

FACILITATION MANUAL

2017

EXPLORING STBBI_s AND STIGMA

An introductory workshop for health
and social service providers



Calgary
Sexual Health
Centre



**CANADIAN
PUBLIC HEALTH
ASSOCIATION**



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FOR MORE INFORMATION, CONTACT:

Canadian Public Health Association

404-1525 Carling Avenue, Ottawa, ON K1Z 8R9

T: 613-725-3769

info@cpha.ca

www.cpha.ca facebook.com/cpha.acsp @CPHA_ACSP

Calgary Sexual Health Centre

Suite 304, 301-14 Street NW, Calgary, AB T2N 2A1

T: 403-283-5580

F: 403-270-3209

generalmail@calgarysexualhealth.ca

www.calgarysexualhealth.ca facebook.com/CalgarySexualHealthCentre @YYCsexualhealth



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SECTION 1

BACKGROUND

In April 2014, the Canadian Public Health Association (CPHA) launched the project *Impacting attitudes and values: Engaging health professionals to decrease stigma and discrimination and improve sexually transmitted and blood-borne infection (STBBI) prevention*. Funded by the Public Health Agency of Canada, this project aims to enhance the prevention of STBBIs and reduce the associated stigma and discrimination by developing capacity-building resources for health and social service providers.

As part of this project and in collaboration with the Calgary Sexual Health Centre (CSHC), CPHA produced a suite of professional development workshops that were pilot tested in several Canadian cities with a diverse group of frontline service providers. Resources include facilitation manuals, participant workbooks and workshop slide decks.

PARTNER ORGANIZATIONS

CANADIAN PUBLIC HEALTH ASSOCIATION

The [Canadian Public Health Association](#) (CPHA) is the national, independent, not-for-profit, voluntary association representing public health in Canada. CPHA's members believe in universal and equitable access to the basic conditions that are necessary to achieve health for all Canadians.

CALGARY SEXUAL HEALTH CENTRE


The mission of the [Calgary Sexual Health Centre](#) (CSHC) is to normalize sexual health in Alberta by providing evidence-informed, non-judgmental sexual and reproductive health programs and services. The CSHC vision is for all Albertans to experience healthy sexuality across the lifespan.

WORKSHOP DEVELOPMENT

CPHA and CSHC developed the introductory workshop *Exploring STBBIs and stigma: An introductory workshop for health and social service providers* to help define stigma, the multiple factors that contribute to it, and the potential impacts on service users (clients) and public health interventions. The workshop also focuses on strategies at the individual and organizational levels to foster change and ultimately create a more welcoming and inclusive environment for clients.

To develop the workshop content, CPHA conducted literature reviews (peer-reviewed and grey literature) to identify different types of stigma and its causative factors at various socio-ecological levels. CPHA also held key informant interviews with health and social service providers from across the country, as well as focus groups with service users from across the country in order to identify promising practices for reducing STBBI-related stigma within health and social service settings. All workshop activities are based on adult learning principles, with many adapted from CSHC Training Centre workshops that have been rigorously evaluated to ensure their applicability and relevance to adult learners.

CPHA and CSHC pilot tested the workshop content in 2015 and 2016 with frontline service providers (e.g., nurses, nurse practitioners, social workers, physicians, health educators, peer workers, etc.) in several cities and evaluated the workshop content using participant pre- and post-workshop questionnaires. Overall, the workshops were well received and a majority of pilot participants reported an increased awareness of and comfort level related to STBBIs, sexuality and harm reduction. The content was revised based on the evaluation findings to better meet the learning needs of frontline health and social service providers in Canada.



THE WORKSHOP EXPLORING STBBIS AND STIGMA: AN INTRODUCTORY WORKSHOP FOR HEALTH AND SOCIAL SERVICE PROVIDERS INTRODUCES STBBI-RELATED STIGMA AND HELPS FRONTLINE SERVICE PROVIDERS INCREASE THEIR COMFORT AND SKILL IN DISCUSSING STBBIS, SEXUALITY AND SUBSTANCE USE.

TWO OTHER WORKSHOPS WERE DEVELOPED AND SIMILARLY PILOT TESTED AS PART OF THIS PROJECT WITH CSHC:

1. *Moving beyond the basics: An advanced workshop about sexual health, substance use, STBBIs and stigma* – Offers service providers in sexual health, harm reduction or other STBBI-related services an opportunity to enhance their discussion skills around sexuality and substance use, and provides several strategies and tools to mitigate stigma within health and social service settings.
2. *Challenging organizational stigma: Providing safer and more inclusive sexual health, harm reduction and STBBI-related services* – Offers frontline service providers, program planners and management an opportunity to review the policies, practices and culture of their own organizations, and to assess their strengths and challenges in providing safer, more inclusive sexual health, harm reduction and STBBI-related services.

The facilitation manuals, participant workbooks and slides for these workshops can be found [here](#). The workshops can be presented together to create a more comprehensive training opportunity.

PURPOSE OF THE MANUAL

This manual, with the participant workbook and slide deck, will help you present the workshop within your own workplace or community.

THE MANUAL IS ORGANIZED IN FOUR SECTIONS:

1. **Background:** General information about the workshop and manual.
2. **Workshop preparation and evaluation:** Considerations for workshop preparation, timing, facilitation and evaluation.
3. **Workshop content:** Workshop slides and associated activities, learning objectives, required materials, and discussion points. You can modify the content based on group size, your facilitation experience, participants' experience and the learning needs of your group or community.
4. **Appendices:** Additional resources to assist with workshop preparation and facilitation.



SECTION 2

WORKSHOP PREPARATION AND EVALUATION

TARGET AUDIENCE

This introductory workshop is for health and social service providers working outside the fields of sexual health or harm reduction, as well as professionals new to these fields. For professionals with advanced knowledge and experience in STBBIs, sexual health or harm reduction, please refer to the workshop *Moving beyond the basics: An advanced workshop about sexual health, substance use, STBBIs and stigma*

LEARNING OBJECTIVES

UPON COMPLETION OF THE WORKSHOP, PARTICIPANTS WILL HAVE:

- increased knowledge of the various forms of stigma and the factors that contribute to STBBI-related stigma, including personal values and beliefs as well as organizational policies and practices;
- increased ability to self-reflect on personal values and beliefs related to STBBIs, sexuality and substance use;
- enhanced comfort in discussing STBBIs, sexuality and substance use; and
- increased knowledge of tools and strategies to create safer and more inclusive services.

WORKSHOP MATERIALS

TO FACILITATE THIS WORKSHOP, YOU WILL NEED:

- laptop, projector and screen
- microphone (optional depending on group and venue size)
- flipchart paper and markers, or black/white board
- name tags (optional depending on group size and familiarity)
- [workshop slide deck](#)
- [participant workbooks](#) (one for each participant)

- *Stigma case scenario* (one for each participant; see Appendix B)
- *Self-assessment tool for STBBIs and stigma* (one for each participant; see Appendix C)
- *Sample challenging scenarios/ questions worksheets* (one for each participant; see Appendix D)
- *Pre- and post-workshop evaluation questionnaires* (one set for each participant; see Appendix E)

Additional resources

- *Sample recruitment poster* (see Appendix F)
- *Glossary* (see Appendix G)
- *Supplementary resources* (see Appendix H)



WORKSHOP TIMELINES

The workshop content can be delivered in various timeframes: over 5 hours, 3 hours or 90 minutes. Identify the best format for your group based on size, learning needs, resource and time constraints and prepare accordingly based on the sample agendas found in Appendix A. If your organization intends to train all staff, consider offering a series of shorter formats with small groups.

- The **5-hour format** will cover all of the activities in this manual. This format is ideal for groups with a mix of service providers from different backgrounds as it gives participants the time to fully understand the impacts of stigma; identify its primary drivers; challenge their own attitudes, values and beliefs; practice using the tools; and work towards an action plan for change.
- The **3-hour format** allows participants to engage with the same material as the 5-hour session but over a shorter period of time. It can be used with newcomers to the fields of STBBIs, sexual health, and/or substance use as it still allows for exploration of new concepts.
- The **90-minute format** serves as a basic introduction to STBBI-related stigma for groups that would like to consider stigma in their work context but have limited time and resources for training.

PREPARING FOR THE WORKSHOP

If you are offering the workshop to individuals outside your organization, begin recruitment several weeks in advance. Adapt the recruitment poster template in Appendix F to support your recruitment efforts. Consider reaching out to the health and social service organizations in your community for help in recruiting participants (e.g., forwarding the recruitment poster to their networks, promoting the workshop on their social media).

It is strongly recommended that you complete the [Facilitating adult learning](#) online course before the workshop, particularly if you do not have a lot of facilitation experience. The course

takes approximately 30 minutes to complete and offers several strategies to help you facilitate workshops to adult learners focused on sexual health, harm reduction and STBIs.

Review this facilitation manual before the workshop, including the *Glossary* (see Appendix G) to ensure that you use consistent terms and definitions. Also, review the participant workbook and the *Supplementary resources* (see Appendix H) so that you are prepared to answer questions and refer participants to other resources during the workshop.

ROOM SET-UP

Make sure the workshop location is accessible for wheelchair users and people with other access issues. Arrive early to check the audiovisual equipment and room set-up. Participants need to feel comfortable (e.g., room temperature and lighting), and the set-up has to work for group discussion and activities. If possible, try to limit the amount of space between yourself and the participants to encourage group discussion and to avoid a lecture-based format. Below are some images of typical room set-ups with tips to work within these spaces.

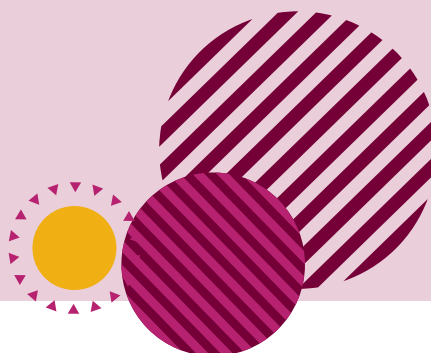
BELOW ARE SOME IMAGES OF TYPICAL ROOM SET-UPS WITH TIPS TO WORK WITHIN THESE SPACES.



A circle is typically the best format for this style of workshop as it encourages group discussion.



This format gives participants room for writing, which is often needed, especially for small group work. Set up several table rounds as needed.





This is often the default set-up you will find in a room on arrival. If possible, ask participants to move their chairs to form a circle. The podium creates a barrier, so use it sparingly and move around the room instead.



The lecture hall is common in post-secondary settings. As this space cannot be changed, it is best to encourage your participants to sit close to the front and to move around the room as you facilitate.

WORKSHOP EVALUATION

Evaluation of your workshop is important. It confirms that learning objectives are met, and that the content and facilitation are effective for continuous professional development. Give your participants time to reflect on their learning and make sure they complete the *Pre- and post-workshop questionnaires* (see Appendix E).

There is also a *Reflection sheet for facilitators* to complete following the workshop (see Appendix E). Facilitating adult education requires consistent self-reflection, ongoing learning and improvement. Use the reflection questions and evaluation results to continue to develop your facilitation skills.



SECTION 3 WORKSHOP CONTENT

MODULE 1: INTRODUCTION

SLIDE 1: WELCOME AND QUESTIONNAIRE

OBJECTIVE: To introduce yourself and have participants complete the pre-workshop questionnaire.

MATERIALS: *Pre-workshop questionnaire*
(see Appendix E)



STEPS/DISCUSSION POINTS:

1. Introduce yourself. Share some information about your organization; your professional group; how long you have been working in STBBI prevention, sexual health or harm reduction; or what you hope to learn from the workshop and the participants.
2. Give each participant a pre-workshop questionnaire.
3. Tell participants that their responses are anonymous and that they do not need to identify themselves on the form. The questionnaire will help measure the group's learning experience and the overall effectiveness of the training content. Tell participants that they will complete a post-workshop questionnaire at the end of the session.

SLIDE 2: BACKGROUND

OBJECTIVE: To describe the workshop's development and potential benefits for individuals and organizations.

MATERIALS: Participant workbooks (one for each participant)



STEPS/DISCUSSION POINTS:

Describe how the workshop evolved and how it can be of benefit to participants' professional practice.

1. Distribute the participant workbooks.
2. Set a tone of sharing and collaboration before the session begins.
 - a. Tell participants that the workshop will be a facilitated discussion rather than a lecture. Explain that, as the session facilitator, you will guide the group discussion through a series of activities rather than function as an expert.
 - b. Acknowledge the breadth of experience that the participants bring and encourage them to share their knowledge with their peers.
 - c. Promote the workshop as an opportunity to network and learn about other services available in the community.
3. Provide some context on the development of this workshop and inform participants why this session was chosen for the group (see text below and refer to Section 1, above, for more information).

