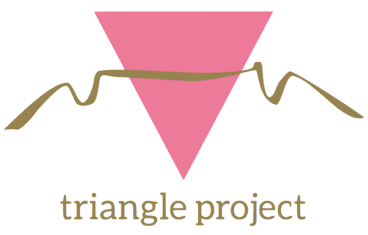
Health workers attending to counter normative sexual orientations and gender identities

SEXUAL AND REPRODUCTIVE
JUSTICE COALITION
AND TRIANGLE PROJECT, 2020



Forward and acknowledgements

In 2010, Triangle Project worked with Marion Stevens to develop training material for health workers to address poor attitudes, lack of defined services and lack of understanding of LGBTI needs and of requirements within the health system. Triangle Project was funded by Charles Schorer for this work in 2010. Having been part of the Women's Health Project which developed Health Workers for Change in the 1990s[1], Marion requested permission from Professor Sharon Fonn to adapt this methodology[2] which has been widely used and researched globally.

Some years later Triangle Project found itself needing to refer clients for sexual and reproductive health services. In particular issues of screening for cervical cancer and abortion services surfaced as neglected services. An informal referral network was developed as the Sexual and Reproductive Justice Coalition (SRJC) was being formed. This involved collaboration with Sister Judiac Ranape a Reproductive Health Manager and Trainer in the public service.

In October of 2018, the SRJC held a workshop in collaboration with Triangle where participants reflected on their health needs in conversation with health providers noting challenges and barriers that queer persons experience. This translated in closer collaboration and members of Triangle participated in the Abortion Provider Appreciation Days in 2019 and 2020 articulating their gratitude to sensitive health workers who have provided care.

Overtime language has evolved as has clinical practice and knowledge; we appreciate that these changes will continue as we refine and improve health care and systems to be responsive to the needs of persons with counter normative sexualities and gender identities. This manual is now being published for wider use to enable improved care within the health system for persons of counter normative sexualities and gender identities.

Aluta continua

Marion Stevens and Sharon Cox

[1] Fonn, Sharon & Xaba, Makhosazana. (2001). Health Workers for Change: developing the initiative. Health policy and planning. 16 Suppl 1. 13-8. 10.1093/heapol/16.suppl_1.13.
[2] Haaland, Ane & Vlassoff, C. (2001). Introducing Health Workers for Change: from transformation theory to health systems in developing countries. Health policy and planning. 16 Suppl 1. 1-6. 10.1093/heapol/16.suppl_1.1.

Contents

Introduction

This training manual has been developed for Triangle Project fieldworkers to facilitate change directed at health workers through capacity building and leadership training. The orientation of this manual draws heavily on Health Workers for Change: A manual to improve quality of Care[i] (Hw4C) and Health Workers for Choice: Working to Improve Quality of Abortion Services[ii] and we gratefully acknowledge these sources. The training is directed to the team which provides healthcare, and this includes but is not limited to: porters, administration clerks, doctors, various categories or nurses, drivers, pharmacists, etc.

This particular training manual is directed towards enabling health workers to become sensitive in relation to LGBTI issues and to control what they can in providing for a more LGBTI friendly environment. Health services are orientated towards a heteronormative society and have been blind towards the needs of people who have sexual identities which fit into the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) continuum. As such, many LGBTI persons have not felt able to access health services and many of the health issues that health workers should be providing for are overlooked. This manual complements existing materials which address training on sexualities, sexual orientations and gender.

The manual has also been crafted for use in further political education of LGBTI and sexual and reproductive health and rights (SRHR) activists and also aims to provide guidance for leadership development, through skills training. Similar to the Hw4C manuals, we have also drawn on the pioneering social change manuals of Training for Transformation[iii] and the Oxfam Gender Training Manual. [iv] As such, we embrace queer theory and work to further an intersectional sexual and reproductive justice perspective in this body of work.

Methodology and Approach

Given the realities that it is really difficult to get health workers or NGO workers to take time out of their usual schedules for more than one day: Triangle Project wanted to develop a workshop that would be able to be completed in one day; albeit a long day!

The orientation of the training has been to utilize participatory adult education methods, which the HW4C manuals adopt. These have been drawn from Paulo Freire's work on critical awareness in providing a philosophy of education and development, and a very practical method of: getting participants actively involved, breaking through apathy, and developing critical awareness of the causes of problems. It also conceptualizes people as valuable beings whose experience is acknowledged as opposed to just formal qualifications. The approach of problem-based learning is central to sustained change. 'Problem based education is prophetic, and as such is hopeful, corresponding to the historical nature of human beings. It affirms people as beings who transcend themselves, who move forward and look ahead…for whom looking at the past must only be a means of understanding more clearly what and who they are, so that they can more wisely build the future.'[v] This approach has been instrumental in informing the methodology of this training manual.

The key areas that this Manual explores:

- Self-examination of opinions and attitudes, including social constructions of gender and sexualities;

- Reflections of persons with counter-normative sexualities and gender identities limited access to care, including sexual and reproductive health, psycho-social health and violence;
- Health workers' rights and responsibilities; and
- Creating one's own solutions.

The training is arranged in three workshops which are planned to last two hours each.

Facilitator's Guide

Facilitation can be challenging, and the success of the workshop series depends on having good facilitators. It's important to prepare for running the workshop whether you are a new or seasoned facilitator. Some methods may be new to you and it's always best to try them out with a group of people before doing the workshop. Don't be discouraged if things don't go well the first time as planned; experience and hindsight always improves our work. It's also recommended to work as a team and two facilitators are recommended for this workshop series. An advantage of this is to track and reflect together working collaboratively in improving your facilitation skills.

As this work is about crafting social change it is important to be realistic with participants about the expectations of the workshop series. Homophobia and heteronormativity have infiltrated all facets of our society. As with internalized racism and sexism, one is bound to come across elements of internalized homophobia within some LGBTI persons. It is important to acknowledge this and to be honest about laying open our thoughts and then our goal of wanting to facilitate change. Change is slow and it is useful not to be discouraged but to provide a space for participants to commit to the goal of changing health services to be accessible to LGBTI persons.

Planning the workshops

Good facilitators are essential for the success of the workshop series. A facilitator is someone who allows people to discover their own knowledge and find their own solutions. Facilitation is a skill that is learnt through training and mostly through experience. Some people have a talent for facilitations, others have not. The attitude of the facilitator is essential, she or he has to have respect for and an interest in people's opinions and feelings, be a good listener, and be able to get people in a group to interact and express themselves without feeling judged.

Often watching someone run a session will give you an idea if they are good or not. Some of the things you should look out for include:

- Establishing a good physical environment (spacing and arrangement of furniture, light, heating, ventilation, water on tables);
- Establishing a good atmosphere in the group as an introduction to a session;
- Encouraging participation by limiting domination by one person and facilitating silent participants to engage;
- Following up on people's contributions to get to the bottom of an issue;
- Listening to what people say and checking for understanding;
- Being aware of non-verbal communication (arms crossed, heads down, shifting, etc.);
- Having a non-judgmental attitude;
- Being comfortable with silences;
- Allow full participation and not interrupting contributions; and
- Using open ended questions.

Choosing participants

The number and mix of participants is an important aspect to the outcome of the workshops. Running the workshop with 12-15 participants is ideal. The workshop is meant for participants who straddle spaces, professions and categories from doctors to nursing staff to administrative assistants and general assistants.

Scheduling

The various workshops take about 2 hours each. Ideally, they should be done over more than one day to allow participants time to reflect and think through learning either one a week or two workshops over a few days. But given limited time constraints, the workshop can be provided for in one LONG day.

Step by Step guide

For health service managers, researchers and activists:

1. Decide why you want to run this series. What is your goal? What behaviours do you hope to influence? Having done this thoughtfully you will assist in deciding who the participants should be
2. Choose the health centre, clinic or hospital where you would like to hold the workshops
3. Obtain permission from the relevant authorities to run the workshop series
4. Meet with the individual participants – either face-to-face or by telephone. After explaining to them what is involved let them know they are free to participate or not, but that you would like to encourage everyone to take part
5. Select the facilitator (using the guidelines spelled out under 'Choosing facilitators' (above) If there is no one readily available, you should find someone you think would do a good job and arrange for that person to get training
6. Decide with the facilitators how you want the report of the findings prepared and how you will use the results

For facilitators:

1. Read the whole manual thoroughly in order to prepare yourself adequately with the principles and practical aspects of running the workshops
2. Plan a meeting with the workshop participants. See the section – introduction to the series to participants'
3. Plan for and run each workshop as described in the manual. Remember to have enough time, at least an hour, before each workshop to go through it
4. Write up
5. Present your report to the relevant people: workshop participants, health service managers, managers.

