PROMOTING HEALTH FOR ALL:

PARTICIPANTS HANDBOOK FOR HEALTHCARE PROVIDERS FOCUSING ON KEY POPULATIONS

First edition

JUNE 2018

PROMOTING HEALTH FOR ALL

SAfAIDS 2018

ISBN: 978-0-7974-9491-6

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INTRODUCTION TO THIS HANDBOOK

The Zimbabwe Constitution Amendment (No. 20) ACT 2013 (under Chapter 2 Section 29 and Chapter 4 Section 76) recognises every Zimbabwean citizen and resident's right to access healthcare, not to be turned away from any facility regardless of race, colour, religion, sexual orientation, gender identity and expression or sexual behaviour.

This is particularly important for those populations who are marginalised by mainstream society; those who engage in sex work and those individuals and groups of diverse sexual orientation, as well as those who engage in risky sexual practices or who use or inject drugs.

Definition of KPs in Zimbabwe: The term includes: male and female sex workers (SWs); men who have sex with men, including men in prisons and in other closed settings (MSM); people who use and/or inject drugs, (PWUD, PWID); transgender and intersex people (TI)

This Training Handbook is provided to all participants attending the national *Health For All* curriculum workshops, a Ministry of Health and Child Care (MoHCC)-led training programme to educate and equip healthcare providers in Zimbabwe with the knowledge and skills to enable them to provide health services that support and adequately cater for the unique healthcare needs of sex workers, men who have sex with men, transgender and non-gender conforming people ,and people who inject and use drugs. Providing these groups with the proper attention and care that is their right is critical if Zimbabwe is to become HIV free.

The Handbook accompanies the *Health For All* Trainers Guide and is a take-home Job Aid for participants to use in their day-to-day service provision and in their continued working towards greater inclusion in our public healthcare facilities, using the knowledge and skills gained from training. The resources include elements taken from the Trainers Guide and are listed by module. Please note that these resources are intended for health service providers who have received training in the full *Health For All* curriculum and do not provide a complete insight into the curriculum as stand alone materials.

ABBREVIATIONS

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

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MODULE ONE:

UNDERSTANDING KEY POPULATIONS

GLOSSARY of Terms

The following terms are specific to particular key populations. It is important to fully understand these terms as a service provider to both enhance your understanding of issues affecting the individuals you may come across in the course of your work as a healthcare service provider and to support better communication with those in your care.

Addiction: A condition characterised by compulsive drug or alcohol seeking and use (or behaviour), despite harmful consequences. Drug and alcohol addiction are considered a disease of the brain because these substances change the brain's structure and how it works.

Aftercare: Types of follow-up care to support those who use drugs or alcohol to maintain sobriety or abstinence, continue their personal growth and reintegrate into their families or communities.

AIDS (Acquired immune deficiency syndrome): A medical condition in which there is severe loss of the body's cellular immunity, greatly lowering a person's resistance to infection and malignancy. It is a result of untreated HIV infection. **HIV is a manageable chronic condition**, provided medication (ARVs) is taken as prescribed. It is caused by a virus (the human immunodeficiency virus, or HIV), which is transmitted through bodily fluids during unprotected sex and through blood-to-blood transmission, as well as from an infected mother to her baby during pregnancy, delivery and breastfeeding.

Agender: Means 'without gender' – agender people prefer to avoid terms that refer to or define gender in any way, as they do not identify with any gender at all. Agender people try to avoid any gendered pronouns and prefer terms such as 'they'. See also they/them as a pronoun.

Speaking about Nosipho who is agender, I will say for example: "They walk down the street to find a taxi"

Alcohol: This includes beer, wine and spirits, all of which act as central nervous system depressants. Alcohol is usually taken orally and is known to be addictive.

Amphetamine: A synthetic, addictive, and mood-altering prescription drug, used both legally and illegally. It is a central nervous system stimulant and is usually taken orally, but may also be snorted, smoked, injected or inserted anally.

Anal Sex: Is the insertion and thrusting of the erect penis, fingers or sex toys into another's anus and rectum for sexual pleasure.

Anal taboo: A general avoidance of references to the anus because of complex social constructs that associate the anus with shame, guilt and dirt.

Androgyny: Not having clear masculine or feminine physical characteristics or appearance. An androgynous person has a combination of feminine and masculine characteristics, making it difficult for others to identify them as a specific gender.

Antiretroviral medicine (ARV): ARV medicines are used to slow the rate at which HIV makes copies of itself (multiplies) in the body. They help people living with HIV live long and healthy lives. Usually a person takes a combination of three different ARVs, often combined in a single pill. They need to be taken exactly as instructed for life.

Antiretroviral therapy (ART): Includes taking ARVs and ensuring that a person adheres to treatment, clinic appointments and other requirements of the therapy.

Anxiety: Worrying about issues or situations over which a person has no control. It affects how individuals feel and behave and may also manifest physical symptoms.

Asexual: Lack of sexual attraction (interest in and desire for sex). An asexual person has the ability to form relationships but is not interested in sexual intimacy.

Back-loading: Sometimes referred to as piggybacking, is a way of sharing liquid drugs. A drug user draws a liquid drug such as heroin into a syringe and then squirts a portion into the back of another person's syringe after removing the plunger.

Bare-backing: Anal penetration without using any barrier method, often through a conscious decision not to use condoms.

Bipolar disorder: Previously known as manic depression, is a mental disorder that causes recurring periods of depression and of abnormally elevated mood (mania).

Bisexual: A sexual orientation in which the person is attracted to both males and females. This is seen as primarily a sexual attraction but it is not only based on sex. It can also be attraction on other levels such as feelings, physical, intellectual and spiritual. Some people who identify as bisexual may be more attracted to one sex, but find both attractive at some point. Bisexuals may not be attracted to both sexes at the same time and may choose to differentiate between the types of relationships or sexual interactions they have with members of the same or opposite sex (also see MSM and WSW)

Bodily Integrity: Is the importance of human beings' personal autonomy over their own bodies. It relates to self-determination and means that people should be able and have the right to make decisions about their own bodies.

Bottom: A slang term for the receptive partner during anal sex (not just for anal sex only); the opposite of a 'top'.

CD4 count: A laboratory test to check the number of CD4 cells in a person's blood sample. The average person has a CD4 count of between 500 and 1500. When you are HIV positive the virus attacks the CD4 cells and the CD4 count gradually drops as infection progresses. The CD4 count indicates how well the immune system is performing and is a marker of how well ARV treatment is working.

Cisgender: A person whose 'inner' experience of gender matches the body parts that they were born with. The Latin prefix *cis* stands for 'on the same side'. The opposite of *cis* is *trans* meaning 'on the opposite side'. We talk about a *cis woman*, meaning someone whose 'inner' sense of being a woman matches the body she was born with. A *cis man* is someone whose inner sense of being a man is in line with the body he was born with. The term cisgender has a more positive connotation than using the term 'normal'.

Chlamydia: A group of sexually transmitted bacteria commonly responsible for urethritis/ proctitis. It can lead to infertility in women.

Chancroid: A sexually transmitted infection (STI) caused by the bacterium *Haemophylisducreyi*. It results in ulceration and swollen lymph nodes and Increases the likelihood of HIV transmission.

Chipping: Refers to heroin users who stick to very strict rules, such as only using on weekends, using once a week, etc. They are considered to be not (yet) addicted to heroin.

Cocaine/ crack cocaine: This refers to substances derived from the coca plant that act as a central nervous system stimulant; can be snorted, injected or smoked.

Co-infection: Is when an individual has signs and symptoms for two infections at the same time, such as HIV and TB, each of which requires specific treatment and management. Possible medicine interactions need to be managed.

Cooker: Refers to a variety of containers used to heat or dissolve drugs in solid form into liquids to prepare them for injection.

Coming out: Coming out refers to making your identity (sexual or gender, or both) known to others who may presume you to have a different identity. Some individuals may have known this for a long time but only decide to share it at a later stage. When an individual chooses not to come out (which is also their right), the colloquial term used is 'to stay in the closet'.

Concurrent sexual partners: Means having more than one sexual partner and involves overlapping sexual partnerships, where intercourse with one partner occurs between two acts of intercourse with another partner.

Condom: A thin, rubber sheath worn on a man's penis, or inserted into a woman's vagina during sexual intercourse as a contraceptive or as protection against sexually transmitted infections and HIV infection. NB. The condom worn on a man's penis and that inserted into a woman's vagina are made of different materials and function differently. They cannot be interchanged.

'Corrective' rape (see homophobic rape): This is a hate crime in which people are raped as a form of punishment or in the misplaced belief that it will 'correct' their sexual orientation. In 2015, the United Nations decided not to use this misleading term anymore. The preferred term is homophobic rape.

Craving: Strong desires that are linked to the effect of drugs on the brain and that can cause strong physiological effects.

Dead name: This is a transgender person's birth name. A trans person rejects it because it is linked to the gender assigned at birth, which they have now rejected so the name is 'dead and buried' to that person. A new name, chosen by the trans person (and usually a new set of pronouns) should be used to show that you respect and honour their right to their new identity. It is bad manners to ask a trans person what their 'dead' or 'previous' name was!

Decriminalisation: By decriminalising sex work, all laws that criminalise it will be removed. Decriminalisation is different from legalising.

Depression: Is a common but serious mood disorder where there is a low or depressed mood, with loss of interest or pleasure in life and activities that disrupts everyday functioning and lasts for a period of two weeks or more. It is characterised by sadness, inactivity, difficulty concentrating and thinking, significant increase or decrease in appetite, difficulty sleeping and may include suicidal thoughts.

Dental dams: A thin piece of latex that is placed over the labia lips, clitoris and entrance to the vagina and/or anus during oral sex, frottage or tribadism (where genitals rub directly against each other). It prevents contact with body fluids that can expose those involved to STIs. When dental dams are not available it is possible to use a cut-open latex glove or condom, or a layer of non-microwavable cling wrap.

Detoxification or detox: A process where the body frees itself of a drug. During this period the symptoms of withdrawal are also treated. It is part of many drug treatment programmes and can be used in treating addiction to alcohol, heroin, inhalants, sedatives and hypnotics. The goal is to allow the body to adjust and heal itself after being dependent on a substance.

Discharge: The fluid that naturally lubricates the vagina. In cases of infection, it refers to the fluid oozing from an area of inflammation. Discharge may come from the penis, anus, vagina or throat as a result of sexually transmitted infection.

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

Downer: Refers to a type of depressant or tranquilising drug.

Drug: A chemical substance that when inhaled, injected, smoked, consumed, absorbed via a patch on the skin, or dissolved under the tongue causes a temporary physiological change. Drugs of abuse often affect the normal functioning of the central nervous system and have both physical and mental effects.

Drug/ substance dependence: Drug or substance dependence occurs when an individual's body is changed by and physically dependent on a drug (or alcohol) for normal physiological functioning as a result of constant exposure to a drug. It results in symptoms of withdrawal when the drug is no longer used.