This workshop was created as part of a national project coordinated by the Canadian Public Health Association (CPHA) focused on improving STBBI prevention efforts and reducing associated stigma and discrimination in Canada. Through focus groups and key informant interviews, CPHA worked with many community-based organizations, researchers, educators, policy-makers, health care providers and service users from across Canada to identify best and promising practices for health and social service providers in the areas of STBBIs, sexual health and harm reduction. Based on these consultations, CPHA partnered with the Calgary Sexual Health Centre to create professional development resources for service providers to develop a deeper understanding of stigma and its impacts, and to learn some strategies to use individually as well as organizationally to reduce stigma. The workshop content is founded on adult learning principles and draws from much of the evidence base surrounding stigma reduction found in the peer-reviewed and grey literature. The workshop was pilot tested in several cities across the country with a range of health and social service providers and revised accordingly.

4. Describe why your community or agency sees this training as important.
5. Provide concrete examples of the workshop's value for participants, such as:
 - a. "After this workshop, you may feel more comfortable and confident talking about STBBIs, sexuality, and substance use with your clients."
 - b. "You'll likely have a greater understanding of stigma and how it affects your clients."
6. Provide relevant and community-specific resources to the group, when needed.

SLIDE 3: LEARNING OBJECTIVES

OBJECTIVE: To present the learning objectives, clarify the workshop focus, and identify what participants want to get out of the workshop.

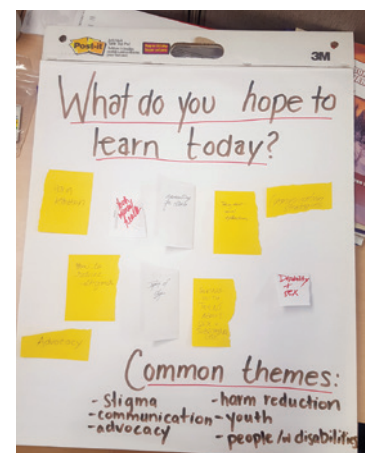
MATERIALS: n/a

Learning objectives

- Increase knowledge of the various forms of stigma and the factors that contribute to STBBI-related stigma, including personal values and beliefs as well as organizational policies and practices.
- Increase ability to self-reflect on personal values and beliefs related to STBBIs, sexuality and substance use.
- Increase comfort in discussing STBBIs, sexuality and substance use.
- Increase knowledge of tools and strategies to create safer and more inclusive services.

STEPS/DISCUSSION POINTS:

1. Describe how the group will work together, sharing experiences and learning with one another through a series of self-reflections, discussion and practice activities.
2. Read each of the learning objectives and provide participants with context of what they will be learning throughout the day.
3. Tell the group that the goal is for each participant to leave with strategies and tools they can use in their organizations or workplaces.
4. Start a roundtable and ask participants to identify their professional role and how long they have worked in their field. To save time, ask for a show of hands for nurses, social workers, educators, physicians, etc. Understanding your audience will help you modify the workshop content to keep it relevant. This roundtable can also facilitate networking, as it allows participants to identify with whom they would like to connect to discuss referrals, common challenges or potential strategies for service provision in the community.
5. Acknowledge the breadth of experience and expertise in the room, but remind participants that even the most advanced learners continue to learn from one another and from reflecting on their own attitudes, values and beliefs. Encourage participants to share their challenges and 'best practices' in sexual health, harm reduction and other STBBI-related services.
6. Ask participants what they hope to learn from their participation in this session. Write the responses on a flipchart or white board to keep as reference. This list will help you tailor the discussion to your group's learning needs. To save time, you can email participants before the session to ask for the sexual health, harm reduction and STBBI-related topics they would like to cover in the workshop. You can then prepare in advance and gather additional resources, if needed.



Sample image of "What do you hope to learn today?"

SLIDE 4: LEARNERS' RIGHTS

OBJECTIVE: To set some basic ground rules for the group.

MATERIALS: Flipchart paper or white board. As you speak about the rights, write them on the flipchart or white board as reference for the group. The list can help if you have someone who is not respecting the rights of others or creates a potentially unsafe environment.



STEPS/DISCUSSION POINTS:

1. Emphasize to the group that discussing stigma, sexuality, substance use and STBBIs can be difficult.
2. Inform the group that individuals will come with a variety of attitudes, values, beliefs and experiences. Create a safe space for dialogue and learning. To help create such an environment, touch on the points listed below.

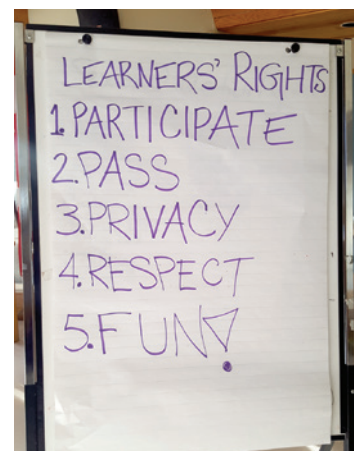
DISCUSSION POINTS

- Explain how learning rights help ensure that all people feel safe exploring their attitudes, values and beliefs during the workshop.
- Tell participants that they may feel uncomfortable during the session, and that this is not necessarily a bad thing. Feeling some discomfort can help participants to learn and question their own unconscious attitudes, values and beliefs. Setting up clear learners' rights will help create a space where participants expect to feel challenged, but also know they can opt out if they feel uncomfortable.
- Adults learn best in positive environments that build on their prior experience and knowledge. So, focus on the positive ideas that participants express and encourage them to share the strategies that work well for them. This approach will create a more inclusive and welcoming space.

ADDITIONAL INFORMATION TO INCLUDE:

- **Participate:** Encourage individuals to ask questions, share examples and engage in the activities and discussions. Remind participants that your role is not as an expert presenting information, but rather as a facilitator creating a safe space for them to reflect and express.
- **Pass:** Inform participants that they have the right to remain quiet and not participate in any or all of the activities. Sharing stories about sexuality, substance use and stigma can be triggering; they should not feel obliged to share if they do not feel safe doing so.

- **Privacy:** Encourage individuals to share practice examples and real-life scenarios to help frame the discussion. However, caution them to avoid using any identifying information about service users, clients or organizations (i.e., respect confidentiality). Remind participants that any personal information shared within the group remains confidential. (Note: If someone breaks confidentiality or shares a lot of personal information, remind them of the participant rights. Post the rights in the room and ask all to respect them as the group agreed.)
- **Respect:** Acknowledge that as adults and health/ social service professionals, you recognize that they are respectful learners. However, encourage them to be curious and open about others' values and experiences. Also, remind them to be mindful of how they express their own values and experiences.
- **Fun:** Sexuality, substance use, stigma and STBBIs can be intense topics. Many people have not experienced these topics in positive ways. Tell participants that today you hope to make this a positive experience and, as a group, you will be choosing activities that add enjoyment to the learning experience.



Sample image of the learners' rights

Once you have discussed the learners' rights, ask participants if they agree with the list or would they like to add more.

SLIDE 5: KEY TERMS

OBJECTIVE: To ensure that participants share a common understanding of the terms used in the workshop.

MATERIALS: Participant workbook (pages 2 and 3)

Key terms

STBBIs
Sex-positivity
Harm reduction
Trauma- and violence-informed care



STEPS/DISCUSSION POINTS:

1. Direct participants to the term definitions on pages 2 and 3 of the workbook and provide time to review. Read the definitions aloud to accommodate different learning styles.
2. Ask for questions or comments about the terms.
3. Direct participants to the glossary found on pages 16-18 of the workbook. Participants can refer to the glossary of terms during the workshop. Encourage participants to ask you for clarification if a term used during the workshop is not found in the glossary.

DISCUSSION POINTS

- **STBBIs:** To measure the group's level of prior knowledge, ask participants to call out various STBBIs (e.g., genital herpes or herpes simplex virus, hepatitis B and C, HIV, human papillomavirus or HPV, chlamydia, gonorrhea, syphilis, pubic lice, scabies, trichomoniasis).
- **Harm reduction:** To measure the group's level of prior knowledge, ask participants to call out various harm reduction approaches (e.g., condom distribution, peer support programs, supervised injection facilities, needle exchange programs, naloxone programs, education services).
 - Identifying many different examples of harm reduction approaches will help your group learn a comprehensive definition of harm reduction. Tell participants that harm reduction approaches are used in other areas of public health beyond sexual health and substance use.
- **Sex-positivity:** Sex-positivity recognizes sexuality as central to our humanity and removes some of the shame often wrapped up with sexuality. When discussing sex-positivity with the group, highlight that not all people have experienced or learned about sexuality in a positive and affirming way. For this reason, it is important to use a trauma- and violence-informed approach at all times when discussing sexuality.

NOTE: For questions about gender and sexual diversity, refer participants to the supplementary resources listed in Appendix H and to the online learning course [Introduction to LGBT](#) developed by Rainbow Health Ontario and the University Health Network

SLIDE 6-8: KEY TERMS

OBJECTIVE: To present a general introduction to trauma- and violence-informed care.

MATERIALS: Participant workbook (page 3)

What is trauma-informed care?

"In trauma-informed services, safety and empowerment for the service user are central, and are embedded in policies, practices, and staff relational approaches. Service providers cultivate safety in every interaction and avoid confrontational approaches. Trauma-informed approaches are similar to harm-reduction-oriented approaches, in that they both focus on safety and engagement."

Reference: Trauma-informed practice guide, BC Provincial Mental Health and Substance Use Planning Council, 2013, available at http://bcoceh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

What is Trauma-informed care?

"A key aspect of trauma-informed services is to create an environment where service users do not experience further traumatization or re-traumatization (events that reflect earlier experiences of powerlessness and loss of control) and where they can make decisions about their treatment needs at a pace that feels safe to them."

Reference: Trauma-informed practice guide, BC Provincial Mental Health and Substance Use Planning Council, 2013, available at http://bcoceh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf



What is trauma- and violence-informed care (TVIC)?

TVIC expands on the concept of TIC to acknowledge the broader social and structural conditions that impact people's health, including institutional policies and practices. Talking about sexuality and substance use within service settings can be difficult; using a TVIC approach helps ensure that the broader structural and social conditions are acknowledged and that organizational policies and practices as well as provider practices do not contribute to re-traumatization.

Example TVIC strategies:

- acknowledging the effects of historical and structural conditions;
- seeking client input about safe and inclusive strategies;
- encouraging client empowerment in relation to treatment options and adoption of harm reduction strategies; and
- implementing policies and processes that allow for flexibility and encourage shared decision-making.

Reference: Varcoe CM, Warren, CN, Ford-Gibson, M, Smyke, V, Browne, A. VEGA briefing note on trauma- and violence-informed care. VEGA Project and Provok. Research Network, 2016

STEPS/DISCUSSION POINTS:

1. Give participants time to read the statement on the slide. Read the content aloud to accommodate different learning styles. Ask participants why they think a trauma- and violence-informed approach is important when talking about sexuality and substance use and when designing services. After their responses, encourage them to think about trauma as a broad concept that occurs along a range of experiences. Trauma can include experiences of harassment, racism, sexism, homophobia, transphobia, colonization, sexual abuse and assault, violence, among others. Remind participants that trauma and violence can also be perpetuated by structural factors, such as institutional policies and practices.
2. Ask participants to reflect on the circumstances that could cause clients to experience feelings of powerlessness or loss of control when interacting with a service provider who is trying to implement public health best practices. One example is STBBI testing – clients may be strongly encouraged to participate in STBBI testing before they are ready or before they fully understand potential testing implications.
3. Ask participants to think about the impacts of trauma and/or violence and consider, as the workshop unfolds, how services, policies, practices and relational approaches can be designed with an awareness of these experiences.

NOTE that through their conversations and relationships with clients, service providers have the potential to trigger prior traumatic experiences. How service providers ask questions, lead conversations and engage with clients can cause individuals to re-experience trauma. However, through supportive policies, practices and an inclusive environment, organizations can help empower clients so re-traumatization is reduced.



MODULE 2: EXPLORING STIGMA AND FACTORS THAT CONTRIBUTE TO STIGMA

SLIDE 9: ACTIVITY - WHAT DID YOU DO ON THE WEEKEND?

OBJECTIVE: To explore the impact that stigma may have on clients.

MATERIALS: Participant workbook (page 4)

What did you do on the weekend?