Preparing for the workshops

The methodology used in this workshop series presents and reflects back to participants their own experiences. Each workshop has an exercise which enables people to examine themselves. The facilitators job is to run these exercises' and then to facilitate the discussion after each exercise. The discussion will generate the content of the workshops and will come from the participants themselves. The manual presents each workshop as a separate chapter. Each chapter begins with the title of the workshop, its objective, and a short description of the 'background' to the objective. The materials needed for the workshops are listed and a timetable. A section called 'methods' provides details about running the workshop and in some sections pointers and examples are provided. Please also note the addendum which includes examples of ice-breakers or team-building exercises.

Introducing the series to participants

Introducing the workshop series to the participants and getting their voluntary agreement to participate is an important step. Ideally this should be a face-to-face meeting, but given time constraints one could use the options of emailing or texting information to potential participants and getting them to respond in a contractual agreement.

In order for the participants to be able to agree, they need to know:

- Who you are and whom you represent
- What they will be doing
- Why they will be doing it
- How much time they must commit to the workshops
- That all information that is collected during the workshop will be anonymous. No comment or opinion will be attributed to a specific individual

Develop a handout which includes the titles of the different workshops, noting that all of you together will be looking at these issues. Explaining that the reason you are doing these workshops is that people frequently talk about the health service, but few people ask health workers themselves what they think. In this workshop series you are interested in what they think and their experiences. It's important that participants understand that the workshops build on each other and are inter-related. Often solutions are decided by management and people at the top; in this series participants can identify solutions and commit to change. Let participants know what each workshop will take about 2 hours. Allow space for questions, to clarify language, and time to answer queries. If you do not know the answers, let participants know and tell them that you will try and find out the answers. Communicate the dates, time and venue of the workshop(s).

If meeting the participants; a good introductory process could also include an ice breaker. If communicating with them electronically, prepare a briefing addressing all these points and ask them to tick the boxes and sign and return the form to you.

Writing up the workshop sessions

It's tempting to leave the writing for later, but we suggest that you write up the findings at the end of every workshop. The longer one waits, the more likely you may forget important details. One needs to record what happened so that each workshop leads smoothly to the next. You will also need the notes from each workshop to prepare for the final workshop. You may be asked to present your findings to groups or decision maker that you hope to motivate for change. Or you may be asked to publish your results or lobby for change. Let you participants know that this could be another outcome of this workshop process.

At the start give some demographic information about the participants' age, sex, qualifications, skills and functions. Describe the circumstances in which they work, rural or urban, if the services are well equipped or not, how many patients they see in a day. Keep notes of what people say, the range of opinions, and the predominant view. Remember to keep confidentiality.

Workshop Process Chart

Things to keep in mind

If you have more time, you could explore using other workshops in the original Health Workers for Change. The one relevant generic workshop that could be used is 'Overcoming obstacles at Work'. This workshop is available online on the WHO website.

While the workshops in this manual are all different – here are some general considerations that apply to all which you should consider as a facilitator:

Up to 80 percent of communication is nonverbal. How can you recognize it?

Positive /encouraging

- Making eye contact (in some cultures)
- Smiling, friendly
- Relaxed body position
- Active listening (nodding, shaking the head, leaning forward, uttering ' uhm-hm' 'ah' 'oh' etc.
- Touching (where appropriate, in some cultures)
- Gesturing (e.g. to invite someone to sit down)

Negative/discouraging

- Keeping attention on papers/wiring/laptop
- Fiddling with something, for example, a pen, a button, something on the desk
- Tapping with a pen or fingers on the table
- Frowning, making faces
- Tense body position (eg. crossing arms or feet)
- Looking out the window
- Looking at your watch
- Yawning, sighing
- Not acknowledging what the person has said (verbally or non-verbally

Plan adequately

- Discuss which issues are likely to arise in the discussion, and how you will respond to them
- Try out unfamiliar methods with colleagues before the workshop
- Decide on what kind of information you want to collect and in how much detail.
- Decide when to write down exact wording, and whether you and the group would be comfortable to be recorded.
- Define the roles of the facilitator clearly, for example, who will take notes, who will lead the discussion, who will be the timekeeper to ensure that the workshop stays on schedule
- If necessary arrange for an interpreter at the workshop and translation of notes
- Be aware of possible problems in the group process. For example, you might say, 'Some people often talk less than others. So in this group, let's try to make sure everyone gets an opportunity to talk if they want to.'
- Be prepared for emotional responses during a workshop. If someone cries, say that it is okay to cry and ask what they would like to do. Some people may want to leave the room, let them do so. Go on with the workshop, but do talk with the person alone afterwards about how they are feeling
- Know when you need to take control and direct the proceedings to maintain the focus and when you can let the discussion flow and let people voice their feelings and frustrations

Focus on the objective

Sometimes the discussion can go off track. To avoid this you must always focus on the objective and bring people back to the point at hand.

- Reinforce important points as you go along
- Draw together common themes
- Ask a group member to summarise the proceedings as needed. Add your own summary points if necessary and relate them to the main focus

Establish rapport and build trust

- Invite health workers to ask questions of you and what you are doing
- Where appropriate, participate in exercises. Do the workshop with rather than on the members
- Break down the barriers between the facilitator and the participants. For example, if you as the facilitator can say, 'we are all human beings'. If you have a common bond as women or as parents or whatever common ground you may have.
- Ask each person how he or she would like to be addressed. Make people feel comfortable: use their names, make small talk, and use humor where appropriate.
- Give participants privacy where necessary. If they are doing exercises that require them to reveal details about their personal lives, do not intrude. Ask permission to join a small group discussion.
- Be careful not to find fault or make critical comments when you respond to people.

Maintain good communication

- Arrange seating to enhance communications. For instance, remove physical barriers and use a circle where possible
- Listen to what people are saying. Check your understanding by summarizing what you heard and requesting examples to open the discussion.
- Watch for non-verbal messages
- Make eye contact with all participants, if appropriate
- Speak slowly and clearly but do not be patronizing
- Check that participants understand what you mean. It is not good to say, 'do you understand?' Rather, be humble and say, 'I am not sure if I have made myself clear. Can someone here say it in another way?'
- Use open-ended questions. For example, asking, 'was this session useful?' is a closed question; the group can only answer yes or no. But if you ask, 'how have you found this session?' the group is free to discuss anything about it
- Acknowledge contributions. Reinforce points that focus on the objective of the workshops either verbally or nonverbally.
- Be comfortable with silence when appropriate – give people time to think
- Do not interrupt
- Remember that all workshop participants have a right to their own opinions. If there are disagreements, you can simply note that on a particular issue people disagree

Conclude each workshop carefully

- Remind participants of the objective
- Summarize the main findings
- Ask participants if you have accurately summarized what was said; ask them to add to the summary if they like
- Evaluate the workshop with participants. Ask them what they learned, and what they liked and didn't like about the workshop
- Thank participants for their time and contributions

Know yourself

- Be aware of your own feelings and prejudices and try to avoid imposing your views on the group
- Take time after each session, just before you write it up, to think about how it went. Consider what you might
- do differently the next time, and what you will try to continue to do. If you work with a coordinator, talk about your work, as well as how you felt working with each other. In this way you avoid problems developing between you.

