DFPA
THE DANISH FAMILY PLANNING ASSOCIATION

Leaving No One Behind

– a Facilitator Guide for training HSPs on provision of SRH services for LGBT+ persons

In cooperation with FWC

REPUBLIC OF KENYA
MINISTRY OF HEALTH

Who is this Guide for?

The intended users of the Facilitator Guide are persons who 1) have pre-existing experience as facilitators and have undergone training as facilitators, and 2) possess extensive knowledge of LGBT+ persons' challenges, needs and risks in sexual and reproductive health.

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Dr. Adel Ottoman
County Director, Promotive and Preventive Health Services, Hornabay

Dr. Fredrick Odhiambo Oluoch
HSC County Director, Health and Sanitation, Kisumu County

Dr. Otieno Kennedy
Assistant Director Medical Services Kisumu County

Florence Onyango Aketch,
National SRH Trainer of Trainers & Ministry of Health Representative, Kisumu County

Justus Ochola,
National SRH Trainer of Trainers & Ministry of Health Representative, Homa Bay County

Jackton Oliver Okeyo,
National SRH Trainer of Trainers & Ministry of Health Representative, Kisumu County

Diner Awuor Pinya,
National SRH Trainer of Trainers & Ministry of Health Representative, Homa Bay County

Rebecca Odhiambo,
Facilitator and representing Western Kenya LBTQ Feminist Forum

Humphrey Rakewa,
Facilitator

Caroline Mwochi Rucah,
Facilitator and representing Western Kenya LBTQ Feminist Forum

Juma Bernard Washika,
Festo Washika Consulting/FWC

Festo Collins Owino,
Festo Washika Consulting/FWC

Lisbet Dinsen,
Danish Family Planning Association /DFPA

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ABOUT THIS FACILITATOR GUIDE

WHY, WHAT AND FOR WHOM?

Why this facilitator's guide?

This Facilitator Guide aims to support trainings that strengthen the capacity of Health Service Providers to provide non-discriminatory sexual and reproductive health (SRH) services for LGBT+ persons. Specifically, the intended training outcomes are:

- To increase Health Service Providers' understanding of SRH needs among LGBT+ populations
- To improve positive attitudes among Health Service Providers towards provision of SRH services for LGBT+ persons
- To equip Health Service Providers with skills on provision of LGBT+ friendly SRH services

What does it contain?

The Facilitator Guide contains 11 training modules, which can be used consecutively for a 5-day training. Each of the 11 training modules includes guidance for facilitators. Tools for training evaluation, groupwork handouts and facilitator's own notes are enclosed in the Annexes at the back of the Guide.

Facilitators are expected to develop their own visual aids for presentations (e.g. Powerpoint slides) in order to build ownership of the information shared and discussed with participants. Visual aids for presentations are therefore not included in the Facilitator Guide.

The Facilitator Guide has a strong focus on interactive and participatory methods in order to maximize the learning for participants. The training is designed to build and strengthen participants' knowledge, attitudes and skills to offer non-discriminatory SRH services to LGBT+ persons.

Who is it for?

The intended users of the Facilitator Guide are persons who 1) have pre-existing experience as facilitators and have undergone training as facilitators, and 2) possess extensive knowledge of LGBT+ persons' challenges, needs and risks in sexual and reproductive health.

The target audience for the trainings are Health Service Providers in Kenya. If the Facilitator Guide is used for other health stakeholders – e.g. policy makers or decision makers within health or community health workers – some adaptation should be expected.

Relation to national & international standards

The Facilitator Guide is founded in universal human rights standards. These standards and their application to issues of sexual orientation, gender identity, gender expression and sex characteristics are set out in the Yogyakarta Principles.

Moreover, the Facilitator Guide is developed for use in Kenya, based on an identified need for training materials specific to this context and to the needs of training participants. It contains references to the legal and policy framework specific to Kenya, which will require modifications if used in other contexts.

> This Facilitator Guide aims to support trainings that strengthen the capacity of Health Service Providers to provide non-discriminatory sexual and reproductive health (SRH) services for LGBT+ persons.

Specific Ministry of Health policies and guidelines used include:

- National Adolescent Sexual and Reproductive Health Policy (2015)
- National Guidelines for HIV and STI Programming with Key Populations (2014)
- National Guidelines for HIV and STI Programming among Transgender People (2021)
- National Guidelines for HIV and STI Programming among Young Key Populations (2018)
- National Guidelines for Prevention, Management and Control of STIs (2018)
- Kenya Health Sector Referral Strategy 2014-2018
- National Reproductive Health Policy (2007)
- Kenya AIDS Strategic Framework 2020/2021 – 2024/2025

Moreover, for training aspects, the Facilitator Guide draws on the following resources, all of which allow for reuse:

- The European Union's "Trainer's Manual: Reducing Health Inequalities Experienced by LGBT+ People: What is your role as a health professional" (2018)
- The Desmond Tutu HIV Foundation's "Health Care Provision for Men who have Sex with Men, Sex Workers, and People who Use Drugs - An Introductory Manual for Health Care Workers in South Africa" (2013)
- Rutger's toolkit "Adopting a Gender Transformative Approach in sexual and reproductive health and rights, and gender-based violence programs" (2019)
- Underviserportalen.dk, an online resource for comprehensive sexuality education.

A complete list of references and further reading materials can be found in the Annex C.

TERMINOLOGY AND ACRONYMS
USE OF THE TERM LGBT+

Terminology and use of language around sexual orientation, gender identity and expression and sex characteristics is dynamic and evolving.

This guide uses the term "LGBT+" to encompasses people who identify as Lesbian, Gay, Bisexual, Transgender and, by the "+" symbol, people whose identities do not fit typical binary notions of male and female or who identify themselves using other terms to describe their gender identity or their own understanding of their sexuality. This includes e.g. people who are intersex and people who identify themselves as pansexual or queer, but also people who are exploring their sexual orientation and/or gender identity or people who may not want to identify themselves with any existing category.

The term "LGBT+" is used while acknowledging and appreciating that the abbreviation SOGIESC (Sexual Orientation, Gender Identity and Expressions, Sex characteristics) is in fact a more inclusive term that speaks to a general human experience rather than using LGBT+ identifiers. When the term "LGBT+" is used nonetheless in this Facilitator's Guide, it is because the understanding of non-conforming sexual orientations, gender identities, gender expressions and sex characteristics is still evolving and require an explicit space at this time.

When it comes to usage of "LGBT+" in relation to rights, the guide is consistently speaking of human rights. The term "LGBT+ rights" is purposefully avoided as it suggests that there are special rights for LGBT+ persons, when in fact the opposite is true: The rights of LGBT+ persons are human rights, applicable to every human being regardless of any identity markers such as sexual orientation, gender identity and expression, and sex characteristics.

ACRONYMS

AIDS: Acquired Immunodeficiency Syndrome

DFPA: Danish Family Planning Association

FWC: Festo Washika Consulting

HIV: Human Immunodeficiency Virus

HSP: Health Service Provider

MSM: Men who have Sex with Men

NASCOP: National AIDS and STI Control Program

SGBV: Sexual and Gender Based Violence

SOGIESC: Sexual Orientation, Gender Identity and Expression, Sex Characteristics

SRH: Sexual and Reproductive Health

SRHR: Sexual and Reproductive Health and Rights

STI: Sexually Transmitted Infection

WSW: Women who have Sex with Women

GUIDANCE FOR FACILITATORS

PRINCIPLES AND CONTENT

Training principles

The training is built around the following seven principles:

1. **Rights-based:** Human rights – the rights that apply to all persons regardless of sexual orientation, gender identity, gender expression or sex characteristics – are foundational to the training. With the rights-based approach as the starting point, the training seeks to strengthen capacity of Health Service Providers to respect, protect and fulfil human rights, including eliminating discrimination against LGBT+ persons when accessing health services.

2. **A positive approach to sexuality:** Sexuality is a positive and dynamic part of life and wellbeing, and everyone should have space to explore and learn about sexuality without judgement and shame. For training purposes, this means ensuring that sexuality is framed as a natural part of health and wellbeing, and that discussions around the diversity of sexuality are respectful and non-judgmental. The positive approach does not mean that topics on risks or vulnerabilities arising from sexual behavior should be avoided during the training.

3. **Norm-critical approach to gender and sexuality:** A norm-critical approach involves encouraging participants to identify, reflect upon and widen existing norms for what is considered "normal" "acceptable" and/or " appropriate". Methods for questioning, challenging or deconstructing stereotypical norms are built into the training material through discussions, videos, case studies and other exercises.

4. **Inclusive of LGBT+ sub-groups:** The training is developed to be inclusive of all LGBT+ sub-groups, spanning all sexual orientations, gender identities, gender expressions and sex characteristics. In this aspect, it goes beyond the "Key Population" focus that may be applied in selected health policies or guidelines.

5. **Training environment as a safe space:** Creating a training environment that supports inclusion, respect and where participants feel comfortable engaging in discussions without fear of ridicule or judgment, is important in any learning context. It is even more important when the training involves topics that may be seen as sensitive. For this particular training, this translates into paying continuous attention to creating a safe space by making sure discussions are conducted in a respectful manner and that participants' privacy is protected.

6. **Learning through interaction:** Learning through interaction as opposed to receiving information is well-proven to lead to higher subject interest, higher attention levels, and higher learning retention. For this reason, the Facilitator Guide emphasizes group work, quizzes, case studies and even physical activities to strengthen participants' space to interact and engage. It also impacts the Facilitator's role, which becomes more that of a guide who balance guidance with giving space for the participants to explore questions and answers.

7. **Action-oriented learning methods:** The content of the training is related directly to the day-to-day work of Health Service Providers whenever possible. This includes individual and group work, quizzes, case studies and other activities which encourage participants to critically reflect on their role as Health Service Providers in relation to non-discriminatory access for LGBT+ persons to SRH services. The purpose is to support participants in linking workshop learning to their day-to-day work, allowing participants to see concrete ways that they can translate learning into practice and support the change that may be needed.

Training content

The Facilitator Guide is designed as a 5-day training program consisting of 6 training hours a day.
It is divided into 11 modules that allow for:

- Doing all 11 modules for a 5-day training
- Adapting training content to participants'
  for the particular group of participants

Module No	Topic	Duration
1	Introductions and training content	2.5 hrs
2	Legal and policy framework	3 hrs
3	Anatomy & physiology	1.5 hrs
4	Sex, gender & sexuality	4.5 hrs
5	Clarifying values and attitudes	2 hrs
6	Discrimination, stigma and inequality	4 hrs
7	SRH risks & vulnerabilities for LGBT+ persons	4 hrs
8	Integrated SRH interventions	2.5 hrs
9	Referrals and monitoring health outcomes	2 hrs
10	LGBT+ friendly practice	2.5 hrs
11	Closing and evaluation	1.5 hrs

PREPARING FOR TRAINING

Adapt to audienc

The Facilitator Guide is just that – a guide. Prior to the training, the facilitator(s) should assess participants' preexisting capacities to adapt training content and methods to their needs.

Facilitators are expected to develop their own presentations/ visual aids in order to build ownership of the information to be shared and discussed with participants. Each session contains a "Background Information to Facilitators" section with Key Information that can be used to develop these short presentations. It is important to keep the presentations short to allow for interactive learning. See the Training Principles (p. 9) for guidance.

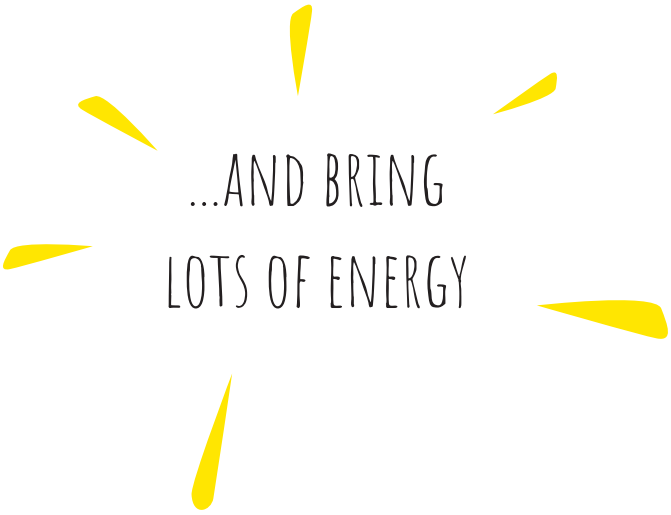
Here is what you need to bring to the training

Equipment:

- Flip chart, markers, tape, stickers + projector and computer (if available)

Prints:

- From Annex A: Pre-and-post tests and evaluation forms
- From Annex B: Handouts for group work
- Attendance list



DO'S FOR FACILITATORS

- Be positive and energetic
- Pay continuous attention to creating and upholding the training environment as a safe space
- Focus on professional, not personal experiences, to protect participants' privacy
- Encourage and create space for active participation
- Support participants during group work and individual work sessions
- Have all your materials ready and organized before the training day starts
- Keep track of time – both during breaks and in your own presentations & sessions
- Draw linkages to participants' contributions and discussions in previous sessions to reinforce learnings at every opportunity
- Have participants summarize learnings in their own words at the end of every day + the next morning to reinforce key learning points of the day
- Be conscious of the language you use – Always stay positive, inclusive and non-discriminatory.
- Use energizers as needed

FACILITATOR NOTES SHEET

Instructions session no.: _____

Print the amount you need

The modules

BACKGROUND INFORMATION AND INSTRUCTIONS FOR THE FACILITATORS

MODULE

1.

