a penis should be asked about insertive intercourse as well as receptive intercourse. Transgender people who have a vagina should be asked about vaginal as well as anal intercourse. It is important to ask questions relevant to the client's sexual and medical history in a non-judgemental way. Open-ended questions that do not assume the anatomy and sex or gender of partners will provide the most information.

Show video clip # 4 (slide #8): So, are you gay?

SAY: Clinicians should assess risk for HIV and other sexually transmitted infections (STIs) based on the client's unsafe behaviours. Transgender people differ in hormone use, history of gender-affirming surgery, and behaviour patterns. It is crucial that clinicians avoid making assumptions about the presence or absence of specific anatomy, sexual orientation, or unsafe practices.

Distribute "incorrect" risk assessment questions to each team. Instruct teams to review each question, identify the problem (i.e., judgemental, not relevant), and then rephrase each risk assessment question to make it more appropriate to assess a transgender person. After sufficient time has passed, review rephrased questions:

Clinical history assessment questions

Incorrect	Rephrased ¹⁶
Do you sleep around?	<p>Are you having sex?</p> <p>Do you use a condom every time you have sex?</p> <p>Are you on PrEP?</p> <p>How many sex partners have you had in the past three months?</p>
Are you gay?	Who are you having sex with (include anatomy and gender of partners)?
Why do you have anal sex?	What types of sex are you having?
Are you a prostitute?	Do you exchange sex for money, drugs, or a place to stay?

How many STIs do you have?	<p>What STIs have you had in the past, if any?</p> <p>When last were you tested for STIs?</p> <p>Has your partner(s) ever been diagnosed with any STIs?</p>
----------------------------	---

Incorrect	Rephrased ¹⁶
Don't you use condoms?	<p>How do you protect yourself from STIs?</p> <p>How often do you use condoms?</p>
Which drugs do you take?	Do you use alcohol or any drugs when you have sex?

Show slide #9 Harm reduction risk assessment



SAY: Risk assessment of transgender people should include questions regarding risk behaviours, including harm reduction practices. For instance, transgender women who inject hormones or drugs should be asked about safe injecting practices to reduce the risk of HIV, as well as hepatitis B and C infection. Transgender women taking hormone therapy should also be asked about tobacco use, due to increased risk of venous thromboembolism (VTE).

Instruct participants to divide into pairs and then ask each other three harm reduction questions relevant to transgender women. Ensure that each participant has the opportunity to ask and answer questions. After sufficient time has passed, invite volunteers to demonstrate risk assessment questioning for the group at large. Highlight appropriate, relevant, and non-judgemental questions.

SAY: Before we conclude the session, let us hear some parting words from Letisha.

Show video clip # 5 (slide #10): When we visit

SAY: Please take a few moments to write down key points from the session in your workbook. After sufficient time has passed: Let us close with a brief review activity.

Read the statements on the next page one at a time. Instruct participants to remain seated if they believe the statement is true, and to stand up if they believe the statement is false. Review statements at the conclusion of the activity.

Show video clip # 6 (slide #11): You will be told

Show video clip # 7 (slide #12): We are also human

True or false statements

1. A transgender person is someone who is trapped in the wrong body. False.
2. A transgender woman is a person who was assigned male at birth and identifies as female. True.
3. Transgender people are at increased risk of HIV acquisition, compared to the general population. True.
4. People taking hormone therapy should not take ARVs because they are contraindicated. False.
5. When taken by transgender women, hormone therapy may cause breast development, reduced testicle size, and thinning hair. True.
6. Transgender women may not seek health services due to fear of discrimination, and unease about the physical examination. True.
7. All transgender people are gay. False.
8. "What do you have down there?" is an appropriate risk assessment question. False.

Key points

A transgender person is an individual whose gender

identity differs from what is typically associated with the sex assigned to that person at birth.

Some transgender people live as their chosen gender without surgery or medication. However, many also choose to undergo surgery and/or take medication so that their external expression aligns with their identity.

HIV and its treatment are not contraindications to hormone therapy. In fact, providing hormone therapy may improve engagement and retention in HIV care, and therefore help to improve adherence and reduce viral load.

Symptoms a transgender woman might experience when taking hormone therapy include breast development, fat redistribution, reduced muscle mass, thinned or absent body and/or facial hair, softened or thinner skin and/or testicles that decrease in size or retract.

Transgender people are at greater risk of HIV for many reasons, including stigma and discrimination, social rejection, violence and trauma, clinicians' insensitivity to/lack of transgender issues, and injecting hormones with shared syringes, among many others.

Transgender people may avoid seeking primary healthcare services at the facility due to fear of discrimination or stigma, or unease about the physical exam.

Providing a safe and welcoming environment for transgender clients will encourage transgender and gender non-conforming clients to stay engaged in HIV prevention, care, and treatment services.

Above all, it is essential to be respectful and not make assumptions about a client's gender identity, beliefs, or sexual orientation.

LESSON PLAN

Healthcare and screening needs

Transgender people:

PARTICIPANT WORKBOOK – same suggestions as in facilitator section

Objectives

At the end of this session participants should be able to:

Define the terms “transgender person”, “transgender man” and “transgender woman”.

Identify at least two barriers transgender people face when seeking health services.

Describe at least two physical changes that may occur when a transgender woman takes feminising hormones.

State at least four risk assessment questions to ask transgender people regarding sexual and reproductive health.

State at least two risk assessment questions to ask transgender people regarding harm reduction.

Instructions: fill in the missing words for the statement below.

A transgender person is an individual whose gender _____ differs from what is typically associated with the sex assigned to that person at

_____.

What are some barriers to care that transgender people might face?

What are some ways for healthcare workers to overcome these barriers?

a. Build rapport. What are some ways to build rapport?

- b. Clearly explain reasons for asking explicit questions. What are some things you could say to help the person feel more comfortable about the questions you need to ask?

True or false: People on antiretroviral therapy (ART) should not take hormone therapy.

True

False



What changes might you expect a transgender woman to have as a result of taking feminising hormone therapy?

Open-ended questions

Instructions: Convert the closed-ended questions below into open-ended questions. Remember that the purpose of open-ended questions is to encourage dialogue and communication.

Closed-ended question: So, are you gay?

Re-written open-ended question:

1. Closed-ended question: You don't work, do you?

Please tell me about yourself daily routine

Re-written open-ended question:

2. Don't you use condoms?

How do you protect yourself against HIV and other STIs?

Re-written open-ended question:

3. Since you are a transgender woman, I will address you as "Miss", ok?

How would you like to be addressed?

Re-written open-ended question:

4. Do you understand how to take your medications?

5. How do you take your medication?

Re-written open-ended question:

Key Points

7.  CASE STUDY | LETISHA

Transgender people

Provider knowledge

Letisha is a transgender woman who loves to model, perform, and do outreach work. She is an activist living proudly. Today,

she is going to try a new clinic for the first time: The admin clerk says “Hi, ma’am, can we have your ID?” Letisha presents her ID. The clerk sees someone who looks

like a man in the ID photo and says, “How? But is this you?” Letisha says, “Yeah”. The receptionist says, “But this is a guy”. Everyone in the waiting room is

watching and listening. The clerk continues and says, “I need to write down your gender or sex here, what should I write?” Letisha mumbles, quietly, with her head down, “Don’t worry about that part, I can discuss it with my doctor”. The receptionist’s face freezes and she says, “Move aside. Next please”.

Is this a safe space for Letisha? Why or why not? Possible answers:

Why? This all depends on whether Letisha is experienced with this type of treatment and has devel-

oped strong coping and communication skills to navigate the obviously embarrassing situation! If a healthcare provider is in the area and sees or hears the interaction, they must step in to assist Letisha and follow-up with the receptionist to discuss the importance of a competent approach to interacting with clients of all types, race, colour and/or sexual orientation.

Why not? Most likely, the interaction took place in a crowded, small area where everyone can hear what clients and receptionist are saying. Letisha's appearance is female and by saying "But this is a guy" when her ID is presented, will only make Letisha feel like she needs to leave rather than be subjected to public embarrassment. This interaction and the lack of confidentiality from the receptionist has potentially put Letisha at risk for individual and community discrimination as well as safety and security issues.

How should the clerk have handled this interaction? What can we do better to welcome people to the facility? Possible answers:

The best approach for this type of situation is to prevent it from happening in the first place. Facility managers have an opportunity to provide competency training that includes interacting with transgender persons. Training should be offered to all new clinic staff including receptionists, guards as well as providers. Throughout the year, include a topic that addresses a particular issue such as interacting with sex workers or substance users.

Healthcare workers can be role models for all staff through their verbal and non-verbal communication when interacting with clients. Remember that non-verbal communication includes facial expressions and body language such as talking to a client with your arms folded which can be interpreted as being angry (or “closed-minded”) versus arms at your side (more “open-minded” and inviting).

Facility managers and healthcare providers can also use quality improvement projects to address specific issues and test possible solutions by using a PDSA (Plan Do Study Act) cycle.

Clinic staff have a responsibility to report negative or insensitive interactions between staff and clients. These can then be handled by the facility manager individually and during team meetings. It is important for facility managers to avoid naming the staff member at fault. The scenario can be described without naming staff.

Despite the challenging encounter at the clinic, Letisha is concerned for her health and has heard that VMMC is a way to reduce her chances of getting HIV. She goes to the health centre for a circumcision.

Clerk: Hi ma’am. How can we help you?

Letisha: I came to find out about VMMC.

Clerk (confused): Oooh, ok. But you know VMMC is for me, right?

Letisha: Yes, I know that. I am here to have a circumcision.

Clerk (still confused): Oh, so you came to circumcise your penis.

Letisha: Yes, because I am a trans woman.

Clerk: So, you are a transgender woman... (then, loudly) OOOOH I am sorry – I have never had a transgender woman here, ever in South Africa.

The queue keeps moving, and various health providers come to check Letisha out – they keep coming by to ask her if she is ok, and they give her a lot of unwanted attention because she is a transgender woman. Throughout the VMMC procedure and afterward, Letisha feels she is being treated like an object, rather than a human being because she is a transgender woman, and not a man, coming in for a circumcision.

What could the receptionist and health providers have done differently? What could they have said that might have made her feel more welcome and less like a curiosity? Possible answers:

Training for VMMC clinic staff including receptionists should include sensitisation and competency training that includes interactions and communication with the transgender community.

If staff are to be rotated to the VMMC clinic then a brief orientation is needed to avoid the interaction that Letisha experienced. The information should include what VMMC is, why it is done and the importance of confidentiality, respect, and professionalism.

Staff should be observant of the interactions their colleagues are having with VMMC clients before, during, immediately after the procedure and at the follow-up appointment.

What impact might these two experiences with the health-care system have for us as health workers? What could we do better? Possible answers:

Remember that VMMC is a procedure that can be stressful for potential clients. Support that begins with the front staff and continues with staff during the procedure and follow-up is crucial for individual success as well as success of the programme. Since this is a voluntary procedure but one that is an important component of HIV prevention, it is essential that the community knows the successes of the programme to ensure that people who are eligible have the VMMC procedure.

Understand how our words and actions can affect how clients deal with their health both in prevention and treatment.

Understand that ALL clinic staff are responsible for the way they interact and treat ALL clients no matter their sex, gender, sexual orientation, religion, or race. Remember that non-verbal communication can be as powerful as words. Smile even when you are tired, upset or angry.

Think about the way you speak to clients e.g. using language that is authoritarian such as “you should” or “you will”.

Judgement

You are a fellow peer educator, meeting Letisha for coffee. You ask her how she is, and she tells you she is so frustrated by all of the judgement she experiences. She talks about how people do not know what a transgender person is, and so they assume that she is gay, or they call her a “she man”. She says it also makes people curious about what is under her clothes and “who bends and who is penetrated and who is penetrating”.

Is Letisha being overly sensitive or too critical about people’s reactions? Why? or Why not? Possible answers:

Why? Letisha has made an important and significant decision to disclose that she is a transgender woman which is still a minority population in South Africa. She should realise and understand that not everyone will be accepting of her decision and lifestyle and be prepared for the comments and reactions from her community and healthcare providers.

Why not? Letisha should expect unbiased, equal, quality healthcare free from moral judgement from healthcare providers and staff about her choice of sexual identity or lifestyle. Healthcare providers and staff must not be allowed to discriminate against key populations or any other clients.

LESSON PLAN

SESSION 13 – People who use and inject drugs

Learning objectives

At the end of this session participants should be able to:

- List at least three common health complications that people who inject drugs experience.
- Describe at least two barriers people who inject drugs face when seeking health services.
- Identify at least three signs or symptoms of opioid withdrawal.
- Identify three signs of opioid overdose.
- Explain the association between opioid substitution therapy and ART adherence.
- State at least four risk assessment questions to ask people who inject drugs regarding harm reduction.

Session overview

Content	Activity	Materials
Learning objectives Introduction	Large group discussion Video	Slides 224-226
Routes of drug administration Why people use drugs	Mini lecture Brainstorm Small group discussion	Slides 227-229
Barriers Denial of care Needle use and risks Stigma Health complications	Large group discussion	Slides 230-237
Opioid use disorders Withdrawal & overdose OST	Mini lecture Small group body map activity	Slides 238-244
Risk assessment	Question swap activity Video	Slides 245-246
Review	Find and fix activity	Slides 247-250
Stages of dependence	Mini lecture	Slide 251
Key points and closing	Questions and answers	Slides 252-253

Indicates a workbook prompt.

Opener

Show slide 224

Session 13 Learning Objectives

- By the end of this session participants should be able to:
- List at least three common health complications among people who inject drugs
 - Describe at least two barriers people who inject drugs face when seeking health services
 - Identify at least three signs or symptoms of opioid withdrawal
 - Identify three signs of opioid overdose
 - Explain the association between Opioid Substitution Therapy and ART adherence
 - State at least four risk assessment questions to ask people who inject drugs regarding harm reduction
 - Discuss stages of dependence



Show slide 225



SAY: Meet Nelson, who lives in Pretoria.

Show video clip #1 (slide 226): My name is Nelson

SAY: We will hear more from Nelson in his own words, but first, let us take a few moments to discuss illicit drug use.

Show slide 227

People Who Use and Inject Drugs

What do you know about people who inject drugs?

ASK: What do you know about people who inject drugs?

Show slide 228

Why do people use drugs?

- To have fun or a party
- To build confidence, to be brave
- To forget or escape
- To numb feelings of pain or hunger
- To increase libido
- To socialise or to fit in with peers
- To relax, to calm nerves
- To cope
- To sleep or be awake
- To get over a break-up or other problem

Other???

SAY: Please take a few minutes to discuss the following questions in pairs or small teams.

After sufficient time has passed, invite one member of each team to report back. For each “fact” that is reported about what participants know about people who inject drugs, address whether they are true or false. Do these “facts” really apply to all people who inject drugs? Highlight the following.

SAY: People from all walks of life may choose to use drugs for many different reasons. Though you may feel like you know something about a person who injects drugs, there is very little you can know without having a conversation. Be kind and respectful with an intention of risk and harm reduction in your interactions with each and every client you see – without being judgemental.

SAY: The focus of this session is people who inject drugs. Let us begin...

Show slide 229

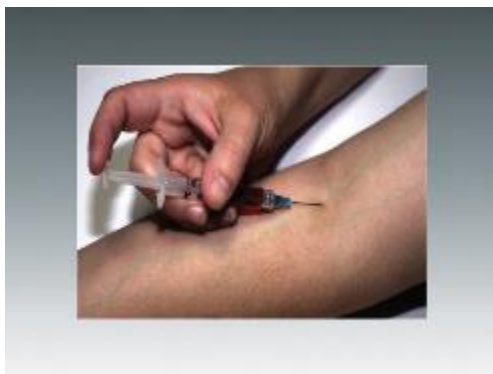


Divide participants into small teams. Instruct each team to brainstorm routes of drug administration. After sufficient time has passed, invite each team to share one route of administration. Highlight the following routes, if not mentioned:

- Oral
- Smoked
- Snorted
- Vaporised
- Injected (intravenous, intramuscular, intradermal)
- Transdermal (across the skin)
- Rectal

ASK: Drug use – regardless of route – may increase unsafe behaviour related to HIV and other infectious diseases. From a public health perspective, which route of administration is of greatest concern? Why? Correct reply: Injection, due to blood-borne pathogen risk.

Show video clip #2 (slide 230): You go to the health centre



Show

slide 231

SAY: Non-sterile injection practices place people who inject drugs at risk of infection, including HIV, hepatitis B and C, skin infection such as abscesses, and endocarditis (an infection of the inner lining of the heart). Sharing water to clean injecting equipment may also cause infection.

EMPHASISE: It is best to clean injecting equipment with bleach.

Show video clip #3 (slide 232): Pavement talk

ASK: True or false: Needle and syringe programmes (sometimes wrongly called “needle exchange programmes”) that provide clean needles and equipment to people who inject drugs are illegal in South Africa.

Correct reply: False. For more information regarding needle and syringe programmes in South Africa, please refer to the “Resources” section of your workbook.

SAY: A client at your facility who is a person who inject drugs says, “I always blow on my needle before using it, to protect me from HIV”. How should you respond? Please take a few minutes to discuss your response in teams.

After sufficient time has passed invite one member of each team to report back. Highlight the following, if not mentioned:

- HIV may be transmitted from person to person through sharing needles or using non-sterile injection practices.
- Blood in a syringe is not exposed to air, so if the HIV virus is present, it will remain alive.
- Using clean needles and sterile technique is the safe option.

SAY: Complications related to poly-drug use, adulterants (substances other than the active ingredient in an injection), and poor general health may motivate people who inject drugs to seek care at the facility. Mental health disorders are also common among people who inject drugs and may lead them to seek healthcare.¹¹ For more information about health complications people who inject drugs face, please refer to the “Resources” section of your workbook.

Show video clip #4 (slide 233): This individual belongs to someone

Barriers

SAY: People who inject drugs may not seek healthcare due to concerns about poor treatment by staff, or fear of being arrested or fear of waiting at the facility. Once at the clinic, people who inject drugs may be stigmatised or denied care for a health complaint because of a staff member's belief that she "brought it on herself".

Show slide 234



ASK: Would a type two diabetic patient ever be turned away from the clinic or denied insulin because he "brought it on himself" by eating too much? Why or why not? Elicit replies.

SAY: Clinicians may be less likely to prescribe ARVs to people living with HIV who inject drugs, due to concerns about adherence. Do you agree? Why or why not? Elicit replies.

Show video clip #5 (slide 235): Virally suppressed people who inject drugs

SAY: Evidence suggests that improving the overall setting in which people who inject drugs receive HIV treatment increases adherence to ART.¹⁰

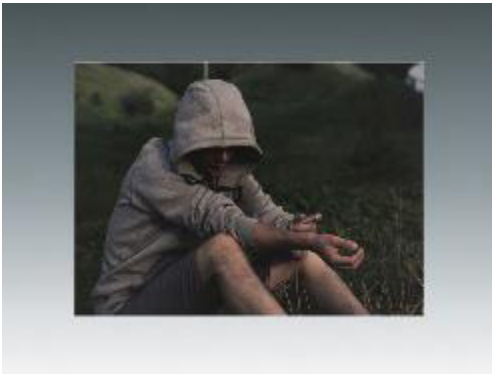
Let us review what we have covered so far. Please turn to the person next to you and discuss the following:

Show slide #236

People who inject drugs may experience health complications related to needle-sharing and non-sterile techniques, including:

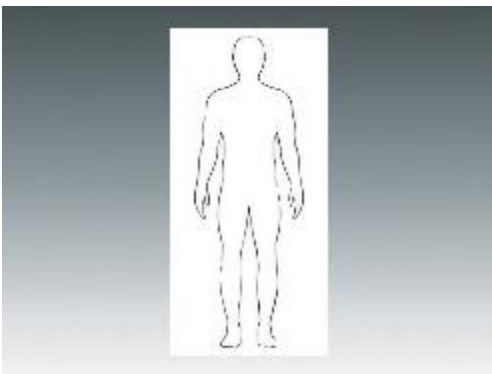
- 1.
- 2.
- 3.