The Workshops

My Childhood: being different

Objective

For participants to describe the way society expects boys and girls to behave (social constructions of gender), and to investigate its influence on sexualities, gender identities and sexual orientations and health worker –client interaction

Background

People's abilities to do things in their lives, go to school, wear clothes of their choice, groom themselves in a particular fashion, to have children, to not have children, where they live and with whom, where they work , what work they do, and some on depends on many things. How rich or how poor they are, if they are urban or rural and race can be important determinants. A powerful factor that determines what people may or may not do, are the norms that society defines as acceptable behavior for men and women, with socially prescribed sexualities, sexual orientations and gender identities. In this workshop we examine these issues

Methods

Individual drawing
Group discussion
Personal Commitment to change

Things Needed:

- A meeting room
- Large sheets of paper
- Writing paper (A4 size)
- Small squares of paper (3x3 inches)
- Different felt coloured pens or pencils
- Something to stick paper on the wall
- One envelope

Time Table	2 minutes
• Introduction to the workshop	5 minutes
• Explaining the objectives	5 minutes
• Explaining the exercise	10 minutes
• Drawing	10 minutes
• Sharing in the group	30 minutes
• Discussion after the exercise	40 minutes
• Summary	5 minutes
• Personal Commitment to change	10 minutes

VARIATION:

Some participants may feel that they were never treated differently in their childhood. As a facilitator, realize that whilst those need not be the case, the participant will not be able to engage in the discussion. In such situations ask the participant to think of experiences that happened later in their life. For example going to college or starting a job or being in a relationship. This is also an opportunity to explore the pressures to be in a heteronormative relationships. Take time to assist participants who may be resistant or simply do not understand.

Steps

1. Explain the drawing exercise

Drawing is a medium that allows us to express feelings or thoughts that at times are difficult to express in words. Often we feel that drawing is something that children do and are therefore inhibited about drawing. But this exercise is not to see how good or how bad we are at drawing. This exercise is to allow us to stop for a moment and to think of our past experiences. On a sheet of paper ask each participant to draw their most memorable childhood experience when they realized they were different to the opposite sex. For example, they discovered they were different because of the different household tasks given to boys and girls – girls were to cook and boys were to chop wood or that girls had to wake up earlier to get the breakfast ready for their brothers, or girls had to wear dresses and boys trousers, or the different restrictions for boys and girls – girls only went out with brothers, while brothers could go out by themselves, or the different status given to boys and girls – girls had to listen to brothers.
Explain that the difference that they need to think about should not be a physical difference between males and females. Examples of physical differences are – boys have a penis and girls have vaginas or boys stand to urinate and girls sit. After they complete their drawing they should write on the same sheet of paper, their feelings when they realized that they were different. Examples of feeling angry because of the unfair distribution of household tasks, or feeling superior because of the higher status in the house, or feeling helpless because of the dependent status.

Remind participants that the group will not be looking at their artistic skills. If participants are not sure what to do, draw an example and show them what you mean. As the participants draw, go around the room and talk with each in turn. Do not scrutinize their drawings, but ask if they understand and are managing to do the exercise. Ask if they want any help. If participants wish to talk privately about their experience, give them the opportunity to do so.

Sit in a place where all the participants can see you and do your own drawing. This will show workshop participants that you too are looking at yourself. You too will share information on your life. This indicates the principle of doing the workshops with participants rather than on participants.

2. Share the drawings and feelings in the larger group

Bring everyone together as a large group. Ask participants to share their drawings and feelings. To write these down, you could use a table. On a sheet of paper draw columns and label them like this:

Men's experience	Feelings about it	Women's Experience	Feelings about it

Summarize the participants experience when writing on the large sheet of paper. To do so, do not write word for word the entire experience. Try to find two to three words that will capture the experience. For example, one male participant shared the following on one of our workshops. 'My first instance of being treated differently from my sisters was when my mother insisted that I look after my sisters. I had to hold their hands when crossing the road on our way to school. My sisters were told to listen to me. I felt that I needed to protect them as they were helpless and needed me. I

also felt good as they looked up to me.' When listing this experience, simply write the words 'protect his sister as they were helpless' and when listing the feelings, simply write the words 'felt good'.

Notice examples of how participants' experiences and feelings have been captured

Men's Experience	Feelings about it	Women's Experience	Feelings about it
Boys worked outside the home, girls worked in the home	Did not feel anything at the time	More household jobs for girls	Cheated, not loved, resentful
Wanted to wear dresses	Ashamed, confused	Certain jobs reserved for boys (eg. Altar boys)	Nothing. Took my mother's word as law
Was attracted to my soccer coach who was a woman and yet I felt I had to be with boy friends	Anxious, sad, unfulfilled	Wanted to wear trousers at school and had to wear a dress	Angry, uncomfortable, vulnerable

3. Discuss how these experiences and feelings influence our present lives

After you have completed the list, ask if there are any other experiences or feelings participants think are important that is not on the list. Then begin a discussion focusing on the following points:

- To describe the way society expects men and women to behave. Ask – based on these experiences and feelings, how does society expect men and women to behave? For example men are expected to protect women. Women are seen as inferior to men and have to be submissive. Men are expected to be the bread earners – the head of the household. Women are expected to stay at home and be dependent on their husband. Men are to be shown more respect.
- To identify how society's expectation of men's and women's behaviour reinforces heterosexual relationships as the norm and makes it difficult of for LGBTI persons to free to express their innate sexual orientation and gender identity. Based on the previous discussion how does society's expectation of male and female behaviour lead to homophobia, transphobia and hetereonormativity. For example, if a man feels compelled to marry a woman because of societal pressure when he secretly adores his male lover. A young girl who is non-gender conforming and may want to identify as a trans-man, who is forced to wear dresses at school, may experience serious anxiety or depression. A young lesbian woman who is raped may feel unable to access health care as she would be judged by those at the clinic for being butch and would rather not get treatment to prevent pregnancy or HIV transmission (post-exposure prophylaxis). As women are dependent on their husbands they do not have the money to come to the clinic for contraception, or young girls sleep with men for money as their fathers do not want to spend money educating girls, or men rape women as they think they are their property. These are some of the manifestations of the social constructions of gender, homophobia, transphobia and heteronormativity.
- To assess if participants acknowledge the influence society's definition of men and women's behaviour has on heteronormativity, transphobia and homophobia: Ask participants if we take into account society's influences when providing for LGBTI members of our population.

4. Summarize

To summarize go through what you covered during the workshop. Describe to the group the major points that came out of the session and areas where there were consensus and differences. Ask the group if the group agrees with the summary.
For this workshop, list the different experiences and feelings when the participants realized they were different from the opposite sex or from dominant sexualities, sexual orientations or gender identities. Then describe how these experiences depict society's expectation of gendered behaviours and sexualities and how these influence poor health seeking behaviour amongst LGBTI persons and health worker – client interaction.

5. Do the personal commitment to change exercise

Give all participants one square sheet of paper and a pen. Say that based on what emerged from this workshop; they should write one thing they would do differently. This could either be that they would start to do something new from today or start to do something new from today. If participants are unsure, begin with yourself. For example, 'I will stop being submissive to my husband' or 'I will start treating LGBTI clients with respect'. Explain that this fits into the solution workshop (refer to the workshop chat). Remind them that they do not need to sign their names. Collect the pieces of paper in an envelope and write the workshop name on the envelope.

6. Write-Up

List all the events that made people realize that society treats men and women and sexual identities differently. List all the feelings that people shared when they realised these differences. You will find the table used during the workshop will form the basis for this section. List how participants describe society's expectation of male and female behaviours, the influence of societal expectations on heteronormative relationships, and the extent to which health workers and participants take these into account when interacting with clients. Use the structure provided in step three to write up the discussion.

Describe the group's overall feelings – whether on averages they take or do not take into account society's influences when providing for LGBTI clients. Describe any examples and quotations that health workers give in the workshop to illustrate these points.

How do we see our clients and colleagues?

Objective

For health workers to examine their perceptions of LGBTI clients and colleagues providing services, and how this influences their interaction with clients and colleagues

Background

Research has shown that providers are often judgmental or blind to LGBTI clients' needs. When talking with health workers about LGBTI health needs, health providers have not been trained to identify needs or provide for clients. Often clients are shamed because of their non-gender conforming dress or behavior before the client has reached the consultation room. LBGTI persons have similar health needs to the rest of the population, but avoid seeking care, which can exacerbate ill-health. Negative or dismissive comments that providers make, at times unconsciously may have a deleterious impact on client's health seeking behavior.