Session 1.1: WELCOME AND SETTING EXPECTATIONS

Session 1.2: TRAINING CONTENT

INTRODUCTION AND TRAINING CONTENT

LEARNING OUTCOMES

At the end of Module 1, the participants will be able to:

- Understand what to expect during and from the training
- Understand the ground rules for engaging in the training

SESSION 1.1:

WELCOME AND SETTING EXPECTATIONS

1.5 HRS

MATERIALS TO HAVE READY:
3-4 slides for presentation, flipchart and pre-test (p. 69)

METHODS:
Presentation, individual work & plenary discussion

Background information for facilitators:

On how to establish a safe space

It is the facilitator's responsibility to create a learning environment where participants feel comfortable to participate and where different perspectives and views are respected. It is even more important when discussing topics that can be sensitive – e.g. sex, sexuality, and stigma.

A secure learning environment is one where:

- Participants do not share personal stories nor disclose confidential information about others. It is important to avoid that any participant shares information about their private lives, their personal relations or their clients, as it may violate confidentiality, or they may regret having shared it after the training.
- Language that stereotypes, generalizes or is condescending is not accepted. Encourage the use of non-discriminatory, inclusive and positive language.
- Active participation is valued and encouraged. Views and opinions are shared and discussed respectfully.
- An openness to changing attitudes, reflections on dilemmas and willingness to adapt practices to new knowledge and attitude changes is encouraged.

Instructions session 1.1:

Welcome and introductions

1. Facilitators welcome participants and introduce themselves to the participants.
2. Participants are asked to introduce themselves briefly. Alternatively, they can be introduced by their neighbor after a brief exchange.

Ground rules

3. Facilitator sets out ground rules / training norms for the training environment to be a safe space.

Know-Expect-Learn exercise

4. Each participant is asked to write
   a) Three things that they know about SRH needs of LGBT+ persons.
   b) Three things that they expect to learn from the training.
5. All participants share the three things they know and the things they expect to learn. The identified knowledge is briefly discussed in plenary and the expectations are recorded on a flipchart that will be used the last day. Should some of the expectations be entirely opposite to the training intentions, facilitator can guide expectations in a more suitable direction.

Facilitator notes: Please use print page 12

SESSION 1.2:

TRAINING CONTENT

1 HRS

MATERIALS TO HAVE READY:
Pre-test (p. 69), video and 1-2 slides with training objectives and training program

METHODS:
Presentation, individual work & plenary discussion

Background information for facilitators:

- None

Instructions session 1.2:

Pre-test

1. Participants are asked to fill the Pre-training test.

Purpose of training

2. Facilitator motivates why we are here + show video (KTN news piece, 2min and 32seconds https://www.youtube.com/watch?v=AmmxAbGA6W8. Following video, plenary debrief where Facilitator reinforces points about how LGBT+ persons often seek health services too late and the critical role that front line health staff play in supporting health seeking behavior among LGBT+ persons.

3. Facilitator presents training objectives:
   a. To increase Health Service Providers' understanding of SRH needs among LGBT+ persons.
   b. To improve attitudes among Health Service Providers towards provision of SRH services for LGBT+ persons.
   c. To equip Health Service Providers with skills on provision of LGBT+ friendly SRH services.

Training program

4. Facilitator presents training program and time schedule.

Facilitator notes: Please use print page 12

MODULE

2.

Session 2.1: LAWS, RIGHTS AND NON-DISCRIMINATION

Session 2.2: HEALTH AND RIGHTS

LEGAL & POLICY FRAMEWORK

LEARNING OUTCOMES

At the end of Module 2, the participants will be able to:

- Understand the Kenyan laws and international legal frameworks that affect LGBT+ persons' rights
- Have knowledge on policy frameworks and guidelines for LGBT+ persons' access to health in Kenya, including sexual and reproductive health and rights

SESSION 2.1:

LAWS, RIGHTS AND NON-DISCRIMINATION

1.5 HRS

MATERIALS TO HAVE READY:
4-5 slides for presentation, video

METHODS:
Presentation, group work, plenary discussion

Background information for facilitators:

On how to establish the foundation on equality, non-discrimination and privacy for all - and what it means for HSPs

Here is the Key Information you can consider sharing with participants:

- **Non-discrimination is a fundamental human right.** The Universal Declaration of Human Rights starts with the words: *"All human beings are born free and equal in dignity and rights" (Article 1)*. According to this, people should be treated equally. and no one should be denied their rights regardless of their gender, age, race, religion or beliefs, sexual orientation, gender identity, disability or anything else.

- **Non-discrimination in the Kenyan Constitution:** People in Kenya have rights to non-discrimination according to the Kenyan Constitution:
  - Preamble: We, the people of Kenya (...) a government based on the essential values of human rights, equality, freedom, democracy, social justice and the rule of law
  - Article 10, (2, b): The national values and principles of governance include (...) human dignity, equity, social justice, inclusiveness, equality, human rights, non-discrimination and protection of the marginalized
  - Article 27 (1): Every person is equal before the law and has the right to equal protection and equal benefit of the law.
  - Article 27 (2): Equality includes the full and equal enjoyment of all rights and fundamental freedoms.

- **Privacy in the Kenya Constitution:** People in Kenya have a right to privacy according to the Kenyan Constitution. Article 31 states "Every person has the right to privacy, which includes the right not to have:
  - (a) their person, home or property searched
  - (b) their possessions seized
  - (c) information relating to their family or private affairs unnecessarily required or revealed, or
  - (d) the privacy of their communications infringed

- **Other legal instruments:** Kenya is a signatory to a number of international human rights laws and treaties, including the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, Convention of the Rights of the Child, and Convention on Elimination of all forms of Discrimination Against Women. This means that Kenya has accepted to respect the enjoyment of human rights, to protect individuals and groups against human rights abuses, and to fulfil human rights through taking positive action to fulfill such rights. The application of human rights law to diversity in sexual orientations, gender identities, gender expressions and sex characteristics are called the Yogyakarta Principles [1] .

- **What does the international legal framework mean for Health Service Providers?** In international human rights law, we are all right holders – i.e. people who hold the same rights. But in addition, there are people who are "duty bearers". A duty bearer is someone who has a responsibility to support others in realizing their rights. Health Service Providers are duty bearers through their jobs as public officials, just like police officers and teachers. This means that a HSP has a responsibility for helping others achieve their human rights. Specifically, it means that HSP are obliged to respect, protect and fulfill human rights of others and to abstain from human rights violations.

Continued on the next page

1. *Further information on the Yogakarta Principles is available here: https://yogyakartaprinciples.org/*

- **Sexual rights:** Sexual rights are related to multiple human rights, including the rights of all persons – free of coercion, discrimination, and violence - to [2]:
  - seek, receive and impart information related to sexuality
  - sexuality education
  - respect for bodily integrity
  - choose their partner
  - decide to be sexually active or not
  - consensual sexual relations
  - consensual marriage
  - decide whether or not, and when, to have children
  - pursue a satisfying, safe and pleasurable sexual life

Instructions session 2.1:

Facilitator presentation

1. Facilitator presents Key Information.

Video and group work

2. Facilitator shows video https://www.youtube.com/watch?v=vvL1lDTEtOA

3. In groups of maximum 4-5 persons, participants are asked to discuss the following questions on the video:
   a. What are the human rights violations that have occurred?
   b. If the police refuse to investigate or apprehend perpetrators, are the police officers upholding their obligation to protect and respect human rights of everyone?

4. Groups present their findings in plenary followed by a discussion facilitated by the Facilitator.

Facilitator notes: Please use print page 12

[2] *Further information on sexual health and rights is available here: https://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/*

SESSION 2.2:

HEALTH AND RIGHTS

1.5 HRS

MATERIALS TO HAVE READY:
4-5 slides, case study 1 (p. 89)

METHODS:
Presentation, group work with case, plenary discussion

Background information for facilitators:

On rights and policy frameworks specific to health, SRH and LGBT+ persons.

Here is the Key Information you can consider sharing with the participants:

- **Constitution Article 43: Highest attainable standard of health:** Kenya's Constitution states that every person has the right to "the highest attainable standard of health, which includes the right to health care services". This includes access to sexual and reproductive health services, e.g. access to contraception, but also accessing services without discrimination.

- **The Penal Code and public health:** Kenya's Penal Code contains punitive laws against same sex sexual activities, even between consenting adults. These laws date back from British colonial rule.

  The key sections are:
  - *Section 162 and 163*, which make sodomy a felony
  - *Section 165*, which makes acts between two males a felony

The criminalization is a huge barrier for access to SRH services, including access to HIV prevention and treatment and care, which has fatal health consequences for LGBT+ persons.

- **SRH Policies relevant to LGBT+:** Both nationally and at county-level, Kenya has a number of SRH policies and guidelines with relevance for service provision for LGBT+ persons.

  These include amongst others:
  - National Adolescent Sexual and Reproductive Health Policy (2015)
  - National Guidelines for HIV/STI Programming with Key Populations (2014)
  - National Guidelines for HIV and STI Programming among Transgender People (2021)
  - National Guidelines for HIV and STI Programming among Young Key Populations (2018)
  - National Reproductive Health Policy (2007)
  - Kenya AIDS Strategic Framework 2020/2021 – 2024/2025

Note that while these policy frameworks and guidelines are referring specifically to "Key Populations", which include a few LGBT+ subgroups [3], this training material is inclusive of all LGBT+ subgroups for SRH service provision.

Instructions next page

[3] *Key Populations are defined as "Men who have Sex with Men, Female Sex Workers, Persons Who Inject and Use Drugs and Transgender persons" in the 2020/21 – 2024/25 Second Kenya AIDS Strategic Framework.*

Instructions session 2.2:

Key Information

1. Facilitator presents Key Information.

Case study 1

2. Facilitator introduces Case Study 1 (p. 88) [4]
3. In groups of max 4-5 persons, participants are asked to discuss the case study based on the following questions:
   a. How are the men's rights violated?
   b. How are the police officers involved in the rights violations?
   c. What is the role of the hospital staff in the rights violations?
   d. What does the final decision by the appellate court and the resolution by the Kenya Medical Association mean for Health Service Providers, if police officers request anal testing in the future?

4. Participants discuss their findings in plenary. Facilitator draws out the forced anal examination, forced consent (i.e. no consent), lack of privacy, lack of dignity and how duty bearers (police, HSPs, magistrate judges) fail to uphold basic human rights of the two men. Emphasis should also be placed on question d), explaining that despite the contradiction between the Penal Code and the Constitution, the court decision has clarified that HSPs must uphold rights around privacy, dignity, consent.

Facilitator notes: Please use print page 12

[4] *For further information on Case Study 1, refer to: https://www.hrw.org/news/2018/03/22/kenya-court-finds-forced-anal-exams-unconstitutional*

MODULE 3.

Session 3.1: INTIMATE BODY PARTS & FUNCTIONS

ANATOMY & PHYSIOLOGY

LEARNING OUTCOMES

At the end of session 3, participants will be able to:

- Talk openly and freely about intimate body parts
- Understand the functions of the reproductive organs

SESSION 3.1:

INTIMATE BODY PARTS & FUNCTIONS

1.5 HRS

MATERIALS TO HAVE READY:
3-4 slides for presentation with pictures of male & female sexual and reproductive organs

METHODS:
Presentation, plenary discussion

Background information for facilitators:

On how to "break the ice" around naming intimate body parts and body functions.

Even though Health Service Providers already possess knowledge about anatomy, cultural sensitivities mean that language around body parts and functions tend to be underutilized.

The information in Module 3 is very basic. It focuses on sexual and reproductive organs and introduces the term "intersex". Diversity in sex characteristics will be further elaborated in Module 4.

▸TIP:
If you know that participants are already highly comfortable with talking freely about body parts and body functions, you can consider skipping Module 3.

Here is the Key Information you can consider using when describing the body parts and functions:

Male sexual and reproductive organs

- Glans – The glans is also called the head or tip of the penis. The opening of the urethra is here. This is where pee, semen and pre-ejaculate come out.
- Penile shaft – The shaft of the penis extends from the tip to where it connects with the lower belly. It looks like a tube. The urethra is inside the shaft.
- Scrotum – is the sac of skins that hangs below the penis, holding the testicles and keeps them at the right temperature. The scrotum is covered with wrinkly skin and hair.
- Testicles – two ball-like glands inside the scrotum. They make sperm and hormones, such as testosterone
- Epididymis and Vas deferens - the tubes where sperm matures (epididymis) and are carried to the urethra (vas deferens). Vas deferens is the duct that is severed during vasectomy.

Female sexual and reproductive organs

- Vagina – the vagina is the canal that connects the uterus to the external genitalia. Babies and menstrual blood leave the body through the vagina. Its wall is made of muscle and mucosal layer. The muscles are arranged in a circular manner, which allows the vaginal walls to expand and contract.
- Labia (lips) – the labia are folds of skin around the vaginal opening. The labia majora (outer lips) are fleshy and covered with pubic hair. The Labia minora (inner lips) are inside the outer lips. They begin at the clitoris and end under the opening of the vagina.
- Clitoris – it is an erectile tissue that corresponds to the male penis. However, its only known role is erotic. The visible/external part of the clitoris is just the beginning of the clitoris. The clitoris extends inside the body to the sides of the vagina.
- Uterus – is a pear-shaped muscular organ. It is sometimes called the womb because it is where a fetus grows during pregnancy. The activity of the ovarian hormones on the uterus leads to the formation of menstrual blood
- Cervix – the cervix divides the vagina and uterus, located right between the two. It looks like a donut with a tiny hole in the middle. This hole connects the uterus and the vagina, letting menstrual blood out and sperm in. Cancer of the cervix is the most common reproductive tract cancer in females in Kenya.
- Ovaries – are the female gonads that produce eggs and produce hormones, including estrogen, progesterone and testosterone. These hormones control menstruation and pregnancy.
- Fallopian tubes – are two narrow tubes that carry eggs from the ovaries to the uterus. Sperm travel through them to try to fertilize eggs.

Continued on the next page

Intersex

- Intersex is the term used to describe people born with chromosomes, external genitalia and/or internal reproductive organs that do not clearly fit into either sex category of 'male' or 'female'.