Ecstasy or MDMA: A drug belonging to the class of drugs known as amphetamines. Commonly used as a recreational drug, it's desired recreational effects include increased empathy, euphoria, and heightened sensations.

Ejaculation fluid (cum): Fluid released from the penis during ejaculation (cumming). Many viruses and bacteria that are responsible for sexually transmitted infections may be present in this fluid.

Female condom (femidom or woman's condom): A loose polyurethane sheath with an inner ring at the closed end and an outer ring at the open end, that is inserted inside the vagina or anus during sexual intercourse as a barrier contraceptive and to reduce the risk of STIs.

Fingering: In this context, it refers to using one or more fingers to stimulate the genitals, including the insertion of the fingers into the anus or vagina.

Flashback: A sudden, usually powerful, re-experiencing of a past experience or elements of a past experience, often a traumatic one).

Frontloading: A way of sharing liquid drugs. A drug user draws a liquid drug such as heroin into a syringe and then squirts a portion into the front of another person's syringe after removing the detachable needle.

FTM/ trans man: A trans man, or female-to-male, starts his life with a female body, but his gender identity is male. Always use male pronouns. The term *FTM* is not commonly used any more; the preferred term is *trans man*.

Frottage: is the rubbing of male sex organs – particularly penises – together, for the purpose of sexual stimulation.

Gang rape: Gang rape is when more than one person rapes someone.

Gay: This refers to men/ males who are primarily attracted to men/ males. This is mostly based on sexual attraction but also has elements of emotional, physical, intellectual and/or spiritual attraction. It refers to both attraction and also how the person identifies. Some men who are attracted to or have sex with men do not self-identify as gay and this term should not be used for them. See below for an explanation of men who have sex with men (MSM). A trans man may also identify as gay.

Gender: Gender is how society and culture views a person as being male or female. This can vary in different cultures and can change over time. Many people identify with their gender (they feel they are the gender that matches their body parts). However, for some people, their gender doesn't feel that it matches how their community expects them to be.

Gender-based violence (GBV): This can be physical, emotional, social, legal or financial misuse of power and aggression to 'punish' or 'correct' someone who does not behave as the aggressor thinks she, he or they, should behave as 'a woman' or a 'man'. A lesbian may be gang raped so that she can 'learn to like sex with men', because according to the rapist, that is what a 'woman is supposed to like'. A sensitive boy may receive beatings 'to make a man out of him' if he cries. Trans and intersex persons may be publicly humiliated and killed because they do not live their gender identities as the dominant (meaning those with the most power) in society feel is 'appropriate'. For gender non-conforming individuals, violence is directed towards them because their behaviour challenges notions of sexuality, gender identity and expression.

Gender binary: The belief that there are just two genders: male and female. Some trans people feel that they are the opposite gender 'inside' from what is shown on the 'outside' – in other words, their body parts. For example, "I was born with a penis, but 'inside' I have always been a woman". Not ALL trans or intersex persons feel this way. For some, having only two options is too limited to describe who they really are. Neither experience (binary or non-binary) is wrong; an individual's choice of identity should be respected.

Gender dysphoria: This refers to the great pressure experienced when the 'inner' and 'external' experiences of gender clash – when who/ what I feel like inside does not match my body parts. Others feel that it should be understood to refer *only to the distressing emotions* that are keeping the person from living a full, happy life, at peace with themselves. For some people, this is more a feeling of mismatch than stressful or confusing. Some trans persons may not experience

gender dysphoria – meaning they are not distressed by this mismatch to the point of it impacting on their emotional or physical well-being. This DOES NOT mean that they are happy with it or do not want to change their bodies to more closely resemble their internal experience of themselves.

Gender equality: People who strive for gender equality want everyone to have the same power to influence decisions, access resources, responsibilities and opportunities to live a good life. This has less to do with everyone doing the same wor, than it has to do with fairness for all. For example, women should have the same job opportunities, chances of promotion and salary. Fathers should help with childcare; this should not only be the duty of the mother.

Gender expression: There are things we can do or change about how we look to confirm what our gender is to ourselves and others. Some (trans or intersex) women born with male body parts wear dresses, braids and head-scarves and remove all body hair. Some (trans and intersex) men born with female body parts flatten their breasts, wear their hair in men's styles and wear men's clothing.

But gender expression isn't only about how you dress! It can also be about how you behave. In some cultures, it is seen as good for 'men' to open doors for 'women', for 'women' to stay home and do the cooking and look after the children, whilst 'men' go out and work in order to support their families. It is important to note that how someone dresses and what a person chooses to do does NOT make that person a 'man' or a 'woman'!

It is sometimes difficult and even dangerous to live completely openly as the gender you believe you are.

Gender identity: This has to do with how one makes sense (in terms of one's own life) of the 'inner' and 'outer' parts and experiences of one's gender and how you fit in to the social world around you. This has to do with ME and how I experience who I am, REGARDLESS of which body parts I have or do not have. For example, "Even though I was born with a penis, I IDENTIFY or see myself as a woman". "Even though I developed breasts as a teenager, I IDENTIFY or see myself as a man".

Gender non-conforming: Gender non-conforming people do not follow societal gender roles and expectations.

Genderqueer: An umbrella term for gender identities outside the gender binary of male and female and the heteronormative outlook. Genderqueer people may think of themselves as both man and woman (bigender), neither man nor woman (agender), moving between genders (genderfluid), and/or third gender. Some people have specific opinions about using the word genderqueer, as it has a political and historical background.

Gender role: The socially accepted (agreed upon) roles that people are expected to play, based on their gender. For example, the primary caregiver of a child should be gentle, loving and nurturing while a man should have a strong, protective role and not show emotions.

Genital: Relating to sexual organs such as the vagina, penis.

Gonorrhoea: An STI caused by the bacteria *Neisseria gonorrhoea*, commonly affecting the penis, anus and vagina, and less commonly the throat. May be transmitted via oral sex.

Hallucination: A common side effect of some drugs that cause individuals to perceive objects that are not really present.

Harm reduction: Refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are: the focus on the prevention of harm, rather than on the prevention of drug use itself; and the focus on people who continue to use drugs. Where injecting drug use is concerned, harm reduction also includes the provision of needle exchange programmes to help prevent the spread of HIV and hepatitis.

Hate speech: Speech intended to degrade, intimidate, or provoke violence or harmful action against a person or a group of people based on their identity, including based on race, gender, age, ethnicity, sexual orientation or gender identity.

Health service providers: In this manual, this refers to anyone who could come into contact with members of sexual minorities such as LGBTI people and sex workers who are accessing services for prevention, treatment and care. This could include nurses, doctors, and counsellors providing voluntary counselling and testing (VCT) and/or HIV testing and counselling (HTC) or supportive services. It also includes management staff responsible for designing and monitoring these services and those who provide an indirect service, e.g. a secretary or security guard, with whom the sex worker or LGBTI client will have contact.

Hepatitis: Inflammation of the liver, which may be caused by a virus, drugs or rarely, by diseases of the immune system.

Heroin: Belongs to the class of drugs known as opiates. It is a central nervous system depressant and analgesic; usually injected but can also be smoked. Also known as H, horse or smack.

Herpes: A group of viruses that are spread through direct contact. *Herpes simplex type 1* is responsible for 'cold sores' – superficial ulcers around the mouth and nose. *Herpes simplex type 2* is the cause of most cases of painful sores found around the penis, anus or vagina (genital herpes). Herpes infection increases the risk of HIV transmission.

Heteronormative: Hetero means 'different'; a heterosexual is therefore attracted to the opposite sex. Normative means 'normal'. One of the social beliefs many communities share is that heterosexuality is the norm; this is the meaning of heteronormative. Society caters for what it considers 'the norm' first and foremost, paying less attention to providing resources for anything that falls outside that box. This can be seen on many levels, like advertising billboards that always show a family with a mom and dad with the children, and never other kinds of families. This can cause legal problems, as in many cultures the daughters cannot inherit land and same-sex couples cannot share custody of children, obtain pension or other benefits like tax reductions and shared medical plans.

Heterosexual/ straight: Attraction between two people of the opposite sex on various levels (emotionally, physically, intellectually, spiritually, and sexually), where the sex of the attracted person is key to the attraction. Heterosexism is a cultural bias in favour of heterosexual lifestyles and against others.

HIV: Stands for human immunodeficiency virus – the virus that, left untreated, leads to AIDS. HIV is primarily transmitted through unprotected sex (it is an STI), though it can also be transmitted from infected mother to baby and through blood-to-blood contact. There is no cure for HIV, but it can be managed in the same way as other chronic, life long medical conditions like diabetes and high blood pressure, by taking regular medication – in this case, ARVs.

HIV prevention: Various ways of preventing HIV transmission, e.g. ARVs, condom and lubrication use, abstinence, new technologies such as PEP (post-exposure prophylaxis) and PeEP (pre-exposure prophylaxis), prevention of mother-to-child transmission (PMTCT) programmes, voluntary medical male circumcision (VMMC) etc.

Homophobia: Unfounded fear of homosexual feelings, thoughts, behaviours or people. A belittling (looking down on) of homosexual identities resulting in prejudice, discrimination, bullying, bias and hatred against homosexual individuals.

Homophobic rape: Homophobic rape is the term preferred in place of the misleading terms 'corrective' or 'curative' rape. Homophobic rape is where one or more people rape someone because they think the person is gay, lesbian or trans, in the belief that it will change them. The intention is to punish perceived abnormal behaviour and reinforce heterosexuality.

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

Hotspot: Refers to a community space that is commonly understood to be affiliated with certain key populations, such as sex workers, MSM and people who use drugs.

HPV (*human papilloma virus*): The virus responsible for genital warts. Different subtypes exist, some of which are associated with the development of anal, penile and cervical cancer.

Human rights: The basic rights and freedoms that all people are entitled to regardless of nationality, sex, age, gender, health status, sexual orientation, nationality or ethnic origin, race, religion and language, amongst others. Freedoms around gender identity are also basic human rights. These rights are written in the highest law of every country – the constitution.

Identity: Refers to who a person is or who a group of people are; the qualities of a person or group of people that make them different from others.

Incidence: The number of new people who develop a condition or disease during a particular period of time, expressed in percentages/ proportions. This measurement is different to prevalence.

Infanticide: The intentional killing of infants.

Insertive partner ('top'): In anal sex, the partner who penetrates the other's anus.

Indoor work: When a sex worker performs their business inside any enclosed space, such as brothels, bars, massage parlours and venues that have dedicated managers for sex workers.

Internalised homophobia: Is when a homosexual person internalises (makes their own) the shame and hatred projected onto gays and lesbians by a homophobic society.

Intersex: This refers to individuals who are born with a combination of both male and female reproductive organs, chromosomes, and/or hormones that are either fully or partially developed and cannot always clearly be distinguished as female or male. In some cases, it is not possible to know a person is intersex, as the differences can be internal, or reveal themselves only at puberty. The term 'hermaphrodite is inaccurate and offensive.