STEPS/DISCUSSION POINTS:

1. Direct participants to page 4 of the workbook.
2. Ask participants to write down the name of the most important person in their lives. Encourage participants to keep it to one person's name, though they may think of more.
3. Ask participants to write down the three most important things in their lives. This can include pets, hobbies, activities that they enjoy, etc. Steps 2 and 3 should take about 2 minutes.
4. Now ask participants to pick a partner within the group (easiest choice is a person to their right or left).
5. Each person should tell their partner about what they did on the weekend. However, they are not to speak about anyone or anything written on their list.
6. Pause for a moment to make sure everyone understands the instructions. Typically, people will have non-verbal reactions to this task. If people seem surprised or resistant, comment on the reactions of the group.
7. Give participants 2 minutes to discuss their weekends. While they are talking, walk around the room and listen to what people are sharing.
8. Bring the group together to debrief. Ask participants to share what the experience felt like for them.
9. Ask participants what they learned about their partners. What did they share about themselves?
10. Ask them if they were able to get to know one another based on what they shared.

11. Ask them if they accidentally began to tell their partner about someone or something that was on their list. If so, how did their body feel? Did they feel stressed? Did they feel like they had to police themselves?
12. Ask the group if they think their clients ever censor or edit themselves?
13. The closing point is that clients may not share all of themselves with their service providers. This is often due to stigma and shame. People may not talk about their sexual orientation, gender identity, substance use, sexual practices, relationships, or even what they truly want and need from their service provider. It is our professional duty to be aware of and work with the barriers or perceptions that create stigma so that we can have honest conversations with clients.

DISCUSSION POINTS

Ask participants to share what the activity felt like to them.

- For many, it may feel awkward and/or difficult.
- For some, it may be challenging to have a conversation without mentioning anyone or anything on their list.
- Many people may say they focused on the superficial elements of their life.
- Some people may say they decided to lie or to say nothing at all.

Ask participants what they learned about their partners and what they shared about themselves.

- Some may say they learned very little about each other because they were not able to share about the people and things they value most.

Ask if they accidentally began to talk about something written on their list. If so, how did their body feel? Did they feel stressed? Did they feel like they had to police themselves?

- Participants may say they felt tense or stressed when they wanted to talk about a person or things on their list, and that this would have been upsetting or exhausting had they continued on with the activity for a long time.

Ask the group if they believe clients police themselves in this way with their service providers.

- Explain that there are many reasons why someone may not want to be honest or forthcoming with a service provider. It could be because of shame, stigma, fear of judgment, fear of losing services, restrictive organizational policies, etc.

SLIDE 10: ACTIVITY - EARLY MESSAGES ABOUT SEXUALITY AND SUBSTANCE USE

OBJECTIVE: To reflect on the messages received as children or adolescents about sexuality and substance use and to consider how these formative messages influence attitudes, values, beliefs and interactions with clients.

MATERIALS: n/a

Activity

Where did you first learn about sex? What do you remember?



STEPS/DISCUSSION POINTS:

1. Explain the rationale for this activity. Early-life messages received about sexuality and substance use can have a lasting impact on our attitudes, values and beliefs, and may affect how we speak about sexuality and substance use as professionals.
2. Allowing people to speak about sexuality and substance use and giving them a safe space to do so is an extremely important role for health and social service providers.
3. In small groups, ask participants to discuss where they first learned about sex. Direct participants to page 4 of their workbook if they would like to take notes. Ask them to try to recall how their body felt when they first learned about sex, and whether this was a positive, neutral or negative experience. Encourage the groups to look for common themes across their experiences (e.g., who first taught them about sex; did they receive positive, negative or neutral messaging; how they felt during these early experiences). Give roughly 5-7 minutes to discuss as a small group.
4. Come back together as a large group and ask if anyone feels comfortable sharing a brief description of the early messages they received about sexuality
5. After participants have shared some stories, ask by a show of hands if anyone learned about sex in school, from the media, from their friends, from their parents, or not at all.
6. As a group, look for common themes and messages. Many participants may have received very little information about sexuality as children and adolescents. Many may have been taught that sexuality is not to be discussed or that sexuality and STBBIs are shameful. Some may have been taught very little about sexual and gender diversity or their schooling may have been heterosexist and/or cissexist. For others, early messages may have included very strong gender scripts (e.g., an overemphasis on reproduction among female-bodied persons and an emphasis on pleasure among male-bodied persons).
7. Ask the group what they wish they had learned, or from whom they would have liked to get this information. How do these formative learning experiences shape our attitudes and values, as well as those of the people accessing our services?

DISCUSSION POINTS

Responses to this activity from past workshops:

- Some children and adolescents may have received positive messaging related to sexuality that focused on healthy and informed decision-making. Conversely, some young people may have received negative information that focused almost exclusively on the potential harms associated with sexual activity, such as pregnancy or STBIs. Still others may have received little or no information at all. Silence when it comes to sexuality can send a very strong message to young people that sexuality is not to be discussed and, in turn, shameful. This also means that children and youth are not provided with the information they need to make informed decisions about their sexual health.
- We learn about gender and sexual scripts. For example, in school, when learning about puberty, we focus on erections, ejaculation and wet dreams when talking about male-bodied individuals. However, for female-bodied individuals, the emphasis is often on reproduction. This reinforces traditional gender scripts that stress pleasure for men and reproduction for women.
- Sexual health education in school may have been heterosexist and/or cissexist, meaning that the curriculum was not inclusive of diverse sexual and gender identities.
- People may first learn about sexuality through the media (e.g., movies, television, magazines), which can have a profound impact on understanding gender roles and sexuality.
- Research shows that children learn best from their parents; yet parents do not always feel comfortable or equipped to talk about sexuality.
- Parents who talk about sexuality with their children from a young age can help normalize sexual health as part of one's overall health and well-being. This increases children's willingness to ask questions and be open with their parents. Early education should focus on equipping children and youth with the knowledge and skills they need to make healthy and informed decisions.

ADDITIONAL ACTIVITY - WHERE DID YOU LEARN ABOUT SUBSTANCE USE?

1. Ask participants if they recall learning about substance use as a child or adolescent. If the group is larger, ask by a show of hands if anyone learned about substance use in school, from the media, from their friends, from their parents, or not at all.
2. After a few minutes reflecting on how they learned about substance use, ask participants to share what they remember and to highlight the key messages they received.

DISCUSSION POINTS

Use these questions with a quieter group to stimulate conversation:

- What messages did you receive about substance use?
- Did you get the same messages about all substances, or were some talked about differently?
- What is the impact of fear-based messaging around substance use?
- What did you learn from these early messages? Do these early messages still affect your personal attitudes or values, or your professional practices? How might the dominant and negative rhetoric around substance use affect our clients?

Responses from past workshops that can be used to facilitate discussion:

- Some participants may share that they were primarily given fear-based messaging (e.g., don't do drugs; marijuana is a gateway drug).
- People may have learned that only specific types of people use substances (e.g., people who are homeless, etc.).
- Some participants may share that certain drugs were presented as more acceptable and desirable than others. For example, prescription drugs and caffeine are socially acceptable, yet people who use illicit substances are seen as very disreputable.
- Some participants may say they had no education on substance use.
- Stigma around substances can create situations where clients may not feel safe to disclose their use.
- Professionals may not discuss substance use or harm reduction with all clients because of misguided assumptions or beliefs about those who use substances and which populations could benefit from harm reduction.
- Early education and information about substance use can influence an individual's attitudes, values and beliefs about substance use and may in turn influence professional practice.

SLIDE 11: UNPACKING STIGMA

OBJECTIVE: To brainstorm a definition of stigma, identify where stigma is experienced and its impacts. This is a chance to gauge the level of knowledge within the room and to build on it.


MATERIALS: Participant workbook (page 5)

Stigma

What is it?

Where do we see it?

What is the impact?



STEPS/DISCUSSION POINTS:

1. Ask participants to break into small groups to brainstorm a definition of stigma.
2. Ask them to discuss where stigma occurs and its impact on individuals, such as their:
 - ability to talk to service providers about sex, substance use or STBBIs;
 - willingness to get tested for STBBIs;
 - ability to negotiate condom use;
 - willingness to discuss their gender and sexual identity; and
 - ability to access non-judgmental health and social support services.

Refer participants to page 5 of their workbooks if they would like to take notes.

If you are short on time, do this activity as a group brainstorm. This approach is not recommended for quieter groups.

3. Encourage groups to consider the following points:

- Social construction of sexuality and substance use: How do our common messages about sexuality and substance use impact stigma around STBBIs?
- How do predominant messages related to sexuality and substance use – often negative and/or fear-based – influence us as service providers, and how do they influence how we form perceptions about people engaging in our services? How may this impact a client’s willingness to discuss their sexuality or substance use with health or social service professionals?

4. Give roughly 5 minutes to discuss in small groups, then come back together to debrief as a large group.

DISCUSSION POINTS

- The Joint United Nations Programme on HIV/AIDS (UNAIDS) defines stigma as “a dynamic process of devaluation that significantly discredits an individual in the eyes of others, such as when certain attributes are seized upon within particular cultures or settings and defined as discreditable or unworthy. When stigma is acted upon, the result is discrimination. Discrimination refers to any form of arbitrary distinction, exclusion or restriction affecting a person, usually (but not only) because of an inherent personal characteristic or perceived membership of a particular group.”¹
- Service providers working in STBBI prevention, testing and treatment need to understand the far-reaching impacts of stigma.^{1,2,3}
- Stigma can lead to harmful outcomes for individuals living with or affected by STBBIs such as psychological stress, fear of disclosure and avoidance of STBBI prevention, testing and treatment services.^{2,4,5,6,7} Stigma within health service settings can impact the quality of care as well as a client’s well-being and confidence in the health care process.⁸

1 Joint United Nations Programme on HIV/AIDS (UNAIDS). *UNAIDS terminology guidelines*. Geneva, Switzerland: Joint United Nations Program on HIV/AIDS, 2015. Available at http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf (Accessed January 7, 2015).

2 Fortenberry DJ, McFarlane M, Bleakley A, Bull S, Fishbein M, Grimley DM, et al. Relationships of stigma and shame to gonorrhea and HIV screening. *Am J Public Health* 2002; 92(3): 378-381.

3 Ford JV, Barnes R, Rompalo A, Hook E. Sexual health training and education in the U.S. *Public Health Reports* 2013;128(Suppl 1):96-101.

4 Balfe M, Brugha R, O'Donovan D, O'Connell E, Vaughn D. Young women's decisions to accept chlamydia screening: Influences of stigma and doctor-patient interactions. *BMC Public Health* 2010;10(425).

5 Mahajan AP, Sayles JN, Patel VA, Remien RH, Ortiz D, Szekeres G, et al. Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward. *AIDS* 2008;22(Suppl 2): S67-S79.

6 Mill J, Edwards N, Jackson R, Austin W, MacLean L, Reintjes F. Accessing health services while living with HIV: Intersections of stigma. *Can J of Nurs Res* 2009;41(3):168-85.

7 Rusch ML, Shoveller JA, Burgess S, Stancer K, Patrick DM, Tyndall MW. Preliminary development of a scale to measure stigma relating to sexually transmitted infections among women in a high risk neighbourhood. *BMC Womens Health* 2008;8(21).

8 Kinsler JJ, Wong MD, Sayles JN, Davis C, Cunningham WE. The effect of perceived stigma from a health care provider on access to care among a low-income HIV-positive population. *AIDS Patient Care STDs* 2007;21(8):584-92.

- Stigma is exacerbated when society takes an overall negative view of sexuality and substance use or focuses on a fear-based approach to STBBIs. Stigma is often worsened by health promotion or public health discourses that emphasize 'at risk' populations, which can perpetuate negative attitudes based on sexual orientation, gender identity, race, class, etc.⁹ A focus on specific populations can reinforce common beliefs that only 'certain' groups of people are at risk of STBBIs. This may lead to limiting harm reduction messaging or testing opportunities only to those deemed most 'at risk'. It may also create a false sense of security among individuals who do not identify as belonging to an 'at risk' group.

Questions to help the group consider the impact of stigma:

- **How does stigma impact harm reduction conversations?**

Stigma reinforces the idea that certain behaviours are acceptable and others are not. For example, some substances are viewed as more socially acceptable and deemed less harmful, even if research indicates otherwise.

- **Do any of our health promotion practices or interventions contribute to stigma?**

For example, do your lab requisitions necessitate a reason for people to get tested for HIV? Is there a list of checkboxes that includes population groups deemed as 'high risk'?

9 Joint United Nations Programme on HIV/AIDS (UNAIDS). *Fact Sheet: Stigma and discrimination*. Geneva, Switzerland: Joint United Nations Program on HIV/AIDS, 2003. Available at: http://data.unaids.org/publications/Fact-Sheets03/fs_stigma_discrimination_en.pdf (Accessed January 7, 2015).

SLIDE 12: STIGMA DEFINED

OBJECTIVE: To explore a more succinct definition of stigma; its various forms; its health, social, and psychological consequences; and the need for tailored interventions for different forms of stigma.