This workshop seeks to make health workers more aware of their behavior, the motivation behind it, its impact on others, to create a sense of simpatico and identification with LGBTI clients. It's imagining ourselves in someone else's place that we can reflect on our work and our selves effectively.

Methods

Role plays
Group discussion after the role plays
Personal commitment to change

Things Needed:

- A meeting room
- Large sheets of paper
- Small squares of paper (3x3 inches)
- Writing pens or pencils
- Different colour felt-tip pens
- Something to stick paper on the wall
- One envelope
- Each role play characters description written on a sheet of paper

Specific for the role play:

- Enough furniture to make it look like a clinic (for example a chair for each participant)
- Enough 'stage' acting space. Make sure that the group is all facing the state and that the actors can be seen

Time Table

• Introduction to the workshop	5 minutes
• Explaining the objectives	2 minutes
• Explaining role plays	2 minutes
• Preparing for first two role plays	5 minutes
• Acting first two role plays	10 minutes
• Discussing the first two role plays	35 minutes
• Preparing for the 3rd and 4th role play	5 minutes
• Acting the 3rd and 4th role play	10 minutes
• Discussing the 3rd and 4th role play	35 minutes
• Summary	5 minutes
• Personal commitment to change	10 minutes

Steps

1. Explain what a role play is

Tell the participants that in this workshop there will be four role plays. Explain that in a role play, people act or pretend to be someone other than themselves. The people in the role play are given their characters and then act out the situation in any way they like. The value of the role plays is that by acting in it or watching it we can begin to understand why people behave as they do. Actors get a feeling for how it is to be the person in the role play and can tell the audience how it feels. In the role play we begin to see how it feels to be someone else. It is usually a fun way of exploring situations we are familiar with but do not often think about. Emphasise that this is acting. People are not being themselves but are acting out a role. For instance, when you are discussing the role play, if someone uses the real actors name, you should say, 'You mean when he/she was acting as a nurse so and so'

2. Conduct the first two role plays on health worker-client interaction

Ask for four participants willing to act in the role play. Below is a role play we can use in our workshop. You should adapt it to your local situation. Explain to each person individually the role he or she is to act. Do it privately so that only the actor knows what the role is. Ask people participating in the role play to go out and think about their roles by themselves, without talking to each other. Tell them that they will act for about 5 minutes

Role play on health worker client interaction in a clinic: One volunteer had the following instructions on a piece of paper:

ROLE PLAY ONE

Jo

Jo is a trans man (born as a woman). He lives in Hannover in the Northern Cape and has not had access to any services with regard to his transition. He looks like a butch (masculine) woman. He arrives at the clinic is very nervous and is wanting to ask for help. Initially the sister does not get you, but then begins to listen to you and offer you assistance.

The other volunteer has the following description:

Sister Silver

You run the contraception clinic, a person comes into see you. You ask them about their boyfriend and whether they want another injection. The person is very nervous and shy and then tells you that they are not really a woman, but they feel like they are a man. You realise that you are out of your depth, but give them a chance to speak, asking them how they feel and what they may need. Then you refer them to a NGO that provides for transgender persons and give him their telephone number.

ROLE PLAY TWO

Ian

Ian is a well-groomed man who is married to Cindy and they have two children and a poodle dog. They live in Hermanus where Ian works in local government and travels around the Western Cape. The family is

very religious and are practicing Roman Catholics. Ian however is very attracted to men and has regular anonymous anal sex. He has a discharge from his penis and a painful gland in his thigh. He feels very worried as he loves his family but is not sexually attracted to Cindy but cannot face being out as a gay man. You receive treatment from the nurse for your STI but also want to talk about your sexuality, she is not able to assist and leave feeling awful.

The other volunteer has the following description:

Sister George

You run the STI clinic and Ian has come to visit, he looks like a nice man and you are charmed by him. He is married and presents with a STI. You see him as just another man who is messing around with other women. You give him treatment but then he starts to tell you that he is not seeing other women but actually having anonymous sex with men. You say that is terrible and he must stop it. You ask him if he really is a moffie and what God would think of him. You ask him how can he live with himself and tell him to please leave.

While the actors are out of the tool preparing, ask the group to pay attention to the content of the story and non-verbal communication between the actors. The group should take special note of health worker-client interactions. For example, words used, attitude, body language and eye contact.

When the actors come back after five minutes, set the scene. For example, 'We are at a clinic. Nurse So and So is the clinic nurse when client so comes to see her'

3. Conduct a group discussion

Follow these questions to discuss the role play:

- Ask each actor how he or she felt playing their role
- Ask the group if they thought what was acted could happen in real life. In other words ask if they can imagine this taking place at their clinic, health centre or hospital. If they say it would not happen as it did in the role play ask them to describe how it would be different
- Ask the group watching the role play to describe the interaction between the health worker and the client. In other words:
    - Was the nurse or receptive or dismissive of the client's problems;
    - Did the client talk freely or in a restrained manner;
    - What did the body language or the nurse of client communicate to us
    - Ask the group:
        - What do such interactions tell us about health worker think of LGBTI clients?; and
        - Why do health workers' have such opinions;

      Note the responses on paper

Applaud the actors for their participation and get the participants back to a large group. If you have extra time and the discussion is interesting, you can ask for other volunteers to come up and act the same situation differently to illustrate a point in the discussion.

4. Conduct the third and fourth role plays on health worker – client interaction

Ask for four participants willing to act in the role play. Below is a role play we can use in our workshop. You should adapt it to your local situation. Explain to each person individually the role he

or she is to act. Do it privately so that only the actor knows what the role is. Ask people participating in the role play to go out and think about their roles by themselves, without talking to each other. Tell them that they will act for about 5 minutes

ROLE PLAY THREE

Thando

Thando is a butch (masculine looking) woman who lives in a urban township. She is a lesbian woman and last night she was raped by three men on her way home from the shops. You come to the clinic as you are scared of getting HIV and you just want tablets to stop you getting HIV. As a Lesbian woman you have not come to the clinic as you don't need contraception or any help and you are nervous of being judged or having health workers examine you. But this sister is very nice to you and you learn a lot about how to look after your health as a lesbian woman.

The other volunteer has the following description:

Sister Estelle

Thando is a butch (masculine looking) woman who arrives in your consultation room asking for post exposure prophylaxis (PEP). She looks nervous and clearly is hiding a lot. She reminds you of your own aunty who was a lesbian woman who died of cervical cancer and you are determined to help her and try and get her tell you about her needs and feelings. You ask her about her health, her partner, what her needs are. She tells you she was gang raped last night. You acknowledge that she is very traumatised and that she has the right to a forensic examination and medicine to prevent pregnancy and also contracting HIV. You also discuss that she should also have a pap smear as she may have contracted the HPV virus and could be at risk of cervical cancer. You suggest to her that there are things that she should do now (PEP, report to police, forensic exam) and some things that can wait till later (counselling, pap smear). You tell all these are her choices but that as a Lesbian woman, she has equal right to health as any another person in society and you would welcome her back to the clinic if she would like to come again for further assistance.

ROLE PLAY FOUR

Jane

Jane is 30 years old and is very feminine woman who is a lesbian. She and her partner have been in a relationship for three years are married and live in a urban area. Jane comes to ask for information about fertility options in getting pregnant. You do not initially tell her that you are a Lesbian woman. The health worker you see is not very open to your wanting to get pregnant. You say that you believe you just need a referral letter to the fertility clinic at the main hospital.

The other volunteer has the following description:

Sister Oliphant

A lovely young attractive woman comes to see you at your primary health care clinic. She would like to get pregnant and asks you for advice. You tell her no problem and that she should just go off her contraception and take folic acid. She then tells you that she is not taking contraception and you find out that she is a lesbian woman. You then tell her that she should really find a man and not be a lesbian as she is so pretty. She tells you that she is married to a woman. You are surprised and just don't understand. You tell her that she has

then chosen her path and can't have children and you can't help her. You also say that what would a child do with two Mommies and no Daddy.

While the actors are out of the tool preparing, ask the group to pay attention to the content of the story and non-verbal communication between the actors. The group should take special note of health worker-client interactions. For example, words used, attitude, body language and eye contact.