- Example: Instead of an XX or XY set of chromosomes, a person may be born with an XXY set. Or instead of a penis or vagina, a person may be born with genital variations.

- Sometimes, intersex traits are visible at births, sometimes they are not apparent until puberty – and some intersex variations may not be physically apparent at all.

- Globally, 1-3% of the population is estimated to be intersex.

Instructions 3.1:

Key Information and plenary discussion

1. Facilitator shows pictures of male sexual and reproductive anatomy and
   a. Participants name the body parts in local languages.
   b. Facilitator describes functions of the male sexual and reproductive anatomy.

2. Facilitator shows pictures of female sexual and reproductive anatomy and
   a. Participants name the body parts in local languages.
   b. Facilitator describes functions of the female sexual and reproductive anatomy.

3. Facilitator introduces the term "interex".

Facilitator notes: Please use print page 12

MODULE 4.

Session 4.1: SEX, GENDER & DIVERSITY

Session 4.2: SEXUALITY AND SEXUAL BEHAVIOR

Session 4.3: QUIZ ON HUMAN SEXUALITY

SEX, GENDER & SEXUALITY

LEARNING OUTCOMES

At the end of module 4, participants will be able to:

- Understand the difference between sex, gender, sexual orientation, gender identity, gender expression, and sex characteristics
- Understand that human sexuality is varied and dynamic
- Question stereotypical thinking around human sexuality and sexual behavior

SESSION 4.1:

SEX, GENDER & DIVERSITY

2 HRS

MATERIALS TO HAVE READY:
4-5 slides including picture of Genderbread person, Handout 1 (p. 76), Handout 2 (p.76)

METHODS:
Presentation, small group work, plenary debrief

Background information for facilitators:

On how to break down concepts of sex, gender, sexual orientation, gender identity, gender expression and sex characteristics.

The concepts in this session are building blocks for the rest of training, so it is important that the participants have sufficient time to take in the information. Keep in mind that for some participants, this may be the first time they are introduced to the idea that gender roles are not 'Naturally given' and that our understanding of sexuality and sexual practices are shaped by cultural and social norms.

▸TIP:
Do consider using Handout 1 after presenting Sex & Gender, before moving on to the next concepts of SOGIESC. This helps participants process the information step-by-step. Handout 2 is best used at the very end of this session, giving participants an opportunity to apply the more advanced concepts.

Here is the Key Information you can consider using to explain first sex and gender, and second, sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC): [6]

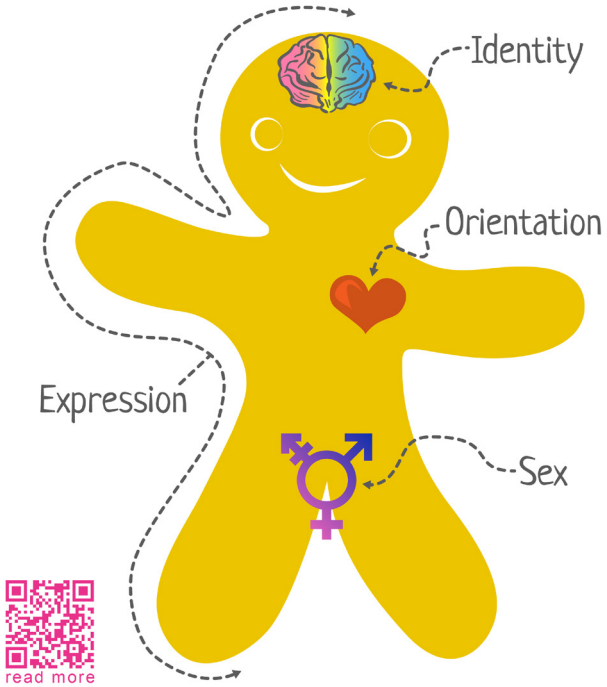
Sex and gender

- Sex is the biological concept that categorizes individuals based on certain characteristics like their chromosomes, internal and external genitalia, and their hormonal profile. A person's sex is usually categorized according to the binary terms as either 'male' or female'.
- Gender refers to the socially constructed roles, behaviors, expressions and identities of girls, women, boys, men, and gender diverse people.
- Dominantly, current social norms do not distinguish between a person's gender and a person's biological sex. Although, this distinction is crucial to understanding and working with SRH.
- Gender roles are not Naturally given, but expectations related to 'female' and 'male' behavior created through cultural, religious and societal norms.
- Examples on such expectations/gender roles are that "women wear dresses", that "men are breadwinners", that "women are natural care givers" etc.

Continued on the next page

[6] *Text is adapted from Ben Brown, Zoe Duby, Delene van Dyk (2013).*

SOGIESC



To visualize the differences between Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics, we will use a picture of the Genderbread person [7].

Sexual Orientation:
Sexual orientation refers to the way in which a person feels attraction to other people of a specific sex or gender. Sexual orientation includes sexual attraction but also includes emotional, romantic, and intellectual attraction.

Essentially, sexual orientation encompasses all of a person's intimate psychological and physical feelings towards others.

Gender identity:
Gender identity refers to a persons' innermost concept of self as male, female, a blend of both or neither. Basically, how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.

Transgender person is a term for persons whose gender identity is different from their sex assigned at birth.

- Example of transgender: A person who is born with female sex characteristics, and identify as a man or other genders. Some transgender people choose to transition (from male to female or vice versa) with the help of medical procedures, such as hormone therapy and/or surgery.
- Being transgender has nothing to do with sexuality, and transgender persons can be heterosexual, bisexual, homosexual (and all other sexualities) - just like any other person. Transgender persons are diverse in their gender identities and gender expressions.

Gender expression:
Gender expression is how an individual expresses their gender identity to the outside world – how they dress, interact, etc.

Sex Characteristics:
Sex characteristics refers to biological aspects, such as chromosomes, hormones, internal and external reproductive organs. Sex characteristics are not only 'male' or 'female', but can be diverse. There is a wide variety of sex characteristics. Intersex is the term used to describe people born with chromosomes, external genitalia and/or internal reproductive organs that do not clearly fit into either sex category of 'male' or 'female'.

- Example: Instead of an XX or XY set of chromosomes, a person may be born with an XXY set. Or instead of a penis or vagina, a person may be born with ambiguous genitalia.
- Sometimes, intersex traits are visible at births, sometimes they are not apparent until puberty – and some intersex variations may not be physically apparent at all.
- Often, intersex children are assigned a gender as boy or girl after tests (hormonal, genetic, radiological) have been done and the parents have consulted with the doctors on which gender they believe the child is more likely to feel when they grow up.
- Often doctors perform surgery on intersex children – often in infancy – with the aim of making it easier for them to grow up as a boy or a girl. However, the results are often catastro -phic, the benefits are largely unproven and there are rarely urgent health considerations requiring immediate, irreversible intervention. In addition surgury violates a fundamental right of the child, it's right to bodily integrity.

[7] *You can find more information on the Genderbread person here: https://www.genderbread.org/resource/genderbread-person-v1. For the purposes of this exercise, it is advised that you use Version 1 (not later versions) for consistency with terminology used in the module.*

Instructions 4.1:

Sex and Gender

1. Facilitator presents Sex and Gender.
2. Facilitator introduces Handout 1.
3. Participants work in pairs to determine whether the statements reflect something that is biologically determined (sex) or shaped by culture, values and attitudes (gender).
4. Upon completion, facilitator encourages discussion and directs group reflections towards the right answers.

The Genderbread person and SOGIESC

5. Facilitator introduces the Genderbread Person (picture) and explains Sexual Orientation, Gender Identity & Expression, Sex characteristics as well as Transgender and Intersex as terms.
6. Upon completion of the presentation, the participants are given handout 2 – a clean copy of the Genderbread Person. In pairs, they are now asked to fill it out, listing “Sexual Orientation”, “Gender Identity”, “Gender Expression” and “Sex Characteristics” where appropriate on the handout. This is done to reinforce learning.
7. Facilitator debriefs in plenary, re-stating the terminology for sex and gender diversity, including intersex and transgender.

Facilitator notes: Please use print page 12

SESSION 4.2:

SEXUALITY AND SEXUAL BEHAVIOR

1 HRS

MATERIALS TO HAVE READY:
4-5 slides for presentation and
Handout 3 (p. 77)

METHODS:
Presentation, group-work, plenary discussion

Background information for facilitators:

In this session, the complexity and dynamic nature of sexuality and sexual behavior is explained, and the participants explore how understandings of sexuality relate to their work as Health Service Providers.

Below is the Key Information you can consider sharing with the participants, prior to starting the group work.

What is sexuality?

- A central aspect of being human throughout life
- Experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships.
- Influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, legit, historical, religious and spiritual factors:

What is sexual behavior?

- Sexual behavior is the way in which individuals experience or express their sexuality
- Most people, but not all, use their bodies to experience sexual pleasure, on their own or with others.
- Sexual behavior and roles are independent from, but may be influenced by an individual's biological sex, sexual orientation, and sexual identity.
- Human behavior, particularly sexual behavior, is complex. Exploring sexuality often exposes individuals to the vast spectrum of human behavior that exists in society.

Why is it important to understand sexual behavior?

- There are many ways to have sex with a partner, for instance vaginal sex, anal sex, masturbation, oral sex and body rubbing. Though some people may think that sex is limited to when a penis goes into a vagina, this is not true. Sexual behavior varies from person to person, regardless of sexual orientation or gender identity.
- We choose here to cast extra light on certain forms of sexual behavior that are surrounded by stigma and misconceptions:
  - Anal sex is a sexual act that may involve penetration of the anus either with a penis, sex toys, fingers etc. Anal sex can be practiced by any individual regardless of their sex, sexual orientation and/or gender identity. The inside of the anus and rectum can be easily hurt and damaged and it is highly susceptible to STIs and carries a high risk of HIV transmission, *relative to vaginal sex. Though anal sex is often associated with gay men, it is also practiced among heterosexual men and women and among lesbians, all of whom also practice anal sex due to pleasure. Some practice anal sex to avoid pregnancy.
  - Female-to-female sex: Female-to-female sex may involve oral sex, masturbation, body rubbing, clitoral, anal or vaginal stimulation with fingers, sex toys, etc. It is a misconception that female-to-female sex is not "real sex" – female-to-female sex is just as real sex as other types of sexual behavior, and there are many ways to have sex without penetration. Transmission rates for STIs are lower for women who have sex with women, but it is still possible to acquire and transmit infections in female-to-female sex. And if one partner is a transgender woman with a penis and the other partner has a vagina, reproductive health needs may need to be considered.
- Understanding that there are many ways to have sex with a partner helps Health Service Providers to provide relevant and non-discriminatory SRH services.

Instructions next page

Instructions 4.2:

Welcome and introductions

Key Information

1. Facilitator presents Key Information on sexuality and sexual behavior.

Group work – part 1

2. Group work– groups of 4-5 persons
   a. Each group receives statements cut out from Handout 3.
   b. In each group, a participant reads the statements one at a time. For each statement, other group members give a concrete example of what that statement means in everyday life.
   c. Once all statements have been read out aloud and exemplified, the group now must agree on selecting four statements that are most important to them in their work as HSPs on provision of SRHR.
   d. Facilitator debriefs by leading discussion on
      i. which disagreements and discussions arose in groups.
      ii. asking for examples of how the statements relate to their work with patients in health facilities.

Group work – part 2

3. Group work – groups of 4-5 participants.
   a. Groups are asked to answer: Identify 2-3 reasons why it is important for Health Service Providers to understand variations of human sexuality and variations in sexual practices among LGBT+ people?
   b. Debrief in plenary.

Facilitator notes: Please use print page 12

SESSION 4.3:

QUIZ ON HUMAN SEXUALITY

1 HRS

MATERIALS TO HAVE READY:
Signs with Agree, Disagree, Not sure
(p. 82-84)

METHODS:
Quiz

Background information for facilitators:

This activity has two purposes:
1) to get participants off their chairs and encourage active participation, and
2) to have the participants reflect on their own immediate assumptions and possible normative thinking.

It is therefore important that the facilitator create room for movement, both physically and in attitudes. You can support this by encouraging respectful discussions, including discussions between participants – perhaps they can convince each other, supported by you, rather than you telling them the right answer?

Statements to be read out loud:
a) A female who looks very masculine is always lesbian
b) A male who looks very masculine can be bisexual
c) Transgender men cannot conceive
d) Anal sex is practiced among people of all sexual orientations
e) You will usually only know a person's sexual orientation if they disclose it to you
f) Intersex persons do not engage in sexual activity
g) A transgender woman can be sexually attracted to women, men, both, no one, or any other preference

The correct answers are listed below for clarity – but do keep in mind that the discussion with and between participants to question stereotypical or normative thinking is more important than a quick answer.

Correct answers: a) DISAGREE, b) AGREE, c) DISAGREE, d), e) AGREE, f) DISAGREE, g) AGREE

Instructions 4.3:

Quiz

1. Facilitator places a sign with the word "AGREE" in one end of the room, another sign with the word "DISAGREE" in the other end of the room, and "NOT SURE" in the middle of the room (print pages 82-84)

2. Facilitator reads the statements, one by one. For each statement, participants have to go to the "AGREE", "DISAGREE" or "NOT SURE" signs depending on what they think

3. After all participants have moved to one of the signs, 1-2 persons from each group are asked to explain their answer.
   Facilitator invites participants to reflect on their immediate assumptions and guides group discussion.
   Perhaps some participants move to a different sign during the discussion?
   Allow time for this, before moving on to the next question.

Facilitator notes: Please use print page 12

MODULE

5.