MATERIALS: Participant workbook (page 6)



STEPS/DISCUSSION POINTS:

1. Ask the group to read the definitions in the workbook on page 6 or on the slide. To fit different learning styles, read the definitions aloud. Emphasize that although stigma is often talked about, it is rarely clearly defined, making it challenging for providers to address the topic in their organizations. CPHA conducted a literature scan and identified the following working definitions:
 - **Perceived stigma:** Awareness of negative social attitudes, fear of discrimination and feelings of shame.¹⁰
 - **Internalized stigma:** An individual's acceptance of negative beliefs, views and feelings towards themselves and the stigmatized group to which they belong.¹⁰
 - **Enacted stigma:** Encompasses acts of discrimination, such as exclusion, or physical or emotional abuse (towards an individual's real or perceived identity or membership to a stigmatized group).¹⁰
 - **Layered or compounded stigma:** A person holding more than one stigmatized identity (e.g., HIV positive serostatus, sexual orientation, race, ethnicity).¹⁰
 - **Institutional or structural stigma:** Stigmatisation of a group of people by way of policies and procedures.¹¹
2. Tell participants that it is critical to understand the different types of stigma. Research shows that trying to reduce stigma is futile unless the complexity of stigma is understood and the intervention is linked to the type(s) of stigma that clients are experiencing.¹²
3. For each of the five types of stigma, ask participants to think of an example they have witnessed within health and social service settings or within the community.

10 Adapted from: Stangl A, Brady L, Fritz K. *Measuring HIV stigma and discrimination*. Strive, 2012. Available at: http://strive.lshtm.ac.uk/sites/strive.lshtm.ac.uk/files/STRIVE_stigma%20brief-A3.pdf (Accessed January 7, 2015) and Loutfy MR, Logie CH, Zhang Y, Blitz SL, Margolese SL, Tharao WE, et al. Gender and ethnicity differences in HIV-related stigma experienced by people living with HIV in Ontario, Canada. *PLoS ONE* 2012;7(12):e48168.

11 Adapted from Corrigan PW, Markowitz FE, Watson AC. Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin* 2004;30(3):481-491.

12 Stangl AL, Lloyd JK, Brady LM, Holland CE, Baral S. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? *AIDS Society* 2013;16(Suppl 2):18734.

DISCUSSION POINTS

For a quieter group, use these examples to guide your discussion of the different types of stigma.

- **Perceived stigma:** Someone walks into a clinic and sees posters and brochures targeting mostly heterosexual couples. As a result, they expect to be stigmatized because of their sexual orientation and refrain from honestly discussing their relationships with their service provider.
- **Internalized stigma:** Someone internalizes the negative societal attitudes, values and beliefs about their identity and starts to believe they deserve the stigma and discrimination they are experiencing. This contributes to feelings of low self-worth and adoption of unhealthy behaviours.
- **Enacted stigma:** Based on a conversation with their service provider, someone is made to feel that they got an STBBI because of their 'risky' behaviour, or that they deserve it because of their personal choices and identity.
- **Layered or compounded stigma:** A newcomer to Canada does not feel welcome at an HIV service organization because of their ethnicity, and does not feel welcome at their local immigrant service organization because of their HIV status.
- **Institutional or structural stigma:** An organization refuses to provide services to someone who is intoxicated.

SLIDE 13: ACTIVITY - STIGMA CASE SCENARIO

OBJECTIVE: To consider how each form of stigma affects the health and well-being of clients.

MATERIALS: Participant workbook (pages 7 and 8), *Stigma case scenario* (see Appendix B)



STEPS/DISCUSSION POINTS:

1. Ask participants to look at the diagram in the workbook on page 7. Explain that CPHA created this framework to show the different types of stigma and the many levels that people experience stigma as well as the levels at which organizations can address stigma. The five stigma types are shown as overlapping circles to highlight their interconnectedness. These are encircled by intersecting sources of stigma, including racism, gender inequality, heteronormativity, cisnormativity, classism, colonization, ableism, etc. The diagram highlights the socio-ecological levels at which clients experience stigma and at which organizations can mount stigma-reducing actions and interventions. Some effects of STBBI-related stigma are shown including poor mental health, adoption of unhealthy behaviours, withdrawal and fear of disclosure, and limited use of available services.

2. Pass out the stigma case scenario to each participant (Appendix B).
3. Ask participants to spend a few minutes reading the scenario and then to form groups of three or four.
4. Instruct the groups to once again review the scenario and identify the different types of stigma. Then, ask participants to brainstorm some potential strategies to reduce the stigma described in the scenario. Give participants approximately 10 minutes before coming back together to debrief. Some participants may choose to work individually. Direct participants to page 8 in their workbook if they would like to take notes.
5. Ask participants how they felt as they read the scenario. Possible responses include:
 - It reflects the way things are within health and social service settings.
 - It was overwhelming or discouraging. Note: In this case, encourage participants to focus on the solutions they brainstormed that could help to reduce stigma in health and social service settings.
6. As a group, read the scenario paragraph by paragraph and identify the different types of stigma. **Refer to Appendix B for possible discussion points for this scenario.**
7. Ask participants to share 1-2 ideas to counter the stigma examples in the scenario.

DISCUSSION POINTS

- Encourage participants to reflect on the potential drivers of stigma within health and social service settings. Highlight the many factors that contribute to stigma, including individual, interpersonal, community, institutional and policy/legal factors. Some examples include fear of transmission through casual contact, fear due to the incurability of some STBBIs, social judgment from the association of STBBIs with actions deemed immoral or reprehensible (e.g., substance use or sexual promiscuity), no or poor access to services because of discriminatory policies and procedures, and discriminatory policies such as the criminalization of HIV non-disclosure in Canada.^{13, 14}
- Be solution-focused in the discussion. Allow participants the space to share their stories and experiences, but also try to keep the discussion strengths-based and encourage the group to brainstorm solutions.
- If the group becomes marred in hopelessness about the structural or systemic nature of stigma and the oppression of groups of people through policies and institutions, discuss how change occurs through collective action.
 - The purpose of our jobs as service providers is to work towards creating more socially just conditions. We have the ability to work together to advocate and create positive change. Even participating in this discussion can be a start towards action.

13 Sengupta S, Banks B, Jonas D, Miles MS, Smith GC. HIV Interventions to reduce HIV/AIDS stigma: A systematic review. *AIDS Behav* 2011;15(6):1075-1087.

14 Wagner A, Hart T, McShane K, Margolese S, Girard T. Health care provider attitudes and beliefs about people living with HIV: Initial validation of the health care provider HIV/AIDS stigma scale (HPASS). *Journal of AIDS and Behaviour* 2014;18(12):2397-408.

- Remind the group that unlearning our own attitudes, values and beliefs moves us toward social change. For the remainder of the workshop, encourage participants to think about changes they can make in their personal practice and organizations to deliver safer and more respectful services. Encourage participants to network with one another and, where possible, identify opportunities for collaboration to elicit positive change at the community level

SLIDE 14: WHAT DO CLIENTS THINK?

OBJECTIVE: To highlight the research on clients' views and feelings when being asked by service providers about their sexual health and/or substance use.

MATERIALS: n/a

What do clients think?



Research has shown that professionals should not worry about asking their clients about sexual health. Clients in many settings and across age groups expect their service providers to ask questions about their sexual health (Sargent, Smallwood and Finlay, 2014).

While less is known about clients' expectations around talking about substance use, the positive outcomes associated with screening for substance use are well documented, so long as discussions are respectful and non-judgmental (Registered Nurses Association, 2015).

Discussions about sexual health and substance use assist in the detection, prevention, and treatment of STBBIs. Conversations also provide professionals with an opportunity to discuss harm reduction strategies with their clients in a safe and respectful way.

STEPS/DISCUSSION POINTS:

1. Explain that a common assumption is that clients do not want to talk about sexual health or substance use with their service providers. After giving participants time to read the slide, ask whether they agree that most clients welcome and expect service providers to talk about sexuality and substance use.
2. Allow participants time to share their experiences.
3. Ask why service providers often assume that clients do not want to discuss their sexual health and/or substance use.

DISCUSSION POINTS (OR PROMPTS IF THE GROUP IS QUIET)

Both the grey and academic literatures note that individuals expect service providers to ask questions about their sexual health.¹⁵

- A service provider's attitudes, values and beliefs about substance use and sexuality can create barriers to open discussion. If the provider is not comfortable or confident in addressing sexuality or substance use, the client may sense their discomfort and avoid the topic altogether.
- Social stigma and shame can create barriers between providers and clients.

¹⁵ Dyke E. *Scan on talking about sexuality/substance use and taking a sexual health and substance use history* (unpublished internal document). Ottawa: Canadian Public Health Association, 2014.

- Assumptions about who is most at risk or who may benefit most from harm reduction can make providers focus only on some groups when talking about sexuality and substance use, while avoiding others. For example, older adults or those in monogamous relationships are less likely to be asked about sexuality by their physicians.¹⁶

While less is known about clients' expectations around talking about substance use, the positive outcomes associated with screening for substance use are well documented, so long as discussions are respectful and non judgemental.¹⁷

It is important to discuss sexual health and substance use with all clients, and to do so using a trauma- and violence-informed approach. If a client is not prepared to discuss sexual health or substance use, or is not prepared for treatment or referral to other services, you must provide non-judgemental care while working within their boundaries.

**IT IS IMPORTANT TO DISCUSS SEXUAL HEALTH
AND SUBSTANCE USE WITH ALL CLIENTS, AND
TO DO SO USING A TRAUMA- AND VIOLENCE-
INFORMED APPROACH.**



16 Ports KA, Barnack-Tavlaris JL, Syme ML, Perera RA, Lafata JE. Sexual health discussions with older adult patients during periodic health exams. *The Journal of Sexual Medicine* 2014;11(4):901-908.

17 Registered Nurses Association of Ontario. *Engaging clients who use substances*. Toronto, Ontario: 2015. Available at: http://rnao.ca/sites/rnao-ca/files/Engaging_Clients_Who_Use_Substances_13_WEB.pdf (Accessed August 15, 2016).

MODULE 3: STRATEGIES TO REDUCE STIGMA AND DISCUSS SEXUAL HEALTH, SUBSTANCE USE AND STBBIS

SLIDE 15: WHAT CAN YOU DO?

OBJECTIVE: To consider the personal changes participants can make to improve their practice.

MATERIALS: n/a

What can you do?

1. Clarify your values
2. Use correct terminology
3. Use inclusive language
4. Be aware of your body language
5. Be cognizant of the many layers of stigma
6. Practice answering tough questions
7. Consider your professional obligations
8. Create and maintain inclusive and affirming spaces



STEPS/DISCUSSION POINTS:

1. Ask participants to read the slide and highlight the suggestions that resonate with them. Ask for any additions to the list. You can refer back to the stigma framework and emphasize that stigma can appear and be confronted at many levels. Ensuring that interactions with clients are safe, respectful and inclusive is a first step.
2. Encourage participants to reflect on the power differential within the client-provider relationship and understand that it can drive an experience of stigma for clients, particularly those from marginalized communities. Providers need to be proactive in their approach (e.g., explaining to clients why they are asking questions about sexuality or substance use).



SLIDE 16: IMPORTANCE OF PRIVACY AND CONFIDENTIALITY

OBJECTIVE: To consider the importance of respecting client privacy and confidentiality

MATERIALS: n/a

Importance of privacy and confidentiality

Respect your client's right to privacy and confidentiality.

Ensure clients understand potential limits to confidentiality.

Ensure you are in a private and comfortable space.

For more information, refer to *Reducing stigma and discrimination through the protection of privacy and confidentiality*, Canadian Public Health Association and Canadian HIV/AIDS Legal Network, 2017.

STEPS/DISCUSSION POINTS:

1. Ask participants to read the slide and to share their thoughts on why it is so important to respect client privacy and confidentiality in the context of stigma reduction.
2. Ask participants to consider some possible limits to confidentiality (e.g., public health reporting requirements, how information is shared amongst care providers within their organization, reporting requirements if a child is in need of protection). Ask them to share how they discuss possible limits to confidentiality with clients.
3. Use the points below to guide your discussion.

DISCUSSION POINTS:

As a service provider, you need to create a safe space for clients to share intimate details and personal experiences without fear of losing control over their personal information or being subject to stigma and discrimination as a result of revealing personal information.

Clients have a right to know how you will use their personal information and with whom it will be shared. There may be circumstances where the law authorizes or requires you to disclose confidential information. Clients should be told about such limitations so that they can maintain control of how their personal information will be handled by others.

Clients should also be told about practices they might not know about; for instance, that provider-client records can be seized under a search warrant for a criminal investigation, or that the provider is obligated to report a child “in need of protection” under provincial or territorial legislation.

Agencies should also consider what ‘protecting privacy’ means, beyond formal systems to maintain files. For example, confidentiality may require that service providers not communicate, even casually, with clients they meet outside the office, to avoid unintentionally revealing that the client has a certain condition, or has accessed a certain program (e.g., HIV support group).