When the actors come back after five minutes, set the scene. For example, 'We are at a clinic. Nurse So and So is the clinic nurse when client so comes to see her'

5. Conduct a group discussion

Follow these questions to discuss the role play

- Ask each actor how he or she felt playing their role
- Ask the group if they though what was acted could happen in real life. In other words, ask if they can imagine this taking place at their clinic, health centre or hospital. If they say it would not happen as it did in the role play, ask them to describe how it would be different
- Ask the group watching the role play to describe the interaction between the health worker and the client. In other words:
    - Was the nurse or receptive or dismissive or the client's problems;
    - Did the client talk freely or in a restrained manner;
    - What did the body language or the nurse of client communicate to us
    - Ask the group:
        - What do such interactions tell us about health worker think of LGBTI clients?; and
        - Why do health workers' have such opinions;

      Note the responses on paper

Applaud the actors for their participation and get the participants back to a large group. If you have extra time and the discussion is interesting, you can ask for other volunteers to come up and act the same situation differently to illustrate a point in the discussion.

6. Summarise

To summarise go thought what you covered during the workshop. Describe to the group the major points that came out of the session and areas where there were consensus and differences. Ask if the group agrees with the summary.

For this workshop, summarise the way the group described the reasons for perceptions and opinions of LGBTI clients and the effect these would have on client – health worker relationships

7. Do the personal commitment to change exercise

Give all participants one square sheet of paper and a pen. Say that based on what emerged from this workshop, they should write one think they would do different. This could either be that they would start to do something new from today or stop doing something from today. Explain that this fits into the final solutions workshop. Remind them that they do not need to sign their names. Collect the pieces of paper in an envelope and write the workshop name on the envelope.

8. Write-up

Describe how the actors played out their characters. List the points that they group identified. Describe the groups' overall feelings – whether on average they think positively or negatively about LGBTI clients about health workers attitudes and engagement with LGBTI clients. List the effects such perceptions have on relationships with clients. Describe any examples and quotations that health workers give in the workshop to illustrate these points. Some of what you write will come from the sheets of paper you filled in during the workshop.

Solutions

Objective

To draw together what has been learnt in the previous workshops and to conclude by planning things that can be done in your particular context to improve the quality of your services.

Background

The point of this workshop series is to sensitise health workers to the needs of LGBTI clients, and how they themselves view their work. If the workshops have been successful, there will be at least some change, however small, that health workers will want to make to improve services, The changes may be personal – and refer to things that health workers want for themselves, which will affect the way they relate to clients, or the changes may be things that affect the client more directly.
We aim to get traction and firm up these ideas in this workshop. While some factors are beyond the control of health workers in improving quality of care, many opportunities do enable improved services and access to care for LGBTI persons. The motivation for this workshop is to end with health workers feeling that they have some definite course of action open to them. That given the will, they can change things themselves – and that they have the power to do something.

Methods

- Presenting the summaries from the previous workshops
- Running a group discussion to generate a list of possible things to do

Things needed:

- Prepared summary list for all the other workshops
- Large sheets of paper
- Different colour felt-tip pens
- Something to stick paper on the walls

Time Table

• Introduction to the workshop	5 minutes
• Explaining the objectives	5 minutes
• Summarising reports from previous workshop	20 minutes
• Small group discussion	60 minutes
• Large group discussion	20 minutes
• Summary	10 minutes

Steps

1. Prior preparation for this workshop

To prepare for this workshop, you need to go through your notes from the previous workshops and write down all the things from each workshop that health workers have identified as identified as influencing their interactions with clients. Also write down the things that health workers identified as influencing the quality of their work. So from workshop one - you could write biased socialisation and expectations of boys and girls, plus add all the other factors that surfaced. From workshop two you could write, lack of support from management or policy direction, disrespect for people's choices, and so on. You will eventually have a full list of factors that have come up.

Also go through the envelopes from the personal commitment to change exercises' that were done at the end of the first two workshops and list what people wrote down. Group them together, if need be. For example, if one person wrote, 'start treating clients with respect' and another noted, 'to start respecting choices of clients' then you could group them under ' to be more respectful to clients and their choices'. Also note the number of people who mentioned similar commitments. For example, the majority (14 participants) mentioned to be more respectful of clients and their choices or two participants mentioned stop turning away LGBTI clients who required services from the clinic.

2. Presenting the summary to the group

Take the list you have prepared and tell the participants 'I went through our previous two workshops and have listed the issues that affect health worker- client relationships or health worker- health worker relationships and your personal commitments to change actions that have come up. I will list them and you can add if I have forgotten anything.'
Then list the issues and commitments. You can write them onto the workshop process chart with lines linking them to the workshops that they came from – see illustration.

3. Small group discussion

Divide into smaller groups (three persons each) and give each group a few of the issues identified. Asked them to discuss what solutions could be undertaken by the health facility or work space they work in to rectify these issues.

Draw four columns on a large sheet of paper and stick it on the wall. The columns which will be labelled, and should look like the table given below. Give each group large sheets of paper, on which they can draw the table.

Problem	Solutions	By when	By whom

It is important to emphasise that they should identify solutions which they themselves can implement and that do not take years to implement. Ask the groups to put time frames to the solutions. Groups should put names of people wherever possible next to the identified solution. Be specific about by whom – not health workers or management, but Mr So and So or Nurse so and so, then making people responsible for implementing these solutions is possible. If participants are not sure of any particular person's name, then they can specify the department that will be responsible for implementing that solution.

4. Large group discussion

Get each small group to present their list of solutions. Ask the other participants if they can add to the list in terms of other solutions or who else can be involved in implementing the solutions.

After all the groups have presented, ask the participants if they would like to make any additions or deletions. This is important as this is the plan that they as a group agree to implement.

Example of specific solution plan

Problems	Solutions	By whom	By when
Negative attitudes of colleagues including management towards LGBTI clients	Provide relevant education and information to all departments to clarify the need to provide LGBTI persons with access to care	Management Lulu to organise a session in the gynae ward in hospital and Gwen at the health centre. Aaron will be the resource person to speak at these sessions	To begin early May and end in early June
Lack of support from colleagues	1. Invite knowledgeable people to give lectures/run workshops like these 2. Supervision to be provided to providers	a. Supervisors and assistant directors b. Unit managers c. Trevor to organise and motivate for funds for refreshments	a. Once or twice a month during regular staff meetings b. Within two months
Lack of willing staff	1. Explain how lack of access to health services for LGBTI persons causes ill-health 2. Invite resource persons to meet with health workers 3. Arrange one on one discussions with individuals	a) Managers and all the staff b) Participants to meet with resource persons are Jacob, Lulu, Helen, Patricia. Ensure that Robert and Zanele can meet with the group c) Palesa	a) In three months b) End of April
Male dominance over women	1. Women to be educated about their rights and how to stop taking abuse from men. Men to be educated on respecting women's rights 2. Educate women at antenatal clinics, regarding equality in relationships and equal treatment of	a) Eddie and Mathilda b) Vanessa c) Human resource managers	a) Immediately b) Immediately c) Within three months

	male and female children 3. Encourage in-service training in the workplace where gender relations are discussed		

5. Summarise

To summarise go through what you covered during the workshop. Describe to the group the major points that came out of the session and areas where there was consensus and differences. Ask if the group agrees with the summary.

For this workshop go over the Workshop process chart again and show the linkages between the workshops. Discuss with the group how they will take this whole process forward and tell them what you are going to do. For example, you may write a report or present your findings to the health service managers.

Thank everyone for their participation

6. Write up

Here you need to list all the actions that the participants identified. Remember to include their personal commitments to change. Also remember to include who they think should take action. If you have used the table during the workshop, it could form the 'home' of your reports. In this workshop you have tried to get the participants to make real plans for change, so present your report in their time scale in which these actions will be taken.