Session 5.1: VALUES AND PRINCIPLES

Session 5.2: VALUE CLARIFICATION

CLARIFYING VALUES & ATTITUDES

LEARNING OUTCOMES

At the end of Module 5, participants will be able to:

- Understand values, the sources of values and how values influence decision making and behavior
- Reflect upon their own values around diverse sexual orientations, gender identities, gender expressions and sex characteristics

SESSION 5.1:

VALUES AND PRINCIPLES

1 HRS

MATERIALS TO HAVE READY:
Flip chart

METHODS:
Small group work, plenary discussion

Background information for facilitators:

On how to reflect upon values, how values are not static and how they are influenced by culture, religion etc.

In this session, it is important that the participants themselves are speaking to support their reflection process. Hence, the facilitator's role is merely to guide group work and discussions – not to present information.

The key points to draw out through discussion are:

- Our values form fundamental parts of our lives
- Values are closely related and affected by our beliefs, ideals, and knowledge
- Values are things that we support or are against – e.g. girls' right to education
- Values are influenced by families, religious teachings, culture, friends and media – but we also choose our values
- Values affect how we behave

Instructions 5.1:

Group work & plenary discussion on values

1. Small-group work: Participants brainstorm for 5 minutes in pairs on examples of values.
2. In plenary, Facilitator asks for examples from participants and lists them - drawing out different types – e.g. Family values, religious values, cultural values but also values that are not shared or values that are contradicting.
3. Plenary discussion of where the values come from, drawing out that values are shaped by time and society, and therefore are not static. The facilitator guides discussion to ensure that the key points listed in Background Information is covered, using participants' own words and phrasing to be listed on flip chart.

Facilitator notes: Please use print page 12

SESSION 5.2:

VALUE CLARIFICATION

1 HRS

MATERIALS TO HAVE READY:
Signs with Agree, Disagree, Not sure
(p. 83-85)

METHODS:
Presentation, Value Shuffle, plenary discussion

Background information for facilitators:

On how value clarification is the process of becoming aware of, considering and affirming or rejecting values around a particular topic.

This activity is designed to encourage active participation as well as critical reflections. It is best done by moving physically with ample time between statements to have discussions and allowing participants to change their minds and move to a different position during discussions.

We will explore values around diverse sexual behaviors and non-confirming sexual orientations, gender identities, gender expressions and sex characteristics in relation to the work of HSPs. Since participants' own values come into focus here, it is extra important for the Facilitator to ensure that discussions take place in a non-judgmental and respectful tone and by that ensuring a safe space for participants.

Here are the statements to be used:

- It is immoral to have anal sex in a gay relationship
- It is immoral to have anal sex in a heterosexual relationship
- Counselling should focus on ensuring that LGBT+ persons abstain from sex
- LGBT+ persons will not use SRH services even if they are offered
- LGBT+ persons do not deserve to be offered SRH services
- Homosexuality is a psychological disease
- Parents of a young LGBT+ person (under 18) should be informed, whether they agree or not
- LGBT+ persons deserve the same confidentiality measures as my other patients
- As a Health Service Provider, I have a duty to provide the same quality of services to everyone, regardless of sexual orientation or gender identity

Instructions next page

Instructions 5.2:

Activity – Value Shuffle

1. Facilitator places a sign with the word "Agree" in one end of the room, "Disagree" in the other end of the room and "Not Sure" in the middle and introduces the activity "Value Shuffle".

2. Facilitator reads the statements, one by one. For each statement, participants have to go to the "AGREE", "DISAGREE" or "Not Sure" signs depending on what they think, and 1-2 persons per answer is asked to explain their response. Facilitator also asks: Did you know right away how you felt or did you need a minute to think about it? What influenced your decision? Did others influence your decision? Is there anything that could make you change your mind on this issue? If so, what?

3. Wrap-up by facilitator to re-emphasize:
   - It is normal that our values change over time and is influenced by new knowledge.
   - Our values influence behavior.
   - Health Service Providers are duty bearers and has a responsibility to provide equal services to all people regardless of sexual orientation, gender identity/expression and sex characteristics (refer to learning points from Module 2).
   - The personal values of Health Service Providers must never influence their professional practices.

Facilitator notes: Please use print page 12

MODULE

6.

Session 6.1: UNDERSTANDING STIGMA AND DISCRIMINATION

Session 6.2: POWER AND INEQUALITIES

STIGMA, DISCRIMINATION AND INEQUALITIES

At the end of Module 6, the participants will be able to:

- Understand stigma, discrimination and stereotypes often faced by LGBT+ persons and how it relates to accessing health services
- Understand how being an LGBT+ person can negatively affect access to basic rights

SESSION 6.1:

UNDERSTANDING STIGMA AND DISCRIMINATION

2 HRS

MATERIALS TO HAVE READY:
4-5 slides, video, Handout 4 (p. 78)

METHODS:
Presentation, group work, plenary discussion

Background information for facilitators[8]:

On how to build knowledge on stigma and discrimination and to understand how it affects LGBT+ .

▸TIP:
This session offers excellent opportunities to link to the previous Modules and reinforce key learning points: Module 2 on human rights, non-discrimination and the obligations of duty bearers to respect, protect, and fulfil the rights of others; Module 5 on what influence values and how values impact behavior.

Here is the Key Information you can consider sharing with the participants:

What is stigma? Stigma refers to the strong negative feelings or disapproval that is linked to a specific group, person, or trait. In Kenya, stigma has been witnessed against people living with HIV, people experiencing some form of disability etc. LGBT+ persons are also stigmatized in the Kenyan society. Stigma develops because of many factors but is often influenced by values and beliefs.

What is discrimination? Stigma often leads to discrimination, where a person is treated un-justly or unfairly because of a specific trait that they possess.

What is prejudice? A prejudice is a preconceived idea or opinion towards a person or a group. Prejudices are usually negative, they are constructed by societal and cultural norms and often connected to identify markers such as sex, age, ethnicity, religious background, sexuality, etc.

What is a social norm? A social norm is a certain way of looking, acting and being that is considered to be so normal that you do not even notice or question it. Some social norms or rules can help make social situations easier and more inclusive, for example being silent when someone else is speaking. But social norms can also exclude, for example that girls and boys are expected to wear certain clothes: it is a social norm in many countries that only girls wear dresses or skirts and boys wear trousers, even though there is no particular universal reason for this. In fact, in some cultures, men wear skirt-like garments. Social norms support social hierarchies, for example when people or a community considers some types of relationships more acceptable than others, for instance a male/female based relationships versus a female/female relationship.

Why are LGBT+ persons stigmatized? Some of the reasons why LGBT+ persons are stigmatized include:

- Insufficient legal protection: The Penal Code that criminalize same sex relations create foundation for stigmatizing LGBT+ persons despite the non-discrimination principles embedded in the Constitution and human rights frameworks
- Negative values and social norms: Negative values and belief systems marginalize and exclude LGBT+ persons
- Homo- and Transphobia: Fear, rejection or aversion against same-sex sexual behavior and transgender people
- Association with other stigmas: LGBT+ persons can also be stigmatized and blamed for HIV, sex work, etc.

Continued on the next page

[8] *Text is adapted from Ben Brown, Zoe Duby, Delene van Dyk (2013).*

How does stigma affect LGBT+ persons in health services?

- Reduced access to health services: Health Service Providers are meant to provide support, care and treatment to all people who are in need. However,
  - fear of discrimination and stigma may lead LGBT+ persons to avoid seeking health services.
  - negative values and social norms among Health Service Providers may lead to reduced service delivery (or reduced quality of service delivery) to LGBT+ persons.
  - if LGBT+ persons do not feel certain that the Health Service Provider will respect their privacy, this will impact the information they disclose to the Health Service Provider.
- Reduced access to justice: LGBT+ persons may also be discriminated by the police or other duty bearers, not just because of the Penal Code but also because they are seen as undeserving of the rights granted to all other citizens. They may experience violence and sexual assault. Negative attitudes from the police, Health Service Providers and other duty bearers make addressing these violations very challenging.

Instructions 6.1:

Stigma and discrimination

1. Facilitator presents Key Information.
2. Video: https://youtu.be/Z_5Uwb9nC6g Personal story of stigma and discrimination.
3. In groups of 4-5 persons, participants are asked to discuss the following questions:
   a. In which ways is Arnest being treated differently and discriminated against?
   b. Why do you think the officer behaves the way he/she does?
   c. What would have been the right way of handling Arnest's request, keeping in mind that the police officer is a duty bearer?
   d. In case of not knowing how to handle a request like Arnest's, how could the officer have sought help to behave more in accordance with his/her duties?
4. To debrief, groups share and discuss their findings in plenary, and Facilitator links back to key points about discrimination, stigma and prejudice.

External and internal stigma

5. Facilitator introduces Handout 4 on internal and external stigma.
6. In groups of 4-5 persons, participants work to identify internal and external stigma and discuss how it relates to LGBT+ persons and their own roles as Health Service Providers.
7. Facilitator debriefs in plenary, highlighting the linkages to LGBT+ persons and the role of Health Service Providers.

Facilitator notes: Please use print page 12

SESSION 6.2:

POWER AND INEQUALITIES

2 HRS

MATERIALS TO HAVE READY:
1-2 slides, Handout 5 (p. 79) cut into strips – 1 strip/character per participant

METHODS:
Presentation, Power Walk, plenary discussion

Background information for facilitators:

On how to explore the links between social norms, discrimination and access to rights.

In this session participants will do an excercise called the Power Walk to illustrate how social norms influence social hierarchies and lead to inequalities, even though formally speaking there are equal rights. The exercise serves to make the power of discriminatory norms and stereotypes visible and reminds us all to be aware of and challenge these norms.

Here is the Key Information you can consider sharing with participants before doing the Power Walk:

From Module 2 we know that:

- The Universal Declaration of Human Rights states that "All human beings are born free and equal in dignity and rights"

- The Constitution of Kenya states that "Every Person is equal before the law and has the right to equal protection and equal benefit of the law".

In practice, however, people experience differences in access to rights, including access to health services.

- Consider for instance the case of a university-educated man:

  Is he likely to access the SRH services he needs? And how does the likelihood change if he is in a same-sex relationship? Or if he was a transwoman? Adding these social identities – first sexual orientation, then gender identity – is likely to reduce access to SRH services in practice, even though it is the same person with the same rights.

- We all have overlapping and intersecting identities, e.g. being a woman, being lesbian, being a business owner, and together these identities shape how we are perceived by others. Social norms and values reinforce the existing social hierarchies, for instance on how women and men are expected to act – and this in turn shape how affected an individual is by prejudice, discrimination and power imbalances.

- People face inequalities based on factors such as gender, age, ethnicity, disability, sexual orientation, gender identity, gender expression, and many more – and often, these factors may reinforce each other to deepen inequalities.

The purpose of the Power Walk exercise is to explore and gain understanding of how an individual's identity markers affect their access to rights.

Instructions next page ➜

Instructions 6.2:

Key Information

1. Brief presentation by Facilitator – key points from Module 2 and introduction to the Power Walk.

The Power Walk

2. Each participant is given a character (Handout 5, p. 78), and participants line up on a straight line.
3. Facilitator reads out statements (see below) one at a time.
4. Each participant now imagines being the character they were given. In their community as it is today, does the statement apply to them?
   a. If a participant's character can answer "Yes" to the statement, the participant takes a step forward.
   b. If a participant's character is likely to answer "No" to the statement, the participant does not move.
   c. After all statements are read, participants will be unevenly distributed though having the same starting point: Some characters have moved forward a lot, others not very much.
5. Here are the statements you can consider using for the power walk [9] :
   a. I have access to news – newspaper, radio or TV stations.
   b. I can influence decisions in my community.
   c. I have a say about who I marry and when I marry.
   d. I can assume that service providers understand my SRH needs when I visit health clinics.
   e. I have control over decisions about my body, including when to have children and how many.
   f. I make decisions about major purchases in my household.
   g. I am afraid that health providers laugh at me behind my bag.
   h. I am not in danger of being sexually harassed or abused.
   i. I have access to information about HIV and treatment if I need it.
   j. I eat at least two full meals a day.
   k. My opinion is respected and has weight in the village where I live.
   l. My family and I are not vulnerable to natural disasters.
   m. I went to secondary school or I expect to go to secondary school.
   n. I can negotiate condom use with my partner.
   o. I can afford to buy condoms.
   p. I have access relevant and friendly services related to my sexuality and sexual practices when I visit health clinics.
6. To debrief, facilitator asks group to reflect on patterns:
   a. Which characters moved forward a lot – what did they have in common in terms of identity markers and social groups, e.g. age, gender, or being a LGBT+ person?
   b. Which characters did not move much – what did they have in common?
   c. For the LGBT+ characters, which specific inequalities did they face? How did it impact their access to health services, economic or job opportunities, education, possibility of sharping their own lives?

Facilitator notes: Please use print page 12

[9] *Some statements are from Rutgers (2019), p 46.*

MODULE

7.

SRH RISKS AND VULNERABILITIES FOR LGBT+ PERSONS

LEARNING OUTCOMES

At the end of module 7, participants will be able to:

- Understand SRH risks and vulnerabilities for LGBT+ persons
- Understand common mental health challenges among LGBT+ persons
- Understand how Health Service Providers can contribute to improving access and utilization of SRH service for LGBT+ persons

SESSION 7.1:

RISKS AND VULNERABILITIES FOR LGBT+ PERSONS

1.5 HRS

MATERIALS TO HAVE READY:
3-4 slides + flipchart

METHODS:
Presentation, group work, plenary discussion

Background information for facilitators:

On how stigma, negative attitudes, and repressive societal structures and power dynamics contribute to higher risks and health vulnerabilities for LGBT+ persons.

The text in this Background Information for Facilitators builds upon Ministry of Health's National Guidelines for HIV and STI Programming among Transgender People, though here expanded to include all LGBT+ sub-groups for the purposes of making the training inclusive.