Refer to [Reducing stigma and discrimination through the protection of privacy and confidentiality](#) for more information.

SLIDE 17: ACTIVITY - VALUES CLARIFICATION

OBJECTIVE: To reflect on one's own attitudes, values and assumptions about STBBIs.

MATERIALS: *Self-assessment tool for STBBIs and stigma* (see Appendix C)

Activity



Values clarification

STEPS/DISCUSSION POINTS:

1. Pass out the *Self-assessment tool for STBBIs and stigma* to each participant. Explain that this tool can be used by health and social service providers to reflect on and assess their own attitudes, values and beliefs related to STBBIs. The tool is adapted from the [Health care provider HIV/AIDS stigma scale \(HPASS\)](#) to reflect the range of STBBIs and was validated following two rounds of pilot testing with 276 service providers from across Canada.
2. Tell participants that as service providers we are not immune to bias and that our biases can affect how we (often unconsciously) interact with clients. Remind participants that reflecting on our attitudes, values and beliefs should be an ongoing exercise and that it can raise awareness about the impact of biases and assumptions and, in turn, help us feel more comfortable in discussing STBBIs with clients.
3. Give participants several minutes to review the tool independently. Some participants may want to write down their immediate responses to the statements in the tool, others may prefer to reflect quietly on their responses to each statement. Encourage participants to reflect on their immediate responses to each statement and to be honest with themselves. Tell the group that they will not be asked to share their responses with anyone.
4. Encourage participants to explore their unconscious or implicit attitudes and values—i.e., those that have been learned over a lifetime and that may be seen through more subtle behaviours or thoughts. Although implicit attitudes and values happen without conscious awareness, they can lead to everyday behaviours that perpetuate stigma.
5. Remind participants that it is important to understand their less “socially acceptable” responses. Often when surprised or acting out of instinct, we reveal our implicit attitudes, values and beliefs to clients. This activity offers a safe way to explore these implicit attitudes and values so that, as professionals, we are prepared in a real-life setting.
6. After allowing participants enough time to reflect on their responses independently, bring the group together to debrief. Ask participants the following questions:
 - How did you feel when responding to the statements?
 - Were you surprised by any of your initial responses to the statements?
 - Did your body have an immediate reaction to any of the statements?
 - Overall, did your responses vary across the different STBBI categories?

SLIDE 18: ASSUMPTIONS

OBJECTIVE: To consider the impact of stigma through a short reflective activity.

MATERIALS: Participant workbook (page 9)

Assumptions

What are some common assumptions or beliefs we may have about individuals accessing our services?

How might these assumptions or beliefs impact our engagement with clients?

What is the impact of these beliefs on service delivery?



STEPS/DISCUSSION POINTS:

1. Give participants a minute to think about the questions on the slide. Refer participants to page 9 in their workbooks if they would like to take notes.
2. Bring the group together to discuss.

DISCUSSION POINTS

- When debriefing, refer to the [Factors impacting vulnerability \(FIV\) to HIV and other STBBIs](#), which lists key factors, in addition to the social determinants of health, which may affect a person's vulnerability to STBBIs. Understanding these factors can help service providers ensure their conversations with clients are inclusive and span individual, community and systemic elements (e.g., a client's self-esteem and understanding of health, transience due to economic migration or on/off reserve migration, language barriers, sexual health messaging, geographic distribution of services, oppression, etc.).
- When we have assumptions about clients, we fail to truly see them and, in turn, may not learn about their unique lived experiences. Provider's assumptions about who is at risk can limit opportunities for honest and authentic conversations about prevention and harm reduction practices. Stigma related to sex, sexuality and substance use can derail conversations between professionals and clients, and adversely affect STBBI prevention, testing and treatment efforts.
- Assumptions about who is most at risk for STBBIs can mean that those who need prevention or testing information – despite being outside the 'at-risk' groups – do not receive it.



SLIDE 19: ASSUMPTIONS TO AVOID

OBJECTIVE: To consider one's own assumptions and beliefs.

MATERIALS: n/a

Assumptions to avoid



All people are heterosexual/cisgender.

All people are embarrassed to talk about their sexuality or substance use.

All people are sexually active or not sexually active.

All sexual activity is consensual.

All people have the same worldview about sexuality and substance use.

All people have the same level of knowledge about sexuality and substance use.

STEPS/DISCUSSION POINTS:

1. Give participants a minute to read the slide.
2. Ask if anyone would like to share an immediate reaction to the assumptions on the slide.
3. Ask how these assumptions could influence their practice. For example, if you assume all sex is consensual, how would that change your discussions about sexual health or STBIs with clients.
4. Mention the social construction of sexuality and substance use that was discussed during the first half of the workshop, emphasizing society's focus on fear-based messaging, heterosexism, gender scripts, shame and sex negativity. Assumptions are often rooted in the cultural construction of sexuality and substance use.

DISCUSSION POINTS

- Who has permission to be sexual? Typically, participants will talk about the media and its sexual images; namely young, able-bodied, heterosexual people.
 - Who is missing from this? The large majority of people.
- How does the media influence our ideas about sexuality? Some may discuss how the mainstream media hyper-sexualizes some groups (e.g., women, youth, men who have sex with men), which can affect how we provide services to those we think fit in those groups. Some may feel less comfortable or skilful when talking about sexuality with people they presume are asexual (e.g., people with developmental disabilities, older adults in care facilities).
- What are some assumptions about substance use and the people who use substances? Some may mention negative media messaging about people who use substances, or that some substances are deemed more socially acceptable. Media portrayals often reinforce stereotypes about who uses substances, which can shape our implicit attitudes, values and beliefs if we fail to consume media with a critical lens.

SLIDE 20: DIFFICULT QUESTIONS OR SCENARIOS

OBJECTIVE: To practice responding to questions or scenarios in a safe environment.

MATERIALS: n/a

What are some difficult questions that you have been asked? Or scenarios that you have dealt with?



Why do people ask questions?

STEPS/DISCUSSION POINTS:

1. Hand out post-it notes or small pieces of paper to participants.
2. Ask participants to write down challenging questions or scenarios that have come up in their practice related to substance use, stigma, sexuality or STBBIs. Encourage participants to think about any questions from clients related to STBBIs, substance use and/or sexuality that they struggled to answer, or to consider a challenging scenario they have encountered. For example, it could be a client repeatedly saying that they feel contracting an STBBI is inevitable, so they are not interested in testing or using barrier methods. Give participants a few minutes to write their questions or scenarios on the post-it notes or small pieces of paper. Be prepared to modify the scenarios so you can use the formula found on slide 18. It is helpful to reframe scenarios into a question format.
3. Collect the questions/scenarios from participants, which will be used to practice the model found on the next slide.
4. **NOTE:** If the group is very vocal, you can simply ask participants to share their scenarios aloud as you write down the questions/scenarios on a flipchart or whiteboard. If they are reluctant to share their own experiences, use the *Sample challenging scenarios/questions* (see Appendix D). Alternatively, you could send out a request for participants to email questions and/or scenarios in advance of the workshop. This gives you more time to consider answers and prepare for the activity on slide 26.
5. Ask the group, "Why do our clients ask questions?"

DISCUSSION POINTS

"Why do people ask questions?"

- To see if they are normal
- To test if the service provider is a safe person
- To gauge the service provider's values and beliefs
- To get more information
- To make an informed decision
- Possibly to shock the person (though this is rare)

6. As service providers, we never know why an individual asks questions and so all questions must be answered in an open and balanced way. We can stigmatize someone if our responses are not supportive or positive, or if we impose negative values and beliefs even when not intending to do so.

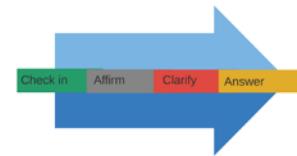
SLIDE 21: FOUR-STEP PRACTICE TOOL

OBJECTIVE: To introduce a practical tool for responding to clients' questions and experiences in a safe and inclusive way, helping clients to feel respected and supported.

MATERIALS: Participant workbook (page 10); scenarios/questions generated by the group or the *Sample challenging scenarios/questions* (see Appendix D).

Four-step practice tool

Responding to difficult scenarios or questions



STEPS/DISCUSSION POINTS:

1. Direct participants to page 10 in their workbook.
2. Tell participants this is a four-part practice model for answering difficult questions from clients. Practicing this model helps providers respond in a neutral, affirming and non-stigmatizing manner.
3. Depending on the nature of the question, you may not need to employ each step of the four-part model.

STEPS

1. **Check-in:** What are your personal values? What are your assumptions? What is your body language communicating?
2. **Affirm:** Let the client know that it is okay to ask you, or that their question is a common one. This helps you validate the client's experience.
3. **Clarify:** Check-in with the client to clarify what they are asking. Do you know exactly what it is they want to know and what they already know?
4. **Answer:** Provide the facts, and refrain from imparting your own feelings and values.

Ensure your body language, facial expressions and tone of voice reflect safety and inclusivity.

SLIDE 22: FOUR-STEP PRACTICE TOOL

OBJECTIVE: To review the first step of the model, which focuses on personal reflection.

MATERIALS: Participant workbook (page 10)

Check-in



- What are your initial reactions to the question or situation?
- What is your body language communicating?
- What are your beliefs and/or values about this situation or question?
- Is your initial reaction related to unconsciously learned beliefs or values (e.g., about certain groups of people, about certain sexual or substance use behaviours)?
- What are your professional responsibilities to the client?

STEPS/DISCUSSION POINTS:

1. Explain that during the check-in phase, service providers should pause and consider their initial reactions, values and assumptions. Have them consider their body language and what it may communicate (perhaps unintentionally) to the client.
2. Tell participants that if they feel a conflict between their personal values and what the client is expressing, they should consider their ethical code of practice. Modify this discussion as needed; for example, if the participants are nurses or social workers, go into more detail about their ethical code and how it aligns with the provision of safer, more inclusive services.
3. Tell participants that the check-in step should be quick and completed within seconds. This step will become simpler and more instinctual with time.

SLIDE 23: FOUR-STEP PRACTICE TOOL

OBJECTIVE: To review the second step of the model, which focuses on affirming the client, acknowledging their experiences and validating their questions and concerns.

MATERIALS: Participant workbook (page 10)

Affirm



- Let the person know that you are glad that they came to talk to you.
- Let them know that their question/scenario is normal.
- Normalize any thoughts/concerns that they may have about their question/the scenario.

STEPS/DISCUSSION POINTS:

1. The affirm step signals to the client that you are an open, welcoming and safe person. Tell participants that during this step, it is imperative that service providers are aware of their body language and what it may be communicating to the client.

2. Initial reactions to a client scenario or question can leave a lasting impression, which can either build rapport or create mistrust among clients and providers. Our role as professionals is to mitigate mistrust and fear by providing a welcoming and open space for discussion.

EXAMPLES OF AFFIRMING RESPONSES

"Thanks for asking me about that. That is certainly something we can talk about."

"That's a great question; lots of people wonder about that."

"That sounds tough; you must be dealing with a lot. I'm glad you came in."

SLIDE 24: FOUR-STEP PRACTICE TOOL

OBJECTIVE: To introduce the third step of the model, which focuses on understanding the client's needs.

MATERIALS: Participant workbook (page 10)

Clarify



- Ask the individual what they need (e.g., what they already know, what they would like to know, if they would like access to specific services).
- Ensure that you understand the scenario or question correctly.
- Clarify the language they are using and be sure to use inclusive language in your discussion.

STEPS/DISCUSSION POINTS:

1. This is a key step in the process. Tell participants that during this step, they may need to respond to the client's question with another question to clarify exactly what it is the client needs.
2. Providers need to check-in with the client to determine what the client already knows and exactly what they want to know – a key step in building an open relationship. Asking them what they know demonstrates that you want to listen and communicates to them that you recognize they are the experts in their own lives. The clarify step also helps the provider understand the question and not make assumptions based on beliefs or values. Note, however, that not all questions or scenarios require the clarification step. If a person is asking a clear and direct question, it is best to skip the clarify step.

EXAMPLES OF CLARIFYING RESPONSES

- "It sounds like you're dealing with this situation ____ and may need ____ resources."
- "It seems like you're worried about ____."
- "Tell me what you know about ____."

Refrain from asking value-laden questions like, "Why do you need to know that?"

SLIDE 25: FOUR-STEP PRACTICE TOOL

OBJECTIVE: To introduce the fourth step in the model, which focuses on the importance of a fact-based response and the need to consider how personal values can be expressed when sharing information with clients.

MATERIALS: Participant workbook (page 10)

Answer

- Provide the facts.
- Be aware of your values and ensure that they are not present in your answer.
- Check-in with the individual to see if they have further questions or need more information/access to specialized services.
- Provide a meaningful and safe referral, if necessary.
- Be aware of nonverbal body language.