Addendum

Ice Breakers

These are short activities designed for the beginning of the workshop or each day to help people relax and get to know each other and gain confidence to speak in front of the group. They should encourage participation and mutual support among the participants. They should not include deep personal disclosures or actions which could make people feel ill at ease. It's important to select icebreakers most suited to your group. This is likely to vary according to how well the participants know each other, cultural backgrounds, gender and so on. Here is a list of ice breakers:

Your own space

Ask each person to find a space where they do not touch anyone else. Then ask them to close their eyes and do anything they wish to do within their own space (eg. Jump, dance, stretch, exercise). Then ask them to hug themselves and generally feel and touch themselves. Ask them to move again in their own space, and then ask them to describe quickly in one or two words how they feel about themselves (relaxed, tense, good, bad etc.)

Beautiful Busi

'I'm Busi and I'm beautiful' Each person says their name and a positive word to describe themselves (no put downs allowed) and goes on to introduce the proceeding members of the group: ....'I'm Marlow and I am marvellous' ... and this is ' Elsbeth and she is excellent'.

Energisers

Energisers can be used at any time during a workshop particular when the group is getting tired. This usually happens after lunch or a long session. They can be used to encourage positive feelings in the group – or after a session where there have been sharp differences or difficult issue to face.

The Bridge

The participants split into two groups and stand on chairs that are in two rows, facing each other. Each group has one more chair than the number of members. The task is to reach the goal line, drawn at some distance, by passing the last chair in the line, drawn at some distance, by passing the last chair in the line through the hands of the group until it is placed closest to the goal line. The participants then move one chair closer to the goal and before moving the last chair forward again. If somebody falls from the chair, he/she is removed and the group must move two chairs at a time. The first group to arrive at the goal line wins. This game energises the participants and encourages team work.

Streets and Avenues

The group splits into four or five groups. Each group builds rows in the form of streets by grasping hands in one direction. When the facilitator says 'avenues', the participants make a quarter turn to the left and grasp the hands of the persons who are now beside them. An order for 'streets' returns the group to their original position. Two volunteers take on the role of cat and mouse. The cat has to catch the mouse. But giving orders for the formation of 'streets' and 'avenues' , the facilitator tries to keep the cat away from the mouse. Neither is allowed to pass through a row. Everyone has to react quickly so that the cat does not catch the mouse. This exercise energises the group spirit and concentration

Writing with your hips

Get participants to stand in a circle and to put their hands on their hips and to swivel around and loosen up. Then ask each person to write their names with their hips 'as the pens' spelling out their names with each letter as a separate hip movement. This exercise energises the group and is fun.

Word and Deed

The first person in the circle does one action, while describing another. For example, she says,' I am cooking' while pretending to type. The second person then acts out something the first person said she was doing, while saying she is doing something else: 'I am scratching my nose' while pretending to cook. This then continues around the circle. This one is hilarious - but it's not for people who want to remain dignified at all costs!

Considerations for Lesbian or Queer folks needing an abortion

How a person in your clinic became pregnant and decides that this pregnancy is not supportable, should not be your concern.

Be mindful that sexual violence is endemic in all communities and do provide screening and referral for sexual violence. Post-abortion contents should be sent for forensic evidence if the pregnancy is the result of sexual violence.

Note that folks with diverse sexual orientations and gender identities are versatile as are heterosexual folks. Do not assume that Lesbians do not have sex with men ever. Counsel all persons on safer sex; dual protection.

Be mindful that some trans gender folks may be on hormone therapy and despite this can get pregnant.

Do not offer contraception to all queer folks or ask what contraception that they are taking. Ask the client first if they would like any information on contraception post the abortion.

An abortion can be an invasive procedure for some person who are not used to having specula inserted into their vagina, ensure the specula is small in size and warmed up and talk with the client about what they can expect to feel.

Prepare the client for bleeding post abortion, this could exacerbate gender dysphoria for trans men not used to menstruating if they have been taking hormones.

For consideration in providing appropriate and non-discriminatory services

If you feel uncomfortable, here is a list of things you can try:

- Remember that it has probably taken a lot of courage for the client to be open about their sexual orientation or gender identity;
- When speaking to your client be honest about your ignorance and show them that you respect them enough not to make assumptions based on stereotypes and prejudices;
- Make an effort to get to know queer folks;
- At least have a list of LGBTI support organisations and friendly doctors, psychologist and lawyers that can give people assistance; and
- Think critically about the source of your own prejudices

Some questions to ask in your department or organisation to evaluate and design better service provision.

Try to be honest when answering these questions. They are not meant to accuse you or 'catch you out' in any way. They are a reflective tool to help you become more aware of discrimination and implement changes in the nature and quality of your service provision:

- How does your work context discriminate against victims on the grounds of race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth in or out of wedlock?

- What are the procedures for reporting homophobia and transphobia in your department or organisation?
- Are LBGTI people afforded the same rights as other people with regard to the dignity, privacy, freedom and security of their person?
- Do you network with any LGBTI organisations?
- Do you ever deliberately invite LGBTI people or organisations to participate in workshops, focus groups or other events?
- What are your department or organisations' guidelines around confidentiality with regarding to LGBTI persons
- What kind of training does your staff receive with regards to issues and challenges specific to LGBTI persons?
- Do you include LGBTI examples, scenarios and images in your educational media and training courses?
- What are the kinds of secondary victimisation that could be experienced by LGBTI persons in your department or organisation and how do you plan to address this?
- What would you do if you have a colleague who refuses to serve LGBTI persons and usually refers them immediately?
- What resources, mechanism and procedures are in place to inform LGBTI victims about their rights?
- Does your Department or organisation have a code of ethics that has committed itself to? What does it say about your department or organisations relationship to LGBTI persons? and
- In what ways do you adhere to the procedures and guidelines as set out in the Service Charter for Victims of Crime, the Victim Empowerment Policy, as well as the Minimum Standards for Service Delivery? (adapted)[vi]

Lessons on evolving language[3]

This glossary is in three sections — green, yellow and red. The items in each section are roughly in alphabetical order.

Green items are things that you can say with confidence. These are words and phrases that are used by many trans people to refer to themselves, their bodies, families and communities.

Yellow items are words and expressions to use cautiously. These are words and phrases that are appropriate in some circumstances and contexts, and not others. We've included when to use these yellow items, and when to avoid them.

Red items should be avoided, as these are words and phrases that are highly problematic and/or discriminatory and have been rejected by trans people.

While this glossary has been adapted from allies in Canada and in the North, we have much to learn from each other, over time, generations, identities, orientations and family configurations. We reference Ken Cage's 2003 The Language of Kinks and Queens. Gayle. A History and Dictionary of Gay Language in South Africa. 'in the resource section, but this is almost 20 years old and mainly refers to identity as opposed to issues of sexual and reproductive justice. Language also changes intergenerationally with different age groups feeling comfort and discomfort with different terms. Recently with the ubiquitous, TV serials that are available there is an enormous north American influence.

As trans communities and people change and grow, so do the words we use. We recognize the right of any trans person to reclaim terms that have been used against them. Trans people of diverse ages, races, abilities, and other identities may also use terms that are not listed here, or understand the terms listed here differently. This glossary is not a set of fixed rules for what to say or not to say, but rather is meant to help inform the language you use.

We encourage you to:
*take a cue from your clients, and mirror the language that they use to refer to themselves;
*provide your clients with opportunities to tell you what language they use to refer to themselves, their body parts, their families, both on written forms and in person;
*ask questions if your clients use terms that you are unfamiliar with.

[3] This section has been adapted from *Trans-Inclusive Abortion Services: A manual for providers on operationalizing trans-inclusive policies and practices in an abortion setting* https://www.optionsforsexualhealth.org/wp-content/uploads/2019/07/FQPN18-Manual-EN-BC-web.pdf with gratitude Federation du Quebec pour le planning des naissances (FQPN) and AJ Lowik for this language guidance

GREEN! (Use with confidence!)

DO use the word 'cisgender' as an umbrella term to refer to all people whose gender identity and the sex they were assigned at birth do align. DO shorten this to 'cis'.

DO use 'cisnormative' to describe the assumption that all people are cisgender, and the ways that this assumption is embedded into our systems and structures.

DO use culturally specific terms such within South Africa colloquially *Notrans* is used in isiXhosa, *Mavis* for some Afrikaans persons. While the word Moffie has been derogatory, it has been reclaimed for use by queer persons[4]. *Hijra* (India), *Fa'afafine* (Samoa), *Kathoeys/Ladyboys* (Thailand), *Khawaja sara* (Pakistan), and other terms used by various communities across the world to refer to non-normatively sexed and/ or gendered people.