Junkie: A stigmatising and judgemental term used to refer to people who use drugs.

Key Populations: refers to groups at higher risk of HIV infection. Their active engagement is key to the success of the HIV response. They include people such as male and female sex workers (SWs); men who have sex with men, including men in prisons and other closed settings (MSM); people who use and/or inject drugs, (PWUD, PWID); transgender and intersex people (TI). There is a strong link between mobility and heightened risk of HIV, depending on the reason for mobility and the extent to which people are outside their social context and norms. Each country needs to define the specific populations that are key to their epidemic based on the epidemiological and social contexts.

Khat/ Cat: A drug belonging to the class known as methcathinone. It is a central nervous system stimulant and is usually snorted but can also be taken orally, injected or smoked.

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

Lubricant (also called just 'lube'): Condom-compatible water or silicon-based lubrications that reduce the risk of a condom tearing during sexual intercourse. Water and silicon-based lubricants or gels (KY-jelly is a well-known type) reduce friction making penetration easier and protecting the skin and condoms from tearing and breaking. It is important NEVER to use anything that contains mineral oil (e.g. Vaseline, hand, body or face cream), because this can destroy condoms, gloves and dental dams very quickly! Cooking oil is also not recommended

Some reasons for not using cooking oil!

- Repeated use can lead to vaginal infections and bacterial overgrowth, making the skin inside the vagina and lips even more susceptible to tearing or cuts that cannot be seen with the eye.
- Should you need to use it you should wash it off completely, straight after. Because it is an oil, it does not easily wash off with water, requiring warm water and soaps that may also cause irritation of the skin, leaving you open to infection.
- It is not very effective, so may not prevent rubbing on sensitive skin, causing irritation.

Marijuana or cannabis: Also known as '*dagga*' or 'weed' comes from the cannabis plant, which is widely grown. Is usually smoked, but can also be taken orally. It is a central nervous system depressant and hallucinogen and also has medicinal properties caused by such as increasing appetite and relieving pain.

Medical male circumcision: This is the surgical removal of the foreskin of the penis by a trained healthcare provider. It lowers the risk of HIV infection in men and of herpes and human papilloma virus, which can cause cervical cancer in women. Circumcised men should still use condoms.

Methadone maintenance therapy (MMT): The most widely known and well-researched treatment for opioid dependence. Goals of therapy are to prevent the physical symptoms of abstinence syndrome or withdrawal, reduce narcotic cravings and block the euphoric effects of illicit opioid use.

Methamphetamine: This includes crystal meth, or tik. They are central nervous system stimulants and can be snorted, ingested orally, injected or smoked.

Misgender: When a trans person makes public their name and pronoun and people continue to ignore this and use their 'old' pronouns. This is referred to as misgendering and causes distress.

Monosexual: Monosexuality is romantic or sexual attraction to members of one sex only. A monosexual person may identify as heterosexual or homosexual.

Morphine: belongs to the class of drugs known as opiates. It is a central nervous system depressant and analgesic. Its primary clinical use is in the management of moderate severe to severe pain. After heroin, morphine has the greatest dependence potential of all the narcotic analgesics.

MTF/ transwoman: A transwoman, or male-to-female, starts her life with a male body but her gender identity is female. Always use female pronouns in reference. The term *MTF* is not commonly used; the preferred term is trans woman.

MSM or men who have sex with men: These men can have any sexual orientation. An MSM can be hetero-, bi, homosexual or trans. This is an inclusive technical, descriptive term rather than an identity.

Multiple stigma: Being stigmatised because of two or more perceived differences, e.g. sexual orientation, being HIV-positive, plus gender, race or belonging to any other 'out' group.

Mutilating: To disfigure, injure, harm or remove from a body. In the case of intersex babies, mutilating is most often used to refer to surgery that results in cutting and changing parts of the baby's genitals to look like that of a boy or a girl. This often leads to problems for the child later in life, if the change contradicts the child's sexual identity.

Needle (syringe): A hollow, cylinder-shaped piece of equipment, often with a needle attached, used to suck liquid out or to push liquid into something. The needle can be put into the skin and used by people who inject drugs (PWID) to deliver them into the blood stream.

Needle syringe programmes (NSP): Needle and syringe exchange programmes that provide sterile syringes and needles in exchange for used ones, to reduce the transmission of HIV and other blood-borne infections associated with re-using contaminated syringes and needles by PWID, by improving access to sterile injecting equipment and safe disposal of used syringes and needles. They often also provide other public health services, such as HIV testing, risk-reduction education and referrals for substance-abuse treatment. Also called needle and syringe exchange (NSE).

Non-binary (person): Non-binary refers to any gender that is not exclusively male or female. A similar term is genderqueer. This term is commonly used in many countries in Africa, and is increasing due to social media and other information sharing platforms.

Normalise: Bring or return to a normal or standard condition or state. In the case of intersex infants this means to perform surgery on infants to make them appear 'normal' or how the majority of people believe they should be. This kind of surgery is no longer recommended and can result in long-term difficulties for the child. See also mutilating and self determination.

Open Relationship: Many people seek alternative ways for their relationships. In most societies, monogamy is upheld as the 'only' way and that every other type of relationship is *wrong*, a *sin* or *not acceptable*. If consenting adults decide to be open, to discuss this, make a joint decision and be honest about their open relationship, this can be very fulfilling for all parties involved. Having an open relationship is not the same as one partner 'cheating' on another. It is the responsibility of everyone in that open relationship to practice safer sex.

An open relationship is when two consenting adults have agreed to engage in additional sexual or romantic relationships.

Opioid dependence: A medical diagnosis of a chronic brain disease characterised by an individual's inability to stop using opioids (e.g. morphine, heroin, codeine, oxycodone, hydrocodone) even when it is in their best interests to do so. This physical, psychological and behavioural need is unrelated to medical necessity for pain relief and develops after a period of regular use of opioids. The time required for dependence to arise varies according to the quantity, frequency and route of administration, as well as individual vulnerability and the context in which drug use occurs. It is a complex health condition with social, psychological, and biological determinants and consequences; it is **not** a weakness of character or will' (adapted from the definition by the World Health Organisation).

Oral sex: Sexual activity in which the genitals (penis, testicles, anus, vagina) of one partner are stimulated by the other, using the mouth, tongue and teeth; may include licking, sucking and kissing. Also known as fellatio or cunnilingus.

Outing: The intentional outing of a person who is gay, lesbian, bisexual, trans, MSM or a sex worker. The person often keeps this information confidential and to 'out' someone can put their life in danger. There are people who make threats, demands, bribery or blackmail for financial gain when they find out a person's sexual identity.

Outbound work: Street based sex workers. This term is commonly used in South Africa.

Pansexual: A pansexual person does not base their sexual orientation on the biological status of their partner. They have the ability to be in a relationship with a cis woman, a cis man, any trans person (feminine or masculine) or intersex persons. The difference between pansexual and bisexual is that bisexual people's interest is limited to men or women only. It is more binary ('bi').

Paraphernalia: Also called 'gear', refers to any collection of tools used to facilitate drug use or drug-taking behaviour. This may include items such as spoons, bottle tops, filters, needles, syringes, etc.

Patriarchy: A system of society or government in which men hold more power than other a/genders, in both everyday and institutionalised ways that systematically disadvantage anyone who is not male. It also regards the eldest male as head of the family and traces descent through the male line. Wives/ females are viewed as dependent; roles assigned to men are considered superior and valued above those of females. Patriarchy forms the basis for discrimination against women and minorities such as LGBTI people.

People who inject drugs (PWID): Persons or people who inject drugs.

Phobia: Excessive anxiety or fear about a specific object or situation.

Positive sexuality: begins with values, honest communication, and straightforward, factual information, including:

- an understanding of sexuality as a natural and healthy aspect of human life;
- knowledge of human sexuality and reproductive rights with which to make responsible choices;
- respectful communication and exchange of personal thoughts and feelings between partners; and
- practice of safe and mutually consensual sexual activity.

Post-exposure prophylaxis or PEP: A short course of ARVs taken after possible exposure to HIV, e.g. through rape or after a condom burst. Visit any PSI facility, or see a doctor or clinic within 72 hours of the event.

PMTCT or prevention of mother-to-child transmission: refers to interventions to prevent HIV transmission from an HIV-positive mother to her infant during pregnancy, labour, delivery, or breastfeeding. This is also known as prevention of vertical transmission.

Popping or skin popping: Refers to injecting heroin under the skin.

Post-traumatic stress disorder (PTSD). A disorder that develops after exposure to a highly stressful event (e.g. threats to one's life, rape, war, natural disasters, being robbed). Symptoms include flashbacks of the incident, difficulty sleeping, recurrent nightmares and avoiding reminders of it.

Pre-exposure prophylaxis or PrEP: The use of a daily ARV pill containing Tenofovir and Emtricitabine to prevent HIV infection. It is recommended for HIV negative people at higher risk of HIV infection, including sex workers, serodiscordant couples and gay men.

Prejudice: An irrational, preconceived opinion, not based on reality or actual experience, which often results in dislike, hostility and unjust behaviour.

Prevalence: The number of people who currently have a particular condition within a particular period of time. This measurement is different from incidence.

Psychosis: A mental disorder characterised by delusional thinking, disorientation, detachment from reality and hallucinations.

Queer: This is a political word that generally describes being outside cis-heteronormativity. It describes identity, expression and attitude. It was originally a derogatory term that has been reclaimed by the community. It has gained popularity through social media in the last few years.

Receptive anal sex or 'bottom': A sex act describing the position or role of the partner who is 'receptive', 'or whose anus is being entered. Being a 'bottom' carries a higher risk of HIV infection.

Rectum: The lower region of the bowel linking the descending colon to the anus.

Relapse: Refers to a period of substance use following a period of no substance use. It usually refers to drinking or using drugs again after a period of abstinence, or of trying to quit drinking or using and being unable to do so. Sometimes it is called 'slipping' or 'falling off the wagon'. Many alcohol- and drug-abuse clinicians differentiate between a slip and a relapse by defining a slip as a one-time, isolated mistake, followed by a renewed commitment to treatment and abstinence. The recovering person may see a slip as a wake-up call regarding the effort needed to achieve lasting, continuous abstinence.

Responsible sex: A sex-positive way of looking at prevention. It emphasises the prevention of STIs, including HIV, through consistent condom use with condom compatible/ water-based lubricants and a reduction in the number of sexual partners.

Rimming: An oral and anal sex act in which one person stimulates the anus of another using the mouth, lips, tongue, or teeth. It is also called anal-oral contact and anal-oral sex (anilingus).

Self-determination: Self-determination and autonomy refer to the ability to make decisions without having to obey other rules. As used when speaking about intersex people, it means they should have the right to make their own decisions about their bodies. An intersex person is unable to exercise their autonomy if surgery was already carried out on their genitals when they were a baby. They can no longer self-determine.