STEPS/DISCUSSION POINTS:

1. Tell participants that responses to clients' questions should be concise, clear, easy to understand, and free of personal values and beliefs.
2. Reflecting on one's attitudes, values and beliefs should be routine for providers so that they are able to give unbiased, non-judgmental information and support to clients. A key element of STBBI prevention is recognizing the unique needs of the individual and offering accurate and non-judgmental information.¹⁸

Here is an example of an inappropriately value-laden answer. A client who is using substances tells you that they are pregnant, and you respond as follows: "I'm happy you told me about your pregnancy. It sounds like you're asking me about your options. There are a few options but since you're using, you may want to first consider the impact of that on the fetus." The error here is that the provider didn't clarify what the client wanted to talk about. Then, the provider made a link between substance use and pregnancy in a way that the client could interpret as judgmental and directive.

3. Stress that service providers should not give advice beyond their role or scope of practice. They can refer the client on if they (or their colleagues) cannot meet the individual's needs. However, it is imperative that referrals are made to service settings that will not stigmatize the client. Providers can identify safe referrals by visiting the service, by accompanying the client for the first visit, or by contacting the service to ask about their understanding/training around sexuality, STBBIs or substance use. Work with your client to understand their experiences with other services or organizations in the community. Note: If you are giving this workshop in a community with no resources readily available, then tell participants about online resources (e.g., www.sexualityandu.ca; www.catie.ca). Some providers may need to advocate for additional local services, or network with nearby communities to identify the supports available in other locations.

18 Canadian Public Health Association. *Core competencies for STBBI prevention*. Ottawa, Ontario: Canadian Public Health Association, 2014. Available at: https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/CPHA_EN.pdf (Accessed May 6, 2014).

SLIDE 26: PRACTICE SCENARIOS

OBJECTIVE: To practice using the four-part model with peers.

MATERIALS: Scenarios/questions generated by the group, or the *Sample challenging scenarios/questions* (see Appendix D)

Practice!



STEPS/DISCUSSION POINTS:

1. Select a question/scenario generated by the group (slide 20) or one of the sample scenarios/questions found in Appendix D. Note that the sample challenging scenarios/questions found in Appendix D include notes to help guide your facilitation of this activity.
2. Write the selected question/scenario on a white board or flipchart and read it aloud to accommodate different learning styles.
3. Work through each step of the four-part practice model for the selected scenario/question. See the example below.

SAMPLE SCENARIO

A person is talking to you after having had a baby. They want to know when they can have sex again.

Check-in: What is my body feeling? What are my personal values? Do I feel comfortable talking about sex? What is my professional obligation to this person?

I know this person needs this information, so I will help now and make sure I refer them to appropriate services.

Affirm: "That's a great question; a lot of people wonder about that."

Clarify: "It sounds like you're asking about when a person is ready to have sex again after giving birth."

Answer: "This really depends on you and your body. It's important to be sexual again only when you feel comfortable, ready and when you want to. How do you feel about that?"

Or, you can say: "It's a personal choice, and you should only have sex once you feel ready and comfortable. Everyone is different; there is no magic number or specific timeframe for when people start feeling sexual again. Is there something specific going on and that's why you're wondering?" This last question gives the person an opening to identify any unique needs (e.g., they want to have sex, but feel ashamed; their partner wants to be sexual but they are not ready).

4. Tell participants to break into groups of two or three to practice using the four-part model. In groups of two, one person will be the service provider and the other will play the client role. In groups of three, the third person will observe and take note of what worked well. Refer participants to the model found in their workbooks on page 10 for reference.
5. Select another question/scenario from the group-generated list (slide 20) or from the sample challenging scenarios/questions in Appendix D. Once again, write it on a white board or flipchart and read it aloud.
6. Give groups roughly 5 minutes to work through each scenario/question. Although they may be tempted to answer without using the model, encourage them to try all of the steps. Acknowledge that using the model may feel uncomfortable at first, but that it will be very helpful if practiced. If individuals report that elements of the model feel uncomfortable, have them consider why it felt more challenging and what they can do to become more comfortable with all steps.
7. Bring the group together to discuss each step of the practice model. Ask participants to share how it felt using the model and how the model might apply in a real practice setting.
8. Time permitting, select two or three additional questions/scenarios and continue to practice using the model. Encourage participants to take turns playing the role of service provider, client and observer (if applicable).



MODULE 4: STRATEGIES TO REDUCE ORGANIZATIONAL STIGMA AND CREATE MORE INCLUSIVE AND SAFER SERVICES

SLIDE 27: CREATING SAFER SPACES

OBJECTIVE: To consider what to do within one's current role and within one's organization to create safer and more inclusive spaces for all clients.

MATERIALS: Participant workbook (page 11), *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBIs) and stigma* (listed as a supplementary resource in Appendix H)

What can we do?



How do we create safer and more inclusive spaces?

STEPS/DISCUSSION POINTS:

1. Tell participants about the importance of reflecting on organizational factors – such as culture, policies and practices – that can create or reduce stigma for clients. Refer to CPHA's *Core competencies for STBBI prevention*, which identify “awareness of the impact that organizational policies and practices have on access to STBBI prevention services” as a core competency.
2. Describe the development of CPHA's 2013 *Core competencies for STBBI prevention*. For the project, CPHA conducted 17 focus groups in six communities; focus group participants reflected on past interactions with service providers and considered what factors impact overall health and access to health services. They noted several barriers to services, many of which operate at the organizational level, including lack of physical space for confidentiality and privacy, body language that portrays judgment, lack of service providers with diverse lived experiences, dismissive attitudes, shame or fear-based approaches to STBBI prevention efforts, and no visual cues to indicate safety and inclusivity.
3. Discuss some of the organizational factors that contribute to, or alternatively, reduce stigma. Focus on what clients see, hear and feel when they access services.
4. Remind participants that culture, policies and practices of organizations affect clients and co-workers alike. Creating safer spaces will not only improve outcomes for those accessing services, but will also create a more respectful environment for staff as well.

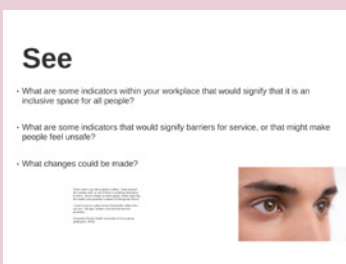
DISCUSSION POINTS

- Stigma manifests in many ways and at many levels. Remind participants that given the prevalence of stigma within society, all organizations should assess their culture, policies and practices on an ongoing basis.
- Encourage participants to focus on the concrete changes that can be made within their organizations to create safer and more inclusive spaces, rather than discussing the structural and systemic barriers to change.
- As a service provider, it can be very challenging to work within organizational structures that, often inadvertently, perpetuate stigma. Participation in this workshop can serve as a catalyst for change. For example, encourage participants to share the workshop resources with their colleagues or to bring the *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBIs) and stigma* to management.
- Remind participants that to ensure a safe learning environment, they should refrain from criticizing or naming specific organizations in the community.
- Finally, encourage participants to reflect on the things that their organization is doing well in addition to those things that require improvement. Ask participants to share these promising practices with the group.

SLIDES 28 AND 29: SEE

OBJECTIVE: To discuss the physical space of an organization with respect to a safe and inviting environment.

MATERIALS: Participant workbook (page 12)



STEPS/DISCUSSION POINTS:

1. Direct participants to page 12 in their workbook.
2. Use the discussion points below to brainstorm potential areas for change when clients access services.

DISCUSSION POINTS

The physical space of an organization is often the first indicator of whether or not the services are truly safe and inclusive spaces for clients. Pose the following questions to elicit discussion:

- When people walk in for services, what is their first impression? Is someone there to greet them?
- What images are on the walls? Would clients see themselves reflected in these images? Are any staff working that they could identify with?
- Do the health promotion campaigns focus on specific populations who are seen as most 'at-risk'? How would individuals who identify with those groups feel? Are they depicted in positive ways? What about the impact on those who do not identify with the groups seen as most 'at-risk'?
- Are staff smiling? Are staff aware of their body language?
- Are client/patient rights posted so that clients can see them?
- Is there space for private discussion?

Share the responses below from the focus groups conducted by CPHA in 2012 as part of the development of the [*Core competencies for STBBI prevention*](#).

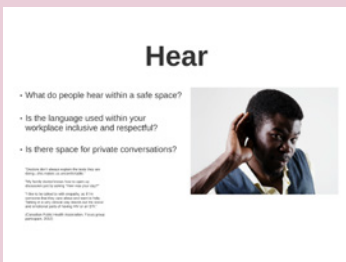
- "Even when I go to a doctor's office, I look around the waiting room to see if there's anything Aboriginal in there — even a blade of sweet grass. Some sign that the health care provider is aware of Aboriginal culture."
- "I want to go to a place where the people reflect who you are. Like gay, lesbian and bisexual service providers."



SLIDES 30 AND 31: HEAR

OBJECTIVE: To acknowledge the importance of inclusive language.

MATERIALS: Participant workbook (page 13)



"Doctors don't always explain the tests they are doing—this makes us uncomfortable."

"My family doctor knows how to open up discussion just by asking 'How was your day?'"

"I like to be talked to with empathy, as if I'm someone that they care about and want to help. Talking in a very clinical way leaves out the social and emotional parts of having HIV or an STI."

(Canadian Public Health Association, Focus group participant, 2012)

STEPS/DISCUSSION POINTS:

1. Direct participants to page 13 in their workbook.
2. Use the discussion points below to brainstorm potential areas for change related to what service users hear when they access services.

DISCUSSION POINTS

Point out that the language of service providers, administrators, forms and policies can help create safe spaces. Language sends a strong message to clients about organizational attitudes and beliefs around sexual and gender diversity, sexuality, culture, substance use, harm reduction, etc. Pose the following questions to elicit discussion:

- What questions appear on your forms about gender identity? Which pronouns are listed on your forms?
- When discussing STBBI transmission, do you ask questions that could be seen as stigmatizing, such as participation in "risky behaviours"? Is routine STBBI testing offered to everyone?
- Are the people accessing your services consistently asked about the pronouns/names they use?
- Are questions about relationships inclusive? For example, asking about partners, spouse or parents as opposed to husband, wife, mother or father?
- Do staff respect clients' right to privacy and confidentiality (e.g., do they not speak about clients with their colleagues unless required for care)? Is respectful language used when talking about your organization's clientele (e.g., "a person who uses substances" rather than a "junkie" or "addict")?

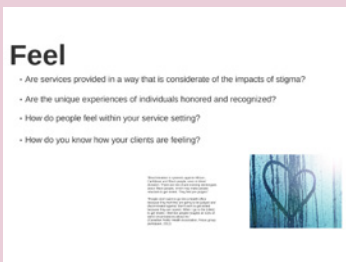
Share the responses below from the focus groups conducted by CPHA in 2012 as part of the development of the [*Core competencies for STBBI prevention*](#).

- “Doctors don’t always explain the test they’re doing — this makes us uncomfortable.”
- “My family doctor knows how to open up discussion just by asking, ‘How was your day?’”
- “I like to be talked to with empathy, as if I’m someone that they care about and want to help. Talking in a very clinical way leaves out the social and emotional parts of having HIV or an STI.”

SLIDES 32 AND 33: FEEL

OBJECTIVE: To better understand a client’s feelings when accessing services.

MATERIALS: Participant workbook (page 14)



“Discrimination is systemic against African, Caribbean and Black people, even in blood donation. There are lots of pre-existing stereotypes about Black people, which may make people reluctant to get tested. They feel pre-judged.”

“People don’t want to go into a health office because they feel they are going to be judged and discriminated against. Don’t want to get tested because they are scared. When I go to the [clinic] to get tested, I feel like people imagine all sorts of weird circumstances about me.”
(Canadian Public Health Association, Focus group participant, 2012)

STEPS/DISCUSSION POINTS:

1. Direct participants to page 14 in the workbook.
2. Use the discussion points below to brainstorm areas for change related to what clients feel when they access services through organizations.

DISCUSSION POINTS

Creating a safe space means fostering a feeling among clients that their personal experiences, beliefs and identities are heard, acknowledged and respected. Central to accomplishing this is providing a mechanism for clients to express concerns and share thoughts on service delivery and improvement. Pose the questions below to elicit discussion:

- Does your organization have an advisory board that includes clients?
- Does your organization have feedback forms? If so, do you follow up with clients who provide feedback?

- Are staff trained on culturally safe practices?
- Does your organization provide training that includes reflection exercises about personal and organizational attitudes, values and beliefs about substance use and sexuality?