Show slide 237 Opioid use disorders



SAY: Heroin is the most commonly used non-prescription opioid in South Africa.¹⁰ Opioid use disorder is a biological condition associated with neurological and behavioural changes, as well as repeated chronic use despite negative consequences (even when the user wishes to stop). As with other chronic conditions, opioid use disorder often requires long-term treatment. When a person with opioid use disorder stops taking opioids such as heroin, s/he may experience withdrawal. Though rarely serious – unless the client is pregnant — opioid withdrawal symptoms are uncomfortable. Clients with opioid use disorders may experience withdrawal symptoms if they must wait in long queues at the facility.

Show slide 238



Instruct participants to discuss withdrawal signs and symptoms in teams, and then note them on or around the body map in their workbooks. After sufficient time has passed, invite each team to share two signs or symptoms. Highlight the following, if not mentioned:

- Abdominal cramps
- Anxiety
- Irritability
- Hot/cold flushes
- Muscle aches
- Nausea
- Sweating
- Dilated pupils
- Increased blood pressure and pulse
- Runny nose
- Diarrhoea

SAY: Withdrawal may be confused with a flu-like illness, or other condition commonly seen in the facility. If a person who injects drugs presents with signs or symptoms of opioid withdrawal, consider treating the withdrawal itself by prescribing a substitute opioid, rather than treating each individual symptom.

Show slide 239 Overdose



SAY: If taken in high doses, opioids may lead to overdose and death.¹² Suspect overdose if a patient has the following signs:

Pinpoint pupils

Unconsciousness

Respiratory depression (slow breathing)

Overdose is a medical emergency. The medication naloxone (Narcan) may reverse an opioid overdose, if administered promptly. For more information on opioid overdose and naloxone, please see the “Resources” section of your workbook.

Show slide 240 Opioid substitution therapy (OST)



SAY: When people with opioid use disorders wish to stop using, they are sometimes prescribed a replacement therapy. This intervention is known as opioid substitution therapy, or OST. Substitution of illicit drugs with a replacement such as methadone or buprenorphine has been shown to reduce illicit opioid use, overdose, and HIV risk behaviours.¹³ OST has also been shown to increase adherence to ARVs among people who inject drugs.¹⁴ Both methadone and buprenorphine are on the WHO Essential Medicines List.

ASK: True or false: Methadone should never be prescribed to HIV-positive people who inject drugs, because they will default on treatment.

Correct reply: False. OST has been shown to increase ARV adherence.

SAY: All people who inject drugs who present at the clinic should be assessed for risks associated with injection drug use, including HIV, hepatitis, and overdose.

Risk assessment (in-person training activity)

Instruct participants to develop a list of five risk assessment questions for people who inject drugs in teams. After five minutes have passed, instruct each team to swap questions with another team. Instruct teams to review the new list of questions, and then add any questions that may be missing. After five minutes passed, instruct teams to swap questions again. Invite one member of each team to share two key risk assessment questions with the group at large. Highlight the following questions, if not mentioned:

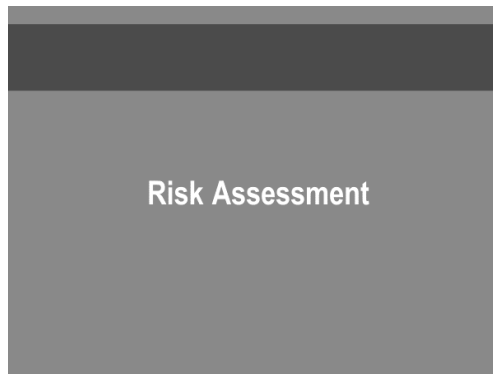
1. Do you use drugs? What is your drug of choice?
2. In the past six months, have you shared needles or equipment with another person?
3. Do you sterilise your needles and equipment? If so, how?
4. Do you exchange sex for money, drugs, or a place to stay?
5. What STIs have you had in the past, if any?

6. When last were you tested for STIs? HIV? Hepatitis?
7. How often do you use condoms?
8. Have you had an accidental overdose in the past year?

SAY: Now that we have our list of risk assessment questions, let us practice...

Instruct participants to practice asking risk assessment questions in pairs. Ensure that each participant has the opportunity to ask and answer at least four questions. If stigmatising language is used, invite participants to rephrase.

Show slide 245



ASK teams to work in small teams to write down one risk assessment question for people who inject drugs. GIVE teams five minutes to do this.

BRING participants back and ask one group to share their question. TYPE it onto the slide.

ASK participants to review the question and revise as needed (in the event that stigmatising or judgmental language has been used).

ASK the next group to share their question. TYPE it into the slide and REPEAT with the remaining questions until you have a final list on the slide.

ASK participants if there are other questions that need to be added to the list.

HIGHLIGHT the following questions (if they were not asked):

- Do you use drugs? What is your drug of choice?
- In the past six months, have you used non-sterile injecting equipment?
- Do you sterilize your needles and equip-

ment? If so, how?

- Do you exchange sex for money, drugs, or a place to stay?
- What STIs have you had in the past, if any?
- When last were you tested for STIs? HIV? Hepatitis?
- How often do you use condoms?
- Have you had an accidental overdose in the past year?

SAY: Now that we have our list of risk assessment questions, let us practice...

INSTRUCT participants to practice asking risk assessment questions in pairs. Ensure that each participant can ask and answer at least four questions. If stigmatizing language is used, invite participants to rephrase. You may do this in breakout rooms OR have each participant role play/ask one to two questions to another participant while the group observes OR choose three to four participants who have not participated much yet. Have those participants role play/ask three to four questions to another participant while the group observes.

SAY: Before we conclude the session, let us hear some parting words from Nelson.

Show video clip 246: This clinic is sharp

SAY: Please take a few moments to write down key points from the session in your workbook.

After sufficient time has passed, instruct participants to turn to the Find and fix activity page in the Participant Workbook, identify errors, and correct them in teams. Review.

Find and fix activity

(Incorrect information in bold)

1. Contaminated needles and non-sterile injecting practices place people who inject drugs at risk of infection, including HIV, hepatitis A, and abscess.

Correction: Hepatitis B and C

2. People who inject drugs may not seek jobs due to

concerns about poor treatment by staff, or fear of being arrested.

Correction: healthcare

3. Opioid use disorder is an acute medical condition that often requires long-term denial.

Correction: chronic; treatment

4. Schizophrenia may be confused with a flu-like illness, or other condition commonly seen in the facility.

Correction: Opioid withdrawal

5. Clients with opioid use disorders may experience hearing loss if they remain in long queues at the facility.

Correction: withdrawal

6. Suspect opioid overdose if a client is unconscious and has respiratory depression and dilated pupils.

Correction: pinpoint

7. Opioid substitution therapy reduces ART adherence among people who inject drugs.

Correction: increases

8. People who inject drugs should be encouraged to use big needles and painless injection technique during every clinic visit.

Correction: clean; sterile

Key points

Drug use – regardless of route – may increase unsafe behaviour related to HIV and other infectious diseases.

Contaminated needles and non-sterile injection practices place people who inject drugs at risk of infection, including HIV, hepatitis B and C, skin infections such as abscesses, and endocarditis.

Because many people who inject drugs may avoid seeking care due to concerns about poor treatment by staff, or fear of being arrested, this also makes them more vulnerable to lack of information or believing incorrect information or “myths” about how to stay safe and healthy.

If people feel valued, they will take better care of themselves.

Heroin is the most used non-prescription opioid in South

Africa.

Opioid use disorder is a biological condition associated with neurological and behavioural changes, as well as chronic use despite negative consequences.

When a person with opioid use disorder stops taking opioids such as heroin, s/he may experience withdrawal symptoms, which can be extremely uncomfortable.

Overdose on opioids is a medical emergency. Symptoms include pinpoint pupils, unconsciousness, and respiratory depression (slow breathing).

The medication naloxone (Narcan) may reverse an opioid overdose, if administered promptly.

Substitution of illicit drugs with a replacement such as methadone or buprenorphine has been shown to reduce opioid use, overdose, and HIV risk behaviours. OST has also been shown to increase adherence to ARVs among people who inject drugs.

LESSON PLAN

Healthcare and screening needs

People who inject drugs

PARTICIPANT WORKBOOK

Objectives

At the end of this session participants should be able to:

List at least three common health complications that people who inject drugs experience.

Describe at least two barriers people who inject drugs face when seeking health services.

Identify at least three signs or symptoms of opioid withdrawal.

Identify three signs of opioid overdose.

Explain the association between opioid substitution therapy and ART adherence.

State at least four risk assessment questions to ask people who inject drugs regarding harm reduction.

What do you know about people who inject drugs?

True or false: Needle and syringe programmes (sometimes wrongly called “needle exchange programmes”) that provide clean needles and equipment to people who inject drugs are illegal in South Africa.

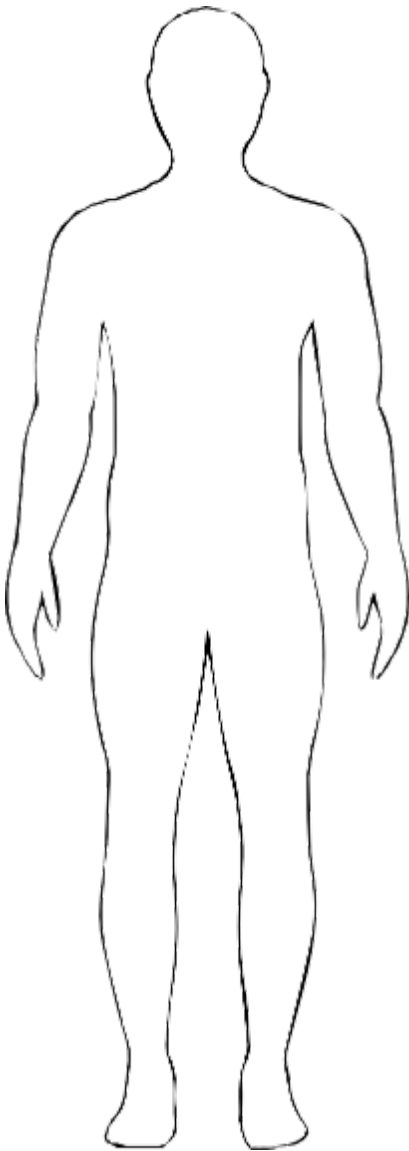
True

False

People who inject drugs may experience health complications related to sharing needles, using contaminated needles, and non-sterile technique. What are some of the complications they might face?

Withdrawal signs and symptoms

Instructions: Discuss withdrawal signs and symptoms in teams, and then note them on or around the body map located below.



True or false: Methadone should never be prescribed to HIV-positive people who inject drugs, because they will get high and default on treatment.

True

False

Key points



Find and fix activity

Instructions: Read the sentences below. Identify the errors and correct them in teams.

1. Non-sterile injecting practices place people who inject drugs at risk of infection, including HIV, hepatitis A, and abscess.
2. People who inject drugs may not seek jobs due to concerns about poor treatment by staff, or fear of being arrested.
3. Opioid use disorder is an acute medical condition that often requires long-term denial.
4. Schizophrenia may be confused with a flu-like illness, or other condition commonly seen in the facility.
5. Clients with opioid use disorders may experience hearing loss if they remain in long queues at the facility.
6. Suspect opioid overdose if a client is unconscious and has respiratory depression and dilated pupils.
7. Opioid substitution therapy reduces ART adherence among people who inject drugs.
8. People who inject drugs should be encouraged to use big needles and painless injection technique during every clinic visit.

8. CASE STUDY | NELSON



People who inject drugs

Support to stop injecting

Nelson is a programme manager for the Step Up Project in Pretoria. He has two children. Nelson started using substances when he was 11, started to inject drugs at the age of

16, and finally stopped using at age 28. He tried to stop multiple times, but he was unable to because there was no methadone available, there were no needle and syringe programmes, treatment centres were ineffective, and the police were always after them. Facility staff would treat people like him very badly and say “you brought this on yourself,

please leave”.

How does this combination of factors work to make it more difficult for people who use drugs to stop injecting? Possible answer:

Individuals who want to stop using injection drugs are more likely to be successful when there is access to OST (opioid substitution therapy) such as Methadone, individual support from a treatment buddy and/or support group. Without these essential components of substance use treatment, people who use drugs are more likely to continue their drug habit and are at risk for multiple physical and psychological complications.

What impact might these barriers to care have on people who inject drugs? Possible answers:

Physical risks include HIV, hepatitis, abscesses and other skin disease and cardiac complications such as endocarditis.

Psychosocial risks include common mental health disorders such as paranoia, anxiety, anger and/or violent behaviour, depression, and memory loss. People who use drugs are also at higher risk of isolation, homelessness, and incarceration.

How might health workers help people who inject drugs to stop using, or to use more safely? Possible answers:

Healthcare workers should have a list of substance use treatment centres, support groups, and needle and syringe programmes within their community. Included in that list should be contact information for treatment buddies if available.

Reinforce the importance of not using alone. The person who is with the user should be alert and know what to do if the user is not able to breathe or becomes unconscious.

All healthcare workers should know how to teach people who inject drugs how to clean needles using bleach, to not share needles and use their own “works” if there are no needle and syringe programmes in their community.

Teach people who use drugs how to clean their skin before injecting and the importance of personal hygiene. If the person is homeless, know where there is a shelter that he/she can go to for a shower, food, or place to sleep.

Value of a syringe

Nelson describes how hard it was to obtain clean syringes when he was using. Pharmacies would often charge someone who looked like a person who injects drugs more than five times the amount that they would charge a person with diabetes. Because syringes were so hard to come by, people who use drugs would often share syringes with each other, or use syringes until they became blunt or the plunger broke. People who inject drugs would also try to clean syringes without knowledge of how to do so properly and would even rent them out to other users.

What are the health implications of these practices?

Exposure to HIV, hepatitis and bacterial diseases

Abscesses and other skin diseases

What are some ways to overcome these risks, thinking specifically about the syringe aspect of injection drug use?

Supply of sterile needles and syringes in harm reduction packs

Make syringes more affordable/available in pharmacies (or free)

Education on how to clean syringes properly

Many policy makers believe that if you provide syringes to people who inject drugs, they will use more, or it will encourage people to start using drugs. Nelson would argue that access to syringes would improve health.

Do you agree? Why or why not?

What are some of the most important health needs of people who inject drugs?

Access to needles, syringes and sterile equipment

Access to opioid substitution therapy

Access to medication, including ARVs

Health workers who are not judgemental and who do the jobs that they are supposed to do (e.g. provide whatever care is needed)

Stigma

Nelson says, “It’s very easy to judge someone like that when you don’t know what they’ve been through or why they are there. Everyone has a story that got them there. You know? Trust me; people aren’t there because it’s fun, or because they’re having fun. It is Flippin’ sucks. Its hard work daily, actually, to like just to try to get by. You eventually get to a point where you don’t know how to stop. Like, how am I supposed to stop? Because I do what you tell me to do, I go here, I go there, I try this, and I try that, and it just doesn’t work”.

How might this type of stigma affect a person’s motivation to help him or herself? Possible answer:

Over time, the person who uses drugs may just feel like it just is not worth trying to stop if no one cares about him/her and there is nowhere to get the long-term help they need. To stop injecting drugs, smoking Nyaope or drinking alcohol excessively requires physical and psychological support. If the person who uses drugs is confronted by stigma and discrimination from the community, family, friends, and healthcare workers then the chance that he/she will stop or reduce their substance use is poor and the risk of relapse is high if they try to quit.

How can we improve as healthcare workers, when working with people who inject drugs? Possible answers:

Clinics need to be “welcoming” to all who attend. This begins with the guards and receptionists and continues throughout all areas. People who inject drugs have the universal right to care and treatment that is not judgemental and upholds the basic rights of dignity and compassion. Providers that have pre-existing stereotypes about people who inject drugs and use labels such as “junkie” or “drug abuser” create barriers to helping them. How we think of and refer to people should always convey respect and tolerance.

Regular staff education should include the incidence and prevalence of people who inject drugs in the community, and the clinical background and manifestations of substance use that includes the genetic risks and overall effects on the body, as well as the psychosocial effects of stigma and discrimination.

Recognising withdrawal

Nelson shows up at the emergency room in bad shape. He smells, he is shaking, he has a fever, and he complains of stomach pain. He is there because he needs treatment for an abscess on his arm. When asked, he does admit to injecting drugs but says that he has not injected for a while. He does not specify how long it has been.

The doctor you are working with wants to prescribe pain medication and medication for his stomach. You are not sure this will address the problem.

What do you think is going on with Nelson? Possible answer:

Nelson may be experiencing symptoms of withdrawal along with an infection from the abscess.

In addition to medication for pain, what additional treatment would benefit Nelson? Possible answers:

Treatment for his abscess that may include debridement and packing as well as an antibiotic for the infection.

Educating Nelson about medication adherence, keeping the abscess clean while it is healing, safe injecting techniques, and the importance of returning to the clinic for follow-up.

Discussing the symptoms of withdrawal with Nelson, the importance cleanliness, hydration, and good nutrition and either working with a treatment buddy or regularly attending support groups.

ARVs

Nelson says, “If you want your ARVs, it’s always such a flippin’ mission”. In Nelson’s workplace, there are “virally-suppressed homeless injecting drug users”. Many people, however, think that people who inject drugs are not able to adhere because they are drug users who get high. Nelson disagrees. “It’s about the way that you teach them or talk to them about their health. If someone feels valued, they will start taking better care of themselves. It’s actually that simple. They want to take better care of their health while they are using, and they don’t want to infect others. 99 per cent come to start treatment not for me first, it’s generally ‘I don’t want to infect anyone else. So, I know if I get on my treatment and I do well that won’t happen, is that true?’ And we explain the viral load, etc. When they start feeling valued, they start taking better care of themselves”.

Do you agree with Nelson? Why or why not?

What implications does your answer have for you as a healthcare provider?

What are some of the ways to help people be successful in reducing or stopping substance use? Possible answers:

Healthcare workers are in an excellent position to use the steps and practices of an evidence-based and cost-effective approach to dealing with substance use known worldwide as “harm reduction”. The goal of harm reduction messages is to reduce the harms associated with the use of substances such as heroin, cocaine, marijuana as well as alcohol and cigarettes. The aim is to focus on reducing the harm rather than preventing or forbidding the drug, alcohol or cigarette use itself. Harm reduction services are designed to meet people’s needs where they are at in their lives. Small gains in behaviour change are welcomed and encouraged. Harm reduction accepts that many people are unwilling or unable to stop using drugs but by providing support, understanding and comprehensive services free from stigma and discrimination, people who inject drugs will remain as healthy as possible while reducing the risks associated with substance use.

Clinic staff will benefit from harm reduction training. The concepts of harm reduction are not complicated and can be easily incorporated into every provider’s care delivery.

Worldwide, there are resources available online or in books and articles that can be used for the clinic or community setting. There are also harm reduction trainings available that providers and staff can attend.

LESSON PLAN

SESSION 14 – People in prisons and other closed settings

Learning objectives

At the end of this session participants should be able to:

- Define the terms “people in prisons and other closed settings”.
- Identify at least two barriers’ people in prisons and other closed settings face when seeking health services.
- Describe at least two barriers to condom acquisition and consistent condom use among people in prisons and other closed settings.
- List at least three healthcare and screening needs of people in prisons and other closed settings.
- State at least four risk assessment questions to ask people in prisons and other closed settings.
-

Session overview

Content	Activity	Materials
Learning objectives Introduction	Large group discussion Video Fill in the blank	Slide 255-258
Barriers Stigma and discrimination	Large group discussion Videos	Slides 259-261
HIV risk Prevention Condoms VMMC	Team role play activity	Slides 262-264
Health & screening TB STIs Mental health PMTCT	Mini lecture	Slides 265-269
Risk assessment	Small group matching activity	Slide 270
Review	Group quiz activity	Slide 271-272
Key points and closing	Questions and answers	Slides 273-274

Indicates a worksheet prompt

Opener

Show slide 255

Session 14 Learning Objectives

By the end of this session participants should be able to:

- Define the terms “prisons and other closed settings”
- Identify at least two barriers people in prisons and other closed settings face when seeking health services
- Describe at least two barriers to condom acquisition and consistent condom use among people in prisons and other closed settings
- List at least three health care and screening needs of people in prisons and other closed settings
- State at least four risk assessment questions to ask people in prisons and other closed settings



Show slide 256



SAY: Meet Luyanda, a former inmate from the Eastern Cape.