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

Sero-sorting: A 'risk-reduction' strategy used by a subset of MSM and transgender individuals to prevent HIV transmission, dependant on being able to identify sexual partners assumed to have the same HIV status. This strategy is not very effective.

Sex: A biological idea or system to classify people as male or female. *'What's in the pants'?* 'Male genitals: penis, testes, testosterone and genetic make-up and female: breasts, vagina, oestrogen, progesterone and genetic make-up. Some people may have a combination of these, whether visible or not visible (see more on intersex).

Sexual behaviour: How people experience and express their sexuality. It may include physical or emotional intimacy and sexual contact.

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

Sexual fluidity: Sexuality that varies across time and situation. Sexual fluidity simply means situation-dependent flexibility in sexual responses. This flexibility makes it possible for some individuals to experience desires for either men or women under certain circumstances, regardless of their overall sexual orientation.

Sexual identity: How a person thinks of themselves in terms of to whom they are romantically or sexually attracted; whether they identify as male, female, masculine, feminine, or some combination of these, and the person's sexual orientation.

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

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

Sexual practices: All behaviour that results in sexual pleasure, practiced by one or more than one person, individually, or together.

Sexual risk assessment: This involves asking questions that give some idea of a client's sexual risk for HIV and other STIs. It includes questions about alcohol and drug use, the number of sexual partners, overlapping sexual partners, types of sexual activity ad possible triggers for unintended and/or unprotected sexual intercourse, as well as questions that may reveal mental health issues, such as history of previous sexual abuse, stigma and discrimination, gender-based violence, etc.

Sex work: Sex for a reward or payment. Sex work is a business transaction between two or more consenting individuals that might also include sex. Sex occurs in exchange for an amount of money that is agreed by the sex worker and the client/s before the sex takes place.

Stereotype: A stereotype is an oversimplified assumption or idea, especially about a person or a group and often driven by stigma. Many stereotypes are racist, sexist, or homophobic.

Stigma: This is when an individual with certain characteristics, for example, an HIV positive or trans woman, is disapproved of by a community or society because of that characteristic. Stigma goes often hand-in-hand with shame. It can result in threats and abuse and generally leads to discrimination.

Stigmatise: The act of treating someone differently or unfairly because of some perceived difference (e.g. sexual behaviour, gender or drug use).

Stimulant: Refers to a drug or substance that when ingested, injected, smoked or snorted, raises levels of physiological or nervous activity in the body.

Street work: Sex work that takes place on the streets, also known as outdoor sex. There may or may not be exchange of money for sex.

Substance dependence: A pattern of habitual substance use that involves physical dependence (with increased tolerance and withdrawal), psychological and behavioural dependence.

TasP (treatment as prevention): Refers to the fact that if ARVs are taken correctly, passing on HIV is less likely.

They/ them (as a pronoun): Many queer, non-binary and some trans people and gender activists prefer the pronoun they/ them instead of he or she. This is a more neutral way of referring to someone. It is polite and shows your support when you respect their wish to be referred to as they or them. Many languages around the world, including many spoken in Africa, do not have – as English does – **only** *he* and *she* pronouns. Some indigenous languages have neutral options anyway, or more options. Queer, non-binary, trans people and gender activists argue that we should open our minds; it just takes a little practice to get use to using they and them.

Thigh sex: The act of rubbing the penis between the partner's thighs until sexual satisfaction or orgasm is reached.

'Top': A colloquial term for the penetrating partner during anal and other sexual activity.

Transactional sex: This refers to exchanging sex where the payment or reward is not limited to money, but includes other benefits like food, housing transport money, school fees and many other items.

Transgender: An umbrella term used to describe a wide range of identities and experiences, including transsexuals, non-binary, trans men, trans women, FTMs, MTFs, queer, crossdressers, drag queens gender-queers, and many more. Commonly used to refer to a person whose gender identity differs from the sex assigned at birth. In this manual, we also use the term trans people. It is important to use their preferred gender pronouns and names, in other words, those of the gender they are presenting.

Trans man: A transgender person who was born female but identifies as male.

Transphobia: The unfounded fear of, and/or hostility towards people who are transgender or who otherwise challenge traditional gender norms. The most direct victims of transphobia are people who are transgender. Because our culture is often very transphobic, transgender people often have internalised transphobia and experience feelings of insignificance and self-prejudice.

Transsexual: This term is less frequently used now but refers to a transgender person in the process of seeking or undergoing some form of medical treatment to bring their body and gender identity into closer alignment. Not all transgender people undergo reassignment surgery. The term transsexual stems from the medical field; many trans people prefer *transgender* or *trans*.

Transitioning: The process of changing one's gender presentation to align with one's internal sense of one's gender. For transgender people, this may sometimes include sexual reassignment surgery, but not always. Some people seek transitioning by means of hormones and others go through what we call social transitioning – meaning they change their names, pronouns, outer appearance, mostly through clothes and hairstyles.

Transvestite: Is an individual who dresses in the clothing of the opposite sex for a variety of reasons including enjoying the temporary experience of membership of the opposite gender, but who has no desire to change or modify their body. Also called cross-dressing.

Trans woman: A transgender person who was born male but identifies as female.

Tribadism: Also known as scissoring; a form of non-penetrative sex in which a woman rubs her vulva against her partner's body for sexual stimulation. It may involve female-to-female genital contact.

Uppers: Stimulants that make the user feel energised, excited, and capable of doing anything, such as cocaine, ecstasy, methamphetamine (tik) and crack cocaine.

Undetectable viral load (see also CD4 count): Viral load is the test to determine the level of HIV virus in 1ml of someone's blood. If this figure is below 10,000 their virus is considered to be controlled but the aim is to be undetectable. The machines used vary in sensitivity. When a person's viral load is undetectable they are very unlikely to infect another person, but they still carry the virus and need to continue taking their ARVs as instructed.

Vaginal sex: Sex that involves the insertion of the penis, fingers or sex toys into the vagina.

Venue-based sex work/ brothel: Sex work that takes place within an established structure or building, as opposed to street-based sex work. See 'Indoor work'.

Versatile: A colloquial term for someone who enjoys being both a 'bottom' and a 'top'.

Withdrawal: In terms of drug dependency**,** withdrawal refers to the group of symptoms that occur upon the abrupt discontinuation of or decrease in intake of drugs and/or alcohol.

In terms of sex and **contraception** it refers to the act of withdrawing the penis from the vagina before ejaculation. STIs and HIV can still be passed on using this method and unintended pregnancy may also occur. It is important to use condoms correctly and consistently every time one has sex.

WSW: Women who have sex with women. A sexual practice that is not related to sexual orientation or gender identity. A WSW can be hetero-, bi- or homosexual. It is a technical term, rather than an identity.

Notes for additional terms

Notes

The Patients Charter

The Patients Charter aims to improve the relationship between patients and healthcare providers. However, while healthcare providers are broadly aware of the requirements of the Patients Charter, it seems that health service providers with strong moral or religious principles that govern their attitudes and responsiveness often neglect it when serving members of key populations. It is for this reason that we reproduce elements of the Charter here, to remind healthcare providers that its provisions apply to ALL clients.

The Charter helps or allows the Ministry of Health and Child Care to:

- Listen to and act on people's views and needs
- Set the best possible standards of health services
- Provide health services that meet these standards.

The Charter explains:

- The kind of service you can expect from the healthcare delivery system
- Your health rights
- Your responsibilities and obligations
- How you can give feedback on the quality of services you are provided with or have required.

The following information has been adapted and extracted from the Patients Charter that guides healthcare providers.

PATIENTS RIGHTS

All patients have the right to healthcare and humane treatment and the right to access competent healthcare and treatment on the basis of clinical need.

Every patient shall be treated with care, consideration, respect and dignity, without discrimination of any kind, taking into consideration issues of accessibility to both physical structures and information.

All drugs and vaccines shall be of acceptable standards in terms of quality, efficacy and safety.

In an emergency, every individual has the right to prompt treatment from the nearest medical/health facility.

CONFIDENTIALITY

A patient's care prognosis and all communication and other records relating to the patient's care shall be treated as confidential, unless:

- Release is authorised in writing by the patient
- It is undesirable on medical grounds to seek a patient's consent, but it is in the patient's interest that confidentiality be broken.
- The information is required by due legal process.

PRIVACY

Patients shall be interviewed, examined and treated in surroundings that ensure reasonable privacy and they have the right to be accompanied during any physical examination or treatment if they wish.

RIGHT TO CHOICE OF CARE

A patient has the right to a second opinion at any time while consulting the same medical or healthcare delivery system.

A patient may authorise in writing for another health professional to obtain a copy of their medical records and to inform him or her of what they contain.

If a patient's health professional refuses to allow another health professional to be called in, or breaches any other provisions of the charter, the patient may seek alternative service/care or take the issue up with the Health Professions Council.

RIGHT TO SAFETY

A patient has the right to a clear, explanation – in lay terms – of any proposed procedure and of available alternative procedures before any treatment or investigation, including information on risks, side-effects, problems relating to recuperation, likelihood of success, risk of death and whether the proposed procedure is an investigation.

RIGHT TO ADEQUATE INFORMATION AND CONSENT

A patient has the right to know the identity and professional status of individuals providing services and to know which health professional is primarily responsible for their care, including:

- The right to adequate understandable information on prescribed medicines.
- The right to choose among competitive products based on unbiased information
- The right to know his or her prognosis and everything about their medical problem

A patient's written consent is required if a patient is included in a research or teaching programme. The patient shall be adequately informed of the aims, methods, benefits and hazards of the study and of any discomfort it may entail and to be informed that he or she is free not to participate in the study and may withdraw his or her consent at any time

To ensure that informed consent is not obtained under duress or from a patient in a dependent relationship to a health professional, consent shall be obtained by a health professional not engaged in the investigation and who is independent of the official relationship between the patient and the health professional responsible for the research.

RIGHT TO REDRESS OF GRIEVANCES

A patient has access to appropriate grievance handling procedures and the right to claim damages for injury or illness incurred or aggravated as a result of a health professional's failure to exercise the required duty and standard of care.

A patient has the right to legal advice regarding any malpractice

RIGHT TO PARTICIPATION AND REPRESENTATION

A patient has the right to participate in decision-making affecting his or her health:

- With the health professionals and other support staff involved
- Through consumer representation in planning and evaluating the system of health services, the types and qualities of services, and the conditions of service under which they are delivered.
- To give an assessment of the quality of services offered.

RIGHT TO HEALTH EDUCATION

Every individual has the right to seek and obtain comprehensive information advice regarding preventive and curative medicine, aftercare and good health.

THE RIGHT TO A HEALTHY ENVIRONMENT

Every individual has the right to an environment conducive to good health, including the health professional's office, health centre, hospital room and any other facilities.

PATIENTS' AND FAMILIES' RESPONSIBILITIES/ OBLIGATIONS

Whilst the patient has the right to be heard, they also have an obligation to listen to medical instruction concerning their treatment.