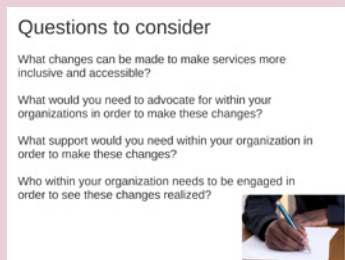
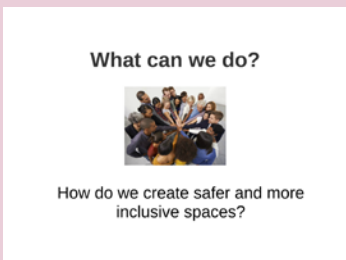
Share the responses below from the focus groups conducted by CPHA in 2012 as part of the development of the *Core competencies for STBBI prevention*.

- “Discrimination is systemic against African, Caribbean and Black people, even in blood donation. There are lots of pre-existing stereotypes about black people, which may make people reluctant to get tested. They feel pre-judged”.
- “People don’t want to go into a health office because they feel they’re going to be judged and discriminated against, and they don’t want to get tested because they’re scared. When I go to the clinic to get tested, I feel like people imagine all sorts of weird circumstances about me.”

SLIDES 34 AND 35: WHAT CAN WE DO?

OBJECTIVE: To consider what each participant can do within their personal practice and organization to create safer and more inclusive spaces for all clients accessing services.

MATERIALS: Participant workbook (page 11)



STEPS/DISCUSSION POINTS:

1. Have participants break into small groups to brainstorm ideas for change within their own organizations. Encourage those from the same organization to come together, or have participants choose groups based on comfort level or previous experience.
Note: If time is short, instead of forming small groups, simply facilitate this activity as a large group discussion.
2. Briefly review the concepts of what clients “see, hear and feel” when they access services and suggest these as a good context for brainstorming ideas for change.

3. Give the groups 5-10 minutes to consider these questions (found on slide 35):
 - a. What changes can be made to make services more inclusive and accessible?
 - b. What do you need to advocate for within your organizations to make these changes?
 - c. What support do you need within your organizations to make these changes?
 - d. Who within your organization should be engaged for these changes to be realized?
4. Tell participants to refer to page 11 in their workbook to document their ideas.
5. Move around the room to answer questions and help brainstorm ideas.
6. Once the groups have their responses, conduct a large group debrief.

DISCUSSION POINTS

Examples for “See”:

- Posters promoting diversity
- Welcoming atmosphere
- Diverse staff base reflecting the community they serve
- Information and posters about harm reduction
- Grievance policy that refers clients to someone if they feel stigmatized
- Confidentiality policy that protects information from being shared and describes potential limits to confidentiality
- Accessible space for people with disabilities and other access issues

Examples for “Hear”:

- Gender-neutral and inclusive language
- Language that does not dehumanize or stigmatize clients
- Language that promotes and normalizes open conversations about STBBIs, sexuality and harm reduction
- Intake forms that are open to multiple definitions of family and relationships

Examples for “Feel”:

- Health and social service providers understand the unique needs of all clients
- Policies and practices that acknowledge that clients are experts in their own lives
- Staff are trained and sensitized to the factors that influence STBBI vulnerability
- Specific outreach strategies are in place to attract diverse populations
- Clients report that their needs are being met
- To reflect community needs, staff consult with community members and groups when creating programs
- Anti-discrimination policies are visible, implemented and enforced

SLIDE 36: ORGANIZATIONAL ASSESSMENT TOOL FOR STBBIS AND STIGMA

OBJECTIVE: To provide a tool for addressing stigma in the workplace.

MATERIALS: Participant workbook (page 15), [Organizational assessment tool for sexually transmitted and blood-borne infections \(STBBIs\) and stigma](#) (listed as a supplementary resource in Appendix H)

Organizational assessment tool for sexually transmitted and blood-borne infections and stigma

The purpose of the Organizational assessment tool for STBBIs and stigma is to help health and social service organizations create settings where all service users feel welcomed and supported in seeking care, and where staff and volunteers are supported in providing care in a safe and respectful environment.

The tool identifies the policy, environmental and cultural factors that contribute to stigma and discrimination, and which can affect individuals' access to and use of available services.

It offers organizations an opportunity to assess their strengths and challenges in providing safe and respectful care and facilitates the development of a targeted improvement plan.

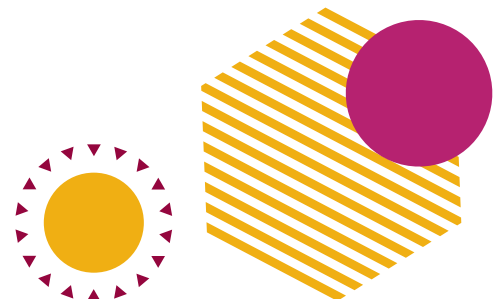
STEPS/DISCUSSION POINTS:

1. Tell participants that the purpose of the *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBIs) and stigma* is to help health and social service organizations create safer and more inclusive settings where all clients feel welcomed and supported in seeking care, and where staff and volunteers are supported in providing care.
 - a. The tool identifies the policy, environmental and cultural factors that contribute to stigma and discrimination, and affect individuals' access to and use of prevention and treatment services.

DISCUSSION POINTS

The *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBIs) and stigma* will help organizations to:

- increase staff awareness of organizational factors (e.g., policies, procedures, culture and environment) that could create stigmatizing or discriminatory experiences for clients;
- help staff identify the strengths and issues in their own organizations related to stigma and discrimination; and
- help staff develop organizational strategies to decrease stigma and discrimination and create a safe and supportive environment.



MODULE 5: CLOSING

SLIDE 37: CLOSING AND QUESTIONNAIRE

OBJECTIVE: To close the session and share final thoughts, comments or questions.

MATERIALS: *Post-workshop questionnaire* (see Appendix E)

Thank you for your participation!

Questions or comments?

Please complete the evaluation questionnaire. Your confidential feedback is very important to us.



STEPS/DISCUSSION POINTS:

1. End the workshop on a positive note. Make sure to thank the participants for all of their comments and feedback, and share what you have learned from the group. Time permitting, ask participants to share a “take-home” lesson from the workshop (i.e., something they intend to change within their practice or organization, something they intend to share with colleagues or other organizations in the community).
2. Remind participants of additional resources, such as the [*Organizational assessment tool for sexually transmitted and blood-borne infections \(STBBIs\) and stigma*](#), the [*Discussing sexual health, substance use and STBBIs: A guide for service providers*](#), the [*Core competencies for STBBI prevention*](#) and the [*Factors that impact vulnerability to HIV and other STBBIs*](#) (see Appendix H for list of supplementary resources).
3. In some communities, this workshop may stimulate future collective action among participants from different organizations. If the group is inspired to continue working together to implement strategies covered in the workshop, make plans at this point for future actions and next steps. Time permitting, provide participants with several minutes to connect with others in the room with whom they would like to partner.
4. Finally, ensure all participants complete the post-workshop questionnaire. Remind them that their feedback is anonymous, confidential and important.

REFERENCES

- Balfe M, Brugha R, O'Donovan D, O'Connell E, Vaughn D. Young women's decisions to accept chlamydia screening: Influences of stigma and doctor-patient interactions. *BMC Public Health* 2010;10(425).
- Baral S, Logie CH, Grosso A, Wirtz AL, Beyrer C. Modified social ecological model: A tool to guide the assessment of the risks and risk contexts of HIV epidemics. *BMC Public Health* 2013;13(482).
- Canadian Public Health Association. *Improving STBBI prevention and reducing associated stigma and discrimination: Analysis of environmental scan and key informant interview findings (unpublished internal document)*. Ottawa: Canadian Public Health Association, 2014.
- Canadian Public Health Association. *Core competencies for STBBI prevention*. Ottawa, Ontario: Canadian Public Health Association, 2014. Available at: https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/CPHA_EN.pdf (Accessed May 6, 2014).
- Canadian Public Health Association. *Factors impacting vulnerability to HIV and other STBBIs*. Ottawa, Ontario: Canadian Public Health Association, 2014. Available at: https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/EIV_EN.pdf (Accessed May 6, 2014).
- Corrigan PW, Markowitz FE, Watson AC. Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin* 2004;30(3):481-491.
- Daley B. *Aligning health promotion and adult education for healthier communities*. In Merriam S, Courteney B, Cervero R (Eds.). *Global issues and adult education: Perspectives from Latin America, Southern Africa, and the United States*. San Francisco: Jossey-Bass, 2006.
- Dyke E. *Scan on talking about sexuality/substance use and taking a sexual health and substance use history (unpublished internal document)*. Ottawa: Canadian Public Health Association, 2014.
- Elias JL, Merriam SB. *Philosophical foundations of adult education* (3rd ed.). Huntington, N.Y.: R.E. Krieger Pub, 2004.
- Ford JV, Barnes R, Rompalo A, Hook E. Sexual health training and education in the U.S. *Public Health Reports* 2013;128(Suppl 1):96-101.
- Fortenberry JD, Mcfarlane M, Bleakley A, Bull S, Fishbein M, Grimley DM, et al. Relationships of stigma and shame to gonorrhea and HIV screening. *Am J Public Health* 2002;92(3):378-381.
- Gagnon M. *Rethinking HIV-related stigma in health care settings: A research brief*. Ottawa, Ontario, 2014. Available at: http://www.cocqsida.com/assets/files/Research-Brief_RethinkingHIV-17juillet2014.pdf (Accessed January 15, 2015).
- Goldenberg SM, Krüsi A, Zhang E, Chettiar J, Shannon K. Structural determinants of health among im/migrants in the indoor sex industry: Experiences of workers and managers/owners in metropolitan Vancouver. *PLoS One* 2017;12(1):e0170642.

Hughes J, Mighty J. *Taking stock: Research on teaching and learning in higher education*. Kingston, Ontario: School of Policy Studies, Queen's University, McGill-Queen's University Press, 2010.

Johnson-Bailey J. *Adult education for community empowerment: Toward the possibility of another world*. In Merriam S, Courteney B, Cervero R (Eds.). *Global issues and adult education: Perspectives from Latin America, Southern Africa, and the United States*. San Francisco: Jossey-Bass, 2006.

Joint United Nations Programme on HIV/AIDS (UNAIDS). *UNAIDS terminology guidelines*. Geneva, Switzerland: Joint United Nations Program on HIV/AIDS, 2015. Available at http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf (Accessed January 7, 2015).

Joint United Nations Programme on HIV/AIDS (UNAIDS). *Fact Sheet: Stigma and discrimination*. Geneva, Switzerland: Joint United Nations Program on HIV/AIDS, 2003. Available at: http://data.unaids.org/publications/Fact-Sheets03/fs_stigma_discrimination_en.pdf (Accessed January 7, 2015).

Kitchenham A. The evolution of John Mezirow's transformative learning theory. *Journal of Transformative Education* 2008;6(2):104-123.

Kinsler JJ, Wong MD, Sayles JN, Davis C, Cunningham WE. The effect of perceived stigma from a health care provider on access to care among a low-income HIV-positive population. *AIDS Patient Care STDs* 2007;21(8):584-92.

Lazarus L, Deering KN, Nabess R, Gibson K, Tyndall MW, Shannon K. Occupational stigma as a primary barrier to health care for street-based sex workers in Canada. *Cult Health Sex* 2012; 14(2):139-150.

Link BG, Phelan JC. Conceptualizing stigma. *Annu Rev Sociol* 2001; 27:363-385.

Logie CH, James L, Tharao W, Loutfy MR. HIV, gender, race, sexual orientation, and sex work: A qualitative study of intersectional stigma experienced by HIV-positive women in Ontario, Canada. *PloS Med* 2011; 8(11): e1001124.

Logie CH, James L, Tharao W, Loutfy MR. "We don't exist": A qualitative study of marginalization experienced by HIV-positive lesbian, bisexual, queer and transgender women in Toronto, Canada. *J Int AIDS Soc* 2012;15(2).

Loutfy MR, Logie CH, Zhang Y, Blitz SL, Margolese SL, Tharao WE, et al. Gender and ethnicity differences in HIV-related stigma experienced by people living with HIV in Ontario, Canada. *PLoS ONE* 2012;7(12):e48168.

MacKeracher D. *Making sense of adult learning* (2nd ed.). Toronto, Ontario: University of Toronto Press, 2004.

Mahajan AP, Sayles JN, Patel VA, Remien RH, Ortiz D, Szekeres G, et al. Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward. *AIDS* 2008;22(Suppl 2):S67-S79.

Mezirow J. Transformative learning: Theory to practice. *New Directions for Adult Continuing Education* 1997;74:5-12.

Mill J, Edwards N, Jackson R, Austin W, MacLean L, Reintjes F. Accessing health services while living with HIV: Intersections of stigma. *Canadian Journal of Nursing Research* 2009;41(3):168-185.