Here is the Key Information on risks and vulnerabilities:

LGBT+ persons face heightened health risks and vulnerabilities due to a range of factors, including:

- **Lack of accessible public health services** that address the needs of LGBT+
- **Social stigma and discrimination against LGBT+ persons,** including homophobia and transphobia, causing LGBT+ persons to be fearful to disclose their sexual behaviors to Health Service Providers
- **Violence against LGBT+ persons,** e.g. physical injuries, sexual assault or rape
- **Intersecting inequalities and power imbalances** that affect access to information and informed decision making about sexual practices, e.g. condom use
- **Alienation and exclusion** from family, friends and social support networks. Mistreatment by relatives can lead LGBT+ persons to be homeless, drop out of school, contribute to mental health challenges, engage in negative coping mechanisms which increase their vulnerability to to for example STIs, HIV and unwanted pregnancies.

Some LGBT+ groups are recognized as "Key Populations" for HIV and STI programs. These groups include: Men who have Sex with Men and transgender persons.

However, all LGBT+ groups face heightened health risks, vulnerabilities and barriers in accessing health services, regardless of whether they are included as a part of a defined Key Population or not. For instance, lesbian women, bisexual women and intersex persons also face barriers for accessing relevant health service which places them at increased health risks.

Guiding principles include[10] :

- Do no harm – do what's good for the person
- Meaningful engagement – LGBT+ people are part of the solution through their participation
- Human-centered approach, with respect for LGBT+ people
- Rights-based approach – uphold the human rights and dignity of all LGBT+ people.

Continued on the next page

[9] *The guiding principles are from "National Guidelines for HIV and STI Programming among Transgender People", though expanded to all LGBT+ sub-groups for the purposes of inclusivity.*

Instructions 7.1:

Key Information

1. Facilitator presents Key Information on risks and vulnerabilities.

Video and group work

2. Facilitator shows video: https://youtu.be/aAuDvlzv5Dw
3. In groups of max 4-5 persons, participants discuss:
   a. Why did Lily Simon drop out of school?
   b. How will this impact Lily Simon's future?
   c. What kind of sexual violence have Lily Simon and Victor experienced and why?
   d. When the rape was reported at the police station and the police officers were hostile, did the police officers fulfil the duties to uphold human rights?
   e. Why does MAAYGO conduct HIV counselling and testing at night?
4. Facilitator leads discussion where group share their findings.

Facilitator notes: Please use print page 12

SESSION 7.2:

MENTAL HEALTH AND LGBT+

0,5 HRS

MATERIALS TO HAVE READY:
4-5 slides

METHODS:
Plenary

Background information for facilitators:

On how LGBT+ persons are at increased risk of experiencing mental health challenges.

It is important that Health Service Providers are aware of this as discrimination and stigma experienced by LGBT+ persons - also from service providers – can be main drivers behind mental health issues.

Here is the Key Information on common mental health challenges among LGBT+ persons:

Minority stress:

- Stress is a part of everyday life and many people experience it. However, general stress is distinct from Minority Stress.
- Minority Stress refers to the additional stress that members of excluded groups experience because of the continuous prejudice, discrimination and violence they face.
- Minority Stress can lead to poorer health outcomes (both mental and physical) compared to individuals that do not experience Minority Stress.

Anxiety and depression

- Anxiety is a normal emotion in everyday life and is closely related to fear. Anxiety can become a mental illness when it is prolonged or never-ending or when the anxiety becomes out of control and affects an individual's daily functioning.
- Social anxiety disorder is a special type of anxiety disorder that may affect LGBT+. They experience intense fear, panic or stress while engaging in everyday social situations. An individual who is experiencing social anxiety may be less likely to seek health services because of fear of being judged or scrutinized by Health Service Providers.
- Depression is a psychological disorder that involves a persistent feeling of sadness, low self-esteem and loss of for an extended period of time. Depression can greatly impact people's health, particularly for someone who is unable to find a means of treatment.
- If depression is severe and left untreated it can lead to substance use and/or increased suicidal behavior.

PTSD

- PTSD occurs after an individual has been exposed to a severely traumatic event. LGBT+ persons may experience traumatic events regularly, e.g. police harassment, rape, torture, physical or sexual assault, "corrective" rape (the rape of a gay or lesbian or transgender person by someone who believes they can 'correct' the survivor's sexuality).
- After the event, an individual who suffers from PTSD may experience panic attacks and extreme fear or they may re-envision the event continually. The disorder can have a significant impact on normal everyday functioning.

Effects of mental health issues

- Depression and minority stress can prevent LGBT+ persons from adhering to medical treatments or even inhibit them from seeking initial health services.
- Anxiety can limit an individual's willingness to engage with others, which may include Health Service Providers.
- Individuals who are experiencing a mental illness may be more difficult to treat for HIV and other SRH issues.
- Unaddressed depressions, minority stress and anxiety can lead to destructive coping mechanisms, such as drug abuse and self-harm which increase SRH risks.

Instructions next page

Instructions:

Key Information

1. Facilitator presents Key Information.

Facilitator notes: Please use print page 12

SESSION 7.3:

SGBV AND LGBT+

1 HRS

MATERIALS TO HAVE READY:
3-4 slides, Case study 2 (p. 89)

METHODS:
Presentation, group work with case, plenary discussion

Background information for facilitators:

On the risks of Sexual and Gender-Based Violence (SGBV) faced by LGBT+.

▸TIP:
This session offers excellent opportunities to link to the previous Modules and reinforce key learning points: Module 2 on human rights, non-discrimination and the obligations of duty bearers to respect, protect, and fulfil the rights of others; Module 5 on what influence values and how values impact behavior; Module 6 on stigma and discrimination.

Here is the Key Information you can consider sharing with the participants:

SGBV:

- Is an umbrella term for any harmful, sexual act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between people with power and people with less power – often referred to within the binary definitions of 'males' and 'females'.

- Includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private spaces. It can for instance be:
  - Sexual assault and rape, including rape expressly used to punish lesbian or bisexual women for their sexual orientation ("corrective rape")
  - Sexual exploitation, abuse and harassment
  - Domestic violence, such as Intimate Partner Violence

- A human rights violation. Acts of SGBV violate a number of universal human rights protected by international instruments and conventions.

LGBT+ persons face comprehensive challenges with SGBV for multiple reasons:

- Increased risk: LGBT+ persons are at increased risk of experiencing SGBV. SGBV committed towards LGBT+ people is often driven by the idea of punishing those seen as not conforming with dominating ocietal gender and sexuality norms. In addition, gender discriminatory norms that uphold men's domination over women place women and girls at increased risk of SGBV, too. This means that women with diverse sexual orientations, gender identities, gender expressions and/or sex characteristics – e.g. transgender persons, bisexual women, lesbians, and intersex women – face intersecting violence and discrimination, thus further increasing risk of SGBV.

- Barriers to reporting and accessing care: Insufficient legal protection, negative values, transphobia and homophobia undermine LGBT+ survivors' ability to report SGBV to the police or accessing the needed support.

Instructions next page

Instructions 7.3:

Key Information

1. Facilitator shares Key Information.

Case study

2. Facilitator introduces case study 2 (WSW and stigma).
3. In groups of max 4-5 persons, participants discuss:
   a. Identify each of the signs of stigma in Joyce's story?
   b. How did Joyce's gender and sexual orientation factor into the violence?
   c. How might Joyce's sexual orientation influence her ability to access the care she needs and report the crime?
   d. Do you believe that a Health Service Provider would give her the treatment she should have at the health clinic? Why/Why not?
4. Discuss group findings in plenary, where Facilitator re-emphasizes the obligation of HSPs to provide non-discriminatory care to all.

Facilitator notes: Please use print page 12

SESSION 7.4:

QUIZ ON RISKS AND VULNERABILITIES

1.5 HRS

MATERIALS TO HAVE READY:
Signs with "True" and "False"
(p. 86-88)

METHODS:
Quiz

Background information for facilitators:

This activity has two purposes:
1) to get participants off their chairs and encourage active participation, and
2) to have the participants reflect on their own immediate assumptions and possible normative thinking.

It is important that the facilitator creates room for movement, both physically and in attitudes. You can support this by encouraging respectful discussions, including discussions between participants – perhaps they can convince each other, supported by you, rather than you telling them the right answer?

Here are the statements that you can consider using for the quiz:

a) Being homosexual or bisexual is a psychological disorder
b) LGBT+ persons are at higher risk of mental health issues, such as depression or anxiety
c) Lesbians do not need family planning services
d) Stigmatization adds to risk of minority stress and poorer health outcomes
e) If HSPs have negative attitudes towards sexual and gender minorities, LGBT+ persons may fear disclosing information relevant to SRH needs
f) Transgender and intersex people cannot have sex and therefore are not at risk for HIV transmission

The correct answers are listed below for clarity – but do keep in mind that the discussion with and between participants to question stereotypical thinking is more important than a quick answer.

Correct answers: a) FALSE, b) TRUE, c) FALSE, d) TRUE, e) TRUE, f) FALSE

Instructions: 7.4

Quiz

1. Facilitator places a sign with the word "TRUE" in one end of the room, and another sign with the word "FALSE" in the other end of the room.
2. Facilitator reads the statements, one by one. For each statement, participants have to go to the "TRUE" or "FALSE" signs depending on what they think.
3. After all participants have moved to one of the signs, 1-2 persons from each group are asked to explain their answer. Facilitator invites participants to reflect on their immediate assumptions and guides group discussion. Perhaps some participants move to a different sign during the discussion? Allow time for this, before moving on to the next question.

Facilitator notes: Please use print page 12

MODULE 8.

Session 8.1: BIOMEDICAL INTERVENTIONS
Session 8.2: BEHAVIORAL INTERVENTIONS
Session 8.3: COMMUNITY EMPOWERMENT

INTEGRATED SRH INTERVENTIONS

LEARNING OUTCOMES

At the end of module 8, the participants will be able to:

- Understand the biomedical HIV prevention, treatment and SRH interventions for LGBT+
- Understand the behavioral interventions available for LGBT+
- Understand the importance of working with LGBT+ community groups/organizations to support health seeking behavior

SESSION 8.1:

BIOMEDICAL INTERVENTIONS

1 HRS

MATERIALS TO HAVE READY:
Handout 6 (p. 80)

METHODS:
Group work, plenary discussion

Background information for facilitators:

Biomedical interventions are interventions that directly influence the biological systems. For the purposes of this training, the focus is on SRH-specific services.

Here is the information on SRH-services that you can consider sharing with the participants:

- **Contraception:** LGBT+ persons who are assigned female at birth and have sex with men are exposed to the risk of unwanted pregnancy, and Health Service Providers should discuss contraceptive needs with them.

- **Condoms and condom-compatible lubrication:** Availability and use of condoms and condom-compatible lubricants reduce risk of sexual transmission of HIV and other STIs in both vaginal and anal sex.

- **Emergency contraception:** Emergency contraception is provided to women and to transmen who are not currently using a contraceptive method to prevent pregnancy after unprotected vaginal sex.

- **Cervical cancer screenings:** LGBT+ persons who are assigned female at birth are at risk of cervical cancer and in need of cervical cancer screenings.

- **Anal cancer screenings:** Anal sex could result in exposure to HPV and progress to anal cancer. Anal cancer screenings are recommended for all LGBT+ persons who engages in receptive anal sex.

- **Post-abortion Care (PAC):** Post-abortion care is the care given to people assigned female at birth who have had an unsafe abortion. It consists of emergency treatment of complications from an unsafe abortion, family planning counselling/services, and provision of testing and counselling.

- **HIV and STI Prevention, screening, testing and treatment:** Screening, diagnosis, care, support, and treatment of STIs are crucial parts of a comprehensive response to HIV.

- **Interventions specifically relevant to transgender persons [11] but typically not available in Kenya:**
  - *Gender-affirming Surgery:* A Gender affirming surgery is a surgical procedure that changes a person's sex characteristics to better reflect their gender identity. This can e.g. include breast augmentation for transmen or an Orchiectomy for transwomen where male reproductive organs are removed, but there is no single model of sex-change surgery. Instead it is a variety of surgeries.
  - *Hormone Replacement Therapy* for transgender persons is when hormonal medications are given to align with gender identity. Hormone therapy makes some transgender people feel more at ease with themselves, both physically and psychologically. This has positive implications and is mentally therapeutic. Feminizing medication include estrogen-based formulation and sometimes medication to reduce effects of testosterone. Masculinizing medications include testosterone-based formulation and medication to lower estrogen levels. MoH's National Guidelines (2021) list Gender-affirming surgeries and hormone replacement therapy as "Desirable Biomedical Interventions". The interventions are typically not available to transgender persons in Kenya. As a result, some jeopardize their health by using unsafe equipment to inject themselves with hormones purchased without a prescription.

Continued on the next page

[11] *Ministry of Health's "National Guidelines for HIV and STI Programming among Transgender People", 2021.*

Instructions 8.1:

Activity 1: Participant led listing of biomedical interventions

1. In groups, participants are asked to list the biomedical SRH interventions for LGBT+ persons they can think of.
2. In plenary, groups consolidate lists to make ONE list of biomedical SRH interventions for LGBT+ persons. Facilitator supplements with any missing information.

▸TIP for Activity 1:
Health Service Providers participates in Continuous Medical Education at their workplace, and participants are likely to be well aware of the full range of biomedical interventions recommended by National Guidelines for Key Populations. Should there be participants who are not aware of the full range of biomedical interventions, their fellow participants are the best trainers – so do allow the participants to lead the listing of biomedical interventions, rather than having them be presented by the facilitator. Hence there is no presentation by Facilitator in this session.

Activity 2: Group work Handout 6

3. Group work:

a. Each group (of maximum 4 persons!) are given a set of cut-out pieces of text. Some are the headlines, e.g. “PEP” and “SRH Services” – these have a dark background. Others are examples, e.g. “testing in a confidential space” or “cervical cancer screenings”.

b. Each group now has to arrange the cut-out pieces of paper to match headlines to examples. Discussions are encouraged within the group.