DO use 'dysphoria' to refer to the profound state of uneasiness, discomfort and dissatisfaction experienced by some trans people in their sexed bodies. DO recognize that this can be referred to as 'gender dysphoria' (i.e. the name of the current diagnosis). DO recognize that not all trans people experience dysphoria.

DO use 'gender' to refer to the social meaning ascribed to sexed differences. This includes gender norms, roles, stereotypes, as well as gender identity and gender expression.

DO use 'intersex' as an umbrella term for the variety of conditions in which a person is born with reproductive or sexual anatomy that does not fit the typical definitions of male or female.

DO use 'misgendering' to refer to the practice of using words (nouns, adjectives and pronouns) that do not correctly reflect the gender with which someone identifies. DO recognize that misgendering can include misnaming (calling a person by the incorrect name), using the incorrect pronouns (for example, using he/him/his for someone who uses she/her/hers), or using other incorrect gendered language (for example, using sir for someone who identifies as a woman, or calling someone's chest their breasts). DO recognize that whether intentional or not, misgendering has a negative impact on trans people, and persistent misgendering is an act of transphobia.

DO use 'non-binary' as an umbrella term to refer to all people whose gender identity are not exclusively male or female, man or woman. These folks might identify with the following: genderqueer, genderfluid, gender neutral, agender, androgynous, neutrois, and others. DO recognize that some non-binary people identify as trans, and some do not.

DO use "people of all and no genders" to recognize that non-gender, agender, gender neutral and other non-binary trans people do not have a gender and are thus not included in statements like "people of all genders."

DO use 'sex' to refer to the classification of people into the categories of male and female. This is a medical and legal assignment made at birth, based largely on the external genitals of newborn infants. DO use female-assigned at birth and male-assigned at birth when you need to speak about people based on their sex assignment. AVOID female-bodied or male-bodied.

DO refer to the social construction of mutually exclusive categories of male/female, man/woman, masculine/feminine, etc. as the sex binary/gender binary. DO recognize that some trans people do not identify with the gender binary.

DO use the word 'trans' as an umbrella term to refer to all people whose gender identity and the sex they were assigned at birth do not align. Some trans people use trans*, a term derived from library and online search functions, where an asterisk stands in for all possible endings to a term. The asterisk is either spoken aloud, or it is implied. DO recognize that some people use 'man/woman of trans experience' to describe their relationship to these gendered categories.

DO use the word 'transition' to refer to the process that some trans people undertake to change their bodies to better reflect their gender identities.

[4] Thank you to Leigh Ann Van Der Merwe from SHE for this clarification.

DO use 'transphobia' to refer to the prejudice against trans people as reflected in antagonistic attitudes, feelings, institutions, policies and practices. DO use 'transmisogyny' (the intersection between transphobia and misogyny), and 'transmisogynoir' (the intersection between transphobia, misogyny and anti-Black racism), to be more specific.

DO reflect indigenous expressions and **cultural practices if raised. As in every orientation and identity, there are transgender persons who are traditional healers**

YELLOW! (Use cautiously!)

ONLY use 'gender-affirmation/gender-confirmation surgery' when discussing the surgical interventions that some trans people access as part of their transition. AVOID assuming that all trans people have, or desire to have, surgery. AVOID using 'sex-change' or 'gender change'.

ONLY use 'pre-', 'post-' or 'non-operative' to refer to trans people who refer to themselves this way. AVOID grouping all trans people into these categories. This centralizes the medical interventions that some trans people use to alter their sexed bodies. Along with 'transsexual', these terms have a legacy in the medicalization and pathologization of trans people that continues today.

ONLY use 'tranny' in those specific instances where this term is being reclaimed, (e.g. 'the tranny stroll', a term used by some trans women to describe the area where they work as sex workers). AVOID using 'tranny' to refer to trans people in general, as it has been used historically as a derogatory slur.

ONLY use 'transsexual' to refer to trans people who refer to themselves this way. DO use this term if you are acknowledging its role in the past and present medicalization and pathologization of trans people. AVOID using 'transsexual' as an umbrella term, as many trans people do not identify with the term. Others object to the focus this term gives to the medical interventions that some trans people use to alter their sexed bodies.

ONLY use the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) as a tool to facilitate access of hormone replacement therapy and other gender-affirming health care for your trans clients. AVOID using these as sources of truth about how trans people are or should be; recognize that these provide a particularly medicalized and pathologized understanding of gender identity and expression. When using the DSM and/or ICD as tools, make sure you are using the most recent edition. AVOID using outdated labels and terms derived from older versions of these sources, such as transgenderism, transsexualism, gender identity disorder, etc.

RED! (Avoid using!)

AVOID using derogatory terms and expressions without context or without acknowledging the bias of the term or expression. This includes, among others, he/she, it, shemale, transvestite, man in a dress, hermaphrodite, berdache, or freak.

AVOID using 'men' and 'women' without qualifying whether you are speaking about cis or trans people, unless you are speaking about all men and women, including men and women of trans experience.

AVOID 'transgenders' or a 'transgender'.

AVOID using 'transgendered' as a noun to refer to a person. AVOID adding an –ed to other words when used to refer to an identity (i.e. intersexed, cisgendered, Two-Spirited).

AVOID the word 'transformation' to refer to the process that some trans people undertake to change their bodies to align with their gender identity. DO use 'transition'.

AVOID speaking generally of your services or space as being for women and trans people. This assumes that women and trans are mutually exclusive categories and makes a problematic distinction between cisgender women and trans women. DO instead say that your services or space are for cisgender women and trans people. This way, you have qualified that your services or space are designed for all cisgender women and all trans people. Alternatively, DO say that your services are for "anyone who experiences _____." This way, you aren't listing particular types of people, but instead are signalling to potential clients that your services are for anyone who experiences a particular phenomenon.

We all make mistakes, but we can also ask questions

We all have questions, and we all make mistakes. These may be about the person we are speaking about or to, or about an issue or experience we do not fully understand. When mistakes are made, it is best to:

1. Apologize
2. Reflect and learn from the mistake
3. Move on

DO respect trans people's right to consent to educate. Trans people (like other marginalized people) are often placed in the position to be the educators on trans issues, or are asked to speak on behalf of trans people. When you can, you should research an item yourself, before asking a trans person.

DO recognize the difference between a trans scholar and a trans person. A trans scholar is a person, regardless of gender identity, who focuses on trans theories, issues, and experiences within their research. Certain questions may be appropriate to ask a trans scholar as an expert, but would be inappropriate to ask a trans person — this might include questions where the answers are upsetting or too personal.

How to ask someone about their pronouns

DO politely and privately ask what pronouns do you use? DO offer up your own pronoun first. This can be done verbally, or by having staff wear nametags that include their pronouns. AVOID only offering your pronoun to people whose pronouns are not obvious to you.

DO use 'they/them' pronouns, the person's name or 'that person' if you do not know the pronouns the person uses, until you are corrected.

DO respect if a person uses different pronouns in different settings. Someone may reveal to you that they use one set of pronouns in private, and another set at work, or with their family.

DO acknowledge that people from diverse communities, cultures, countries, ethnic and racial backgrounds and identities may use different pronouns beyond those available in English or French.

DO use the gender-neutral pronouns that have been created by trans people to refer to themselves. This may include ze/hir, per, hu/hus/hum, hen (Swedish), co, etc.

DO practice if using gender-neutral pronouns is new to you. Practice to yourself to avoid making mistakes in front of others.

How to make a mistake about a person's pronoun, name, or other gendered language

DO say you are sorry as soon as possible. You can acknowledge and correct your error at any time.

DO ask again if you have forgotten something about the person.

ONLY apologize again and again if you keep making the same or different mistakes. AVOID having to do this, by being attentive and asking for support in how to remember how to correctly refer to the person or issue.

AVOID providing a reason or explanation for your mistake.

AVOID over-apologizing for the mistake you have already apologized for.