Show video clip #1 (slide 257): My name is Luyanda

SAY: We will hear more from Luyanda in his own words, but first let us take a few moments to discuss people in prison and other closed settings, or inmates.

Divide participants into teams.

ASK: What words come to mind when you hear the phrase “people in prisons and other closed settings”? Please take the next few minutes to discuss in teams. After sufficient time has passed, invite one member of each team to write one term on a piece of flip chart paper in the front of the room.

Show slide 258



SAY: Please fill in the missing words in your workbook.

Invite participants to share the words they have entered.

SAY: Prisons and other closed settings refers to all places of detention in which people – including juveniles – are held during the investigation of a crime, while awaiting trial, after conviction, before sentencing, and after sentencing.²² Given that sex work and drug use are currently criminalised in South Africa, many key population members are incarcerated at some point in their lives.

Barriers

Show slide 259



SAY: South Africa has the highest prison population in Africa.²² Whereas some detainees access primary health-care services within the prison or detention centre, others access health services at designated facilities. Because of stigma and discrimination, availability of and access to services are often inadequate.

Show video clip #2 (slide 260): Unhygienic conditions

SAY: As Luyanda says, people in prisons and other closed settings may not seek healthcare for fear of being stigmatised or shamed.

ASK: What other barriers may people in prisons and other closed settings face when seeking health services? Elicit replies. Highlight the following, if not

mentioned:

Availability

- Clinicians only available on certain days/at certain times
- Commodities (including condoms and lubricant)

Access

- Lockdown/restriction of movement and rights
- Requirement that inmates be escorted

Belief that detainees and inmates are not entitled to healthcare services

Fear of violent and/or disruptive inmates

Continuity of care for those incarcerated for short periods

Myths and misperceptions about risk

SAY: Barriers to healthcare may continue, even after an inmate is released. We will discuss continuity of care in more detail later in the session.

Show video clip #3 (slide 261): Discrimination

SAY: People in prisons and other closed settings are at higher risk of contracting HIV than the general population. Prison conditions, including sexual violence, injection drug use and lack of access to condoms and lubricants increase the risk of HIV transmission.²³ Sexual activity between men may also be more common in closed settings, as people are segregated by gender.⁴

Show slide 262: Condom usage



ASK: Why may people in prisons and other closed settings find it difficult to access and use condoms consistently?
Elicit replies, which may include:

Poor availability

Fear of stigma

Quantity restriction

Lack of knowledge on correct and consistent condom use



Show video clip

#4 (slide 263): The availability of condoms Show

slide 264

SAY: You are a nurse at a facility near a correctional centre. Prisoners in need of healthcare visit the clinic several times per week. The operational manager comes to you and says, “Don’t bother talking to these inmates about condoms – they should not be having sex”. Please take the next five minutes to prepare a brief role play in teams that demonstrates how you would respond.

After five minutes have passed, invite each team to present. Highlight the following key points, if not mentioned:

Sexual activity (both voluntary and involuntary) takes place in prisons.

Inmates are at increased risk of exposure to HIV.

HIV prevention services available in the community should also be provided to people in prisons and other closed settings.⁴

Condoms and lubricant should be easily accessible, without restriction.

VMMC

SAY: Voluntary Medical Male Circumcision (VMMC) is another way to reduce HIV risk among people in prison. VMMC services should adhere to the same medical ethics as in the community setting, including informed consent, confidentiality and no coercion.⁴

SAY: Let us review what we have covered so far. Please take the next two minutes to write a few key points in your workbook. After two minutes have passed, invite one participant from each group to share a key point from the session thus far. Highlight the following, if not mentioned:

People in prisons and other closed settings have a constitutional right to access health services.

Many key population members are incarcerated at some point in their lives.

People in prisons and other closed settings are at increased risk of exposure to HIV.

Stigma on the part of prison officials and other inmates may prevent inmates from accessing health services.

Show slide 265: Healthcare and screening needs



SAY: Reducing stigma and maintaining confidentiality may increase ART adherence among prisoners living with HIV. Prisoners being transferred to other facilities should have access to enough ART to last until healthcare is established at the new correctional centre.⁴

ASK: What healthcare and screening needs may people in prison and other closed settings have, in addition to HIV screening and treatment? Elicit replies. Highlight the following, if not mentioned:

Tuberculosis

- The NSP identifies inmates as a vulnerable population for TB. People known or suspected to have active TB should be separated (in a clinical setting) from other inmates until non-infectious.

STIs, including hepatitis

Mental health screening and treatment

Show slide #266: Female prisoners



SAY: Female inmates often face greater barriers to HIV screening, care, and treatment services in prison than outside prison.⁴ It is especially important for pregnant inmates to have access to PMTCT services.

ASK: Do you have questions about anything that we have covered so far?

SAY: All prisoners and detainees who present at the clinic should be assessed for risks associated with HIV and STIs, as well as TB.

Risk assessment matching cards

Distribute one set of shuffled Risk assessment matching cards to each team. Instruct each team to match the correct words or phrases to form a risk assessment question. After sufficient time has passed, review questions with the group at large.

Question	Answer
Are you	having sex?
What types of	sex is you having?
Do you	use non-sterile needles?
When were you	last tested for STIs?
What STIs have you	had in the past, if any?
Do you	use drugs?
How often do you	use condoms, every time you have sex?
Have you been in contact with	someone who has TB?

Show slide 267: Continuity of care



ASK: Siphiso is about to be released from prison. He is on treatment for TB and HIV. What steps should be taken before he leaves? Elicit replies. Highlight the following key points, if not mentioned:

Siphiso should be given enough ART and TB treatment to last until linkage is made to a community-based facility.

Continuity of treatment is essential to prevent resistance.

Siphiso may need psychosocial support services.

SAY: Former inmates often face stigma and discrimination in the community following release from prison, which may impact continuity of care.

Show video clip #5 (slide 268): I prefer not to disclose

SAY: Before we conclude the session, let's hear some parting words from Luyanda.

Show video clip #6 (slide 269): Treat me like a human being

SAY: Please take a few moments to write down key points from the session in your workbook. After sufficient time has passed: Let us close with a brief review activity.

Invite participants to stand and form a circle. Introduce a ball. Tell participants that if they catch the ball, they will be asked a question (they may confer with the person on either side, if they do not know the answer). Continue to throw the ball until all questions have been answered.

Show slide 270

People in prisons and other closed settings review questions

1. True or false: “Prisons and other closed settings” refers to all places of detention in South Africa. Correct response: True.
2. What barriers do people in prisons and other closed settings face when seeking health services? Correct responses: Stigma; lack of availability; lack of access; clinician fear; short incarceration; myths and misconceptions about risk
3. Why are people in prisons and other closed settings are at increased risk of exposure to HIV? Correct responses: Sexual violence, injection drug use, lack of access to condoms and lubricants, myths, and misperceptions about risk
4. Why may people in prisons and other closed settings find it difficult to access and use condoms consistently? Correct responses: Poor availability; fear of stigma; quantity restriction; lack of knowledge on correct condom use
5. True or false: VMMC for HIV prevention is not recommended for people in prisons and other closed settings in South Africa. Correct response: False
6. What healthcare and screening needs do people in prison and other closed settings have? Correct responses: HIV; TB; STIs, including hepatitis; mental health screening; PMTCT for pregnant women with HIV
7. Name one risk assessment question to ask people in prisons and other closed settings.
8. Complete this statement: Upon release, inmates with HIV and/or TB should be given _____. Correct response: Enough medication to last until linkage is made to a community-based facility.

Key points

Prisons and other closed settings refer to all places of detention within which people – including juveniles – are held during the investigation of a crime, while awaiting trial, after conviction, before and after sentencing.

Given that sex work and drug use are currently criminalised in South Africa, many key population members are incarcerated at some point in their lives.

South Africa has the highest prison population in Africa.

Inmates are often subjected to unhygienic, over-populated conditions and are particularly vulnerable to infectious diseases.

es such as HIV, STIs, TB, and common mental health disorders.

Barriers to quality care include fear of stigma, discrimination and shaming, fear of violent or disruptive inmates, requirements to be escorted to appointments, beliefs that inmates are not entitled to health services, availability of clinicians, and minimal commodities. There are also myths and misperceptions about risk that keep inmates from seeking care.

Inmates must first request permission from prison staff to seek care and are monitored throughout the process because they are not trusted to behave well. Any medications are entrusted to officials who must remember to give the inmate their dosing at the correct time.

Barriers to healthcare may even continue after an inmate is released, affecting continuity of care.

Prison conditions, including sexual violence, injection drug use and lack of access to condoms and lubricants increase the risk of exposure to HIV transmission. Homosexual activity may also be more common in closed settings, as inmates are segregated by gender.

Risk assessment questions should focus on unsafe behaviours and practices, not the expression of their identity. Establishing rapport using respectful, open communication is essential to providing effective, quality care.

LESSON PLAN

Healthcare and screening needs

People in prisons and other closed settings:

PARTICIPANT WORKBOOK

Objectives

At the end of this session participants should be able to:

Define the terms “prisons and other closed settings”.

Identify at least two barriers’ people in prisons and other closed settings face when seeking health services.

Describe at least two barriers to condom acquisition and consistent condom use among people in prisons and other closed settings.

List at least three healthcare and screening needs of people in prisons and other closed settings.

State at least four risk assessment questions to ask people in prisons and other closed settings.

Instructions: Fill in the missing words below:

Prisons and other _____ settings refer to all places of
_____ in South Africa.

Barriers that people in prisons and other closed settings face when seeking health services include:

- 1.
- 2.
3. Fear of violent and/or disruptive inmates

4. Myths and misperceptions about risk

Sipho is about to be released from prison. He is on treatment for TB and HIV. What steps should be taken before he leaves?

-
-

Sipho may need psychosocial support services.

Key points

-
-
-
-

People in prisons and other closed settings review Questions


1. True or false: “Prisons and other closed settings” refers to all places of detention in South Africa?

True False

2. What barriers do people in prisons and other closed settings face when seeking health services?
3. Why are people in prisons and other closed settings at increased risk of exposure to HIV?
4. Why may people in prisons and other closed settings find it difficult to access and use condoms consistently?
5. True or false: VMMC for HIV prevention is not recommended for people in prisons and other closed settings in South Africa.

True False

6. What healthcare and screening needs do people in prison and other closed settings have?
7. Name one risk assessment question to ask people in prisons and other closed settings.
8. Complete this statement: Upon release, prisoners with HIV and/or TB should be given?

9.  CASE STUDY | LUYANDA



and other closed settings

People in prisons

Health and hygiene

Luyanda is a young man from a rural area in the Eastern Cape. He committed a crime and ended up in prison. Luyanda tells you about the health challenges he faced in

prison, which are related to poor living conditions, including 50 to 60 people being jammed into a small room. He tells you that it takes a long time to get

medical care because “not everything is in the facility, so you would need to be transferred to outside the institution to a hospital where it’s also lengthy

process to get you

there for security reasons". He also cites lack of availability of healthcare

workers, "The correctional centre houses about 1 500 inmates and you find that there are only about four to five nurses and one doctor who comes once a week just for one day and can only see 20 patients when he comes".

How might these challenges impact on inmates' health in general? How would it affect the spread of HIV and TB? Possible answers:

Luyanda and other inmates may turn to other ways to deal with health problems rather than trying to go through the very difficult and lengthy process of seeing the prison doctor/nurse or getting to the hospital. People in prison may ignore symptoms hoping that they will go away. Some may try to "self-treat" using non-registered medicines, creams, or herbs.

Overcrowding increases the risk of onward transmitting TB and other respiratory infections as well as skin conditions such as scabies.

What might be done to improve those conditions? Possible answers:

Inmates who are coughing or have other potentially infectious conditions need rapid and thorough screening and isolation if needed. This will lower the risk of transmission especially in overcrowded conditions.

Cough etiquette and other health education to inmates is an important step that healthcare providers and staff can take to not only lower the risk of transmitting diseases but also provide the necessary information for inmates to take control of their own health.

Luyanda says that in some prisons, inmates in need of healthcare must be transferred to another facility, which requires an escort. He says, "Not every day you can wake up and say I need to see a nurse, I am not feeling well. Sometimes you are told that only happens on a Wednesday. So, if you are sick on a Thursday, you would have to wait until the next week". Luyanda also tells you that when the prison is in lock down, clinicians may help by talking to you through the window, rather than doing an examination.

How might these circumstances make it hard for an inmate to

advocate for his/her health? Possible answers:

Healthcare workers working in correctional settings have an opportunity to provide “healthy living” education to inmates that includes the signs and symptoms of health problems that need attention and the importance of recognising health problems early so that timely care needed will be available to them.

Inmates with little or no experience with navigating healthcare will benefit from health education with emphasis on the importance of washing hands frequently and personal hygiene to lower the risk of infections.

Availability of the clinic staff should be communicated to the inmates at intake and a sign with the days/times posted in the medical unit.

HIV testing and HIV status

Before Luyanda went to prison, he did not believe that being in prison increased the risk of contracting HIV; since his time in prison, he sees how inmates are exposed to HIV. He discovered that “a lot of inmates inside prison are living with HIV and also a lot of inmates actually contract HIV inside the prison through assaults and rapes that occur sometimes in there”. He says “most of the guys inside the system don’t know their status. They are not... encouraged to go and test and the platform to go and get tested is not always provided because... to the medical practitioner him/herself is a process of its own. So, to get a number of people tested is also a process”.

Why is not knowing one’s status a problem? How is the system contributing to this problem? Possible answers:

Knowing your HIV status is important to ensure living healthy and long-term with HIV. Taking medication every day resulting in the HIV viral load being undetectable also lowers the risk of transmitting the virus which is important in correctional facilities and in the community.

Not knowing one’s status can lead to excessive stress, anxiety and depression thinking about what they have heard about the disease or seen with their own family members or friends. Having a test result that is negative is a good opportunity for healthcare workers to provide education about how to stay negative. A positive test result will enable the healthcare provider to counsel the inmate on living with HIV, the medication available and the importance of healthy living.

Stigma and discrimination

Luyanda says that there was a lot of discrimination against inmates from officials working in the prisons. He said that they would make remarks sometimes and “they conduct themselves in a way that shows that they’ve got a problem with you just being an inmate. If an inmate was arrested for theft, should something go missing in the cell that he is sleeping in, they would call him, ‘you, who are arrested for theft, are you still busy with the theft in here?’ So, they would immediately assume”. He says that as an inmate, you are not trusted. He also said that officials would especially make fun of gay inmates.

How would this affect a person if the officials who are hired to keep order in a prison are making fun of inmates, not trusting them, and assuming the worst in them with no evidence? Possible answers:

Inmates in this position will be living with constant stress, anger, and depression. Some will act out as result of the discrimination. Others may internalise the feelings, which can lead to physical problems such as insomnia, stomach symptoms, and headaches.

Inmates may constantly feel on edge and be on alert for how the officials are act toward them or other inmates. The psychological and physical stress is not good for any inmate but especially if they are HIV positive, have another chronic condition such as hypertension, or are being treated for TB.

Luyanda prefers not to tell people that he is an ex-convict, because he feels that they will then treat him differently. He says people mention prison all the time and tell him to handle something “like a prisoner”.

How would this stigma affect a person once they get out of prison? What do you think it means in terms of job prospects, motivation, etc? Possible answers:

Inmates often are hopeful and motivated knowing they are being released from prison. They may have plans (real or imagined) about what it will be like back in the community and believe that getting a job and making money will not be too difficult. The reality is that re- entering a community after prison can be very difficult and stressful for the person especially if he/she does not have support from family and/or friends. Finding a job is difficult enough without also having the background of being incarcerated. Over time, if the person does not find a job and/or has difficulties with whom they are living with, the stress and depression will build up which will only aggravate the situation.

10.  CASE STUDY | ANDREW



and other closed settings

People in prisons

Overcrowding

In the correctional facility, Andrew shares a cellblock with ten other inmates. They all know their HIV status because they got tested upon entering the correctional facility. Two of the men who just entered the cell block have TB and are coughing a lot. There is poor ventilation in their cramped quarters.

How does overcrowding impact the health of inmates and the people who work with them? Possible answers:

Overcrowding, poor ventilation and limited and poor prevention practices can dramatically increase the risk of TB transmission.

Prisons in South Africa have a high burden of TB and along with the crowded conditions the risk of multi-drug resistant TB (MDR-TB).

TB is not only a risk to the inmates but the guards and other correctional facility workers as well.

What should Andrew do? Possible answers:

Andrew can request that the men who are coughing be moved to a medical area of the prison and if not, they must be given masks.

Has Andrew shown the men “cough etiquette” and encouraged them to cough into their sleeve and not spit on the floor?

What should the healthcare workers do? Possible answers:

DOT (directly observed therapy) to ensure the men with TB are taking treatment as directed.

Provide masks and education that includes why masks are important and their correct use.

Screen Andrew and any other men sharing the cell for TB and provide preventative therapy if they qualify. If Andrew or the other men screen positive for TB, follow TB protocol and initiate TB treatment if indicated.

Medical staff should systematically screen newly arriving inmates for symptoms or signs of TB. Men who are coughing and screen positive for TB should be isolated in another area of the prison if possible, until the repeat sputum is negative.

What should the correctional facility do? Possible answers:

This is an urgent problem that needs to be addressed as aggressively as possible. Maximum ventilation should be maintained in all cells especially if the prison is overcrowded.

Decreasing the amount of “lock-up” time can also lower the risk of transmission along with improved ventilation and TB screening.

Class and other socioeconomic issues

Andrew is frustrated. He tells his counsellor that inmates get health treatment “according to the crime you committed” or else based on “the types of people that you associate yourself with within the correctional centre walls”. For example, someone who was convicted of fraud is most likely from a wealthy background, and someone who is convicted of shoplifting is most likely from a poor background. He explains that these distinctions may be upheld within the correctional facility and translate to unequal treatment: those who are perceived as coming from wealthy backgrounds get better healthcare and treatment than those who are perceived as coming from poorer backgrounds.

He feels that because he comes from a poor background, and was convicted for petty theft, he is treated differently

by the correctional officials and the healthcare workers.

Do you think that only the “poorer” inmates suffer under this system? Why or why not? Possible answers include:

Why? Stigma and discrimination in correctional facilities can exist among the guards and other employees. These attitudes can undermine basic medical services and possibly more complex healthcare needs such as HIV or TB care and treatment.

Why not? If guards and other correctional employees label inmates based on why they are in prison, even an inmate who comes from a “wealthier background” could be labelled wrong and be subjected to healthcare according to the crime they committed. As a healthcare worker, what are some ways you can think of to equalise/improve this system so that everyone benefits? Possible answers:

Healthcare providers have a duty to provide the best quality care to every inmate no matter their crime or background. All healthcare providers have an obligation to be a role model for other correctional employees by providing care that is free from stigma, discrimination and by treating inmates equally.

Correctional centre officials, along with healthcare workers at each facility, can identify the successes and challenges of care delivery and propose changes. This can be done using a quality improvement/PDSA (Plan, Do, Study, Act) approach to evaluate the current system of care delivery. It would also be beneficial to include feedback and suggestions for improvement from inmates.

Access to healthcare

Andrew is having a lot of trouble accessing healthcare. He explains to you, his counsellor, how he even feels that he needs to “fight” or “beg” for healthcare. He tells you, “They are hired to do their job. And it’s painful when you must beg someone who is getting paid every per month to take care of you, but you have to run after them for three days [to get help]”. Just last week he had sharp pains in his chest for three to four days and he kept going back and going back to the health clinic for help and they repeatedly told him to drink more water and sleep and he would be fine. His health was deteriorating, he was losing weight, and he was desperate for help. He had to fight to get medication from outside.

How might these obstacles affect an inmate’s attitude toward taking care of him/ herself? Possible answer:

People in prison may already have a history of mental health problems such as depression or

anger issues. If health conditions develop or worsen and healthcare providers dismiss or ignore the symptoms, inmates may have anxiety, get more depressed or decide to treat illnesses themselves which could lead to worsening of a condition and/or spread of disease.

How might this affect adherence to TB or HIV medication? Possible answer:

Depression or other mental health disorders can lead to poor medication adherence.

Limited or lack of client education about the importance of adherence can also lead to inmates refusing to take medication or missing doses.