4. When all groups are done, the facilitator presents the correct answers in plenary, followed by discussion if/as needed.

▸TIP for Activity 2:
The purpose of the exercise is to reinforce participants’ knowledge on the types of biomedical interventions by giving them a “puzzle” to solve. It is likely to be easy, but nonetheless the process of arranging and rearranging the puzzle pieces in small groups is a way to get them talking about biomedical interventions in their own words.

Facilitator notes: Please use print page 12

SESSION 8.2:

BEHAVIORAL INTERVENTIONS

45 MIN

MATERIALS TO HAVE READY:
3-4 slides, flipchart

METHODS:
Presentation, group work, plenary debrief

Background information for facilitators:

Information on behavioral interventions, which are critically important towards supporting LGBT+ persons in adopting heath-seeking behaviors.

The information below is aligned with Kenya's National Guidelines.

▸TIP:
The purpose of the group work is to increase awareness of the participants of behavioral interventions available in their own community. This is best done by having the participants discuss it in small groups, rather than led by the facilitator.

Here is the Key Information you can consider presenting to the participants:

Behavioral interventions are done to:
- Improve knowledge and skills related to HIV/STI prevention
- Increase access to prevention commodities
- Improve peer-to-peer contact, solidarity, and social support
- Enhance referral and linkage to services

Peer education and outreach
Peer educators are people from the LGBT+ community who work with their peers to influence knowledge, attitude and behavior change. Peer education has been proven to increase levels of HIV knowledge, reduce STI prevalence and increase condom use. Peer educators are expected to perform the majority of the outreach, with outreach workers providing managerial or technical support when needed. Outreach entails actively delivering information, products and services to LGBT+ persons in locations where they typically spend time, rather than relying on them to come to clinics.

Behavior change interventions & communication
Communicating with LGBT+ persons to promote health-seeking behavior, safer sex, uptake of counselling and testing for HIV and other SRH needs, is important.

Social media can be used to pass behavior change communication to the LGBT+ community. Social media can expand programmatic reach to individuals who may not otherwise access LGBT+ specific health information, but it should not replace all face-to-face interactions.

Good practice standards for online programs and outreach efforts using smartphone applications ensure the safety and privacy of members and participants. Consistent monitoring is critical to ensure the accuracy and integrity of information presented, but taking steps to ensure online safety is critically important too. This includes ensuring that electronic devices have strong passwords and avoiding discussing sensitive issues in public spaces. Precautions must also be taken to restrict announcements about safe space gatherings or other social events for LGBT+ persons only to social media pages that have restricted access to members only.

Instructions next page

Instructions 8.2:

Key Information

1. Facilitator presents Key Information.

Group work - available behavioral interventions in community

2. In groups of 4-5 persons, participants are asked to identify:
   a. Which behavioral interventions are available or in use within their own community.
   b. How can a service provider provide information to LGBT+ persons on the available behavioral interventions?
3. Presentation in plenary by one of the groups, where other groups add to fill any gaps or add nuance – giving everyone an overview of how behavioral interventions are used in the county.

Facilitator notes: Please use print page 12

SESSION 8.3:

COMMUNITY EMPOWERMENT

45 MIN

MATERIALS TO HAVE READY:
2-3 slides for presentation, flipchart

METHODS:
Presentation, group work, plenary debrief

Background information for facilitators [12]:

On how biomedical and behavioral interventions cannot succeed on their own.

A third group of interventions recommended by the National Guidelines of MoH is about structural interventions, and within this community empowerment.

Here is the Key Information you can consider presenting to the participants:

What is community empowerment?
Community empowerment is the process whereby excluded/ marginalized population groups such as for example LGBT+ people are empowered to take individual and collective ownership to achieve the most effective response towards the challenge/ inequalities they face. Community empowerment seeks to build individual and organizational capacity and partnerships across sectors to address social, cultural, political and economic drivers of inequality.

Key elements of community empowerment among LGBT+ people include:

- Collaborate directly with LGBT+ communities – meaningful involvement, inclusion and leadership of LGBT+ people
- Support LGBT+-led organizations to foster and support community leadership to achieve high impact
- Support organizational capacity strengthening of LGBT+ organizations to conduct robust and comprehensive programs, strengthening resource mobilization, governance, project management, community systems
- Support LGBT+ organizations to influence policy through advocacy promoting human rights

It is relevant to note that these "Key Elements of Community Empowerment" may be somewhat beyond the scope of the daily work of health service providers.

However, what is highly relevant for health service providers to know is the importance of working closely with LGBT+ communities: When health service providers and the facilities they work in collaborate with LGBT+ communities, it builds understanding of LGBT+ persons needs, helps overcome barriers to health care access, and supports health seeking behavior. This particular element of community empowerment will be explored in the group work for this module.

Continued on the next page

[12] *Content is from "National Guidelines for HIV and STI Programming among Transgender People", though extended to LGBT+ and not only transgender .*

Instructions 8.2:

Key Information

1. Facilitator presents Key Information

HSPs and community linkages

2. In plenary, Facilitator leads a brainstorm to identify and name 4-5 LGBT+ community groups/organizations. The community groups or community organizations may include e.g. LGBT+ youth groups, LGBT+ civil society organizations, human rights and advocacy organizations for LGBT+ persons, LGBT+ community platforms, LGBT+ support groups, etc. An example of such a group is MAAYGO, shown in the video of Module 7.1, a community-based group focused on integrated health and human rights of men having sex with men.
3. In groups of 4-5 persons, participants are asked to discuss:
   a. How good are our links as health service providers to these community groups? Where are the gaps?
   b. Can we do more to actively involve LGBT+ community groups to better understand LGBT+ persons health needs and support health seeking behavior? If yes, what/how?
4. Presentation in plenary by one of the groups, where other groups add to fill any gaps or add nuance. Facilitator draws out key points about how working with LGBT+ community groups help health service providers to 1) understand needs and issues faced by LGBT+ persons when accessing health, and 2) reduce barriers to health care access and thereby supporting health seeking behavior.

Facilitator notes: Please use print page 12

MODULE 9.

Session 9.1: PRIVACY, CONFIDENTIALITY AND REFERRALS

Session 9.2: MONITORING & REPORTING HEALTH OUTCOMES

REFERRALS AND REPORTING HEALTH OUTCOMES

LEARNING OUTCOMES

At the end of Module 9, the participants will:

- Understand their role as duty bearers in ensuring privacy and confidentiality for LGBT+ persons, including in referrals
- Be informed about the need for a stronger reporting system on LGBT+ persons' health needs

SESSION 9.1:

PRIVACY, CONFIDENTIALITY AND REFERRALS

1.5 HRS

MATERIALS TO HAVE READY:
3-4 slides for presentation,
Case study 3 (p. 88), flipcharts

METHODS:
Plenary, group work, plenary discussion

Background information for facilitators:

On emphasizing the legal and professional aspects of upholding confidentiality and privacy for LGBT+ clients.

The information below is aligned with Kenya's National Guidelines.

▸TIP:
Connect this session with Module 2 on human rights, Kenya's legal framework, and the obligations of duty bearers.

Here is the Key Information you can consider sharing with the participants:

Kenya's Health Act on privacy and confidentiality:

- Privacy: Every person shall have the right to be treated with dignity, respect and have their privacy respected in accordance with the Constitution and this Act. (Article 5, 2.)
- Confidentiality: Information concerning a user, including information relating to health status, treatment or stay in health facility is confidential except where such information is disclosed under order of court of informed consent for health research and policy planning purposes (Article 11, 1.)

In addition, Health Service Providers are duty bearers who have responsibility for upholding the *human rights* of others, including their rights to privacy and confidentiality. Patients come seeking advice, treatment, and help from Health Service Providers. The HSP is a duty bearer under human rights law, meaning that the HSP has an obligation to uphold the rights of patients.

Privacy and confidentiality in practice for Health Service Providers

Patient privacy can include:

- Physical privacy, e.g. during examinations
- Privacy around personal data
- Privacy around personal choices and relationships

Confidentiality is about patients being able to trust that Health Service Providers will protect information shared in confidence.

Upholding patient privacy and confidentiality is also relevant for referrals.

What is a referral system [13]?

Some health facilities may not be able to provide an entire service package relevant to LGBT+ needs, and there may be a need to refer to service providers in other facilities. A referral system is a mechanism to enable comprehensive management of clients' health needs through resources beyond those available where they access care.

The process of referral should always be done in a safe, ethical and confidential manner.

Types of referral services can include amongst others:

- Counselling, testing, and treatment of STIs or HIV/AIDS
- Sexuality education and / or Sexual Reproductive Health counselling and information
- Counseling / support for SGBV and sexual coercion
- Multisectoral response for SGBV survivor

Continued on the next page

[13] *Text adapted from Ministry of Health's "Kenya Health Sector Referral Strategy (2014– 2018).*

Instructions 9.1:

Key Information

1. Facilitator presents Key Information.

Case study 3

2. Facilitator introduces Case study 3 (At the clinic)
3. In small groups (max 4-5 persons), participants discuss the questions:
   a. What did the service provider do right for patient privacy?
   b. When did the service provider violate privacy?
   c. What consequences did this have?
4. Groups present their findings in plenary for discussion facilitated by the Facilitator.

Facilitator notes: Please use print page 12

SESSION 9.1:

MONITORING & REPORTING HEALTH OUTCOMES

30 MIN

MATERIALS TO HAVE READY:
2-3 slides for presentation

METHODS:
Plenary

Background information for facilitators:

On the need for a stronger reporting system on LGBT+ persons' health needs.

Here is the Key Information you can consider sharing with the participants:

Data collection in the health system is essential for monitoring health outcomes and directing resources to where they are needed.

The Key Populations Data Collection Tool Kit consists of standardized data collection tools which guide users on how to fill, when to fill, and who should fill the data collection forms.

It is developed by NASCOP's Key Populations Technical Working Group in 2014, revised in 2018.

The tools are disaggregated by Key Population typology which include two LGBT+ subgroups: Men who have sex with men and transgender persons.

It is important to note that some LGBT+ groups are not included – e.g. intersex, lesbians, and others. As a result, data about their specific SRH needs and health outcomes are not available. This means that it is difficult to design, implement, and evaluate health initiatives that address their specific needs. Health Service Providers can support creating a demand for more inclusive data collection tools.

Instructions 9.1:

Key information & plenary discussion

1. Facilitator presents Key Information.
2. Plenary discussion on the availability of detailed data for Key Populations but not having detailed data for all LGBT+ groups:
   a. What are the benefits of having detailed data on health needs of Key Populations in your experience?
   b. What would the benefits be of having detailed data on health needs of all LGBT+ groups – e.g. lesbian women?
3. Facilitator draws out key messages from discussion, in particular that more inclusive data collection tools can make LGBT+ persons health needs more visible and help strengthen health initiatives to meet specific SRH needs.

Facilitator notes: Please use print page 12

MODULE

10.

Session 10.1: LGBT+ FRIENDLY ENVIRONMENT & COMMUNICATION

Session 10.2: ASSESSING OWN PRACTICE

LGBT+ FRIENDLY PRACTICE

LEARNING OUTCOMES

At the end of Module 10, participants will be able to:

- Understand how they can contribute to an LGBT+ friendly environment
- Know how to communicate with LGBT+ people in a non-discriminatory and inclusive manner

SESSION 10.1:

LGBT+ FRIENDLY ENVIRONMENT & COMMUNICATION

1.5 HRS

MATERIALS TO HAVE READY:
2-3 slides, Video, Handout 7 (p. 81)

METHODS:
Presentation, role play & plenary discussion

Background information for facilitators:

On how to build communication skills among participants that they can relate to and apply at their workplace.

Here is the Key Information you can consider sharing with them, before starting the activities:

A health service facility becomes an enabling environment for LGBT+ persons when it empowers and supports clients to fully engage with its services.

An individual Health Service Provider can improve service delivery to LGBT+ populations by:

- Establishing a welcoming environment in their health facility that visually shows and affirms LGBT+ inclusivity, e.g. same-sex pictures or illustrations
- Engaging with LGBT+ persons who visit the health facility and those in the surrounding community
- Being educated about LGBT+ persons and not making assumptions about their behavior or person
- Establishing a trusting and supportive relationship and respecting the confidentiality of LGBT+ persons
- Providing client-centered advice and recommendations that do not include judgmental or personal values
- Using appropriate language and asking for clarification
- Providing appropriate services and acting as a referral pathway into care

Instructions next page

10.1 Instructions:

Key Information

1. Facilitator presents Key Information

Role play

2. Four volunteers play out the short dialogue in Handout 7, while the rest of the participants observe
3. After the role play, participants discuss in plenary:
   a. Why are Maria and Alex anxious about going to the clinic?
   b. Which examples of negative body language did you notice in Health Service Provider 1?
   c. What else did you notice about Health Service Provider 1's communication (questions or words used, tone of voice, or other) that showed his/her attitudes to Maria and Alex?
   d. Which examples of positive body language did you notice in Health Service Provider 2?
   e. What else did you notice about Health Service Provider 2's communication (questions or words used, tone of voice, or other) that showed his/her attitudes to Maria and Alex?

Facilitator notes: Please use print page 12

SESSION 10.2:

ASSESSING OWN PRACTICE

1 HRS

MATERIALS TO HAVE READY:
Handout 8 (p. 82)

METHODS:
Individual work and plenary debrief

Background information for facilitators:

On the importance of a LGBT+ friendly environment at health service facilities.

The purpose of this exercise is for the participants to reflect upon the environment they work in and how inclusive/LGBT+ friendly it is.

▸TIP:
It is important here to avoid "shaming" anyone or any clinic that is currently not-fully inclusive of LGBT+ practices. In fact, sharing of areas for improvements should be encouraged as others will learn from them – including ones that may have assessed their clinic to be fully-inclusive/green (but may not be fully inclusive in reality).