How to correct someone who is using the wrong name and/or pronoun or other gendered language

DO stand up for trans people and be an ally.

DO privately and respectfully correct the speaker. DO say, for example, "I've noticed that you are calling [correct name/pronouns] by [the incorrect name/pronouns]. I'm not sure if you know, but [correct name] uses [correct name/pronouns]."

AVOID calling anyone out in public about using the incorrect name or pronouns. AVOID judging or shaming someone for making a mistake.

AVOID outing a trans person by revealing details about their body, medical history, previous names and/or pronouns, etc. AVOID asking someone else about a trans person's body, medical history, previous names and/or pronouns, etc. AVOID gossiping with others about any of your clients, including your trans clients, either within your clinic or once you leave.

How to ask someone about what language they use to refer to themselves, their bodies, etc.

DO ask privately and politely what language someone uses to refer to themselves. You might say, for example "In order to provide you the best healthcare possible, I wonder, what language do you use to refer to your body parts?"

DO make note of any terminology that someone uses to refer to themselves, and then use that terminology in your future communication with them.

DO recognize that trans people may change how they refer to their body parts over time. DO ask "are you still using _____" and DO be prepared to change the language you use.

ONLY ask about someone's body parts in the context of providing service to their body (in this case, abortion services). AVOID asking questions about trans people's body parts if that information is not necessary to provide them inclusive and competent services.

AVOID talking about specific trans people's body parts, except in your professional capacity.

AVOID physical or verbal reactions to people's word choices, even if they are words that you would not choose.

How to make your language trans inclusive, in general

DO use 'folks', you all, everyone, or other gender neutral language to speak to a group of people.

DO describe the person's clothing or another distinct feature when asking someone to speak, for example, in staff meetings. DO say, for example "the person in the red shirt in the back row," instead of "the guy in the back row".

DO acknowledge the potential for trans people being in the space by using expressions like "for those of us who are cisgender" as opposed to "as cis people, we…".

DO ask what you can do to support someone else in remembering to use the correct name, pronoun or other term to refer to a person.

AVOID 'guys and girls', 'ladies and gentlemen', 'sir', 'ma'am', 'miss', 'boy'. These terms make assumptions about sex and gender, as well as race and class.

Language as distress, language as empowerment

For many trans people, language is an important part of how they deal with the world, and they may alter language to suit their needs and identities. Language is used to help make themselves understood, to make their identities intelligible to others, and to help alleviate distress and dysphoria over body parts, among other things. Studies on providing healthcare to trans people have shown that asking trans people about their pronouns and other gendered language is an important element of trans-inclusive care. However, language can also cause a lot of distress. For example, languages can

fall short in having words available for some things, such as for a non-binary aunt/uncle. Misgendering through language can happen in all kinds of inadvertent and subtle ways. It can also happen because how we understand sex, gender, reproduction and parenting is deeply cisnormative.

We should avoid the unnecessary and problematic gendering of body parts (for instance, calling ovaries, fallopian tubes and uteruses parts of the female reproductive system). We might also use language such as "people with breasts," "bodies with penises," "pregnant people", rather than "women with breasts," "male-bodied" or "pregnant women." For some, however, this may not go far enough.

Words like breast, penis, vagina, uterus, may not be how some trans people refer to their own bodies — some common ways that body parts can be renamed includes 'breasts' being renamed as 'chests', 'vaginas' being renamed as 'front bums', 'penises' being renamed as 'clitorises', but many others are possible. While it may not always be possible to alter official medical consent forms, you can ask your clients what language they use to refer to their body and/or mirror the language that they use and make clear notes about this in the client's file.

Words used to talk about partnership and parenting can also fall short for trans people. It may seem straightforward — if trans people take on the parenting role associated with their gender identity, then a trans man would be a father, a trans woman a mother. While this may be true for some trans people, it is not always so simple — some trans people might identify as both mother and father. Other trans people use newly created words, or reclaimed old ones, like 'zaza', 'nini' and 'cennend'. The reproductive experience of pregnancy can be rebranded as being a 'seahorse papa', and lactation and chest-feeding reframed as an animalistic, functional process, rather than being quintessentially womanly experiences. The embodied aspects of parenting can be transformed by trans people who are living in their bodies and forming families on their own terms and changing the language used to refer to these experiences is part of that transformation.

Other useful resources:

Cage, K. 2003. The Language of Kinks and Queens. Gayle. A History and Dictionary of Gay Language in South Africa. Jacana Press. Johannesburg
Joint Working Group. 2003. An ABE of LGBTI. A resource Guide.
Jide, R. 2005. A Pocket Devotional for Lesbian, Gay, Bisexual and Transgender Christians. RBM Consulting. UK.
RFSL Between Women. The Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights. www.rfslungdom.se

Online training

In 2020 we find ourselves adapting to online and virtual ways of working. Training of health providers is complex given the burden of demand for care and limited time for training. However, the need to address improving our services is ever present and this guidance from the Association of Progressive Communications (APC) is a resource to assist in the planning of this should physical meeting be a challenge.

https://www.apc.org/en/pubs/closer-ever-guide-social-change-organisations-who-want-work-online

https://www.apc.org/en/pubs/feminist-internet-ethical-research-practices

Step 1: Choose an online meeting/conferencing system

There are different types of systems. For some of them, in order to participate in a meeting, you need to download and install software; for others you just need a web browser and a password. Most have a basic set of features that include a shared whiteboard, a chat window, audio (either through VoIP or using a telephone conference call) and video.

Here are some reviews comparing different systems so that you can choose the one that fits your needs and budget. As you will see, many systems involve a fee, although some (such as Jitsi) can be used for free. If you would like further information about Zoom, which APC does use for some situations, and which has become a very popular online meeting option for organisations, we have developed an overview of the pros and cons.

Online Meeting Tools Review

7 open source alternatives to Skype

Top 20 Best Linux Video Conferencing Software in 2020

Wikipedia: Comparison of web conferencing software

Step 2: Plan the meeting

As you would do for a face-to-face meeting, you need to plan your virtual encounter.

Define a date and time that is convenient for most participants. Remember to take into account differences in time zones.

Define a purpose, objectives and a process for the meeting, and share it with the participants in advance.

Prior to the meeting, send the participants instructions on technical requirements they will need to connect to the meeting, explaining any adjustments they might need to make on their computers or programmes they might need to download or update. It is very important to offer technical support prior to and during the meeting, as it is very frustrating for participants to be blocked from a meeting due to technical reasons.

Step 3: Facilitate the meeting

Designate one person as the facilitator of the meeting and one person to provide technical support in case it is needed during the meeting.

Define a procedure of how the meeting will be carried out and explain it to the participants.

Have a training meeting for people who are using an online conferencing tool for the first time.

Also, allocate some time at the beginning of the meeting (30 minutes) for participants to become familiar with the platform and make any technical adjustments necessary to participate. As a facilitator, walk them through the main functions they need to handle to participate in the meeting, such as how to raise their hand, or how to send a public chat message to everyone or a private message for technical support.

Step 4: Send a report to participants

Once the meeting has finished, it is important to send an email to participants with a summary of the main meeting points and agreements.

Remember that most online conferencing systems allow you to record the session, which can help you have all the information necessary for the report.

https://genderit.org/resources/report-making-feminist-internet-movement-building-digital-age-africa

[ii] Fonn, S. and Xaba, M. 1995. Health Workers for Change. A Manual to Improve Quality of Care. Women's Health Project and UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR).Geneva
[ii] Varkey, S.J., Fonn, S. and Ketlhapile, M. 2001.Health Workers for Choice: Working to Improve Quality of Abortion Services. Women's Health Project. School of Public Health. University of the Witwatersrand.
[iii] Hope, A. and Timmel, S. 1996. Reprint. Training for Transformation. Training for Transformation Institute. South Africa. Volumes 1,2,3,4
[iv] Williams, S. 2004. Reprint The Oxfam Gender Training Manual Oxfam Publication. UK and Ireland
[v] Freire, P. 1970. Pedaogy of the Oppressed. Seabury Press. NY. p 57
[vi] OUT LGBT Well Being' Understanding the Challenges facing Gay and Lesbian South Africans. Some guidelines for service providers.