How might this affect inmate's health outcomes in general? Possible answer:

Inmates with TB are at risk for developing drug resistance, transmitting MDR-TB to other inmates and prison staff as well as a worsening of their overall health.

Any disease or illness that requires adherence to medication will worsen or not respond if there is poor adherence. This is true for inmates who are HIV-infected, diabetics or have hypertension.

What can you as a health worker do to improve access to healthcare in correctional facilities?
Possible answers:

The role of the healthcare worker includes being an advocate for clients where access and quality care may be putting inmates at risk. Inmates' complaints and feedback can be shared at the team meetings or individually with supervisors and also include suggestions for improvement.

Suggest a quality improvement (QI) approach to clinical and/or systems issues. Identify the challenge and possible solutions. Develop a PDSA (Plan, Do, Study, Act) draft. Remember to evaluate the proposed solution and either continue if successful or test another solution until the issue has been resolved. Make sure that the problem and results of the PDSA are documented and results reported back to the staff.

Healthcare worker attitudes

Andrew needs to see a health worker today because he has had a sore throat for three days with no other symptoms. The nurse, Albert, says that he is leaving in a half an hour (even though his shift does not end for four more hours) but says, "Fine, I will fit you in, but quickly. I am sure you are just trying to get out of work, and you aren't really sick". Albert asks Andrew what is wrong, but is looking at his phone and shuffling through papers while

Andrew tells him what is wrong. When Andrew says, "How can you help me?" Albert says, "There is nothing I can do,

you will be fine. Just drink more water". Albert starts to leave, but Andrew feels he has not heard him, so he tells him again about his sore throat and asks for a strep test. Albert says to come back in a week if it is not better; that he will be fine, he is thinking that Andrew is probably just lazy and greedy for medicine.

How does discrimination against inmates affect their health? Possible answer:

Stigma and discrimination in correctional facilities can add additional stress and fear to an inmate who may already be dealing with mental health issues such as anger, anxiety and/or depression. Stress can also put a burden on the general health of an inmate and contribute to weight loss, stomach symptoms, headache, and insomnia. Within the correctional setting, feelings of being discriminated against may lead to an inmate not seeking healthcare services or non-adherence to prescribed medications.

HIV exposure

Andrew tells you that new inmates may feel scared and vulnerable and not know who to trust, so they associate themselves with certain people who may take advantage of them, which includes agreeing to having sex with them.

What can we do as healthcare workers, to help inmates who want to be more responsible about their health? Possible answer:

Ensure that inmates have been given thorough client education about their illness and/or medications. The information should include what the illness is, why medication is needed, how long to take the medication, possible mild and severe side effects. Suggestions such as taking a medication with food may be helpful.

Healthcare workers in a correctional facility have to work around the set schedule of the facility but if the medication can be given closer to mealtimes, that may help with potential side effects.

What can we do to help new inmates (or any inmates) feel safer so that they are less likely to need alliances for protection and friendship? Possible answers:

Correctional healthcare workers are in an excellent position to not only provide quality healthcare but also provide psychosocial support to inmates, which in turn may lead the inmate to share their feelings of isolation, fear, depression, and anxiety. Inmates who feel comfortable and safe talking to healthcare providers will be less likely to share their medical and/or psychological problems with fellow inmates.

Healthcare providers have an opportunity to provide education and prevention messages specific to HIV, TB and STIs. These messages and the information are important while inmates are in correctional facilities and should be reinforced prior to release back to the community.



CASE STUDY | SOLOMON



People in prisons and other closed settings

Double discrimination

Solomon is frustrated. He feels he is being discriminated against by health workers and correctional facility officials alike, for being an inmate. He says this

happens both in and outside of correctional facilities. In correctional facilities, it is displayed by health workers who do not treat their clients with respect, pay attention to them, or seem to care about their health. Outside of the correctional facility system, health workers become much more anxious and fearful if Solomon tells them he has

been incarcerated.

How might this impact an inmate or former inmate's adherence to HIV treatment? Possible answer:

Lifelong adherence to HIV care and treatment is the only way a person infected with the virus can expect to live a healthy life with HIV. Psychosocial barriers such as actual or perceived stigma and discrimination, fear of disclosure, isolation, labeling as a prisoner, lack of support from family and friends can all contribute to poor adherence to care and treatment.

Healthcare worker attitudes

Solomon describes some of the doctors and nurses as coming in with preconceived notions about inmates – that they are dangerous, or rapists, or thieves – rather than seeing them as people who have a medical problem.

How might this negative attitude affect clients and care?

Possible answers:

Solomon may choose to attend a clinic that is far from his home where the staff may not know him. This can make adherence to care and treatment more difficult. If he is not feeling well or has problems with transportation or the cost, he will be more likely to skip his appointment and be at risk for running out of medication.

Attending a new clinic may also be challenging if a client is not able to provide a thorough and accurate medical history. He/she may be reluctant to tell the new provider they were in a correctional facility where there are medical records that could be shared.

MODULE 5: Towards tailored key population services

The learning objectives for Module 5 will be covered in the following session:

Session 15 – Creating key population-friendly facilities

Understand the service dimensions of key population-friendly services:

- How to adapt the facility
- How to plan for accessible, acceptable, affordable, and appropriate services
- Describe actions to transform facilities into a key-population-friendly environment
- How to provide more effective services for key populations

LESSON PLAN

SESSION 15 – creating a key population-friendly facility

Learning objectives

At the end of this session participants should be able to:

- Know how to adapt the facility to provide key population-friendly services
- Know how to plan for accessible, acceptable, affordable, and appropriate services
- Describe actions to transform your facilities into a key population-friendly environments
- How to provide more effective services for key populations

Session overview

Content	Activity	Materials
Learning objectives	Large group discussion	Slide 278
Identifying areas for improvement	Self-assessment	Slide 279, Form
Debrief self-assessment activity	Reflection Group discussion	Slides 280-281
Closing	Questions and answers	Slide 282

Show slide 278

Learning objectives

- Understand the service dimensions of key population-friendly services:
 - How to adapt the facility to provide key population-friendly services
 - How to plan for accessible, acceptable, affordable, and appropriate services
 - Describe actions to transform facilities into a key-population-friendly environment
 - How to provide more effective services for key populations



EXPLAIN: This session is to help transform learning into actions that will improve services for key populations. Explain that during this session, participants will identify areas that need to be changed to provide more effective care for key populations.

REMINDE participants that key populations experience many challenges in accessing healthcare services. These can range from stigma and discrimination to breeches in confidentiality, as explored in case studies and other exercises in previous modules.

Show slide 279

Facility staff self-assessment

- Distribute self-assessment forms



DISTRIBUTE: Annex 1 Facility staff self-assessment form

Activity 1: Identifying areas for improvement (30 minutes)

ASK: participants to complete their healthcare worker self-assessments (Annex 1).

Show slide 280

- What was the hardest part of identifying improvements in your facility? What was the easiest part?
- Do you anticipate significant barriers to implementing the changes they have planned to make?
- What changes have you identified that you or others will make or pursue immediately upon returning to the facility?
- Are there any areas that require technical or other support to make the changes?
 - Can participants identify specific parts of what they already do that align with the ideas discussed in this session?

Group feedback session:

BRING the group back together, and ASK people to reflect on the exercise by asking the questions on the slide.

Good intentions

Answer the question:

- When you return your daily routine, what is one thing you will do to support the lessons you have learned during this training?
- What is one thing you will do to better support people who are part of a key population?

Please think about this and then write your answer on a piece of paper or be prepared to say it aloud.

CLOSING MODULE: EVALUATION AND ASSESSMENT

The learning objectives for the Closing Module will be covered in the following sessions:

Session 16 – Post-training assessment: Knowledge, attitudes and perceptions

- Assess participant's achievement of learning objectives
- Assess participant's change in knowledge, attitude, and practice regarding service delivery for members of each of the five key population groups prior to and following the training
- Assess change in health worker ability to provide competent care to key populations (post-toolkit intervention)

Session 17 – Workshop evaluation and wrap-up

- Participants will complete workshop evaluation questionnaires
- Final question and answer period
- Next steps, accessing support
- Closing

LESSON PLAN

SESSION 16 – Creating a key population-friendly facility

Learning objectives

At the end of this session participants should be able to:

- Know how to adapt the facility to provide key population-friendly services
- Know how to plan for accessible, acceptable, affordable, and appropriate services
- Describe actions to transform your facilities into a key-population-friendly environment
- Know how to provide more effective services for key populations

Session overview

Content	Activity	Materials
Learning objectives	Large group discussion	Slide 287
Post-training assessment	Self-assessment	Slide 288, Questionnaire
Knowledge, attitude, practice (KAP) survey	Sample questions	Slides 289-291
Closing	Questions and answers	Slide 292

Session 16 — Participant sensitisation pre- and post-training evaluation

Materials

- ☐ Copies: Pre- and post-training knowledge, attitudes, and practices (KAP) questionnaire (Annex 2)

Learning objectives

After completing this session, participants will complete the post-training questionnaire to show what they learned over the course of the training.

Trainer preparation

Make copies of questionnaires for participants.

Facilitation tips

Thank the group for their feedback that will help inform future trainings.

Introduction

Distribute the pre- and post-training questionnaires, and ask participants to complete them. Rather than collecting the completed forms from the participants, ask them to place the forms in a central location (e.g., on a chair or table), so that their responses remain anonymous.

Knowledge, Attitude, and Practice Survey

- Sample question from the 'Attitude' portion



assess a different skill.

SAY: Notice how the different the types of questions in each section aim to

Knowledge, Attitude, and Practice Survey

- Sample question from the 'Practice' portion



LESSON PLAN

SESSION 17 – Workshop evaluation and wrap-up

Learning objectives

At the end of this session participants should be able to:

- Know how to adapt the facility to provide key population-friendly services
- Know how to plan for accessible, acceptable, affordable, and appropriate services
- Describe actions to transform your facilities into a key-population-friendly environment
- Know how to provide more effective services for key populations

Session overview

Content	Activity	Materials
Learning objectives	Large group discussion	Slide 278
Identifying areas for improvement	Self-assessment	Slide 279, Form
Debrief self-assessment activity	Reflection Group discussion	Slides 280-281
Closing	Questions and answers	Slide 282

Session 17 – Training workshop assessment

- Copies: Workshop evaluation form

Learning objectives

After completing this session, participants will be able to share ideas about how the training could be improved or adapted in the future.

Trainer preparation

Make copies of questionnaire for participants.

Facilitation tips

This content of the training, and the personal reflection it required, may have been unusual for many participants, who might be more comfortable and familiar with purely technical training. Recognise and express appreciation for your participants' open-mindedness and thoughtfulness. Thank the group for their feedback that will help inform future trainings.

Introduction

Let participants know that their feedback on this training, and the results of their post-training questionnaire, will help to strengthen future trainings. Tell them that you would like to receive their honest, constructive criticism and specific recommendations for how to improve the training guide. Remind participants that the information from the evaluation forms and post-test questionnaire is anonymous.

Activities

Distribute the workshop evaluation forms and ask participants to complete them. Rather than collecting the completed forms from the participants, ask them to place the forms in a central location (e.g., on a chair or table), so that their responses remain anonymous.

Thank the participants for their time, energy, and honest and open reflection throughout the training. Ask if anyone would like to share any final thoughts or comments with the group.

In closing, remind participants that action and change can start with each of them, and remind them about the commitment statements that they have made. Clearly explain any follow-up training or support opportunities available to them. (10 minutes)

Key messages

- Change starts with each of us.
- Reducing stigma and enabling key populations to access quality comprehensive health services is a critical part of any response to HIV.
- Each one of them has committed to take action (in themselves, their communities, and their facilities) as a result of this training.

Objective:

- Assess participant's achievement of learning objectives
- Assess participant's change in knowledge, attitude, and practice regarding service delivery for members of each of the five key population groups prior to and following the training
- Assess change in health worker ability to provide competent care to key populations (post-toolkit intervention)



SAY: It is important to measure the impact of the training on participant's knowledge, attitude, and perception. Information collected from pre and post-test help partners who are delivering the training to have a better understanding of which topics may need follow on support. It also helps participant's identify their individual strengths and areas for improvement.

Data collection helps us to:

- Assess participant's achievement of learning objectives
- Assess participant's change in knowledge, attitude, and perception regarding service delivery for members of each of the five key population groups prior to and following the training
- Assess change in health worker ability to provide competent care to key populations (post-toolkit intervention)

Knowledge, Attitude, and Practice Survey

- Sample question from the 'Knowledge' portion

6. The population health health facilities

To test the public health program (PHT) and see whether it works

To have separate groups for the population, every five villages

To make appropriate screening and referral, based upon the client's assessment and STI risk outcomes



Annexes

Evaluation forms

- 1) Facility staff self-assessment
- 2) Pre- and post-training assessments
- 3) Workshop evaluation form

Job aids

- HIV-risk screening questionnaire
- STI-risk screening questionnaire
- TB-risk screening questionnaire
- Common mental health disorders screening questionnaire
- HIV-risk screening questionnaire
- HIV-risk screening questionnaire

1. FACILITY STAFF SELF-ASSESSMENT

	Questions	Response		
Facility	1. Where is the health facility where you work?	District:		
	2. What type of facility? (Public/NGO/Other)			
	3. What is the facility name?			
	4. What is your role at this health facility?			
<p>Key populations include sex workers, men who have sex with men, transgender people, and people who inject drugs and inmates. Key populations are more affected by HIV because of risk factors that include stigma.</p>				
	Questions	Yes	No	Don't know

Sex workers	5. Would you get in trouble at work if you discriminated against people who are sex workers?						
	6. Does your facility have written guidelines to protect people who are sex workers?						
	7. In the past three months, have you heard staff at your facility gossip about people because they are sex workers?						
	8. In the past three months, have you heard staff at your facility refuse services to a client because they are a sex worker?						
	9. Should sex workers feel ashamed of themselves?						
	10. Are sex workers to blame for their health issues?						
	11. How would you rate your facility's services for sex workers? Check a number 1-3, where 1 is low quality and 5 is high quality. (If 3-5, skip 11a below)	1	2	3	4	5	
	a. Why is the quality of services low for sex workers?						
	12. How can your facility improve services and make it easier for sex workers to receive services?						
	Men who have sex with men can include gay men, bisexual men, and other men who have sex with men, even if they identify as heterosexual. These populations are at higher risk of HIV exposure than the general population. We will ask you a similar set of questions about men who have sex with men.						

Men who have sex with men	13. Would you get in trouble at work if you discriminated against clients who are men who have sex with men?					
	14. Does your facility have written guidelines to protect men who have sex with men?					
	15. In the past three months, have you heard staff at your facility gossip about people because they are men who have sex with men?					
	16. In the past three months, have you heard staff at your facility refuse services to a client because they are a man who has sex with men?					
	17. Should men who have sex with men feel ashamed of themselves?					
	18. Are men who have sex with men to blame for their health issues?					
	19. How would you rate your facility's services for men who have sex with men? Check a number 1-3, where 1 is low quality and 5 is high quality. (If 3-5, skip 19a below)	1	2	3	4	5
	a. Why is the quality of services low for men who have sex with men?					
	12. How can your facility improve services and make it easier for men who have sex with men to receive services?					
<p>Transgender people include those whose gender identity is different than their sex assigned at birth. Transgender women are at higher risk of HIV than the general population.</p>						

Transgender people	13. Would you get in trouble at work if you discriminated against transgender people?					
	14. Does your facility have written guidelines to protect transgender people?					
	15. In the past three months, have you heard staff at your facility gossip about people because they are transgender?					
	16. In the past three months, have you heard staff at your facility refuse services to a client because they are transgender?					
	17. Should transgender people feel ashamed of themselves?					
	18. Are transgender people to blame for their health issues?					
	19. How would you rate your facility's services for transgender people? Check a number 1–3, where 1 is low quality and 5 is high quality. (If 3–5, skip 19a below)	1	2	3	4	5
	a. Why is the quality of services low for transgender people?					
	20. How can your facility improve services and make it easier for transgender people to receive services?					

We will ask you a similar set of questions for people who inject drugs. For this assessment, people who inject drugs include those who inject drugs recreationally and without the prescription of a physician. People who inject drugs are at higher risk of HIV than the general population.

People who inject drugs	21. Would you get in trouble at work if you discriminated against people who inject drugs?					
	22. Does your facility have written guidelines to protect people who inject drugs?					
	23. In the past three months, have you heard staff at your facility gossip about people because they inject drugs?					
	24. In the past three months, have you heard staff at your facility refuse services to a client because they inject drugs?					
	25. Should people who inject drugs feel ashamed of themselves?					
	26. Are people who inject drugs to blame for their health issues?					
	27. How would you rate your facility's services for people who inject drugs? Check a number 1–3, where 1 is low quality and 5 is high quality. (If 3–5, skip 19a below)	1	2	3	4	5
	a. Why is the quality of services low for people who inject drugs?					
	28. How can your facility improve services and make it easier for people who inject drugs to receive services?					

We will ask you a similar set of questions for people in prisons and other closed settings (inmates). This definition includes people who were previously in prison. Inmates are at higher risk of HIV and TB than the general population.

	29. Would you get in trouble at work if you discriminated against inmates?					
	30. Does your facility have written guidelines to protect inmates?					
	31. In the past three months, have you heard staff at your facility gossip about people because they are inmates?					
	32. In the past three months, have you heard staff at your facility refuse services to an inmate?					
	33. Should inmates feel ashamed of themselves?					
	34. Are inmates to blame for their health issues?					
	35. How would you rate your facility's services for inmates? Check a number 1–3, where 1 is low quality and 5 is high quality. (If 3–5, skip 35a below)	1	2	3	4	5
	a. Why is the quality of services low for inmates?					
	36. How can your facility improve services and make it easier for inmates to receive services?					

2. PRE- AND POST-TRAINING QUESTIONNAIRE

Knowledge, attitudes, and practices (adapted from LINKAGES, 2013)

Please respond to the following questions as best you can according to your beliefs and knowledge. You will be asked to complete this questionnaire at both the beginning and the end of the workshop.

The purpose of this questionnaire is to know if your knowledge and skills working with key populations increased after the workshop. Please do not include your name on this paper. You will create a unique identifier to maintain your confidentiality and allow facilitators to match your pre- and post-workshop responses. This number should be the same each time you respond to this questionnaire.

My unique identifier			
	Number of sisters	Birthday month	Last three digits of your phone number
Example	0	June	357
Identifier	01-06-357		

Date _____

Your position: (e.g., health worker, peer navigator, trainer, educator) _____

Part I

1. Which of the following statements best describes key populations?

(Choose only one answer)

- a. They rarely engage in unsafe HIV behaviours.
- b. Their behaviour is stigmatised and often criminalised.
- c. They have no problems accessing high-quality HIV services.
- d. All of the above

2. Statements such as “girls don’t like science” or “real men don’t cry” are examples of:

(Choose only one answer)

- a. Gender identities
- b. Gender stereotypes
- c. Sexual identities
- d. Gender-role behaviours

3. Repeatedly putting down or making fun of someone is a type of _____ abuse.

(Fill in the blank with an appropriate word)

4. Only men who have sex with men practice anal sex.

(Choose only one answer.)

- a. True
- b. False

5. A harm-reduction approach to reduce HIV risk for people who inject drugs could include:

(Choose all correct answers)

- a. Injecting only certain types of drugs
- b. Not using sterile needles
- c. Living with a family member to monitor drug use behaviour
- d. Receiving harm reduction information and commodities such as clean injecting equipment and naloxone (for accidental overdose)

6. A transgender person is any person whose gender identity or expression differs from their _____ at birth.

(Fill in the blank with an appropriate word.)

7. What is stigma?

(Choose only one answer)

- a. A set of negative and often unfair beliefs or disapproval towards a specific person or group
- b. Treating someone differently and not providing the same quality of service because of a person's behaviour, religion, race, etc.
- c. Feeling depressed and unhappy
- d. Making generalised statements about a person or group of people based on a set of characteristics

8. Which example below best illustrates how stigma affects how a man who has sex with men receives HIV services?

- a. The receptionist complains that young men who have sex with men clients are coming into the clinic right before it closes.
- b. A healthcare provider makes a general statement to her colleague that all men who have sex with men need frequent STI testing.
- c. During a risk assessment, a married man expresses that he is unhappy with his home life but does not disclose that he has sex with men.
- d. A healthcare provider tells a man who has sex with men, "It is my ethical and legal obligation as a healthcare provider to protect your privacy".