The patient and family shall provide accurate and complete information to assist the health professional to plan for their stay and treatment adequately.

The patient and family shall produce proof of inability to pay for healthcare services, except in emergency cases as determined by the healthcare professionals.

To avoid inconvenience to themselves and to others, patients should follow the referral chain and ensure they have the necessary documents to effect their access into hospital.

Patients should keep their hospital notes safe and clean for their next visit or contact with the health services.

The patient and family shall ensure that the patient understands the purpose and cost of any proposed investigations or treatment before deciding to accept it.

The patient shall insist on explanations until he or she is adequately informed and will consult with all relevant persons before reaching a decision.

The patient and family shall accept the consequences of the patient's own informed decisions.

The patient and family shall establish a good relationship with the healthcare provider and follow the treatment determined by the health professional primarily responsible for the patient's care.

The patient and family shall inform the health professional if the patient is currently consulting with, or under the care of another health professional – including traditional medical practitioners – in connection with any complaint.

The patient and family shall keep appointments and inform the health professional if unable to keep an appointment.

Every individual has a responsibility to maintain their own health and that of society by refraining from indulging in:

- Consumption of unhealthy food
- Substance abuse, such as alcohol and drugs
- Life styles that have an adverse impact on health such as having unprotected sex with a partner whose HIV or STI status they do not know, reckless activities and physical inactivity.

Every individual has a responsibility to accept all preventive measures sanctioned by law.

The patient and family must be aware of the limits of healthcare providers.

Patients should not expect a prescription at every visit. Many illnesses are short term and do not require medication.

Patients should take medicines exactly as instructed and complete any course of treatment, take interest in their condition and get more information to get the best out of health promotions.

Patients should not share prescribed medicines.

Pateints should conduct themselves so as not to interfere with the well being or rights of other patients or providers of healthcare.

SERVICES

ADMISSION AND HOSPITAL STAYS

In the event of an accident, illness or emergency, patients will be attended to by competent health workers. and assessed and dealt with appropriately and immediately upon arrival.

Whether A patient is admitted as an emergency case or not, hospital staff shall:

- Inform relatives, next of kin or whoever the patient wishes, where practicable.
- Keep your clothes and valuables in a safe and clean place
- Give clear information about the illness and condition and the treatment plan for the patient's recovery
- Give clear information about domestic arrangements and any other information relevant to the hospital stay.

OUTPATIENT SERVICES

Provided patients follow the referral chain and do not require complex diagnostic procedures, they will receive treatment promptly.

Patients have the right to clear information about their treatment. Health workers will be happy to answer their concerns.

Patients have the right to request for assistance when they require it.

FREE SERVICES IN ZIMBABWE

- Immunisation for children
- Immunisation for pregnant women
- Treatment for mental illness
- Treatment for epilepsy
- Treatment and rehabilitation for children under five years old
- Treatment for survivors of sexual abuse
- Clients attending opportunistic infection clinics and other HIV and AIDS services
- Treatment for tuberculosis
- Treatment of leprosy and its related complications
- Treatment for those aged 65 years and above
- Other as stated in the Ministry of Health and Child Care Policies.

MODULE TWO:

SEXUALITY AND HEALTH

Human Sexuality – the Binaries and Boxes Grid

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

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

SEXUAL ORIENTATION – emotional & sexual expression towards others

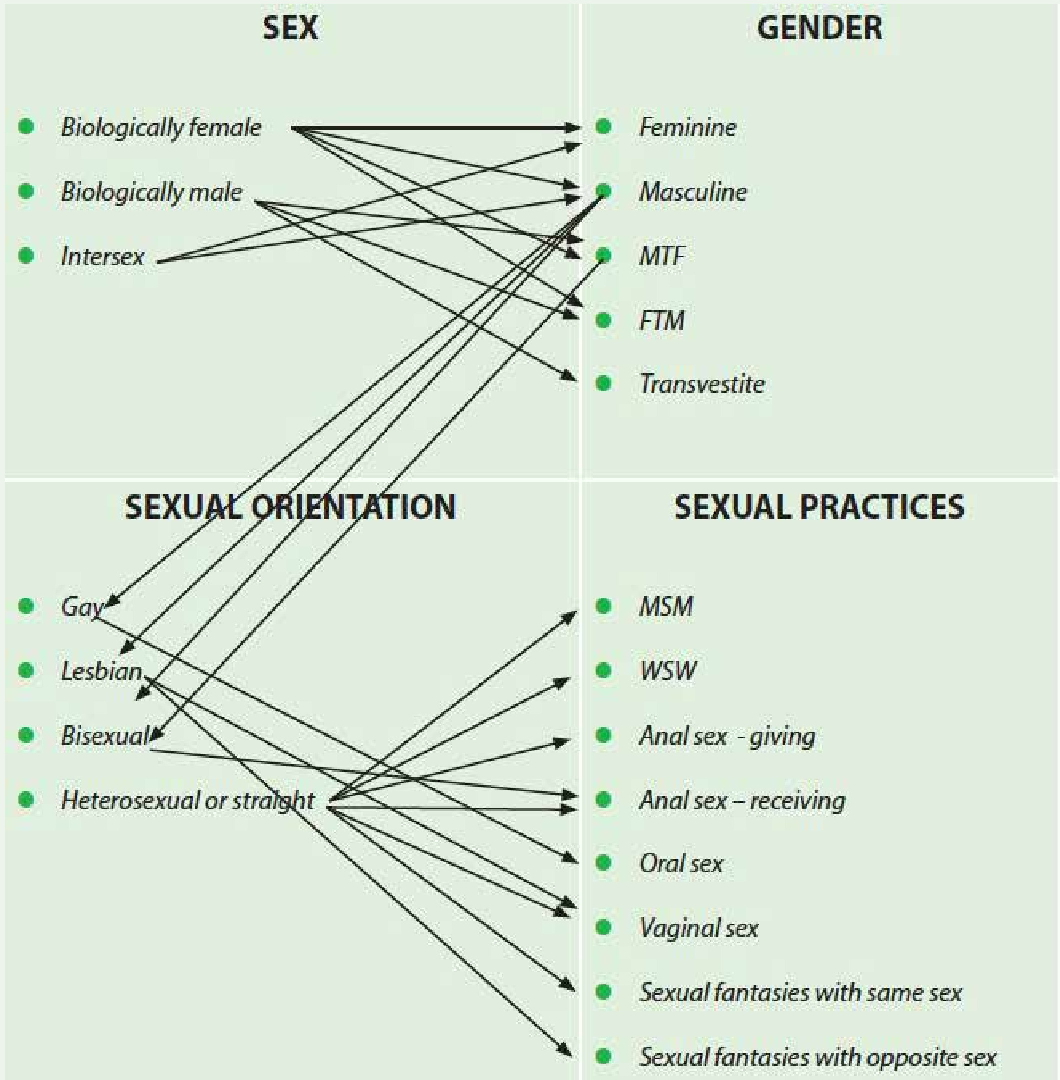
1. Feelings, attraction (on all levels) and self concept
2. how a person expresses themselves in relation to others, i.e. the lasting (more than two weeks) emotional, romantic, intellectual, sexual or intimate feelings (all levels, psychologically, physically, intellectually, spiritually) they have for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

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

1. Learned behaviour, culturally and socially determined, sometimes subtle, often not challenged
2. What is feminine or
3. Masculine
4. Certain tasks and behaviours are considered appropriate for a person's biological sex
5. Gender identity: This refers to how someone feels about themselves in the world as a woman or a man, i.e. a person's sense of themselves as male or female. While most people's gender matches their biological sex, this is not always the case and, for instance, someone may be born biologically male, yet have a female gender identity
6. In many societies, including most in Africa, men are considered superior to women and their roles are dominant. In these so-called patriarchal, heteronormative, heterosexist societies, males, 'masculine' characteristics [such as rationality and competitiveness] and roles assigned to men are considered superior and valued above females' roles, those characteristics considered 'feminine' [such as emotionality and nurturing] and roles assigned to women. Gender and gender roles are, however, not fixed as society and culture are forever changing.
7. Transgender – umbrella term for transsexuals and transvestites
8. Gender presentation: Most biological males [sex] identify as men [gender] and females identify as women. However, there are people whose gender identity differs from the general pattern
9. **Transsexuals***: People whose gender does not match their sex. E.g., a person who is biologically male but feels like a female. Transsexuals often explain being 'trapped in the wrong body'*
10. MTF or FTM (with or without gender reassignment surgery)
11. **Transvestites (cross dressers)***: The term refers mostly to men, usually heterosexuals, who enjoy wearing female clothes and adopt traditionally female character traits for personal satisfaction. This satisfaction may take the form of sexual arousal and/or gratification, but may just as easily be of a non-sexual nature. Transvestites generally self-identify as men and have no interest in becoming women*
12. Other labels – gender benders, twinks, bois, androgynous

SEXUAL PRACTICES – behaviour + meaning

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


SEX
GENDER
Biologically female
Biologically male
Intersex
Feminine
Masculine
MTF
FTM
Transvestite
SEXUAL ORIENTATION
SEXUAL PRACTICES
Gay
Lesbian
Bisexual
Heterosexual or straight
MSM
WSW
Anal sex - giving
Anal sex – receiving
Oral sex
Vaginal sex
Sexual fantasies with same sex
Sexual fantasies with opposite sex

Examples:

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

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

Biological male – *divorced, masculine gender presentation – identifies as heterosexual – has anal sex with and receives oral sex from a man (he is in prison for the next 10 years)*

Biological female – *married (to a man) with a masculine gender presentation – identifies as heterosexual – and has vaginal sex*

Biological female – *with feminine gender presentation – identifies as a lesbian – has sexual fantasies about the opposite sex*

Biological female – *with a masculine gender presentation – prefer to be a FTM – identifies as bisexual – receives anal sex*

Biological female – *married (to a man) with feminine gender presentation – identifies as heterosexual – practices WSW (through threesomes with another women and her husband)*

Notes

MODULE THREE:

BARRIERS TO HEALTH

Key populations, health and the law

Is providing healthcare to members of key populations illegal?

There is nowhere in policy or law that states that it is illegal to provide healthcare services to members of key population groups, including sex workers, drug users, transgender people, gays and lesbians.

In fact, the right to healthcare of all key populations is protected by the Constitution. Chapter 4 Section 76 & 77 clearly states that everyone has the right to access healthcare and services and that no one may be refused emergency medical treatment.

Are health service providers required to provide medical care to members of key population groups?

All Zimbabweans are equal before the law. The constitution binds all branches of government, including public healthcare settings to 'respect, protect, promote, and fulfil' the obligations set out in the bill of rights.

This means that it is every service provider's duty to provide members of key populations with the same care and treatment that they provide to other patients.

It is important that health service providers see members of key populations, including sex workers, transgender people and MSM, as human beings who deserve fair treatment.

What are the consequences of not providing healthcare to key populations?