The exercise uses a "traffic light system", where:

- Green is for practices that are already fully inclusive

- Yellow is for practices that are somewhat inclusive but there are still room for improvements

- Red is for practices that are non-inclusive

Instructions next page ➜

10.2 Instructions:

Self-assessment

1. Facilitator introduces Handout 8.
2. Facilitator reads the following sentences one by one. For each sentence, each participant will individually assess whether their environment (e.g. clinic) is green, yellow or red.
   a. Is the way that LGBT+ persons are treated always respectful and inclusive?
   b. Is the confidentiality and privacy of LGBT+ persons always respected?
   c. Is information available to LGBT+ persons on where they can access specialized services?
   d. Is it common that LGBT+ persons are asked about their sexual orientation and/or sexual practices?
   e. Is staff aware of the SRH risks and vulnerabilities of LGBT+ persons?

Plenary discussion for solutions and action to be taken

3. Facilitator asks for volunteers to share topics marked yellow or red, notes on them on flipchart.
4. Plenary discussion on
   a. Solutions - What can be done to improve these areas?
   b. Are there barriers to implementing solutions? What are they and why?
   c. What are steps that can be taken to overcome the barriers?

Facilitator notes: Please use print page 12

MODULE

11.

Session 11.1: EVALUATION AND CLOSING

CLOSING & EVALUATION

At the end of Module 10, participants will be able to:

- Key learnings have been identified
- Participants have filled evaluation forms and post-tests

SESSION 11.1:

EVALUATION AND CLOSING

1.5 HRS

MATERIALS TO HAVE READY:
Flip charts from day 1, post-test + (p. 69)
final evaluation (p. 71-72)

METHODS:
Plenary, group work & individual work

Background information for facilitators:

In this last module, key learnings are identified in an interactive way by the participants themselves.

This interactive method is used to reinforce learning. Finally, participants fill evaluation forms and post-tests, and the training closes.

Instructions 11.1:

Participant-driven learning summary

1. In groups of 2, participants identify their key learnings from the training.
2. Groups share learnings in plenary, listed on flipchart.
3. Facilitator compared learnings with "Expect to learn" from day 1 and plenary discussion on whether expectations were met.

Evaluation & post-test

4. Participants are asked to fill post-training test.
5. Participants are asked to fill evaluation.

Closing

6. Thank you and goodbye.

Facilitator notes: Please use print page 12

ANNEX

Annex A: TRAINING EVALUATION TOOLS

Annex B: HANDOUTS TO BE PRINTED FOR GROUP WORK

Annex C: CASE STUIES. REFERENCES AND READING MATERIALS

TRAINING TOOLS

ANNEX A:

TRAINING EVALUATION TOOLS

The training evaluation tools consists of three parts:

1. Pre- and post-tests to assess participants' learnings
   Participants' pre & post test

2. Training evaluation form for participants to provide feedback to Facilitators
   Participants' evaluation

3. Training evaluation form for Facilitators for continuous learning and improvements in training delivery
   Faciliators' evaluation

Note: The evaluation tools can alternatively be used in electronic formats, e.g. SurveyMonkey or Google forms.

PARTICIPANTS' PRE & POST TEST

A. True or false

	True	False
1. Kenya's Constitution gives everyone the right to highest attainable standard of health		
2. Health Service Providers have a responsibility for respecting, protecting and fulfilling the human rights of their patients		
3. Being homosexual or bisexual is a psychological disorder		
4. Sexual orientation is about who you are attracted to		
5. A woman who looks very masculine and dresses like a man is always a lesbian		
6. Intersex persons do not have sex		
7. Intersex people may not know that they are intersex		
8. Only men who have sex with men practice anal sex		
9. A transgender woman is someone who identifies and feels as a woman but who was born as male		
10. A transgender man is only attracted to women		
11. A woman may contract a sexually transmitted disease from having sex with another woman		
12. Stigma and discrimination against LGBT+ persons reduce LGBT+ persons' access to health services, including SRH services		
13. Being excluded by family or friends can lead LGBT+ persons to be homeless or drop out of school		
14. MoH recommends to uphold human rights and dignity of transgender people		

B. Do you agree or disagree with the statements below?

	Strongly disagree	Disagree	Neither Agree nor disagree	Agree	Strongly agree
15. LGBT+ persons in Kenya have the same access to health services as the rest of the population					
16. I think it is immoral to have anal sex					
17. I find it difficult or shameful to discuss SRH needs with LGBT+ persons					
18. I care about the specific needs of LGBT+ persons					
19. I think it's better if LGBT+ patients keep information on their sexual orientation, gender identity or sex characteristics to themselves					
20. I intervene if I witness a LGBT+ persons being discriminated against in my work place					

C. LGBT+ friendly practice

Do you know three things/steps that a Health Service Provider can do to make the clinic or practice LGBT+ friendly?

Yes ☐ No ☐

If *yes*, please list them below

a. _____

_____

b. _____

_____

c. _____

TRAINING EVALUATION

Part 1: Rating

Put an ✕ on the scale for each statement below:

1: I disagree strongly **2**: I disagree **3:** I neither agree or disagree **4:** I agree **5**: I agree strongly

No	Evaluation items	Scale 1 2 3 4 5
	About the training:	
1.	The training was well prepared	
2.	There was enough time for the training	
3.	The Facilitators explained the exercises clearly	
4.	The Facilitators respected all participants	
5.	The Facilitators were knowledgeable and engaging	
6.	The training is relevant for Health Service Providers	
	LGBT+ knowledge, attitudes and skills:	
7.	I have acquired new knowledge on LGBT+ persons' SRH health risks and vulnerabilities during the training	
8.	I have reflected on my own values and attitudes towards LGBT+ persons during the training	
9.	The training gave me concrete ideas to how I contribute to making health facilities more LGBT+-friendly	
10.	The use of case studies helped me learn	

Part 2: Questions

1. The most important part of the training for me was

Why was this part of the training the most important?

2. The least important part of the training for me was

Why was this part the least important to you?

3. Please list any advice you have for the Facilitators

4. Please list any other comments you have

FACILITATORS' EVALUATION

The purpose of the Facilitators' evaluation is for the Facilitators to gather and reflect on their own learnings from the workshop.
It is done by the Facilitators after the workshop

Training delivery	Which aspects of the training content, methods and implementation were effective?	
	Which aspects of the training content, methods and implementation did not work well?	
	Why do you think they did not work well?	
	What topics should be added or are currently missing?	
Participants	How was the training tailored to this particular group's needs and capacities?	
	Was it the right group of participants gathered for the purpose of the training?	
	When was the participants the least engaged in the training – and what does that mean for your next training?	
Facilitators	Did Facilitators: • Relate the training to daily work of participants? • Keep own presentations within the allotted time? • Give sufficient time for participants' own work & reflections – groups work, case studies, quizzes, etc? • Maintain safe space and respectful interactions?	
	Where can Facilitators' capacities or preparations be strengthened for even better delivery of the next workshops?	
Organization and logistics	Which aspects of the venue, workshop organization and logistics did not work well?	
	How can workshop organization and logistics improve before the next workshop?	

ANNEX B:

HANDOUTS TO BE PRINTED FOR GROUP WORK

HANDOUT 1: SEX AND GENDER

HANDOUT 2: THE GENDERBREAD PERSON

HANDOUT 3: DEFINING SEXUALITY AND SEXUAL HEALTH

HANDOUT 4: EXTERNAL AND INTERNAL STIGMA

HANDOUT 5: CHARACTERS FOR THE POWER WALK

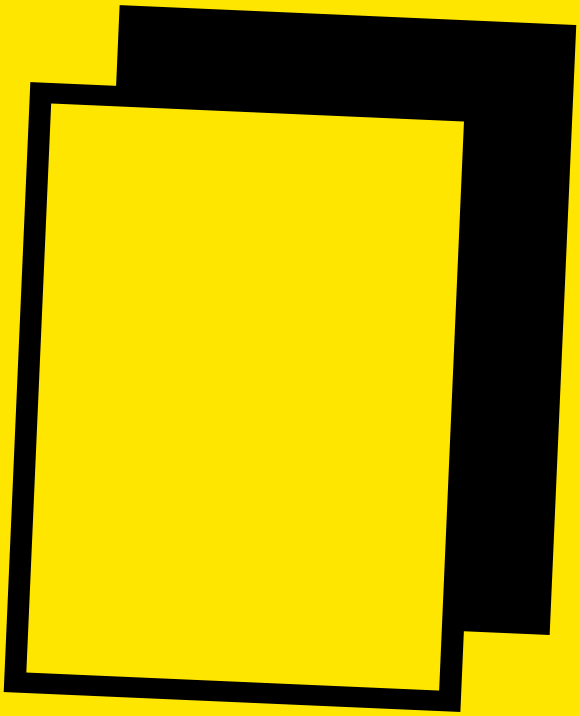
HANDOUT 6: MATCHING BIOMEDICAL INTERVENTIONS

HANDOUT 7: TO THE FOUR VOLUNTEERS ONLY

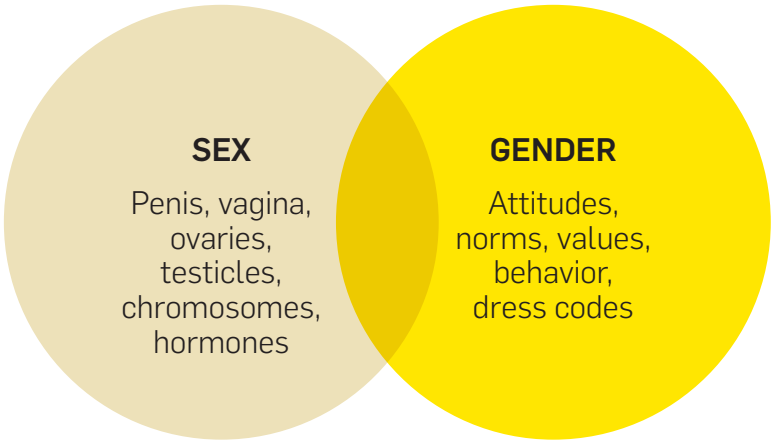
HANDOUT 8: ASSESSING YOUR OWN ENVIRONMENT

QUIZ SIGNS: AGREE / NOT SURE/ DISAGREE

QUIZ SIGNS: TRUE/ FALSE



SEX AND GENDER



Which of the roles or characteristics described below are biologically determined (sex)? Which are shaped by culture and norms (gender expectations)?

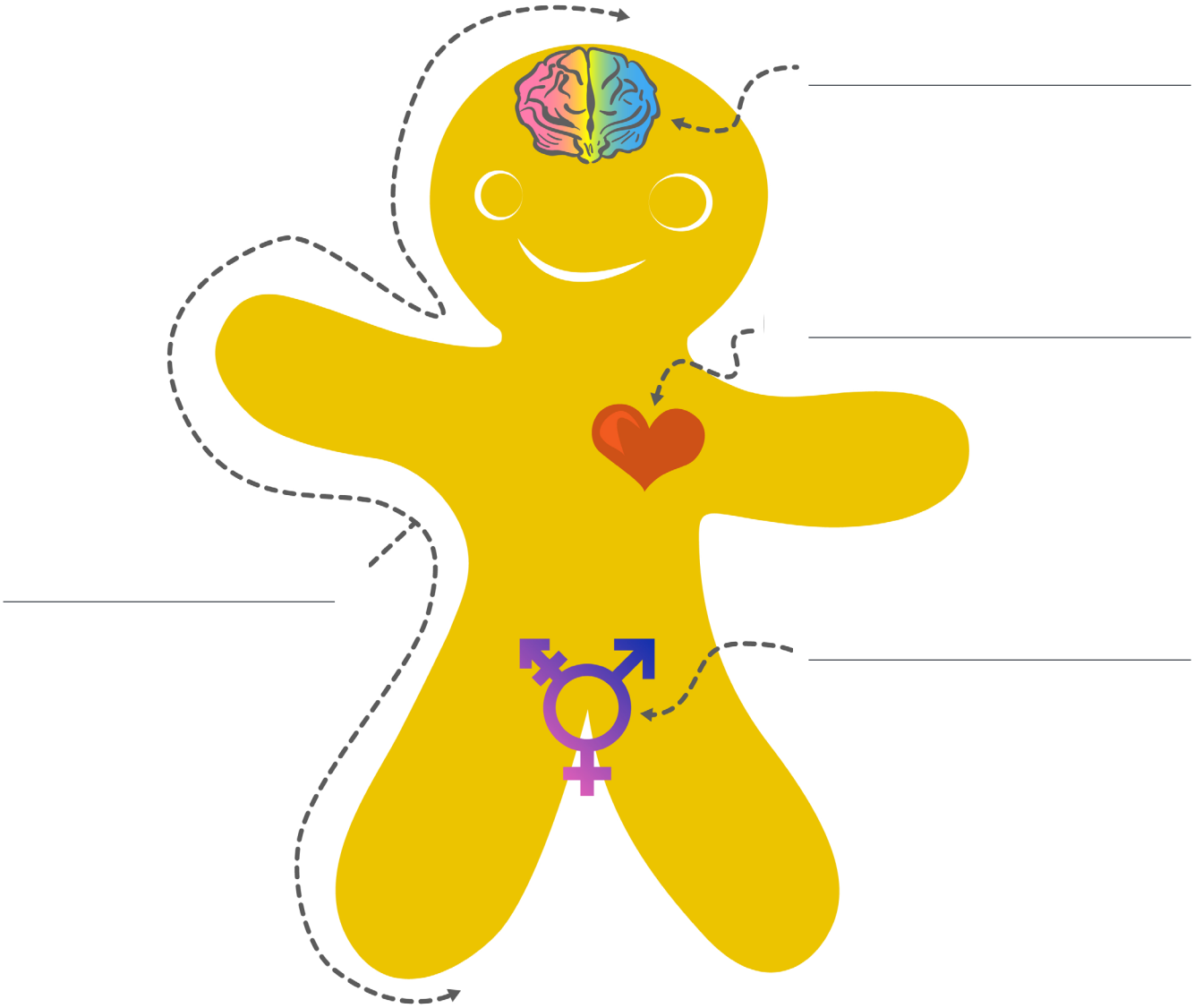
Mark with an ✕

	Biologically determined (sex)	Shaped by culture and norms (gender expectations)
A woman wears a dress		
A man has a penis and testicles		
A man is aggressive and competitive		
A woman is soft-spoken		
A man is expected to be a leader		
A woman cares for the elderly in the family		
A woman can become pregnant		