9. Name two primary care services, other than HIV-related services, that a healthcare worker should focus on, with a client who is a female sex worker.

(Write your answer below)

1. _____

2. _____

10. Name two primary care services, other than HIV-related services, that a healthcare worker should focus on with a client who is a man who has sex with men.

(Write your answer below)

1. _____

2. _____

11. The purpose of providing clients with risk-reduction messages is to...

(Choose only one answer)

- a. Eliminate all HIV risks that clients may experience

- b. Ensure that all clients receive the same messages, regardless of their risks
- c. Decrease the risk experiences by clients according to their behaviours and context
- d. Convince clients to completely change their lifestyle

12. Which of the following statements is false? (Choose only one answer)

- a. Young people living with HIV face unique health, adherence, and psychosocial issues and challenges.
- b. Young people must have their parent or guardian’s permission to receive HIV testing and treatment services.
- c. Health workers need specific knowledge and skills to meet the needs of young clients.
- d. Programmes and clinical services need to be youth-friendly to attract and retain young clients.

13. Name one reason why young people in key populations may be extra vulnerable to stigma and discrimination?

(Write your answer below.)

Part 2.

Please read the following statements and indicate the level at which you agree or disagree by putting a check mark in the appropriate box. Please answer as honestly as possible.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. I have the knowledge and skills to explain to my colleagues why key populations deserve access to stigma-free, high-quality HIV services.					
2. I believe that laws and policies should be in place to prevent men from having sex with men.					
3. I believe that all clients, regardless of their gender identity, age, sexual orientation, and sexual behaviour, must be treated equally and fairly.					
4. I feel strong disapproval when I learn that a young woman is receiving goods or money in exchange for sex.					
5. I will continue to educate myself and others about key populations.					
6. I feel strong empathy for a person who injects drugs.					

7. I am highly motivated to ensure that key populations receive stigma-free, high-quality, comprehensive HIV services.					
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3. WORKSHOP EVALUATION FORM

Workshop evaluation

Date and location of workshop: _____

- Overall, I would rate this workshop: ___ / 10
- What did you like best about the workshop? Please explain.

- Did anything surprise you in this workshop?

If yes, please describe? If not, please explain why not?

- Would you recommend this workshop to a friend or colleague?

Please circle a number 0 –10

0 = Not at all 10 = Extremely likely

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

- How would you improve or change this workshop?

- Is there anything you would eliminate from the training? If so, what?

- What other subjects or activities should have been included in this workshop?

- How well did the workshop encourage the exchange of experiences among participants?

Circle your answer:

Not at all	Somewhat	Quite a lot
------------	----------	-------------

Please explain your answer:

- Tell us how our workshop went (tick box for your answer).

Questions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Strongly agree	Disagree	Neither	Agree	Strongly agree

i. The objectives of the workshop were met.					
ii. The content was organised and easy to follow.					
iii. There was enough time to digest and reflect on the content.					
iv. The tools, activities, and examples were relevant to my context.					
v. The facilitators were well-prepared.					

11. Please share other comments, thoughts, or ideas about the workshop:

THANK YOU FOR YOUR FEEDBACK!

JOB AIDS

1. JOB AID | HIV-risk screening questionnaire

Have you recently had sex?

If “yes” ask the person the following questions

- Did you have condomless sex (i.e. did not use a condom)?
- Do you have sex with a partner/s who are HIV-positive?
- Have you had sex with a person whose HIV status you did not know?
- Do you have sex under the influence of alcohol and/or drugs?

Individuals who answer ‘Yes’ to any of these questions should be considered at high risk of exposure to HIV and should be offered:

- PrEP, if HIV negative
- Combination prevention options, including adequate supply of condoms and lubricant

○

11. JOB AID | STI-risk screening questionnaire



health

Department:
Health

REPUBLIC OF SOUTH AFRICA

YES

SCREENING FOR sexually transmitted infections (STIs)

- All patients between the ages of 15 and 49 should be screened for STIs regardless of clinical presentation

Ask the following three questions:

Do you have any genital discharge?

YES

NO

Do you have any genital ulcers?

NO

YES

NO

- Has/have your partner/s been treated for an STI in the last eight weeks?

If patient answers “yes” to any of the three, refer to the clinician/health professional for further investigation and management according to the National STI Management Guidelines.

NB: GENERAL MEASURES ON STI PREVENTION AND TREATMENT ADHERENCE

- Counselling and education, including HIV testing
- Condom promotion, provision and demonstration to reduce the risk of STIs
- Compliance/adherence to treatment
- Contact treatment/partner notification
- Circumcision
- Contraception and conception counselling

12. JOB AID | TB-risk screening questionnaire

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Client details

Name		Gender		
Surname				
Address				
Referral clinic/ hospital		Client age		
Client contact details				

TB screening questions

Do you have a cough (24 hours or more)?	Yes	No			
Do you have fever?	Yes	No			
Do you sweat a lot at night?	Yes	No			
Do you have weight loss?	Yes	No			
Have you been in contact with a person with confirmed TB?	Yes	No			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">TB suspect?</td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> </tr> </table>	TB suspect?	Yes	No		
TB suspect?	Yes	No			
If "yes" to one of the above questions, refer for TB investigation.					

Name and surname:

Signature:

Date:.....

13. JOB AID | Brief mental health questionnaire

BMH questionnaire

Alcohol (Alcohol use disorders identification test (AUD-C))

1. How often have you had an alcoholic drink in the last year? A “drink” can be a bottle of beer, a glass of wine, a wine cooler, or one cocktail or shot of hard liquor (like whiskey, gin or vodka)

Never	Monthly or less	Two to four times a month	Two to four times per week	Four or more times per week	
0	1	2	3	4	
During the last year, on an average drinking day, how many alcoholic drinks did you typically drink?					

Do not drink	1-2 drinks	3-4 drinks	5-6 drinks	7-9 drinks	10 or more	
0	0	1	2	3	4	
How often in the last year have you had 6 or more drinks on one occasion?						

Never	Monthly or less	Monthly	Weekly	Daily or almost daily	
0	1	2	3	4	
TOTAL SCORE: (add the number for each question to get your total score)					

Scoring: A cut off score of ≥ 4 is screen positive

Depression (The patient health questionnaire – PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	1-7 days	8-11 days	12-14 days	
				days		
1	Little interest or pleasure in doing things	0	1	2	3	
2	Feeling down, depressed, or hopeless	0	1	2	3	
TOTAL SCORE: (add the number for each question to get your total score)						

Scoring: A cut off score of ≥ 3 is screen positive

Anxiety (Generalised anxiety disorder GAD-2)

Over the past two weeks, how often have you been bothered by any of the following problems?

		Not at all	1-7 days	8-11 days	12-14 days	
				days		
1	Feeling nervous, anxious or on edge	0	1	2	3	
2	Not being able to stop or control worrying	0	1	2	3	
TOTAL SCORE: (add the number for each question to get your total score)						

Scoring: A cut off score of ≥ 3 is screen positive

In all instances, screen positive means that the person has symptoms of the disorder and not necessarily the disorder itself

BMH Scoring (Bhana et al., 2019)

The seven-item BMH screening tool comprises internationally validated tools: Alcohol Use Disorders Identification Test (AUD-C), Patient Health Questionnaire (PHQ-2) and Generalised Anxiety Disorder (GAD-2) measures.

AUD-C

The AUD-C comprises the first three items of the 10-item AUDIT, which asks about frequency of drinking alcohol, number of alcoholic drinks and binge drinking. The AUD-C is recommended as a simple and reliable tool for routine assessment of risky drinking and screening for alcohol use disorders. The AUDIT was previously validated for use in South Africa using trained nurses as a gold standard using the same cut-off points.

A score ≥ 4 for is considered as screening positive for alcohol misuse.

PHQ-2

The PHQ-2 is a two-item, self-report questionnaire in which participants are asked to rate how often they felt little interest or pleasure in doing things, and how often they felt down, depressed or hopeless over the past 2 weeks, as a screening measure for depression.

Original item responses of 0-3 (0 = not at all, 1 = several days, 2 = more than half the days, and 3 = nearly every day) were changed to 0 = not at all, 1 = 1-7 days, 2 = 8-11 days, and 3 = 12-14 days), based on a previous criterion validity study of the PHQ-9 among South African primary health care service users with chronic conditions.[31]

A score of ≥ 3 would be considered as screening positive for depression on the PHQ-2.

GAD-2

The scale comprising the first two items of the GAD-7 scale is recommended for screening for anxiety disorders in clinical practice, with further follow-up for those who screen positive. The GAD-2 has been used in screening for detecting antenatal depression and anxiety disorders in South African women and is recommended for screening in primary care settings in the NICE guidelines (Kendrick and Pilling, 2012).

A score of ≥ 3 is considered as screening positive for anxiety on the GAD-2.

Sources:

Bhana, A. et al. (2019) 'Validation of a brief mental health screening tool for common mental disorders in primary health care', *South African Medical Journal*, 109(4), p. 278. doi: 10.7196/SAMJ.2019.v109i4.13664.

Desmond Tutu HIV Foundation (2013) *Health care provision for men who have sex with men, sex workers and people who inject drugs*. Cape Town: DTHF. Available at: <http://www.desmondtutuhivfoundation.org.za>.

Kendrick, T. and Pilling, S. (2012) 'Common mental health disorders - Identification and pathways to care: NICE clinical guideline', *British Journal of General Practice*, 62(594), pp. 47-49. doi: 10.3399/bjgp12X616481.

LINKAGES (2013) *Training health workers for the provision of quality, stigma-free HIV services for key populations*. Available at: <https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-h4all-2018.pdf>.

SA Partners (2017) *Sensitisation training for the Department of Correctional Services: Participant manual*. Johannesburg. Available at: www.sapartners.org.

South African Police Services and COC Netherlands (2017) 'Dignity, Diversity and Policing'. Amsterdam: COC. Available at: https://international.coc.nl/wp-content/uploads/2018/12/LL-48-October-2018_Original.pdf.

14. JOB AID | Key populations

WHO recommended services for all key populations (1)



Sexual and reproductive health interventions

Behavioural interventions

HIV

testing and counselling

Harm reduction interventions for substance use (syringe programmes, opioid substitution therapy)

Prevention and management of co-infections and other co-morbidities (e.g. viral hepatitis, TB, and mental health conditions)

Comprehensive condom and lubricant programming

HIV

treatment and care

15. JOB AID | Key populations

WHO recommended services for all key populations (2)

**Addressing stigma and
discrimination**

**Addressing violence
against people from
key populations**

**Supportive legislation,
policy and financial com-
mitment, including decrim-
inalisation of behaviours of
key populations (e.g. viral
hepatitis, TB, and mental
health conditions)**

**Community em-
powerment**



16. JOB AID | Stigma and discrimination

Key populations refers to groups of people most at risk of HIV, TB and STIs (and related rights violations). Members of key population groups often face additional barriers to realising their rights and accessing services through punitive laws and discriminatory policies, increasing their risks of HIV exposure and transmission.

Stigma refers to negative beliefs, attitudes and feelings towards people based on characteristics seen as 'different' from those thought to be 'acceptable', e.g., sex work and drug use. These views are often supported by prevailing stereotypes and prejudices.

Discrimination refers to negative behaviour or actions that are directly linked to stigmatising beliefs, attitudes and feelings. Stigma and discrimination in health-care settings harm people, violate their rights and undermine health efforts.

Discrimination in healthcare might look like:

- Humiliation
- Verbal and emotional abuse (laughed at, shouted at, called names)
- Involuntary treatment
- Breaches of confidentiality
- Lack of free and informed consent
- Denial of services

Examples of discrimination might look like:

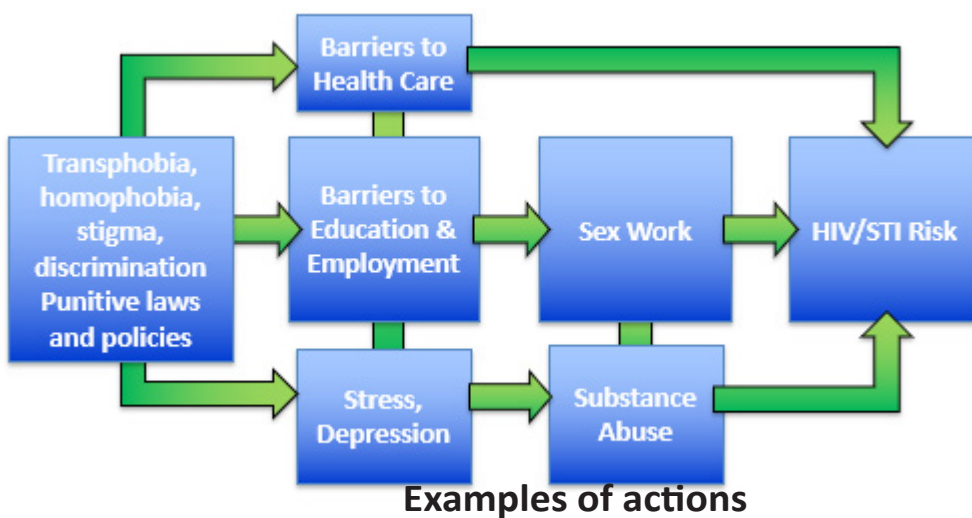
- A transgender man going to the clinic for reproductive healthcare (e.g., Pap smear) is ridiculed by nurses, denied services and told that these services are only available for 'real women'.
- A woman using drugs goes to the clinic for contraceptives and is told that she should use Depo-Provera (i.e., injection), since she cannot be trusted to take a pill every day due to her drug habit.
- A sex worker is denied services at a clinic and told by the nurse that this clinic is not for people 'like you'.
- A transgender woman is publicly laughed at and humiliated because she is called by her name in the ID document (i.e., Mr).
- A gay man going to the clinic for STI treatment is called names and insulted for presenting with anal STIs.
- A transgender sex worker going to the clinic for condoms is told that she has to undergo an HIV test before she can access condoms (i.e., coercive practices).

Biological	Social and Cultural (Non-Biological)	Behavioral
<ul style="list-style-type: none"> Anatomy STIs Acute HIV infection <ul style="list-style-type: none"> (e.g. newly/recently infected) 	<ul style="list-style-type: none"> Stigma, discrimination Policy/legal issues Poverty and economic hardship Violence Power imbalance Family and social support Etc. 	<ul style="list-style-type: none"> Condom use Contraceptive Use Substance use and abuse Etc.

Deter-

minants of Health affecting HIV vulnerability

Vulnerability to HIV in the context of sex work (example)



Intersectionality

- Many key population groups overlap, and you can never assume to know the full story of what is happening in a client's life by appearances. Key population groups are simply not mutually exclusive. Examples:
 - Some men who have sex with men and transgender people are more likely to also be homeless due to stigma and discrimination
 - People (women and men who have sex with men, transgender women, and/or homeless people of all ages) may also be engaging in sex work
 - People in any of these groups may engage in drug use
- Young people (10 to 24 years) who fall into key population groups also experience increased vulnerability to HIV.

Tips for healthcare workers to participate in the human rights response

- Equal treatment and access to healthcare for all, irrespective of who the person is
- Work closely with representatives of key population groups and organisations to enhance service access

- Non-judgemental, non-coercive, non-discriminatory, respectful and dignified treatment for all clients
- Cultivate awareness around and question your own biases

17. JOB AID | External and internal stigma

External and internal stigma

EXTERNAL

STIGMA

- Name calling
- Labelling
- Gossiping
- Making assumptions

Morally judging

Rejecting

Excluding

Denying service

Discrimination

Prejudice

Physical violence, rape, murder

Causes

Lack of knowledge or understanding

Lack of information

Ignorance

Religious beliefs

Cultural beliefs

Perceived difference

Fear

Society norms and expectations

Competition for resources

- Withdrawal
- Loneliness
- Low self-worth
- Substance abuse

- Self-hatred
- Isolation
- Sadness
- Anger

- Hopelessness
- Lack of services
- Depression, suicidal thoughts, PTSD

INTERNAL

STIGMA

Effects

18. JOB AID | Men who have sex with men: Screening – 1

Offer everyone testing, irrespective of their reason for attending.

- ☐ Screening should be done in a secure, private area to ensure confidentiality.
- ☐ Screening is done as stipulated by the South African Department of Health.
- ☐ A register of tests must be completed.
- ☐ A register of bloods drawn and submitted to the lab must be completed.
- ☐ Test kit instructions must be readily available and adhered to.
- ☐ Universal precautions for handling of sharps and infectious waste products must be followed.

<p>ADVISE</p> <ul style="list-style-type: none"> » Benefits of testing » What a rapid HIV test result means » Stress confidentiality » Stress expertise in managing positive results 	<p>CONSENT</p> <ul style="list-style-type: none"> » Signed consent is required for medico-legal reasons » All state clients need to sign the DOH HIV Screening form
<p>TESTING PROCEDURE</p> <ul style="list-style-type: none"> » Finger prick blood if only screening HIV » Ante-cubital phlebotomy if performing HIV confirmatory testing, CD4 count or VDRL 	<p>SUPPORT</p> <ul style="list-style-type: none"> » Counselling and follow-up for all clients according to test results » Condoms, lube, education material for all clients

Step 1: Perform first HIV rapid test

<p>Step 1: RAPID 1 POSITIVE</p> <ul style="list-style-type: none"> » Explain result » Perform step 3 	<p>Step 2: RAPID 1 NEGATIVE</p> <ul style="list-style-type: none"> » Explain window period and assess need for retest » Strategies for remaining negative » Re-book for repeat screening 8 weeks if window period » 3-5 months if high risk behaviours » 6-12 months if low risk behaviours 	<p>Step 2: RAPID 1 UNCERTAIN</p> <ul style="list-style-type: none"> » Explain result » Blood for lab ELISA Gen 4 » Refer to next level of care » ASAP
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Step 3: Perform second HIV rapid test

Step 4: TEST 2 POSITIVE <ul style="list-style-type: none">» Counselling and support» Send CD4 count» Refer for HIV/ARV care	Step 4: TEST 2 NEGATIVE/ UN-CERTAIN <ul style="list-style-type: none">» Explain result» Blood for lab ELISA Gen 4» Refer to physician/HIV specialist
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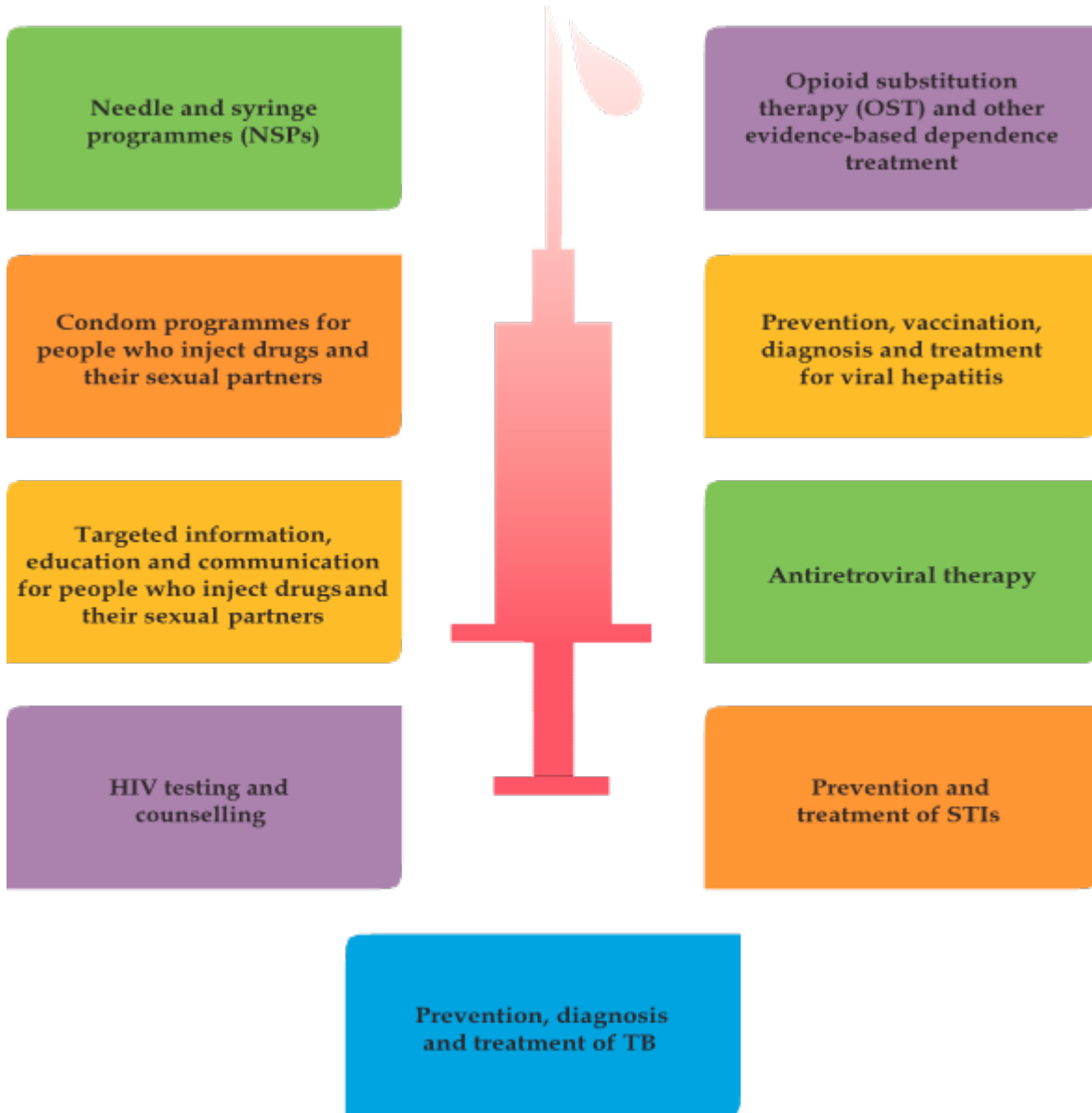
19. JOB AID | Men who have sex with men: Screening – 2