The fact that sex work, drug use and some sexual acts are considered illegal in Zimbabwe can create a variety of situations that negatively affect members of key populations more than the general population. This undermines HIV prevention for the whole nation by affecting these individuals' access to healthcare and its negative impact on their physical and psychological well-being.

Abuse and feeling a lack of control over one's life can mean that members of key populations give low priority to their health needs and behaviour change over more immediate concerns for their safety and survival.

Notes

MODULE FOUR:

CREATING A FRIENDLIER ENVIRONMENT

Understanding the context

The story below and the links that follow share stories of key populations humanity and the challenges they face.

Protecting transgender patients from a persistent threat: HIV

By Alexandra Zavis

…. Finding a job can be especially difficult for some transgender women, so they turn to sex work, which puts them in even greater danger. Many clients don't want to use condoms, and assaults are common. The U.S. Food and Drug Administration approved a regimen marketed as Truvada for use as a pre-exposure prophylaxis against HIV in 2012, but it is not widely prescribed.

A 2013 review of the limited available research [on this vulnerable group] estimated that as many as 22% of transgender women in the U.S. were living with HIV — a rate 27 times higher than for the general population of reproductive age (15 to 49). More than half of African American transgender women could be infected, according to one study. The risk to transgender men is believed to be lower, although there is even less data about them.

The population is so vulnerable because the stigmatised place that transgender people occupy in society translates into extremely high rates of poverty, substance abuse, mental health difficulties, homelessness and incarceration — all of which increase the odds of having sex without condoms or sharing needles, the two most common ways that HIV is spread in the U.S.

Many of those living with HIV refuse to get tested or treated because of bad experiences at mainstream medical facilities.

A survey by the (US) National Center for Transgender Equality in 2015 found that 23% of the nearly 28,000 respondents hadn't seen a doctor when they needed one in the last year because they were afraid of being mistreated. A third couldn't afford to see one. Of those who had consulted a healthcare provider, a third reported being refused treatment, verbally harassed, assaulted or subjected to some other mistreatment.

"You go to the doctor to seek help, but they act like they're disgusted by you sometimes," said Kelly Kline, 42, one of the Kind Clinic's first transgender patients.

She recalled the New Year's Eve that she came down with pneumonia and had to go to the emergency room.

"Everyone was so nice, until they asked for my ID," she said. "Then the receptionist, in front of everybody, asked, 'So, you're a man?!'"

The doctor did a double take when he saw her and checked her chart.

"I'm so sorry," she recalled him saying. "They told me there was supposed to be a man on my table."

Kline … said she has lost count of the number of friends who have died of AIDS-related complications — "so many people." Some refuse to get tested because they can't face the possibility of an HIV diagnosis. But others are afraid of how they will be received. Because transgender people feel so unwelcome at many medical facilities, opportunities for preventing the spread of HIV — the best hope for containing the virus short of a cure or a vaccine — are being missed.

The Austin clinic began in 2015 with the aim of making Truvada [PrEP] more easily available to those at high risk of contracting HIV. That includes anyone who is in a relationship with an HIV-positive person, gay and bisexual men who do not regularly use condoms with partners whose HIV status they don't know, and anyone who sometimes shares equipment to inject drugs or hormones.

Taken daily, the medicine has been shown to reduce the risk of infection by more than 90%.

Though public health officials in Texas and across the nation have made it a component of their strategies against the virus, the U.S. Centers for Disease Control and Prevention has said that many primary care doctors and nurses remain unaware of it.

Extracted and adapted from:

http://www.latimes.com/nation/la-na-texas-transgender-hiv-2017-story.html

Resources

http://www.latimes.com/nation/la-na-texas-transgender-hiv-2017-story.html

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

https://www.facebook.com/PositiveTalkTV/videos/856266097774654/

For more information or to refer clients, contact:

Adult Rape Clinic (working hours only) Ward C9, Parirenyatwa Hospital, Mazowe St, Harare. Tel. 24 793572, 0775672770

CESHAAR: Centre for Sexual Health HIV and AIDS Research, 9 Monmouth Rd, Avondale West, Harare. Tel. (24) 332074, (24) 333393, (24) 308042 Email: admin@ceshhar.co.zw

GALZ: An Association of LGBTIQ People in Zimbabwe, 35 Collenbrander Rd, Milton Park Harare, Tel. 24 741736

Mbare clinic: Sex Workers can access services at the Mbare Health Complex, Third Avenue, Harare, Zimbabwe, Tel. +263 4 700 081

PSI New Start Centres Union Ave, Harare, tel 24 775327

Bambani: Haddon and Sly Building, 4th Floor, Cnr 8th and Five St, CBD, Bulawayo. Tel. (29) 882690

Sexual Rights Centre (SRC), Bulawayo

The Friendship Bench: 41 Lanark Rd, Kensington, Harare

TIRZ: Transgender & Intersex Rising Zimbabwe, 35 Collenbrander Rd, Milton Park Harare, Tel. 24 741736

Wilkins Hospital SGBV Clinic (24 hours) Princes Road, Belvedere Harare

Zimbabwe Civil Liberties and Drug Network, St Barbra House, Cnr Nelson Mandela and Leopold Takawira Street, Harare. Tel. 777056 47, 24 761122

Or visit any Ministry of Health and Child Care facility.

My Additional Contacts

Notes

MODULE FIVE:

PROMOTING MENTAL HEALTH

Stigma and Discrimination Are Killing Gay Men — News From the International AIDS Conference

By Linda Villarosa

What is the effect of the new, repressive anti-LGBT laws around the world?

"We have evidence to show that the law is killing people."

These are the words of Ifeanyi Orazulike (pictured), who runs a clinic for MSM and trans women in Abuja, the capital of Nigeria. Orazulike traveled to the International AIDS Conference last week in Melbourne to talk about his work and how the anti-gay laws are affecting access to healthcare for MSM in Africa.

Earlier this year, Nigeria passed a law mandating a 14-year prison sentence for anyone entering a same-sex union, and a 10-year term for a person or group supporting gay clubs, societies, organizations, processions or meetings. Public displays of affection by gay men and lesbians are also illegal.

"We used to have about 60 people a month; post-law it is down to about 10 to 15 people," said Orazulike, speaking at a standing-room-only press conference that looked at stigma and discrimination affecting MSM and trans women.

"The research shows that around 73 percent stopped accessing healthcare services, for fear of being discriminated against and for fear of being arrested for who they are," he said. "For fear of going to prison, people preferred to stay at home on their sick bed."

At this year's AIDS conference, organizers shifted the focus squarely on attacking HIV in so-called "key populations." The idea that HIV doesn't discriminate has long been a public health mantra. But, increasingly, it does.

Around the world, 35 million people are living with HIV, and UNAIDS is reporting the lowest levels of new HIV infections this century. AIDS-related deaths are at their lowest since the peak in 2005, having declined by 35 percent. And even in hard-hit sub-Saharan Africa, 90 percent of people who know their HIV status are receiving life-saving treatment.

But HIV prevalence is grabbing hold and taking root in four "key" groups. It is:

28 times higher among people who inject drugs
12 times higher among sex workers
19 times higher among gay men and other men who have sex with men
49 times higher among transgender women than among the rest of the adult population.

In the United States, gay and bisexual men account for 63 percent of new HIV infections and 78 of diagnoses among all newly infected men, reports the Centers for Disease Control. As rates for other groups were falling, from 2008 to 2010, new HIV infections increased 22 percent among young gay and bisexual men and 12 percent among gay and bisexual men overall.

And these are the groups that are most often ignored, shamed, stigmatized and discriminated against, even by the laws that are supposed to protect them. Globally, 76 countries criminalize same sex activity. In a study of 4,000 MSM globally, 1 in 12 reported being arrested or convicted of same sex behavior, noted San Francisco researcher Glen-Milo Santos. Sub-Saharan Africa had the highest rate at 24 percent. The same research shows that getting tangled with the law results in less access to medical care.

Needless to say, Nigerian officials deny the legislation is affecting MSM health. In Nigeria, HIV prevalence is about 4 percent, but much higher among MSM — 44 percent in Abuja and 27 percent in Lagos. MSM represent an estimated 3.5 percent of the Nigerian population but account for more than 40 percent of new HIV infections.

"The government keeps saying law does not affect service provision," said Orazulike. "But when you tell people that they are going to go to jail for 14 years for being who they are, how can it not make a difference?"

At one point as Orazulike was speaking, a Nigerian journalist demanded to know where he had collected his data, because "MSM are not that common in Nigeria."

Surprised, Orazulike responded, "It is quite incredible to hear for the first time in my life doing this work for the past 8 years that gay men are not common in Nigeria. I am a gay man; I am Nigerian."

He then pointed to a group of his friends sitting in the front row and added, "they don't live in Australia; they live in Nigeria. We are very visible."

https://www.huffingtonpost.com/lindavillarosa/stigma-and-discrimination_b_5638273.html

Ultra Quick Screening Tool

(Reference: Ultra-Brief Screening Scale for Anxiety and Depression http://www.psychiatrictimes.com/all/editorial/psychiatrictimes/pdfs/ scale-PHQ4.pdf)

Over the past 2 weeks have you been bothered by these problems?	Not at all	Several days	Mote days than not	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3

Administered by (initial):	MD	CMA	Self	TOTAL
Notes: Reviewing provider:				

Depression Screening Tool

This form can either be administered by healthcare personnel or it can be self-administered.

It combines two validated two-item screeners with scores strongly associated with functional impairment, disability days, and healthcare use, and anxiety that had a substantial effect on functional status that was independent of depression (Kroenke et al.).

Total score is determined by adding together the scores for each of the 4 items. Scores are rated as normal (0-2), mild (3-5), moderate (6-8), and severe (9-12).

NB: This is only a screening tool and does not diagnose depression – that must be done by appropriately licensed healthcare personnel., but it does allow you to identify clients at risk, who may need to be referred to mental healthcare, or at least more regularly monitored.

Any key population member with a positive screen (mild, moderate or severe) should be assessed for suicidal ideation.

A positive score, the presence of suicidal ideation and/or your clinical judgment can indicate that further assessment is warranted. Immediate referral is recommended for those with suicidal ideation and/or a severe score.

PID____________________ Interviewer_____________________ Date__________

The Shona Symptom Questionnaire – SSQ-14

(as used by The Friendship Bench)

Now I am going to ask you how you have been feeling over the past week. Please respond yes/no to each question.

Iye zvino ndichakubvunzai kuti mainzwa sei muvhiki rapfuura. Ndapota pindurai hongu kana kwete pamubvunzoumwe neumwe.