THE GENDERBREAD PERSON

Write the following terms where they fit:

- Sexual Orientation
- Gender Identity
- Gender Expression
- Sex characteristics



[14] *This exercises uses the "Genderbread Worksheet" available here:*

https://www.genderbread.org/resource/genderbread-person-v4-0-worksheet-fill-in-the-blanks (Accessed February 5th, 2022)

DEFINING SEXUALITY AND SEXUAL HEALTH [15]

Sexual health requires a positive and respectful approach to sexuality and sexual relationships	Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships
Sexual health requires the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence	Sexuality is a central aspect of being human throughout life, not only in the reproductive years
Sexuality is an integral part of most persons personality	Sexuality is often what drives us to seek love, bonding and intimacy
Sexuality is a basic need for most people and an aspect of being human that cannot be separated from other aspects of life	Sexuality is expressed in the way we feel, move, touches and are touched
Since health and wellbeing are fundamental human rights, sexual health must be a human right too	Sexuality is just as much about being sensual as about being sexual
Sexuality affects our thoughts, feelings, actions, relationships with others and therefore also our mental and physical health	Intercourse and orgasm can be a part of our sexuality, but doesn't have to be. Sexuality is so much more than intercourse and orgasm

15. *This exercise is adapted and translated from DFPA's online resources for sexuality education for youth: https://www.underviserportal.dk/ungdom/materialer/opgave/738-definitioner-af-seksualitet. Accessed February 5th 2022.*

EXTERNAL AND INTERNAL STIGMA [16]

Read this first

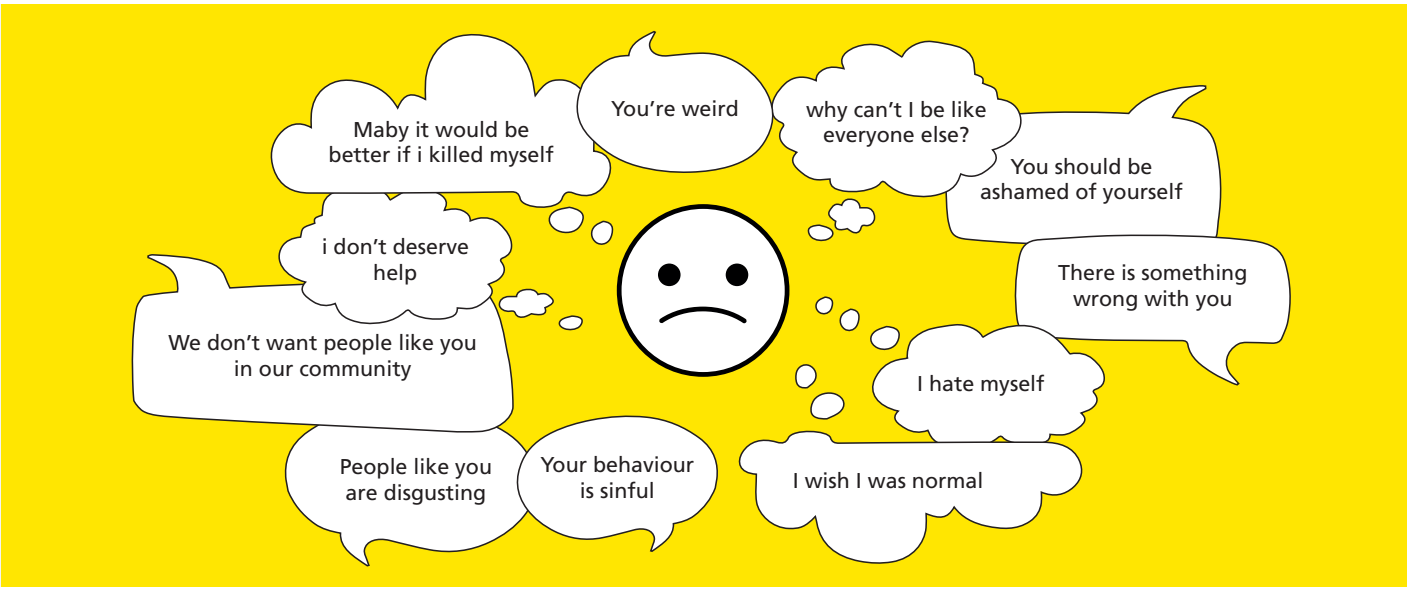
There are two types of stigma:

- Internal stigma is experienced inwardly by an individual who is being stigmatized
- External stigma is experienced when it results from the actions of others

INTERNAL STIGMA is when the individual:	EXTERNAL STIGMA is when the individual:
• Avoids accessing services, including health services, due to fear of being further stigmatized • Has low self-esteem, low sense of self-worth or other self-confidence issues • Withdraws or disengages from social networks • Overcompensates, e.g. being overly grateful when someone is kind to them • Suffer from mental health issues, e.g. depression, anxiety • Substance abuse to cope with stigma • Suicide or attempted suicide to escape the pain of the stigma	• Avoids spending time with stigmatized people • Rejects stigmatized people in their lives, e.g. no longer welcoming LGBT+ people in the family home • Passes moral judgement over another person, e.g. that LGBT+ persons are immoral • Engages in gossip and speaks negatively about other people who are stigmatized • Is unwilling to employ or offer services to people who are stigmatized, e.g. unwillingness to offer health services to LGBT+ persons • Victimizes the stigmatizes person and blames him/her /them for problems that are unrelated to him/her/them

Exercise

1. On the picture below, identify which bubbles are **Internal** and which ones are **External** Stigma



2. In your group, discuss
   a. How this relates specifically to LGBT+ persons
   b. How this relates to your work as a Health Service Provider

[16] *This handout and exercise – including the picture under 1. - is from Ben Brown, Zoe Duby, Delene van Dyk (2013), pp 63-65. Note however, that the text in internal/external stigma table and subsequent questions have been modified to increase focus on LGBT+ persons and the role of Health Service Providers.*

CHARACTERS FOR THE POWER WALK [17]

Facilitator cuts these characters into strips prior to the exercise. Each participant gets one strip/one character.

Male religious leader, aged 56	Male, 45. Member of Parliament
Young man, age 17. Unemployed	Transgender boy, 16 years old
Orphaned girl, age 13. Lives with an aunt and uncle and is sexually abused by the uncle	Girl, age 14. Is attracted to girls. Lives in poor and rural community
Male, age 46. District health director and friends with the President's brother	Married girl, age 16. Involuntarily pregnant, does not know the option of abortion
Male, age 46. Pastor, white, and with British citizenship	Grandmother, aged 60. Her children died with HIV/AIDS. Caretaker of her grandchildren
Widowed woman, aged 33. Has 5 children all below the age of 18. Living with HIV	Women, age 29. Successful shop owner. Her husband is unemployed and has other girlfriends
Poor girl, age 15. Is pregnant and lives 30 kilometers from the nearest health clinic	Man, age 32. Rich businessman. Sometimes hits his wife after coming home drunk
Girl, age 14. Dropped out of school and is now working in the informal sector	Young deaf man, age 17. Not aware of the radio campaigns on SRH
Woman, age 33. Teacher. Trained in comprehensive sexuality education	White female, age 36. Head of an international organization's development program
Young woman, age 21. Found out she is intersex during puberty. Would like to get married to a man and have children	Woman, age 19. HIV-positive but scared to go to the clinic for ARVs. Her relatives who know her status abuse her for it
Young man, age 25. Homosexual and has a boyfriend. Lives in an urban environment. HIV positive transwoman, 38 years old	Lesbian woman, age 24. Is not open about her sexuality. Her parents want her to get married to a man

[17] *Characters are adapted from Rutgers (2018), pp 47-48.*

MATCHING BIOMEDICAL INTERVENTIONS

Use scissors to cut out all squares with text. Every group needs a set. Keep extra un-cut sheets as answer sheets

HIV Counselling & testing	Testing in a confidential space	
	Knowing HIV status	
HIV care and treatment	Provision of ARTs	
	Education on non-adherence and treatment failure	
STI screening treatment	Information on STI symptoms for both male and females	Provision of STI treatment in line with national guidelines
	Oral, vagina, penile and anal exams	Four Cs: Compliance, Condoms, Counselling, Contact tracing
PEP	Indicated for those who present within 72 hours of unprotected risky sexual activity	
	Also used in situations of sexual assault	
SRH services	Contraception, including emergency contraception	Anal cancer screenings
	Cervical cancer screening	Post-abortion care

TO THE FOUR VOLUNTEERS ONLY

Role 1 & 2: Couple coming for cervical cancer screening

Maria and her partner Alex is going to the clinic for cervical cancer screenings. Maria is female and Alex is a trans man. Alex has not undergone gender affirming surgery, so he still has a cervix and uterus. He feels anxious about going to the clinic for cervical cancer screenings as he has had negative reactions from Health Service Providers who knew he was assigned female at birth. Maria and Alex fear that they again will be asked uncomfortable and invasive questions about their gender roles as a couple during the visit to the clinic.

Role 3: The first Health Service Provider (negative attitudes)

The Health Service Provider is not LGBT+ sensitive. His/Her body language is negative throughout the dialogue, and the tone of voice is dismissive. The actor should do his/her best to be as hostile as possible in his/her communication style.
After some discussion, the first HSP refers Maria and Alex to a second HSP.

Role 4: The second Health Service Provider (inclusive attitudes)

The second Health Service Provider is LGBT+ sensitive. His/her body language is welcoming and throughout the dialogue, and the tone of voice is accepting. The actor should do his/her best to be as inclusive and understanding as possible in his/her communication.

ASSESSING YOUR OWN ENVIRONMENT

Exercise

The purpose is for you to reflect on the environment where you provide health services – how LGBT+-friendly is it?

		
Inclusive practice	**Some inclusion but there is room for improvement**	**NON-inclusive practice**

[17] *This handout and exercise is from European Union (2018), p. 74, however text is adapted*


AGREE


SURE
NOT


AGREE
DISAGREE


TRUE


FALSE

ANNEX C:

CASE STUDIES AND REFERENCES AND READING MATERIALS

CASE STUDIES

REFERENCES AND READING MATERIALS

CASE STUDIES

Case Study 1: Forced Anal Testing
Two men were arrested in 2015 in Ukunda, Kwale County on suspicion of having sex. GN and CI allegedly engaged in the acts between February 2 and 17 in Tandoori, Ukunda. They were arrested and presented to court. The Resident Magistrate ordered them to undergo medical tests as part of the police investigation setting them free on a Sh200, 000 bond with a similar surety for each.

The men said they were subjected to forced anal examination by police and staff at a public hospital in Mombasa on orders of a Kwale court to determine if they had engaged in anal sex and were homosexual. The authorities also forced them to submit to HIV and hepatitis tests. The two men were forced to sign consent forms and the tests were conducted in the presence of the police.

Humiliated, the men took their petition to the High court and later appellate courts. In the end, the appellate judges overturned the High Court's decision and declared the tests and examinations were illegal.

The Kenya Medical Association issued a resolution banning the practice of forced anal examination in 2017 on the basis that the tests have no scientific nor medical utility.

Case 2: WSW and stigma
Joyce is a 27 year old woman, who identifies herself as lesbian and is in a long-term relationship with her girlfriend Eve. Joyce likes to wear dresses, has long, braided hair and presents very feminine.

Joyce has worked in the same company for over 5 years, and she is well-liked and respected for her work – her supervisor has recently nominated her for a management training. On an evening out with colleagues after work, Joyce tells her co-workers about her sexual orientation and her girlfriend for the first time.

When Joyce arrives to work the next day, her co-workers treats her differently and some of them mutters negative words for lesbians when she passes them in the hallway. Her manager also informs her that she is not "leadership material" and will not be going on the management training program.

A few weeks later, two of Joyce's male colleagues corner her in the bathroom and rape her, saying that she needs to learn to like men.

Joyce needs medical attention after the rape but does not want Eve to go with her to the clinic.

Case 3: At the clinic
Asha is a 35 year old woman. She has been married for 10 years to her husband and has two kids with him. Asha is also sexually attracted to women and sometimes has sexual relationships with women. She has come to the clinic to get information on how to protect herself and her husband against STIs. To get the best possible advice, she has provided the Health Service Provider with a detailed sexual history, including her multiple female partners. The Health Service Provider provides Asha with the relevant information.

The Health Service Provider finds Asha's sexual practices entertaining, and in the next break, the Health Service Provider tells Asha's story to his colleagues to get a good laugh. He also mentions one of the locations where Asha has met a woman. Afterwards, a colleague approaches the Health Service Provider to ask more details – he recognizes both the name and the location where Asha has met a woman.

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DFPA
THE DANISH FAMILY PLANNING ASSOCIATION

Who is the DFPA? The Danish Family Planning Association is a private, non-governmental organisation without religious or political affiliations. DFPA is the the Danish member association of the International Planned Parenthood Federation, the world's largest sexual and reproductive health and rights organisation. DFPA has worked on improving the SRHR of LGBT+ persons in Kenya since 2014. All work of the DFPA is done in close cooperation and partnership with local partners.

The Danish Family Planning Association
Lergravsvej 63, 2nd floor
DK-2300 Copenhagen S
Denmark
Phone: +45 33 93 10 10
info@sexogsamfund.dk