Summary of screening interventions for gay men and other men who have sex with men

SCREENING INTERVENTIONS FOR GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN		
Screening	Reason for screening men who have sex with men	Benefits of screening
HIV	Higher risk among men who have sex with men	Inform healthcare decisions and management; prevention
Viral hepatitis	Sexual transmission among men who have sex with men	Susceptible individuals to be vaccinated against hepatitis A and B; infected individuals can receive treatment
Syphilis	Increasing rates worldwide	Identifies asymptomatic disease; treatment; contact tracing
Anal exam for HPV	Anal HPV occurs anally in men who have sex with men	Treatment; prevention counselling; monitoring to lower the risk of undiagnosed anal carcinomas. Exclusion of other anal diseases such as haemorrhoids and fissures
Testicular examination	Most common cancer among young men	Early detection of testicular mass simplifies treatment and improves outcome
Prostate	Prostate cancer common in men older than 45 years	Early detection simplifies treatment, improves outcome
Mental health	Depression, anxiety, and alcohol and recreational drug use are common	Can be managed to improve ART adherence; drug interactions can be anticipated and/or avoided

20. JOB AID | People who inject drugs

Comprehensive harm reduction package for people who inject drugs³⁵



21. JOB AIDS | People who inject drugs

Signs and symptoms of opioid intoxication

Euphoria, profound relief from anxiety and tension, followed by apathy

Slurred speech

Initial, mild, brief increased energy, followed by [slowing down]

Hypoactive bowels, constipation

Impaired judgement, concentration, memory

Difficulty with passing urine

“Nodding” – state between arousal and sleep

Dry mouth

Slow respiration, decreased coughing, risk of respiratory depression

Dulling of pain

Nausea and vomiting

Sweating, warm flushing of the skin, itching

Large doses of heroin may result in potentially lethal overdose

Convulsions (rarely)

22. JOB AIDS | People who inject drugs

Signs and symptoms of opioid withdrawal

SYMPTOMS**SIGNS**

Looks like a 'flu-like' illness

Diarrhoea

Anxiety

Increased pulse

Abdominal cramps

Increased blood pressure

Irritability, generalised dissatisfaction with life
Craving

Tears in eyes

Vomiting

Fatigue

Muscle spasms

Hot and cold flushes

Dilated pupils

Muscle aches

Runny nose

Restlessness

Gooseflesh

Nausea, sweating

23. JOB AIDS | People who inject drugs

OST: Advantages for the client

Visit a healthcare professional rather than an illicit drug dealer

Change identity from person dependent on opioids to client



Move away from black market opioids

Variable purity

Improve functioning and
well-being

Expensive

Reduce harm from
illicit drug use

From an un-
certain supply

Stabilise lifestyle

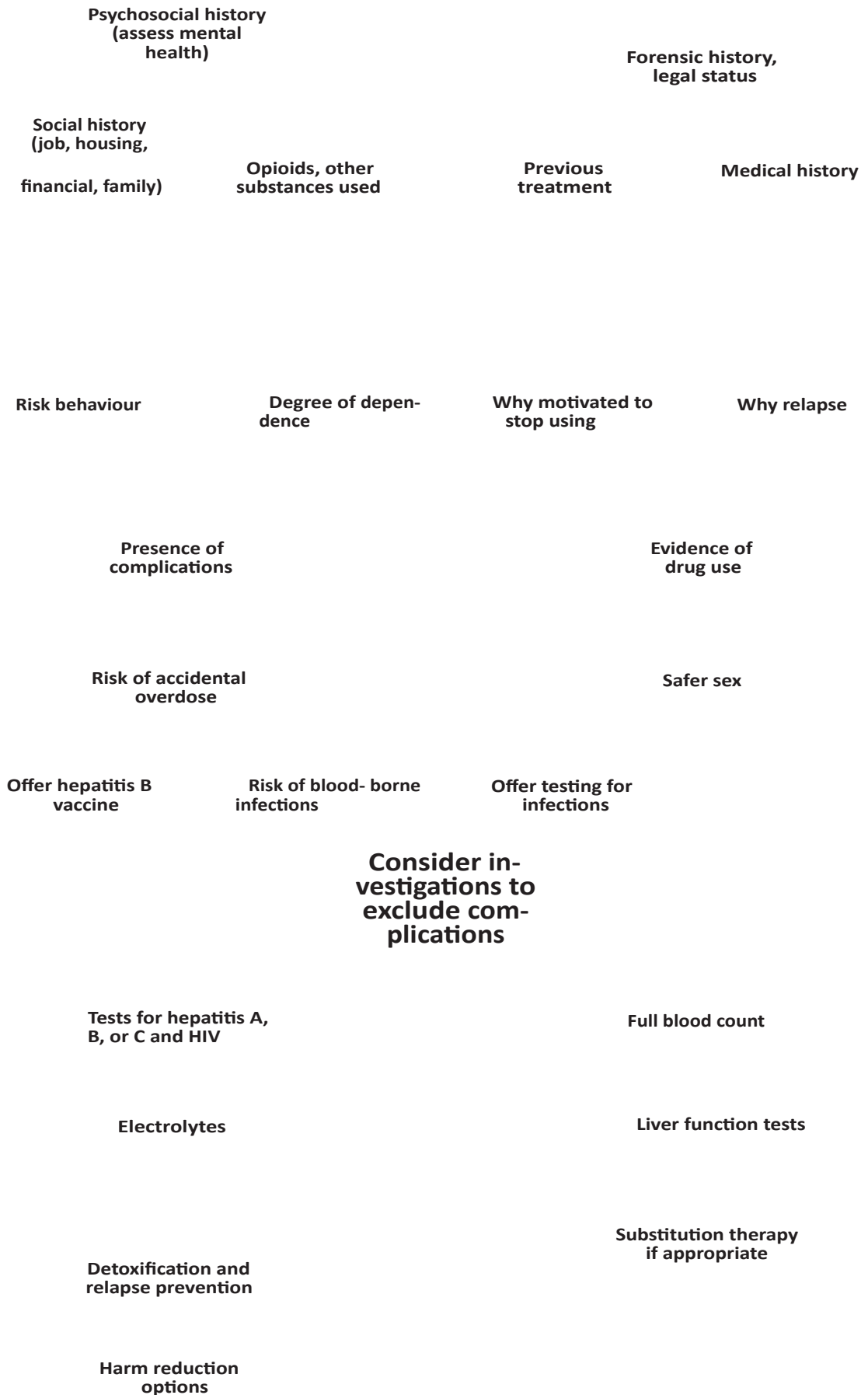
Illegal - risk of
arrest

Develop insight

Potential contam-
inants

24. JOB AID | People who inject drugs

Assessment of people who use opioids



25. JOB AIDS | People who inject drugs

Interventions specifically for people who inject drugs

26. 

**Immediate im-
plementation of
needle**

**and syringe
programmes**

**Immediate im-
plementation of
opioid substitu-
tion therapy**

JOB AIDS | People who inject drugs

Benefits of opioid substitution therapy (OST)^{24, 25, 26, 27}

The benefits of OST are far reaching and have been demonstrated in a variety of low-, middle- and high-income countries. It is estimated that 130 000 new HIV infections outside of sub-Saharan Africa could be prevented every year if access to OST was sufficient.

Alongside its effectiveness in reducing HIV infection, OST has also been shown to decrease hepatitis C infection, increase adherence to HIV treatment and reduce accidental opioid overdose. Many people who inject drugs first make contact with healthcare through OST programmes and then go on to access other services. OST has also been found to reduce the risk of HIV transmission between pregnant women who inject drugs and their infants.

Because it frees people of the need to regularly obtain and pay for an ongoing supply of drugs, OST can also ease financial and other stresses on individuals and their families. For this reason, it has been associated with a decrease in crimes committed by people who inject drugs. It has also helped to strengthen the ability of people who inject drugs to get more involved in the HIV response, resulting in better, community-led HIV and harm reduction programming.

The benefits of OST are particularly felt when OST programmes are supported by structural changes, such as a shift away from punitive drug policies and laws towards public health.

- What are we trying to achieve with OST?
- Keep people alive (reduce deaths)
- Enable people who use heroin to reintegrate into the society
- Reduce high risk behaviour, and risk of HIV and hepatitis C (HCV) infection and transmission
- Improve physical and mental health

Reduce criminality

What are the benefits of OST?

- General
- Reduces the transmission of HIV
- OST has been shown to reduce hepatitis C infection
- Increases adherence to HIV treatment
- Decreases accidental opioid overdose

OST has also been found to reduce the risk of HIV transmission between pregnant women who inject drugs and their infants

- Benefits for clients
- Possibly stabilised lifestyle and improved social functioning. OST enables people who use drugs to better adhere to treatment of other illnesses, e.g. HIV-, HCV- or treatment of mental disorders.
- Increased access to social and psychological support
- Reduced accidental overdose-related deaths
- Enables clients to reduce or stop using substances
- Improved physical and mental health

Reduced risks of HIV and hepatitis

- Benefits for the community
- Reduction in criminal activities of the client: no need to find money for drugs
- Reduced risks of blood-borne infections for the society in general – hepatitis B, HCV, HIV – as the clients reduce or avoid injecting practices. This implies massively reduced treatment needs and costs in the future.

Reduced levels of promiscuity and sex work among people who inject drugs

27.

JOB AIDS | Transgender people

Skills for working with transgender clients

Key points

-
- Providing a safe and welcoming environment for transgender clients will encourage transgender and gender non-conforming people to stay engaged in HIV prevention, care, and treatment services.
- Many transgender people have a history of avoiding or delaying healthcare out of fear that they will be denied services, treated poorly while at the health facility (by staff or other clients), or discriminated against.
- Remember some transgender people access hormone therapy and surgery as part of their transition, and some transgender people do not use hormone therapy or undergo surgical intervention. Medical or surgical status does not determine whether a person is transgender. Transgender people do not need to undergo gender-affirming surgery and/or hormone therapy. Many people choose non-medical means to express their gender. The availability and accessibility of hormone therapy and surgical gender affirmation services is currently limited in South Africa.

Above all, do not make assumptions about a client's gender identity, beliefs, or sexual orientation. Remember that sexual behaviour does not necessarily reflect the person's gender identity.

Intake, history, and risk assessment

- - When working with transgender clients it is important to remember to always:
 - Ask the client if they have a preferred name and pronoun.
- The client's preferred name will often be different than their legal name.
- Use the pronouns that the client prefers (i.e., many transgender women prefer "she" even if their legal documents designate their sex as male). Pronouns might be she, he, or they.
- Do not assume the client's preference – always ask.
- Focus on unsafe behaviours rather than sexual orientation. Transgender people may have sex with men, women, other transgender people, or any combination of the above – ask about consistent condom use rather than sexual practices.
 - Use terms that the client will understand and be comfortable with. Ask clients how they would like you to refer to their body parts.

Note that some transgender people are uncomfortable with medical terms for their body parts (i.e., a transgender woman may be uncomfortable with references to her penis, a transgender man may be uncomfortable with the term vagina, etc.)

Health concerns and screening recommendations

□

- Note: Treat transgender clients like you would treat any other client. Do not insist on examining parts of a transgender person's anatomy unless this is relevant to the reason for the visit.
- Because surgical status may vary among transgender people, it is helpful to ask each transgender client to determine the organs and anatomy present, if this knowledge is relevant to the consultation.
- Providers should remain sensitive to language and terminology, following the client's lead to use terms that are comfortable for them. The basic recommendation for clients is: "If you have it, check it". Providers should follow biological guidelines for screenings.
- If a client is uncomfortable having a full physical examination and there is no medical urgency for a physical examination, postpone the consultation until there is need for an examination.

A respectful way to check in with transgender clients about gender transition, hormone therapy, and/or body modification is to ask: "Where are you in the transition process currently, and what are your plans for the future?"

Hormone therapy

-
- The objective of hormone therapy is to help a transgender person affirm their gender by creating secondary sex characteristics that better align with their sense of self/gender identity.
- Hormone therapy can reduce the effect of gender dysphoria (distress, often clinically significant, that is caused when a person's gender identity is not aligned with the sex they were assigned at birth), thereby reducing the likelihood of depression, anxiety, self-harm, and long-term morbidity and mortality for transgender people.
- Ask all transgender clients if they are using any hormone therapy, with or without a prescription. And what kind.
 - Providers should be aware that many clients may prioritise hormone therapy over other medical care, including HIV-related care and treatment.
- Some transgender clients may order hormones online. Some transgender women may use hormonal contraceptives for gender affirmation.

Offering hormone therapy can enable providers to reduce health risks for transgender clients, keep transgender clients engaged in care, and offer opportunities for health education.

28.

JOB AID | People in prisons and other closed settings

Interventions specifically for people in prisons and other closed settings



Distribution of
toothbrushes
and gloves

Prevention of
HIV transmission
through medical
and dental services

Adequate

Protecting staff
from occupational
hazards

Inmate visit

Prevention of trans-
mission of HIV and
other blood-borne
diseases through
tattooing, piercing and
other forms of skin
penetration

through state
release for
terminal cases

Palliative care

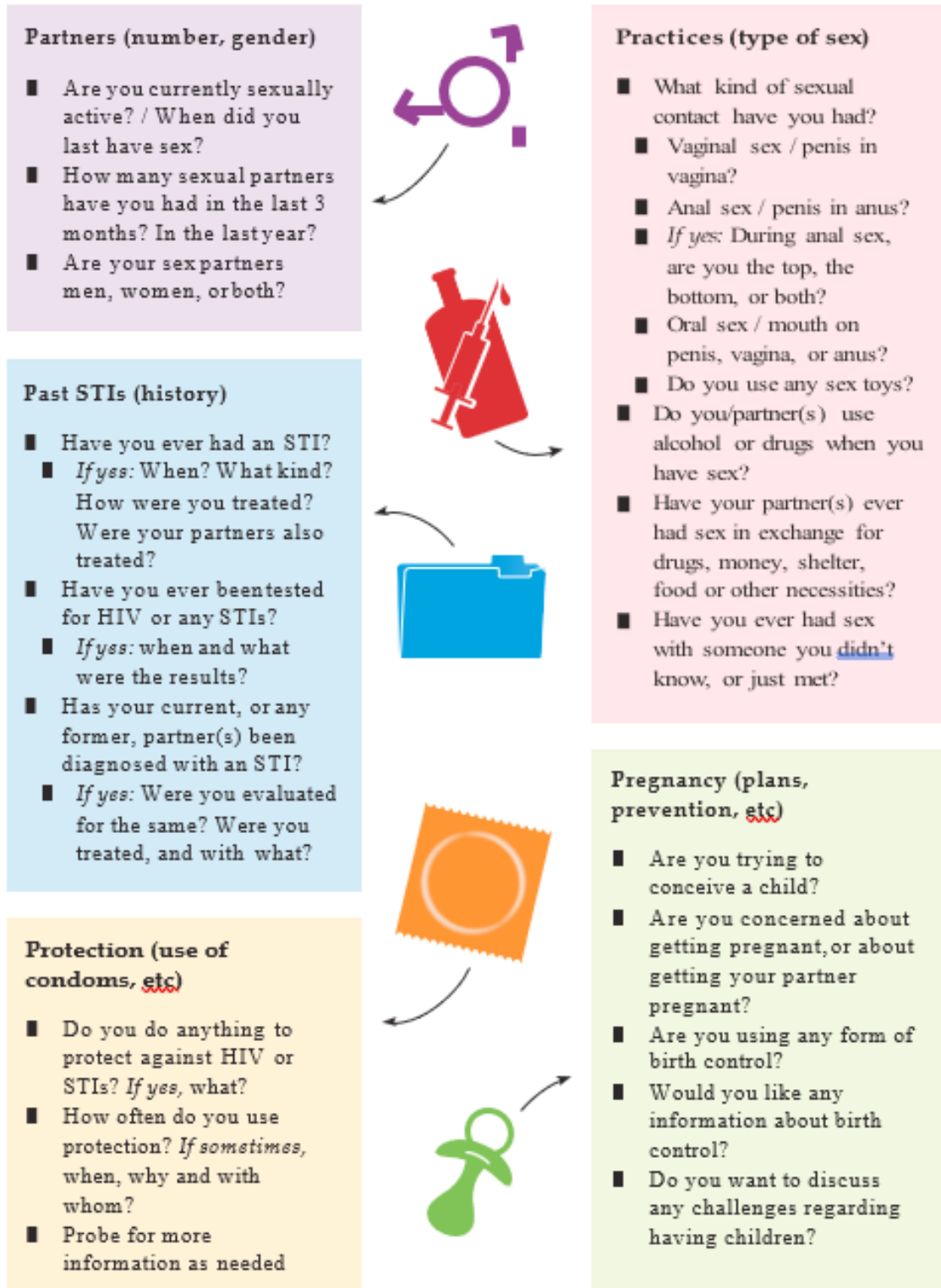
29. JOB AID | HIV testing services (HTS)