	'In the past week …' ***'Muvhiki rapfuura …'***	**t**
1	There were times in which I was thinking deeply or thinking about many things. *Pane pandaimboona ndichinyanya kufungisisa kana kufunga zvakawanda.*	Yes/No
2	I found myself sometimes failing to concentrate. *Pane pandaimbotadza kuisa pfungwa dzangu pamwechete.*	Yes/No
3	I lost my temper or got annoyed over trivial matters. *Pane pandaimboshatirwa kana kuita hasha zvenhando.*	Yes/No
4	I had nightmares or bad dreams. *Pane pandaimborota hope dzinotyisa kana dzisina kunaka.*	Yes/No
5	I sometimes saw or heard things others could not see or hear. *Pane pandaimboona kana kunzwa zvinhu zvaisaonekwa kana kunzwikwa nevamwe.*	Yes/No
6	My stomach was aching. *Pane pandaimborwadziwa nemudumbu.*	Yes/No
7	I was frightened by trivial things. *Pane pandaimbovhundutswa nezvinhu zvisina mature.*	Yes/No

	'In the past week …' ***'Muvhiki rapfuura …'***	**t**
8	I sometimes failed to sleep or lost sleep. *Pane pandaimbotadza kurara kana kushaya hope.*	Yes/No
9	There were moments when I felt life was so tough that I cried or wanted to cry. *Pane pandaimbonzwa kuomerwa neupenyu zvekuti ndaimbochema kana kunzwa kuda kuchema.*	Yes/No
10	I felt run down (tired). *Pane pandaimbonzwa kuneta (kurukutika).*	Yes/No
11	At times I felt like committing suicide. *Pane pandaimboita pfungwa dzekuda kuzviuraya.*	Yes/No
12	I was generally unhappy with things that I would be doing each day. *Ndainzwa kusafara nezvinhu zvandaiita zuva nezuva.*	Yes/No
13	My work was lagging behind. *Basa rangu rainge rava kusarira mumashure.*	Yes/No
14	I felt I had problems in deciding what to do. *Ndainzwa zvichindiomera kuti ndizive kuti ndoita zvipi.*	Yes/No

http://www.mhinnovation.net/sites/default/files/downloads/resource/Friendship%20Bench%20Training%20Manual.compressed.pdf

Scoring: Every yes, is one point. If someone has more than 8 points, we know that this person is very likely to suffer from a common mental disorder (CMD) and needs treatment.

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MODULE SIX:

TAKING A SEXUAL HISTORY

Key Communication Issues

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

- Develop rapport with the client while being sensitive to concerns about confidentiality and assuring the client that they can speak freely without fear of judgment.
- Explain the importance of taking a sexual history. Providers should tell the client they should be open during the interview because these questions will help the provider give optimal care, even though the questions may be sensitive.
- Never assume the client is either heterosexual or homosexual, a sex worker or drug user.
- Use gender-neutral language when talking about sexual or emotional partners with all clients.

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

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

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

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

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

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

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

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

"Tell me about your experience with condom use"

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

"Have you ever been tested for HIV?"

"What about your sexual partners?"

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

"Have you been tested for STIs?"

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

3. Ask about drug and alcohol use

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

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

"Tell me about your alcohol use?"

"What has your experience with drugs been?"

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

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

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

My Notes For Taking A Sexual History

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MODULE SEVEN:

CLINICAL CARE FOR HIV AND STIs

The following notes detail the recommended services. These may not all be available in Zimbabwe, but all of us can advocate for their services to be included or to be accessed on referral to other supporting services.

Recommended Steps for STI Testing

Healthcare providers should assess the STI risk of all key population clients, and the following is suggested:

1. Interview the client and conduct a culturally sensitive sexual history (as per module 6)
2. Identify risk of STI exposure.
3. Assess alcohol use history and drug use and assess if it is relevant to client's sexual health (as per module 7).
4. Assess underlying social and psychological challenges (as per module 4).
5. Ask the client if they are experiencing any STI symptoms and ask about specific symptoms consistent with the presence of an STI. Keep in mind that the client may be asymptomatic. Common symptoms include dysuria, urethral discharge, pain, skin rash, and anorectal pruritis.
6. Consistently provide the following recommended clinical STI prevention services: Testing (at least annually) for: STI signs (visual inspection of the skin, mouth, genital, and anal area).
    - HIV infection if HIV negative or not tested within the previous year.
    - Syphilis with a confirmatory test to establish whether it is incident untreated syphilis, partially treated syphilis, or whether the client is manifesting a slow serologic response to appropriate prior therapy.
    - Urethral *N. gonorrhoeae* and *C. trachomatis* in men who have had insertive intercourse.
    - Rectal *N. gonorrhoeae* and *C. trachomatis* in men and women who have had receptive anal intercourse.
    - Pharyngeal *N. gonorrhoeae* and *C. trachomatis* in men who have had receptive oral sex.
7. Vaccinate against HAV and HBV for all sex workers, gay men and other MSM in whom a previous infection or vaccination cannot be documented.

8. Consider screening for other STIs: Lymphogranuloma venereum (LGV): consider LGV in diagnosis of compatible syndromes (proctitis and proctocolitis) and perform tests to diagnose chlamydia.
9. Check for herpes simplex virus (HSV)
10. Check for human papillomavirus (HPV)

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

Based on the findings in the sexual history and risk assessment, inform the client that physical examination is routine for all sexually active clients and advise them that this will involve three sites: mouth and throat, the genitals and the rectum.

Triple Site Assessment

Triple site examination involves a visual inspection of the mouth and throat, the vagina/ penile areas and the rectum. Depending on the sexual history/ risk assessment and the results of the visual inspection, specific diagnostic tests can then be carried out.

Recommended Triple Site Assessment

It is recommended that triple site assessment is routinely **carried out for all sexually active clients** on their first clinic visit and thereafter at intervals determined by established risk factors. This is especially important because so many STIs are asymptomatic, especially in women.

Triple site examination involves a visual inspection of the mouth and throat, the vagina/ penile areas and the rectum. Depending on the sexual history/ risk assessment and the results of the visual inspection, specific diagnostic tests can then be carried out.

Signs and Symptoms (specific to STIs)

- abnormal urethral, vaginal or rectal discharge
- pain with intercourse
- urinary abnormality – dysuria, frequency, urgency, abnormal colour/ odour,
- vaginal bleeding with intercourse or between menstrual cycle
- ano-genital irritation and inflammation
- ano-genital lesions.

Physical Assessment

This is a head-to-toe approach using inspection and palpation to assess potential sites of infection and inflammation and includes:

- inspection of the mouth and throat for lesions, redness, or swelling
- inspection of the trunk, forearms and palms for signs of rash, lesions (and signs of injecting drug use)
- inspection of external genital, pubic, and peri-anal areas for bleeding, discharge, irritation, lesions, rash
- palpation of the inguinal nodes for swelling/tenderness
- inspection of urinary meatus for redness and/or swelling discharge (mucoid, mucopurulent, purulent)
- urine specimen (if appropriate) – ideally the client should not have voided in 1-2 hours/collect first 10-20 ml. Check for colour, odour, consistency, time since last void.

Male Anatomy	**Female Anatomy**
Palpation of testicles for tenderness or abnormal lumps	Palpate Bartholin's glands (for tenderness and swelling)
The client is symptomatic or urethral discharge is noted at the meatus, ask the client to milk the urethra in attempt to expel discharge from meatus for inspection and testing	Assess vaginal discharge, increased amount, consistency, colour, and odour (mucoid, purulent, thick, frothy, malodorous), pH
	Assess for any abdominal pain
	Inspect vulva, cervix and vaginal wall (e.g., redness, swelling, lesions, and nature of discharge) bimanual exam (cervical motion tenderness, adnexal tenderness, and/or fundal tenderness or to identify abnormalities on palpation)

STI screening and treatment is a critical entry point for HIV prevention and reduction in key populations. Below is a suggested approach to triple site screening.

Triple Site Screening For Sexually Active Clients (oral/ genital and rectal and for pharyngeal gonorrhoea)

Diagnostic Tests

Throat Swabs (if indicated)

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

Vaginal Specimens

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

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

Cervical Specimens

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

Rectal Swabs, if indicated

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

Genital Ulcers or Lesions (perianal swab)

- HSV PCR, if lesion present
- Syphilis

Venepuncture:

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

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

Also recommended:

Yearly screening for C. trachomatis and N. gonorrhoea of all sexually active females aged ≤25 years.

Asymptomatic non-genital Chlamydia/ Gonorrhoea infections contribute to a high burden of infection.

Screening of sexually active young men should be considered in high prevalence settings (e.g. adolescent clinics, correctional facilities, and STI clinics).

MSM with relevant exposures should be screened for urethral and rectal CT/ GC, and for pharyngeal gonorrhea, at least annually. Consider every 3 to 6 months for men at highest risk.

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

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

The following table gives guidance on treatment of critical STIs.

INFECTION	CAUSATIVE AGENT	SYMPTOMS	Recommended treatment
Chlamydia	*Chlamydia trachomatis*	Often no symptoms, can be a discharge from the penis, painful urine, swelling of testes. In women this can spread to the fallopian tubes causing pelvic inflammatory disease (PID) Can also infect the rectum of MSM (proctitis) and may include a discharge with bleeding, pain and swelling.	Azithromycin 1 g orally in a single dose **OR** Doxycycline 100 mg orally twice daily for 7 days
Gonorrhea	*Niesseria gonorrhoeae*	Often no symptoms, whitish, yellowish or greenish discharge from penis or vagina, painful and frequent urination (sometimes burning sensation in women, sometimes PID or vaginal bleeding between periods). Rectal infection in both men and women may include discharge, anal itching, soreness, bleeding or painful bowel movements. Pharyngeal infections from unprotected oral sex can cause sore throats.	Ceftriaxone 250 mg in a single intramuscular (IM) dose **PLUS** Azithromycin 1 g orally in a single dose or doxycycline 100 mg orally twice daily for 7 days If ceftriaxone is unavailable (urethral, rectal, cervical infection): Cefixime 400 mg in a single oral dose **PLUS** Azithromycin 1 g orally in a single dose or doxycycline 100 mg orally twice daily for 7 days **PLUS** Test-of-cure in one week

INFECTION	CAUSATIVE AGENT	SYMPTOMS	Recommended treatment
Syphilis	*Trepomema palladium*	A single sore (chancre) first appears and can become multiple sores usually on the outside of the genitals, inside the vagina or anus and even on the lips of the mouth. Secondary phase leads to skin rashes in the mouth vagina and anus and comes with fever, swollen lymph glands, sore throat, hair loss, headaches, weight loss, muscle aches and fatigue. In the latent phase can last for 10 to 30 years. Untreated it can lead to blindness, dementia and death.	(Primary) Benzathine penicillin G 2.4 million units IM in a single dose (Secondary) Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at one-week intervals. (Latent) Early latent syphilis: Benzathine penicillin G 2.4 million units IM in a single dose. Late latent syphilis or latent syphilis of unknown duration: Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals.
Hepatitis A	*Hepatitis A virus (HAV)*	Loss of appetite, malaise, fatigue, nausea and vomiting, abdominal pain, enlarged liver, dark urine, jaundice rash and arthritis symptoms.	Usually requires only supportive care with rest, abstaining from alcohol, and coping with nausea until the body eliminates the virus. Hospitalisation might be necessary for clients who become dehydrated because of nausea and vomiting and is critical for clients with signs or symptoms of acute liver failure. Medications that might cause liver damage or are metabolised by the liver should be used with caution among persons with HAV.