HTS using rapid antibody test



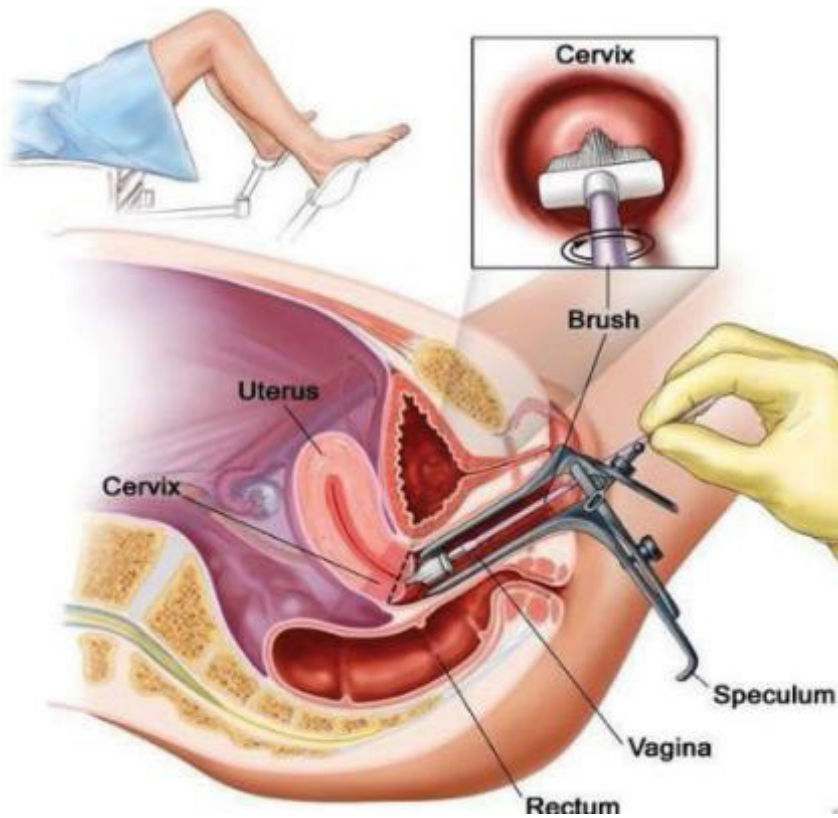
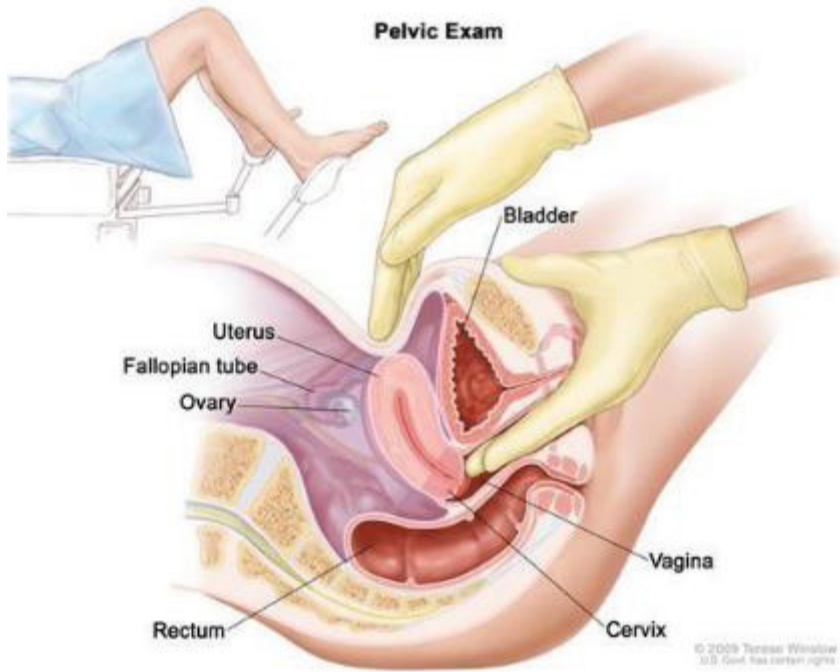
30. JOB AID | Sexual history taking

Sexual history taking: The 5 Ps



31. JOB AID | Female pelvic exam

Female pelvic exam



Speculum exam and Pap

smear

Looking for:

Ulcerative genital disease including classic and atypical HSV

Presence of abnormal vaginal/cervical or urethral discharge (gonorrhoea, chlamydia, trichomoniasis)

Visible anal and perineal lesions

Rash

Presence of inguinal lymphadenopathy (swollen lymph nodes in groin)

Bimanual pelvic exam

Inspect outside of vagina

Lubricate fingers and insert into vagina for bimanual exam

Palpate vaginal walls, cervix, uterus, and ovaries

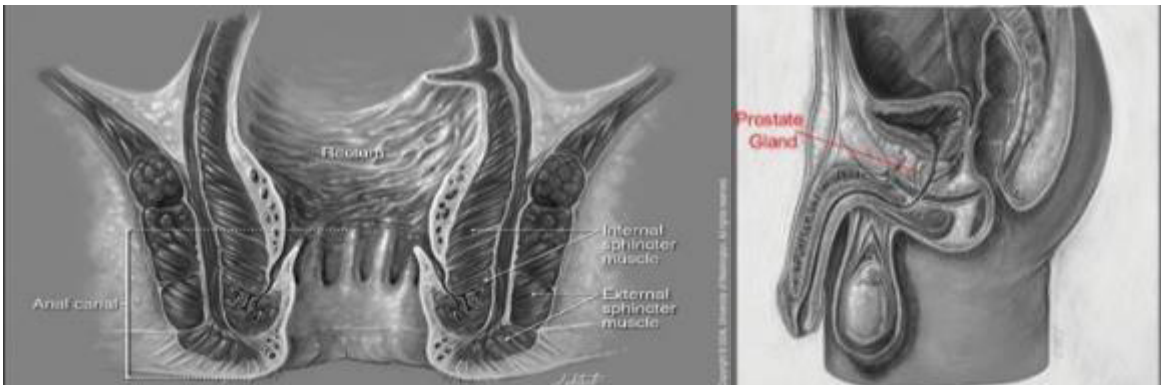
Warm and lubricate speculum and insert into vagina

Visualise cervix

Collects all swabs needed

Note: women may also require digital rectal exam and/or anoscopy.

32. JOB AID | Digital rectal examination



Ensure client is comfortable

Use plenty of water-based lubricant

Use slow circular motions as you advance

Valsalva manoeuvre will relax anal sphincters

If client shows no discomfort, slowly advance your middle finger in the anus as far as possible

Can take up to 1 minute

Gauge their comfort

Palpate the prostate

Note shape, consistency, regularity, and any tenderness

Prostate examination should be performed in all men over 60

Examine for symptoms of urinary obstruction (e.g. prostatitis, benign prostate hypertrophy)

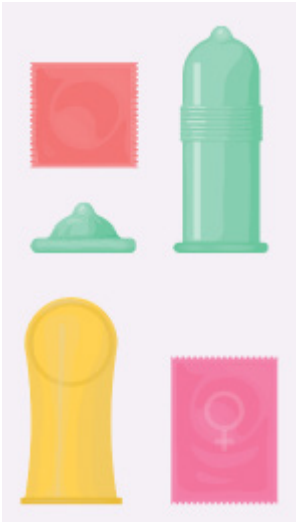
Slowly withdraw your finger

Make note of any blood on examination finger

Perform testing on stool and rectal specimens if indicated




33. JOB AID | Contraceptive methods – 1





Contraceptive methods (1 of 3)

Method	Key factors
<p>Male condom</p>	<p>85-98% Effective as contraceptive method when used consistently and correctly</p> <p>Overall 80% effective in preventing HIV and other STIs</p> <p>Does not affect breastfeeding or interact with medications</p> <p>Must counsel regarding correct use</p> <p>Promote and provide access to emergency contraception</p> <p><i>Condom use should always be encouraged as dual method use to maximise HIV and pregnancy protection</i></p>
<p>Female condom</p>	


<p>Low-dose combined oral contraceptives (COCs)</p> 	<p>Low-dose COCs are those with ≤ 35 μg synthetic oestrogen ethinyl estradiol</p> <p>92-99.7% effective as contraceptive, primarily by preventing ovulation</p> <p>Measure blood pressure prior to initiation, when possible</p> <p>May initiate at any time, if not pregnant or breastfeeding. No restrictions on use from menarche to age</p> <p>40. After age 40 generally can use, but more careful follow-up may be required</p> <p>If breastfeeding, initiate after stops or at 6 months postpartum or after she stops breastfeeding – whichever comes first</p> <p>Drug interactions, including with some antiretrovirals <i>Note: All women on COCs $\geq 35\mu\text{g}$ ethinyl estradiol should be switched to low dose COC</i></p>
<p>Progestin-only pills (POPs)</p>	<p>POPs are appropriate for breastfeeding women and are a useful alternative for women who experience oestrogen-related side effects with COCs, or have health conditions that may preclude safe use</p> <p>of COCs.</p> <p>As commonly used, 90-92% effective; $\approx 99\%$ effective if breastfeeding</p> <p>Primarily thickens cervical mucus and so prevents sperm penetration (after 2 days of use). Also inhibits ovulation in 60% of cycles.</p>

34. JOB AID| Contraceptive methods – 2



Method	Key factors
<p>Progestin-only injectables (DMPA and NET-EN)</p>	<p>Injectables: 94% effective as commonly used; if return for re-injection on time 99.7% effective as contraceptive</p> <p>Concerns regarding bone mineral density in women</p> <p>< 18 years and > 45 years</p> <p>Not protective against STIs, including HIV. Recent studies suggest they may increase the risk of HIV acquisition (specifically DMPA). While awaiting additional research, emphasise importance and proper condom use in conjunction with hormonal and non-hormonal contraceptives to prevent HIV.</p> <p>Alternatives, such as lower dose hormonal contraceptives, and non-hormonal options, such as Cu IUDs, need to be explored with the client. Weigh risk of possible HIV against benefits in preventing pregnancy.</p> <p>Implants: Almost 100% effective, remain in place for 3-5 years</p> <p>Not protective against STIs and HIV</p>
<p>Implant</p>	<p>Highly effective, long-acting and reversible method Approved for use up to 10 years (copper)</p> <p>99.2-99.4% effective No age restrictions</p> <p>Does not affect breastfeeding, intercourse or have hormonal side effects</p> <p>Do not protect against STIs, including HIV and dual method with consistent condom use should be recommended</p>
<p>Intrauterine contraception non-hormonal (Copper □ CuIUD)</p> 	<p>Releases a constant, small amount of progestogen directly into the uterine cavity.</p> <p>Failure rate of 0.2% and continuation rate of 80% at one year, as effective as male and more effective than female sterilisation</p> <p>Thickens cervical mucous and suppresses endometrial development</p> <p>This method is currently only available to clients in private sector and some secondary/tertiary Institutions</p>
<p>Levonorgestrel releasing intrauterine system (LNG-IUS, Mirena)</p> 	

35. JOB AID | Contraceptive methods – 3

Method	Key factors
<p>Emergency contraception pills (ECP)</p>	<p>Use at any time during menstrual cycle within 5 days (120 hours) following condomless intercourse</p> <p>ECPs – POPs 58-95% effective, COCs 31-77% effective (effectiveness depends on how soon initiated following condomless intercourse)</p> <p>Cu IUD – fails in only < 0.1% of cases. Insert under antibiotic cover (to prevent STIs) and remove during the next menstrual period</p> <p>*Risk of infection is higher than risk for pregnancy. Screen for STIs and consider post-exposure prophylaxis for HIV</p>
<p>Sterilisation</p> 	<p>Should not be coerced or performed without consent Permanent contraceptive methods</p> <p>Female sterilisation – 99.5-99.8% effective year one, 98.2% over 10 years.</p> <p>Male sterilisation (vasectomy) – 99.8% effective (use back-up method for 3 months following as may continue to have ejaculate for 3 months)</p>
<p>Lactational amenorrhoea method</p>	<p>Breastfeeding as temporary method of contraception, 98-99% effective if amenorrhoeic and fully breastfeeding during first 6 months after childbirth</p>
<p>Fertility awareness-based methods</p>	<p>Based on identification of natural signs and symptoms of fertile and infertile phases of menstrual cycle. Requires abstinence or condom use during the fertile phase of each cycle.</p> <p>Depends on a woman's ability to identify her fertile window, as well as both partners' motivation and discipline to practise abstinence (or use condoms) when required. 95-97% effective during first year of consistent and correct use but only 75% effective as commonly used</p>
<p>Withdrawal method</p>	<p>Withdrawing penis from vagina and external genitalia prior to ejaculation 73% during first year, 96% if consistent and correctly used</p>

36. JOB AID | STI treatment guidelines – 1

SEXUALLY TRANSMITTED INFECTIONS (STIS) – TREATMENT GUIDELINES^{28, 29, 30, 31, 32}

Diagnosis	Recommended treatment	Special considerations for gay men and other men who have sex with men
Gonorrhoea	Ceftriaxone 250mg intra-muscular injection (IMI) stat Always add empiric treatment for gonorrhoea	Anal pain or discharge may indicate anal gonorrhoea; non-resolving URTI should prompt consideration of a pharyngeal STI
Chlamydia	Azithromycin 1g per os (PO) stat Always add empiric treatment for chlamydia	As for gonorrhoea; many cases of anal chlamydia are clinically silent
Syphilis		Syphilitic chancres are usually painless, may go unnoticed and therefore untreated – especially for anal syphilis, where the chancre could be internal. Regular (yearly) screening of asymptomatic sexually active men who have sex with men is recommended.
Primary syphilis	Benzathine penicillin 2.4mu IMI stat X1	
Secondary syphilis	Benzathine penicillin 2.4mu IMI stat X3	
Latent syphilis	Benzathine penicillin 2.4mu IMI stat weekly for three weeks <i>Doxycycline 100mg 12 hourly for 14–28 days for penicillin-allergic clients</i>	

SEXUALLY TRANSMITTED INFECTIONS (STIS) – TREATMENT GUIDELINES

Diagnosis	Recommended treatment	Special considerations for gay men and other men who have sex with men
Neurosyphilis	<p>Penicillin G 5mu intravenous injection (IVI) for 14 days</p> <p>AND</p> <p>Follow with benzathine penicillin 2.4mu IMI weekly for three weeks</p> <p>OR</p> <p>Procaine penicillin 2.4mu IMI daily AND probenecid 500mg 6 hourly for 14 days</p> <p>AND</p> <p>Follow with benzathine penicillin 2.4mu IMI weekly for three weeks</p> <p>Refer penicillin allergic clients with neurosyphilis to a specialist</p>	<p>Consider and refer all men who have sex with men with a positive blood syphilis serology and neurological deficits</p>
Lymphogranuloma venereum (LGV)	<p>Doxycycline 100mg 12 hourly for 14 days</p> <p>OR</p> <p>Erythromycin 500mg 6 hourly for 14 days§</p>	<p>Supposedly more common among men who have sex with men but unclear if this is true for South Africa</p>
Human papilloma virus (HPV)	<p>Topical therapy including cryotherapy, podophylin, acetic acid or imiquimod Large fungating warts or internal anal or urethral lesions should be referred for surgical excision</p>	<p>Men who have sex with men need anal examination to diagnose warts. Men who have sex with men have an elevated risk of anal cancer especially if they have had anal warts. Warts are easily transferred</p> <p>during anal sex. Counseling is required.</p>

SEXUALLY TRANSMITTED INFECTIONS (STIS) - TREATMENT GUIDELINES

Diagnosis	Recommended treatment	Special considerations for gay men and other men who have sex with men
Hepatitis A (Hep A)	Supportive therapy Notify and trace contacts	HA is usually a food-borne disease but becomes an STI among men who have sex with men
Hepatitis B (HBV)	Pegylated Interferon therapy if available AND Tenofovir 300mg daily AND Lamivudine 300mg daily	Sexually spread among men who have sex with men; all men who have sex with men should be screened and vaccinated. Men who have sex with men with ongoing potential exposure to HB should be vaccinated according to a condensed vaccine schedule.
Hepatitis C (HCV)	Pegylated interferon AND Ribavirin if available Refer to specialist	If HIV co-infected, avoid drugs that cause steatosis or hepatitis; treat early for HIV if co-infected and look for risk factor of IV recreational drug use.
Trichomonas	Metronidazole 2g PO stat	May be seen in men who have sex with men who also have female partners.

39. JOB AID | Hepatitis C (HCV) and HIV co-infection treatment guidelines

- ☐ HCV and HIV co-infection is common in the developed world
- ☐ Co-infection is uncommon in South Africa, but more cases are being seen at primary care clinics
- ☐ Spontaneous cure of HCV occurs in <30% of HIV positive clients
- ☐ High risk groups for HCV include drug users (especially intravenous) and men who have sex with men
- ☐ Co-infection leads to a risk of rapid liver fibrosis and progression to cirrhosis
- ☐ Treatment of HIV in co-infected cases markedly slows the progression of liver disease

Assessing HCV in HIV positive clients

- ☐ Screen for HCV if
 - Client with high risk factor profile e.g. intravenous drug use
 - Abnormal liver function tests (LFT) with negative HBV studies and no other explanation
- ☐ Hepatitis C IgG
 - Usually positive within 1-5 months after exposure, very rarely lost in advanced HIV
- ☐ Liver biopsy is not required to treat HCV
- ☐ LFTs should be monitored by checking serial alanine transaminase (ALT)
- ☐ Ideally, all HCV positive clients should be referred to an academic hospital for further assessment to include the following:
 - HCV viral RNA level
 - HCV genotype
 - Liver ultrasound / fibrosis assessment
 - Possibly liver biopsy

Treatment depends on availability of interferon alpha and ribavirin at academic hospitals or in the private sector. This treatment is very expensive and has profound psychiatric side effects and thus may not be available or suitable for all clients.

IFN not available

- ☐ Treat HIV early to retard liver cirrhosis
- ☐ Start ART in all clients irrespective of CD4 count
- ☐ Use tenofovir/lamivudine (or Truvada/efavirenz preferentially)
- ☐ Avoid medications known to cause hepatic steatosis

IFN available

- ☐ Refer all clients to academic hospital for assessment for interferon (IFN)
- ☐ Start ART in all clients with CD4<500/mm³
- ☐ Defer ART in clients with CD4>500/mm³ until decision is made regarding interferon. If IFN is not suitable, then start ART regardless of CD4 count
- ☐ IFN and treatment response to be monitored at tertiary hospital

ANTIRETROVIRAL DRUG	COMMENT	USE
D4T, DDI	May result in mitochondrial toxicity and hepatic steatosis or steatohepatitis which accelerates liver fibrosis/cirrhosis	Avoid
AZT	Less risk of hepatic steatosis Problematic shared drug side effects with IFN including anaemia and neutropenia	Use TDF if not available or contraindicated
TDF, 3TC	Considered safe No direct anti HCV activity (c.f. HBV)	Use preferentially if accessible Use if IFN available Use if HBV co-infected
Efavirenz	Considered safe	Use preferentially
Nevirapine	Increased risk of hepatitis	Use if no other safe choice
Aluvia® (lopinavir/ritonavir)	Risk of direct liver injury	Use if no other choice
Atazanavir	May cause jaundice but this does not reflect direct liver injury	Use if PI is indicated

Selecting clients for IFN

Clients who meet the following criteria are most likely to benefit from IFN:

- ☐ HCV genotype 2 or 3
- ☐ Absence of insulin resistance
- ☐ Acute HCV infection
- ☐ CD4 > 500/mm³ (Immune restoration should be commenced with ART in all clients with severe immunosuppression)
- ☐ Less cirrhosis and clinical liver disease

Monitor for INSULIN RESISTANCE as this is commonly associated with hepatitis.

New protease inhibitor medications, which are active against HCV are being investigated. These have shown some promise but are not yet available and are not yet considered as standard treatment.

40. JOB AID | STI medications – 1

Side effects, contraindications and client education for frequently used STI medications

Disclaimer: This list is not intended to be all-inclusive, but to provide the participant with frequently occurring side effects, contraindications and most common client education.

Please access other resources for a comprehensive list.

	Adverse reactions	Contraindications
Acyclovir	<p>Occasional: Nausea, Vomiting, Rash, Renal toxicity</p> <p>Rare: Dizziness, central nervous system (CNS): agitation, encephalopathy, lethargy, tremor, transient hemiparesis, disorientation, seizures, hallucinations, anaemia, neutropenia, transaminase elevations, pruritis, headache, hypotension</p>	<p>Hypersensitivity to drug, class or compound</p> <p>Caution with renal or hepatic impairment</p> <p>Caution if concurrent nephrotoxic agents</p>
Azithromycin	<p>Occasional: Nausea, vomiting, diarrhoea, abdominal pain, rash</p> <p>Rare: Hypersensitivity reactions including angioedema, anaphylaxis and dermatologic reactions including Stevens-Johnson syndrome and toxic epidermal necrolysis. Chest pain, anaemia and leukopenia, cholestatic jaundice, hepatotoxicity, prolongation of QT interval and cases of Torsades de Pointes have been reported.</p> <p>Clostridium difficile-associated diarrhoea.</p>	<p>Hypersensitivity to drug, class or compound contraindicated in clients with a history of cholestatic jaundice/hepatic dysfunction associated with prior use of azithromycin</p>

<p>Benzathine Penicillin</p>	<p>Occasional: Nausea, abdominal pain, vomiting, diarrhoea, rash, urticaria, fever, pain at injection site, dizziness, confusion, lethargy</p> <p>Rare: Anaphylaxis, hypersensitivity reaction, Stevens-Johnson syndrome, serum sickness-like reaction, Jarisch- Herxheimer reaction (syphilis), seizures, thrombocytopenia, neutropenia, hemolytic anaemia, nephrotoxicity, interstitial nephritis, pseudomembranous colitis, superinfection, neuropathy, neurovascular damage (IV)</p>	<p>Hypersensitivity to drug, class or compound (Penicillin allergy), IV administration</p> <p>Caution if non-anaphylactic hypersensitivity to beta-lactams</p> <p>Caution if renal impairment</p> <p>Caution if severe allergies Caution if severe asthma</p> <p>Caution if seizure disorder</p> <p>Caution in elderly clients</p>
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41. JOB AID | STI medications – 2

Drug	Adverse reactions	Contraindications
<p>Ceftriaxone</p>	<p>Occasional: Pseudo-cholelithiasis, minimal phlebitis at infusion site, allergic reactions: cross-allergy to penicillin lower than 1st generation cephalosporin, diarrhoea and</p> <p><i>C. difficile</i> colitis, Positive Coombs' test</p> <p>Rare: CNS: convulsions (high dose with renal failure), confusion, disorientation, and hallucinations, drug fever, neutropenia and thrombocytopenia, hepatitis, anaphylaxis reaction, haemolytic anaemia, cholecystitis, interstitial nephritis, calcium-ceftriaxone precipitates in the lungs and kidneys in both term and premature neonates (with calcium solution co-administration)</p>	<p>Hypersensitivity to drug, class or compound, Hyper- bilirubinaemia (neonates <28 days), IV Calcium containing products (neonates <28 days)</p> <p>Caution if hypersensitivity to penicillin</p> <p>Caution if seizure disorder</p> <p>Caution if hyperbilirubinemia</p> <p>Caution if concurrent nephrotoxic agents</p> <p>Caution if hepatic and renal impairment</p> <p>Caution if vitamin K deficiency</p> <p>Caution if GI disorder history</p>
<p>Clotrimazole</p>	<p>Occasional: Burning, itching, erythema, Nausea and vomiting (lozenge)</p> <p>Rare: Elevated transaminases</p>	<p>Hypersensitivity to drug class or compound</p> <p>Caution if hepatic impairment</p>
<p>Doxycycline</p>	<p>Occasional: Photosensitivity, GI intolerance (dose related)</p> <p>Rare: Candida overgrowth, worsening azotaemia if renal failure, rash, "black tongue", oesophageal irritation, elevated liver function tests, Jarisch-Herxheimer reaction, <i>C. difficile</i> associated colitis</p>	<p>Hypersensitivity to drug, class or compound</p> <p>Pregnancy</p> <p>Age < 8 years</p> <p>Avoid Sun</p> <p>Caution if renal or hepatic impairment</p> <p>Caution if systemic Lupus Erythematosus</p> <p>Caution in elderly clients</p> <p>Caution if candidiasis predisposition</p>
<p>Metronidazole</p>	<p>Common: GI intolerance, metallic taste, headache, dark urine</p> <p>Occasional: Peripheral neuropathy, phlebitis at injection sites, disulfiram-like reaction with alcohol, insomnia, stomatitis</p> <p>Rare: Seizures, encephalopathy, aseptic meningitis, optic neuropathy, dysarthria, Stevens-Johnson Syndrome</p>	<p>Hypersensitivity to drug, class or compound</p> <p>Pregnancy</p> <p>Caution if blood dyscrasia, severe hepatic impairment, CNS disorder</p>

42. JOB AID | Useful terms ^{33,34}

Adolescents	People aged 10 to 19 years.
Anal sex	Sex which usually involves the insertion of the penis into the anus (penile-anal penetrative sex).
Assigned sex	The sex one is labelled at birth, generally by a medical or birthing professional, based on a cursory examination of external and/or physical sex characteristics such as genitalia. Also known as <i>designated</i> sex. Sex assignment at birth is used to label one's gender identity prior to self-identification. Sometimes referred to as <i>biological</i> sex, though many transgender persons find this term offensive.
Bisexual	A person who is attracted on different levels (e.g., emotional, physical, intellectual) to and/or has sex with both men and women and who identifies with this as a cultural identity [LGBTI plan 2017-2022].
Children	People younger than 18 years of age, unless, under the law applicable to the child, majority is attained earlier.
Condomless sex	A sex act which is not protected by male or female condoms. Previously known as unprotected sex, this is now increasingly referred to as condomless sex; this is done to avoid confusion with the protection from pregnancy that is provided by other means of contraception. As oral pre-exposure prophylaxis (PrEP) becomes more widespread (and if topical PrEP is introduced), it is important to be clear about the different methods of protection against HIV and the other consequences of sex, and how those methods might be used or combined [UNAIDS. Terminology Guidelines. 2015].
Discrimination	Negative behaviour or action toward people directly linked to stigmatising beliefs, attitudes and feelings.
Discrimination from health-care providers	Key population members experience discrimination, judgemental encounters, breaches in medical confidentiality, and structural violence from healthcare and service providers. Since disclosing drug use/sex work/imprisonment can result in difficult interactions, stigmatised groups can be reluctant to do so, or may not even seek healthcare and service provision in the first place. In short, stigma and discrimination are significant barriers to prioritising the health and wellbeing of people who use drugs and other key population members [INPUD. Consensus statement on drug use under prohibition: Human rights and the health law].
Drug dependence/ Substance dependence	Drug dependence refers to the cluster of physiological, behavioural and cognitive phenomena that occur when an individual highly prioritises use of a drug/substance over other behaviours that once had greater value.
Gay	Can refer to same-sex sexual attraction, same-sex sexual behaviour and same-sex cultural identity. Unless individuals or groups self-identify as gay, the expression men who have sex with men or women who have sex with women should be used.
Gender	Refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialisation processes. They are context-/time-specific and changeable. Gender determines what is expected, allowed, and valued in a woman or a man in a given context. In most societies, there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities" [UNAIDS. Terminology Guidelines. 2015, NSP 2017-2022].
Gender-based violence (GBV)	Violence that establishes, maintains, or attempts to reassert unequal power relations based on gender. It encompasses acts that inflict physical, mental or sexual harm or suffering, threat of such acts, coercion and other deprivations of liberty [UNAIDS. Terminology Guidelines. 2015].
Gender dysphoria	Distress, often clinically significant, that is caused when a person's gender identity is not aligned with the sex they were assigned at birth
Gender expression	The means by which individuals communicate their internal sense of gender to others, through dress, speech, or behaviour. Everyone has a gender expression.

Gender identity	A person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. It includes both the personal sense of the body – which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means – as well as other expressions of gender, including dress, speech and mannerisms. [UNAIDS. Terminology Guidelines. 2015, NSP 2017-2022].
Gender non-conforming	A person who does not identify as being either male or female; who may identify as being a combination of male or female; may identify as being male at sometimes and female at other times; may identify as some other gender. Sometimes people use the terms <i>gender-fluid</i> , <i>gender-variant</i> or <i>non-binary</i> .
Harm reduction	A comprehensive package of policies, programmes and approaches that seeks to reduce the harmful health, social and economic consequences associated with the use of psychoactive substances. The elements in the package are as follows: needle and syringe programmes; opioid substitution therapy; HIV testing and counselling; HIV care and antiretroviral therapy for people who inject drugs; prevention of sexual transmission; outreach (information, education and communication for people who inject drugs and their sexual partners); viral hepatitis diagnosis, treatment and vaccination (where applicable); and tuberculosis prevention, diagnosis and treatment. For example, people who inject drugs are vulnerable to blood-borne infections (such as HIV) if they use non-sterile injecting equipment. Therefore, ensuring adequate supplies of sterile needles and syringes is a harm reduction measure that helps to reduce the risk of blood-borne infections. [UNAIDS. Terminology Guidelines. 2015, NSP 2017-2022].
Hepatitis	Inflammation of the liver, which may be caused by a virus, drugs or rarely diseases of the immune system
Homophobia	(also termed 'homoprejudice') refers to an irrational fear of and/or hostility towards lesbian women and gay men, or same-sex sexuality more generally [LGBTI plan 2017-2022].
Homosexuality	The sexual orientation in which an individual has romantic or sexual feelings toward members of the same sex.
Hormone therapy	Also known as cross-gender hormone therapy or hormone replacement therapy, is a health intervention used by many transgender people. Hormones can be used to feminize or masculinize one's appearance in accord with one's gender identity. Physical appearance is often used to support assumptions about someone's sex, and hormone therapy can help a transgender person to be recognised as the appropriate gender [LGBTI plan 2017-2022].
Human rights	The South African Constitution guarantees a broad range of civil, political, cultural and socio-economic rights, including the rights to equality and non-discrimination, privacy, dignity, freedom and security of the person, access to health care and access to justice [NSP 2017-2022].
Informed consent	Requires full disclosure of the nature of the service offered with adequate comprehension on the part of the client or guardian, and her or his voluntary decision to participate [Code of conduct for HIV and health professionals, IAS 2014].
Inmate	Persons held in confinement, including prisoners and those detained and awaiting trials.
Intersectionality	Intersectionality is an approach to understanding and responding to the multiple social factors that intersect in dynamic ways to privilege or disadvantage people depending on their characteristics and contexts. It is used as a framework to improve health equity by identifying and addressing the social determinants, power relations and structural factors that drive health inequity
Key populations	Populations that are most at risk of HIV, TB and STI exposure or onward transmission as identified in the NSP 2017-2022. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. These include sex workers, men who have sex with men, people who use drugs, transgender people and inmates. Due to specific higher-risk behaviours, these groups are at increased risk of HIV irrespective of the epidemic type or local context. The key populations are important to the dynamics of HIV transmission. They are also essential partners in an effective response to the epidemic. In accordance with the Global TB plan, 'key populations' for TB are defined as people who are vulnerable, underserved or at risk of TB infection. These include people with increased exposure to TB due to where they live or work, people with limited access to quality TB services, and people at greater illness or risk due to biological or behavioural factors. The NSP defines key populations for TB as people living with HIV, household contacts of TB index patients, healthcare workers, inmates, pregnant women, children under five years of age, diabetics, and people living in informal settlements. [UNAIDS. Terminology Guidelines. 2015, NSP 2017-2022, WHO. Consolidated guidelines on HIV prevention, diagnosis, treatment, and care for key populations. 2016].
Lesbian	Refers to a woman who is attracted on different levels (emotional, physical, intellectual, etc.) to and/or has sex with other women and who identifies with this as a cultural identity [LGBTI plan 2017-2022].
Men who have sex with men	Refers to males who have sex with males regardless of whether they also have sex with women or have a personal or social gay or bisexual identity. This concept is inclusive of men who self-identify as heterosexual but have sex with other men [UNAIDS. Terminology Guidelines. 2015, NSP 2017-2022].

Needle (syringe)	A medical tool used to deliver liquids into the blood stream
Needle and syringe programme	The term needle-syringe programme replaced the term needle exchange programme because exchange has been associated with unintended negative consequences compared with distribution. Exchange, as implied by the term, required the presentation of used equipment in order to get new clean ones, and this 'condition' has been associated with negative incidents. Both terms, however, refer to programmes aimed at increasing the availability of sterile injecting equipment [UNAIDS. Terminology Guidelines. 2015].
Opioid substitution therapy (OST)	The recommended form of drug dependence treatment for people who are dependent on opioids. It has proved to be effective in the treatment of opioid dependence, in the prevention of HIV transmission and in the improvement of adherence to antiretroviral therapy. The most common drugs used in OST are methadone and buprenorphine [UNAIDS. Terminology Guidelines. 2015, NSP 2017-2022].
People in prisons and other closed settings	There are many different terms used to denote places of detention, which hold people who are awaiting trial, who have been convicted or who are subject to other conditions of security. Similarly, different terms are used for those who are detained. In this guidance document, the term "prisons and other closed settings" refers to all places of detention within a country, and the terms "inmates", "prisoners" and "detainees" refer to all those detained in criminal justice and prison facilities, including adult and juvenile males and females, during the investigation of a crime, while awaiting trial, after conviction, before sentencing and after sentencing [WHO. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. 2016].
People who inject drugs	Refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. Injection may be through intravenous, intramuscular, subcutaneous, or other injectable routes. People who self-inject medicines for medical purposes – referred to as "therapeutic injection" – are not included in this definition. The definition also does not include individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body shaping or improving athletic performance. While these guidelines focus on people who inject drugs because of their specific risk of HIV transmission due to the sharing of blood-contaminated injection equipment, much of this guidance is relevant also for people who inject other substances [WHO. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. 2016].
People who use drugs	Include people who use psychotropic substances through any route of administration, including injection, oral, inhalation, transmucosal (sublingual, rectal, intranasal) or transdermal. Often this definition does not include the use of such widely used substances such as alcoholic and caffeine-containing beverages and foods [WHO. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. 2016].
Pre-exposure prophylaxis (PrEP)	Refers to antiretroviral medicines prescribed before possible exposure to HIV. Several studies have demonstrated that a daily oral dose of appropriate antiretroviral medicines is effective in both men and women for reducing the risk of acquiring HIV infection through sexual or injection transmission [UNAIDS. Terminology Guidelines. 2015].
Post-exposure prophylaxis (PEP)	Refers to the use of antiretroviral medicines to prevent HIV infection in an HIV uninfected person who has been exposed to HIV [Department of Health. High transmission area guidelines. 2014]. Treatment must begin within 72 hours of a possible exposure by an uninfected individual and continues for four weeks.
Psychosocial support	Addresses the ongoing psychological and social problems of HIV infected individuals, their partners, families, and caregivers [NSP 2017-2022].
Rimming	Also known as anilingus, is the act of orally pleasuring the anus. This can involve licking, sucking, kissing, and any other pleasurable act that involves oral-to-anal contact.
Sex work	Any agreement between two or more people in which the objective is limited to a consenting sexual act, and which involves preliminary negotiations for money or goods
Sex worker	Sex workers include consenting female, male and transgender adults and young people 18 and older who receive money or goods in exchange for sexual services, either regularly or occasionally
Sexual and reproductive health	A state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing [Starrs et al. Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission].
Sexual behaviour	Is distinguished from sexual orientation because the former refers to acts, while the latter refers to feelings and self-concept. People may or may not express their sexual orientation in their behaviour [LGBTI plan 2017-2022].
Sexual orientation	Refers to each person's capacity for profound emotional, affectional, and sexual attraction to (and intimate and sexual relations with) individuals of any sex. SOGI, an often used abbreviation, stands for sexual orientation, gender identity [UNAIDS. Terminology Guidelines. 2015].
Sexually transmitted infection (STI)	Refers to infections that are spread by the transfer of bacterial and/or viral organisms from person to person during sexual contact.

Stigma and discrimination	<p>The term stigma is derived from a Greek word meaning a mark or stain, and it refers to negative beliefs and/or attitudes. Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others, such as when certain attributes are seized upon within particular cultures or settings and defined as discreditable or unworthy.</p> <p>When stigma is acted upon, the result is discrimination. Discrimination refers to any form of arbitrary distinction, exclusion or restriction affecting a person, usually (but not only) because of an inherent personal characteristic or perceived membership of a particular group. It is a human rights violation. In the case of HIV, this can be a person's confirmed or suspected HIV-positive status, irrespective of whether or not there is any justification for these measures. The terms stigmatisation and discrimination have been accepted in everyday speech and writing, and they may be treated as plural [UNAIDS. Terminology Guidelines. 2015, NSP 2017-2022].</p>
Stigma and discrimination against key populations	<p>Key populations face many forms of stigma and discrimination—some examples are:</p> <ul style="list-style-type: none"> Blamed and shamed at home, and in some cases forced to leave home Isolated and made fun of by their peers at school Subjected to verbal and physical abuse and social isolation in the community Denied work opportunities and access to accommodation Given poor treatment by health workers and find it difficult to access health services Subjected to discriminatory laws and unable to exercise their human rights
Stigmatise	<p>The action of treating someone differently or unfairly because of some perceived difference (e.g. sexual behaviour, gender)</p>
Transgender	<p>An umbrella term to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g. hormone therapy) and individuals who identify as having no gender, multiple genders, or alternative genders [UNAIDS. Terminology Guidelines. 2015].</p>
Transgender man	<p>A person who was born female but identifies as male.</p>
Transgender woman	<p>A person who was born as male but identifies as female.</p>
Transition	<p>The process of changing one's body through hormone treatment, surgery, and/or other means of body modification to align with one's gender identity. Sometimes this process is called <i>gender affirmation, gender confirmation, and/or gender reassignment</i>.</p>
Transphobia	<p>The fear or rejection of (or aversion to) transgender people, often in the form of stigmatising attitudes or discriminatory behaviour.</p>
Young key populations	<p>The term specifically refers to young people aged 15 to 24 years who are members of key populations, such as young people living with HIV, young gay men and other men who have sex with men, young transgender people, young people who inject drugs and young people (18 years and older) who sell sex. Young key populations often have needs that are unique, and their meaningful participation is critical to a successful HIV response [UNAIDS. Terminology Guidelines. 2015].</p>
Young people	<p>People aged 10 to 24 years.</p>

43. RESOURCES

General

2019 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy, Adolescents, Children, Infants and Neonates. National Department of Health. <https://www.knowledgehub.org.za/elibrary/2019-art-clinical-guidelines-management-hiv-adults-pregnancy-adolescents-children-infants>

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- National LGBT Health Education Center. <http://www.lgbthealtheducation.org/>
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- One-on-One Risk Reduction, Assessment, Planning and Support Tool. FHI 360. 2012. (28 pages) <http://bit.ly/1Uwkt3y>
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- Patient Health Questionnaire – 9 (PHQ-9) Expanded Tool for Depression Screening. http://www.cqaimh.org/pdf/tool_phq9.pdf
- PrEPWatch PrEP Resources for South Africa. <https://www.prepwatch.org/country/south-africa/>
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anal dysplasia

Anal Dysplasia and Cancer. HIV Clinical Resource, 2007. <http://www.hivguidelines.org/clinical-guidelines/adults/anal-dysplasia-and-cancer/>

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Health of gay men and men who have sex with men

CPR: E-Learning for health professionals serving gay and bisexual men. Global Forum on MSM and HIV. Video library based on UN MSM Implementation Toolkit. <https://msmgf.org/learn-online/>

Health of people who inject drugs

Crack Pipe Mouthpieces. Toward the Heart (project of the BC provincial harm reduction programme) <http://towardtheheart.com/product/crack-pipe-mouthpiece>

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Health of transgender people

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Health of people in prisons and other closed settings

STEPS Implementation Guide: Strengthening Prevention Services: Training Curriculum for the Department of Correctional Services. South Africa Partners with support from CDC. <https://www.sapartners.org/sites/default/files/files/STEPS%20Implementation%20Guide.pdf>

Videos

Anoscopy: Decubitus Position (2 minute video) <https://www.youtube.com/watch?v=IPRKWRBiPsQ> A brief video demonstrates techniques for using an anoscope to conduct an examination.

Transgender Health and HIV (35 minute video) <https://www.lgbthealtheducation.org/training/online-courses/continuing-education/?y=159> This 35-min-

ute module is available to watch online after free registration on the website. Focuses on US populations; however, provides a good overview of HIV-related concerns and best practices for working with transgender women and men in HIV care and treatment settings.

Rectal Examination (4 minute video) https://www.youtube.com/watch?v=bK-1GTLpL_F8&feature=youtu.be This brief video provides an overview of the digital rectal exam, including preparing the patient, conducting the exam, and using a simulator.

Male Genital Examination (5 minute video) <https://www.youtube.com/watch?v=qnDyRGXnsmQ&feature=youtu.be> This brief video demonstrates a comprehensive male genital exam.

Male Genital & Rectal Examination (3 minute video) <https://www.youtube.com/watch?v=qXhYePyqDeo&feature=youtu.be> This brief video provides additional demonstration of a male genital exam and digital rectal exam.

Anal Pap Smear: Anal Pap Smear: A Simple, Fast and Easy Procedure (13 minute video) Available in Dropbox. Thorough review of procedure of collecting anal pap smear screening test.

44. FOOTNOTES AND SOURCE DOCUMENTS

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