INFECTION	CAUSATIVE AGENT	SYMPTOMS	Recommended treatment
Hepatitis B	*Hepatitis B virus (HBV)*	Loss of appetite, malaise, fatigue, nausea and vomiting, abdominal pain, dark urine, jaundice rash and arthritis and may result liver cancer.	No specific therapy is available for persons with acute HBV; treatment is supportive. Persons with chronic HBV infection should be referred for evaluation to a physician experienced in the management of chronic liver disease. Certain therapeutic agents for the treatment of chronic hepatitis B, including some ARVs, can achieve sustained suppression of HBV replication and remission of liver disease in some persons.
Hepatitis C	*Hepatitis C virus (HCV)*	Often no symptoms, but can be loss of appetite, malaise, fatigue, nausea and vomiting, abdominal pain, enlarged liver, dark urine, jaundice rash and arthritis and if chronic, cirrhosis, liver disease and possibly death.	Persons found to have HCV should be evaluated for the presence of active infection, presence or development of chronic liver disease, and possible treatment. Combination therapy with pegylated interferon and ribavirin is the treatment of choice for people with chronic HCV. However, those newly infected may be cured with relatively short course treatment with specific antiretroviral medicines. Healthcare providers should consult with specialists knowledgeable about management of HCV infection.

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

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MODULE EIGHT:

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

A healthcare provider's role is to support a client to better understand the role of drugs in their life, providing accurate information and taking the necessary steps to reach the client-directed position.

It is the service provider's role to serve, not judge!

Warning Signs Of Commonly Abused Drugs

- **Marijuana**: Glassy, red eyes; loud talking, inappropriate laughter, followed by sleepiness; loss of interest or motivation.
- **Depressants** (including Xanax, Valium, GHB): Contracted pupils; drunk-like; difficulty concentrating; clumsiness; poor judgment; slurred speech; sleepiness.
- **Stimulants** (including amphetamines, cocaine, crystal meth): Dilated pupils; hyperactivity; euphoria; irritability; anxiety; excessive talking followed by depression or excessive sleeping at odd times; dry mouth and nose.
- **Inhalants** (glues, aerosols, vapours): Watery eyes; impaired vision, memory and thought; secretions from the nose or rashes around the nose and mouth. headaches and nausea; appearance of intoxication; drowsiness; poor muscle control; anxiety and irritability.
- **Hallucinogens** (LSD, PCP): Dilated pupils; bizarre and irrational behaviour including paranoia, aggression, hallucinations; mood swings; detachment from people; absorption with self or other objects, slurred speech; confusion.
- **Heroin:** Contracted pupils; no response of pupils to light; needle marks; sleeping at unusual times; sweating; vomiting; coughing, sniffling and twitching.[1]

1 http://www.helpguide.org/articles/addiction/drug-abuse-and-addiction.htm

Article adapted from the Zimbabwe Civil Liberties and Drug Network Newsletter June 2018 Issue. No. 5 Volume 1.

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

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

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

"Anything with codeine is my prime product. But lately I now move a lot of ephedrine. Even ecstasy pills are now big bucks" Ephedrine is the base substance used to manufacture cocaine, crystal meth, and meth cathinone. Casper spends most of his day at Bosman station, shipping boxes of prescription medication. His main transporters are bus drivers who hide the boxes in luggage compartments.

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

Approaching Drug Use in the Clinical Setting

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

- Begin by building rapport and confidence with the client.
- Remind clients that any information they share will be kept confidential. If information will be shared, providers must tell the client with whom it will be shared and under what circumstances. This is the same for information that the provider documents. Clients have a right to know if what they disclose will be documented and how that information will be used.
- Remember to use a non-judgmental and non-confrontational approach when discussing drug use with clients.

Other techniques to help when discussing drug use with clients are provided below. These techniques help providers sharpen their overall interviewing skills sensitively and sensibly. These techniques are not meant to serve as stand-alone tools for drug-related history taking.

Normalising

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

Transparency

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

Asking permission

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

Option of now answering question:

"If you are not comfortable answering any of these questions you don't have to answer them".

Avoid asking for judgments or opinions:

Don't say, *"How often do you drink in a week or how many drinks do you have in one setting?"* Better to ask, *"Do you get drunk? Do you drink often?"*

Ask specific instead of general questions:

"Have you ever used mbanje*? Have you ever used cocaine?*

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MODULE NINE:

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

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

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

WHO recommended minimum services for key populations	
Approach	***Services***
Community-based outreach	✓ Dissemination of HIV risk reduction information and targeted media. ✓ Distribution of barrier methods, including the female condom (Femidom), dental dams, condoms and condom-compatible lubricants (NO oil-based lubricants). ✓ Training on correct use of barrier methods. ✓ Provision of referrals and linkage to HIV testing, other HIV prevention programmes, drug and alcohol treatment, mental health care, HIV health care and treatment are non-discriminatory and responsive to the needs of sexual minorities. ✓ Referrals to affirmative health service providers when trauma e.g. gender-based violence, rape, are experienced.
Provision of prevention methods and tools (including condoms and condom-compatible lubricants)	✓ An increased availability of free condoms has been shown to significantly reduce HIV risk. ✓ Condom-compatible lubricants reduce risk of condom breakage during sexual intercourse and are water-based lubricants manufactured for use with condoms. They do not compromise the integrity of latex condoms or have other harmful effects. ✓ The availability of barrier methods for some groups who need special supplies such as the female condom and dental dams.
Positive prevention for living with HIV	✓ Counselling in general, and specifically for sero-discordant couples. ✓ Inclusion of people living with HIV in all interventions, HIV counselling and testing. ✓ Increasing access to HIV testing is critical for reducing the spread of HIV among sexual minorities and their sex partners and facilitating HIV-positive individuals' access to appropriate healthcare. ✓ HIV counselling and testing programmes for sexual minorities should establish strong linkages with other HIV prevention and health service providers and clinics that can deliver appropriate healthcare and treatment in a manner that is responsive to the needs of HIV-positive sexual minorities and that maintains their confidentiality.

WHO recommended minimum services for key populations	
Approach	***Services***
Care, support and treatment services	✓ Timely access to life-saving healthcare, antiretroviral treatment and opportunistic infection prophylaxis has very clear and powerful effects on the health and well-being of people diagnosed with HIV. ✓ Efforts to provide HIV-positive sexual minorities with access to timely and appropriate HIV medical care and ART should form part of a comprehensive HIV strategy. ✓ Comprehensive counselling and trauma debriefing services.
Targeted information, education and communication (IEC)	✓ Targeted IEC seeks to improve HIV knowledge and awareness; promote beliefs, attitudes and norms that reduce risk; build skills and self-efficacy; and motivate HIV testing, changes in substance abuse and sexual practices and promote other behaviours that reduce HIV and AIDS risk. ✓ Activities in this category include evidence-based community, small-group, and individual behavioural interventions, peer education and the development and distribution of targeted media that are used as part of outreach efforts, HIV testing and counselling, behavioural interventions and social marketing campaigns.
Management of sexually transmitted infections	✓ STIs significantly increase the risk of HIV transmission and acquisition. ✓ Information and education about the prevention of STIs should be included as part of a comprehensive package of services. ✓ The improvement of accessibility to and quality of STI prevention, screening, timely provision of STI results and STI treatment for sexual minorities is of utmost importance.

The following list of comprehensive services has been recommended by Zimbabwe's KP Working group chaired by the MoHCC. It provides a definition of key populations in Zimbabwe and the services every public health facility should offer directly or through network referral. You may need to advocate for these services at your facility.

<table>
<tr><td colspan="3">Comprehensive Services For Key Populations in Zimbabwe.
<u>Definition of KPs in Zimbabwe:</u>
Male and female sex workers (SWs); men who have sex with men, including men in prisons and other closed settings (MSM); People who Use and Inject Drugs, transgender and intersex people.</td></tr>
<tr><th>Prevention</th><th>Treatment and Care</th><th>Psychosocial Support</th></tr>
<tr><td>• Male and female condoms & water-based lubricants.
• HTC and ART initiation
• TB Screening (Including for PLHIV)
• Presumptive STI screening (triple site screening)
• Targeted IEC (through peers, mobile phones, internet, etc.)
• PEP and PrEP
• Cervical cancer screening & female sexual health education
• Family planning (all methods expect permanent, which can be done through referral)</td><td>• Diagnosis and treatment of opportunistic infection/TB (Including PLHIV)
• Vaccination, diagnosis and treatment of viral hepatitis
• Antiretroviral therapy (ART)
• STI treatment
• Cryotherapy for genital warts</td><td>• Mental health services, counselling & care
• Legal advice & support
• Establishment of KP peer support groups and networks at clinic sites and in communities</td></tr>
</table>

• Voluntary medical male circumcision & male sexual health education • Anal & prostate cancer screening • HPV vaccinations (SW and MSM)		
By referral (to partners or larger public facility): • Management of severe ART failure. • Harm reduction services, including sterile needles/syringes. • Overdose management, medically assisted treatment. • Drug detoxification & drug dependence treatment. • Relapse prevention including socio-economic and related reintegration services. • Services for the sexual partners of MSM (female, transgender, male) including family planning.		
Cross Cutting Elements: • Key population-friendly outreach and decentralised drop-in centres and clinics • Case management • Peer education • Prevention of violence	• Life skills training • IEC • Crisis response and management • Peer counselling and individual and small group interventions	

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MODULE TEN:

ACTION PLANNING

Topic		
Objectives		
Activities		
Time Frame		
Inputs		
Responsible Person		
Expected Outcome		
Cost		

Notes From the KP Friendly Site Visit

FOLLOW-UP TO MAKE THIS TRAINING MORE EFFECTIVE

Clinic attachments

Participants will benefit greatly from time spent at a healthcare facility experienced in supporting key populations. This could be done on a rotational basis. During the attachment, trainees 'shadow' the clinic's programme staff, working and treating key population members. A feedback meeting can be held every month with all trained public health nurses, the programme nurses, outreach workers and peer educators. Meetings aim to reflect on how the programme is going, sharing experiences on working with key population members, as well as members of key population groups sharing their experiences in working with the nurses from the public system. This is an extremely valuable part of the programme, as it provides health service providers with 'hands on' experience in working with a group with whom they have little familiarity; this further helps reduce stereotypes about key populations and increase willingness to serve them.

Monthly lunchtime meetings

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

Gaining support from local stakeholders is critical

Authorities responsible for managing public sector health services need to be on board with the idea of sensitising health service providers to better meet the needs of members of key populations. The training programme has approval and support from MoHCC management, so staff in local clinics must understand that undergoing the training and changing their attitudes is both expected and encouraged.

Staff turnover can negatively impact sustainability of the training

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

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Web resources

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