Morris A, Faulk D. Perspective transformation: Enhancing the development of professionalism in RN-BSN students. *Journal of Nursing Education* 2007;46(10):445-451.

Nemec P. Transformative learning. *Psychiatric Rehabilitation Journal* 2012;35(6):478-479.

Nyblade L, Stangl AL, Weiss E, Ashburn K. Combating HIV stigma in health care settings: What works? *Journal of International AIDS Society* 2009;12(15):1-7.

Patten S. Local site report: *Halifax community consultations on determinants impacting vulnerability to HIV and other STBBIs* (unpublished internal document). Ottawa: Canadian Public Health Association, 2013.

Ports KA, Barnack-Tavlaris JL, Syme ML, Perera RA, Lafata JE. Sexual health discussions with older adult patients during periodic health exams. *The Journal of Sexual Medicine* 2014;11(4):901-908.

Registered Nurses Association of Ontario. *Engaging clients who use substances*. Toronto, Ontario: 2015. Available at: <http://rnao.ca/bpg/guidelines/engaging-clients-who-use-substances> (Accessed August 15, 2016).

Rusch M L, Shoveller JA, Burgess S, Stancer K, Patrick DM, Tyndall MW. Preliminary development of a scale to measure stigma relating to sexually transmitted infections among women in a high risk neighbourhood. *BMC Womens Health* 2008;8(21).

Sengupta S, Banks B, Jonas D, Miles MS, Smith GC. HIV Interventions to reduce HIV/AIDS stigma: A systematic review. *AIDS Behav* 2011;15(6):1075-1087.

Stangl A, Brady L, Fritz K. *Measuring HIV stigma and discrimination*. Strive, 2012. Available at: http://strive.lshtm.ac.uk/sites/strive.lshtm.ac.uk/files/STRIVE_stigma%20brief-A3.pdf (Accessed January 7, 2015).

Stangl AL, Lloyd JK, Brady LM, Holland CE, Baral S. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? *AIDS Society* 2013;16(Suppl 2):18734.

Trauma-informed practice project team. *Trauma-informed practice guide*. British Columbia Provincial Mental Health and Substance Use Planning Council, 2013. Available at: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf (Accessed September 5, 2015).

Varcoe CM, Wathen, CN, Ford-Gilboe, M, Smye, V, Browne, A. *VEGA briefing note on trauma- and violence-informed care*. VEGA Project and PreVAiL Research Network, 2016. Available at: <http://projectvega.ca/wp-content/uploads/2016/10/VEGA-TVIC-Briefing-Note-2016.pdf> (Accessed November 4, 2016).

Waldo C, McFarland W, Katz M, MacKellar D, Valleroy L. Very young gay and bisexual men are at risk for HIV infection: the San Francisco Bay Area Young Men's Survey II. *Journal of Acquired Immune Deficiency Syndromes* 2000;24(2):168-174.

Wagner A, Hart T, McShane K, Margolese S, Girard T. Health care provider attitudes and beliefs about people living with HIV: Initial validation of the health care provider HIV/AIDS stigma scale (HPASS). *Journal of AIDS and Behaviour* 2014;18(12):2397-408.

APPENDIX A: SAMPLE WORKSHOP AGENDAS

The workshop content can be delivered in various timeframes: over 5 hours, 3 hours or 90 minutes. Identify the best format for your group based on size, learning needs, and resource and time constraints and prepare accordingly based on the sample agendas found below.

5-HOUR SESSION

Note that the 5-hour sample agenda includes two 10-minute refreshment breaks as well as one 60-minute lunch break.

| Module/slide title | Timeframe |
|---|--------------------------------------|
| Module 1: Introductions | 34 minutes (excluding breaks) |
| Slide 1: Welcome and questionnaire | 5 minutes |
| Slide 2: Background | 2 minutes |
| Slide 3: Learning objectives | 2 minutes |
| Slide 4: Learners' rights | 10 minutes |
| Slides 5-8: Key terms | 15 minutes |
| Module 2: Exploring stigma and factors that contribute to stigma | 79 minutes (excluding breaks) |
| Slide 9: Activity - What did you do on the weekend? | 15 minutes |
| Slide 10: Activity - Early messages about sexuality and substance use | 20 minutes |
| Refreshment break | 10 minutes |
| Slide 11: Unpacking stigma | 13 minutes |

| Module/slide title | Timeframe |
|--|--------------------------------------|
| Slide 12: Stigma defined | 6 minutes |
| Slide 13: Activity-Stigma case scenario | 25 minutes |
| Lunch break | 60 minutes |
| Module 3: Strategies to reduce stigma and discuss sexual health, substance use and STBIs | 63 minutes (excluding breaks) |
| Slide 14: What do clients think? | 2 minutes |
| Slide 15: What can you do? | 2 minutes |
| Slide 16: Importance of privacy and confidentiality | 4 minutes |
| Slide 17: Activity - Values clarification | 15 minutes |
| Slides 18-19: Assumptions and assumptions to avoid | 5 minutes |
| Slide 20: Difficult questions or scenarios | 5 minutes |
| Slides 21-25: Four-step practice tool | 10 minutes |
| Slide 26: Practice scenarios | 20 minutes |
| Refreshment break | 10 minutes |
| Module 4: Strategies to reduce organizational stigma and create more inclusive and safer services | 39 minutes (excluding breaks) |
| Slide 27: Creating safer spaces | 4 minutes |
| Slides 28-29: See | 5 minutes |

| Module/slide title | Timeframe |
|--|---------------------------------------|
| Slides 30-31: Hear | 5 minutes |
| Slides 32-33: Feel | 5 minutes |
| Slides 34-35: What can we do? | 15 minutes |
| Slide 36: Organizational assessment tool for STBBIs and stigma | 5 minutes |
| Module 5: Closing | 5 minutes |
| Slide 37: Closing & questionnaire | 5 minutes |
| Total | 5 hours (including breaks) |

3-HOUR SESSION

Note that the 3-hour sample agenda includes two 10-minute refreshment breaks.

| Module/slide title | Timeframe |
|---|--------------------------------------|
| Module 1: Introductions | 24 minutes (excluding breaks) |
| Slide 1: Welcome and questionnaire | 5 minutes |
| Slide 2: Background | 2 minutes |
| Slide 3: Learning objectives | 2 minutes |
| Slide 4: Learners' rights | 5 minutes |
| Slides 5-8: Key terms | 10 minutes |
| Module 2: Exploring stigma and factors that contribute to stigma | 51 minutes (excluding breaks) |
| Slide 9: Activity - What did you do on the weekend? | 10 minutes |
| Slide 10: Activity - Early messages about sexuality and substance use | 13 minutes |
| Slide 11: Unpacking stigma | 5 minutes |
| Slide 12: Stigma defined | 3 minutes |
| Slide 13: Activity-Stigma case scenario | 20 minutes |
| Refreshment break | 10 minutes |

| Module/slide title | Timeframe |
|--|--------------------------------------|
| Module 3: Strategies to reduce stigma and discuss sexual health, substance use and STBBIs | 55 minutes (excluding breaks) |
| Slide 14: What do clients think? | 1 minute |
| Slide 15: What can you do? | 2 minutes |
| Slide 16: Importance of privacy and confidentiality | 2 minutes |
| Slide 17: Activity - Values clarification | 10 minutes |
| Slides 18-19: Assumptions and assumptions to avoid | 5 minutes |
| Slide 20: Difficult questions or scenarios | 5 minutes |
| Slides 21-25: Four-step practice tool | 10 minutes |
| Slide 26: Practice scenarios | 20 minutes |
| Refreshment break | 10 minutes |
| Module 4: Strategies to reduce organizational stigma and create more inclusive and safer services | 25 minutes (excluding breaks) |
| Slide 27: Creating safer spaces | 2 minutes |
| Slides 28-29: See | 2 minutes |
| Slides 30-31: Hear | 2 minutes |
| Slides 32-33: Feel | 2 minutes |
| Slides 34-35: What can we do? | 15 minutes |

| Module/slide title | Timeframe |
|--|---|
| Slide 36: Organizational assessment tool for STBBIs and stigma | 2 minutes |
| Module 5: Closing | 5 minutes (excluding breaks) |
| Slide 37: Closing & questionnaire | 5 minutes |
| Total | 3 hours (including breaks) |

90-MINUTE SESSION

This short session serves as a basic introduction to STBBI-related stigma. Given time constraints, skip several activities and keep group discussions short. The 90-minute sample agenda does not include any refreshment breaks.

| Module/slide title | Timeframe |
|--|--------------------------------------|
| Module 1: Introductions | 15 minutes (excluding breaks) |
| Slide 1: Welcome and questionnaire | 5 minutes |
| Slide 2: Background | 1 minute |
| Slide 3: Learning objectives | 1 minute |
| Slide 4: Learners' rights | 3 minutes |
| Slides 5-8: Key terms | 5 minutes |
| Module 2: Exploring stigma and factors that contribute to stigma | 28 minutes (excluding breaks) |
| Slide 9: Activity - What did you do on the weekend? | 10 minutes |
| Slide 10: Activity - Early messages about sexuality and substance use | Skip this activity |
| Slide 11: Unpacking stigma | 5 minutes |
| Slide 12: Stigma defined | 3 minutes |
| Slide 13: Activity-Stigma case scenario | 10 minutes |
| NOTE: DO THIS ACTIVITY AS A LARGE GROUP DISCUSSION, RATHER THAN IN SMALLER BREAKOUT GROUPS. | |

| Module/slide title | Timeframe |
|---|---|
| Module 3: Strategies to reduce stigma and discuss sexual health, substance use and STBIs | 27 minutes |
| Slide 14: What do clients think? | 1 minute |
| Slide 15: What can you do? | 1 minute |
| Slide 16: Importance of privacy and confidentiality | 1 minute |
| Slide 17: Activity - Values clarification | Skip this activity |
| Slides 18-19: Assumptions and assumptions to avoid NOTE: SIMPLY READ THROUGH THE ASSUMPTIONS TOGETHER AS A GROUP. | 2 minutes |
| Slide 20: Difficult questions or scenarios | Skip activity. Use sample scenarios/questions in Appendix D |
| Slides 21-25: Four-step practice tool | 10 minutes |
| Slide 26: Scenarios and practice NOTE: YOU WILL LIKELY ONLY HAVE TIME FOR 1 SCENARIO. | 12 minutes |
| Module 4: Strategies to reduce organizational stigma and create more inclusive and safer services | 15 minutes |
| Slide 27: Creating safer spaces | 2 minutes |
| Slides 28-29: See | 2 minutes |
| Slides 30-31: Hear | 2 minutes |

| Module/slide title | Timeframe |
|---|-------------------|
| Slides 32-33: Feel | 2 minutes |
| Slides 34-35: What can we do? NOTE: DO THIS ACTIVITY AS A LARGE GROUP DISCUSSION, RATHER THAN IN SMALLER BREAKOUT GROUPS. | 5 minutes |
| Slide 36: Organizational assessment tool for STBBIs and stigma | 2 minutes |
| Module 5: Closing | 5 minutes |
| Slide 37: Closing & questionnaire | 2 minutes |
| Total | 90 minutes |

APPENDIX B: STIGMA CASE SCENARIO

Read the scenario and look for examples of **perceived stigma**, **internalized stigma**, **enacted stigma**, **layered stigma** and **structural stigma**. Refer to the definitions in your workbook. Once you have identified the different forms of stigma, brainstorm some strategies to address the issues presented in this scenario.

An individual interested in STBBI testing takes the bus to the closest clinic, which is located on the other side of town. When they arrive, they realize the clinic is closed and is only open weekdays from 9 am to 4 pm. They work every day from 9 am to 5 pm and do not have paid leave. Several weeks later, they take a day off and return to the clinic.

On arrival, they begin to feel uneasy about getting tested. This is the first time they have been tested, and they are not sure what to expect. They notice that all of the staff are busy, working and rushing about the office. They approach the front desk and are asked by reception the reason for their visit. But there is no privacy to explain their situation. They worry about other people in the waiting room overhearing and so give a vague response. They are immediately given a form to complete without further instruction. They feel that perhaps the person at the front desk is already judging them.

They complete the form but are confused about some of the questions. For many of the questions, only one or two response options are listed and these options do not reflect their lived experience. After a long time, they hear their name called. They are now feeling more nervous and wishing they had not come at all. They go to the front desk and are asked about their health care card. They are told that they missed an appointment in the past and, that if they miss another appointment, they will have to pay a fee. They are now extremely confused and say sorry. They go back to their seat and wait.

Finally, they are called to meet the service provider. They are nervous about explaining why they need to get tested, as they are ashamed of their behaviours and are certain they have an STBBI. They are taken into a small room to wait for the service provider where they notice many posters targeted at groups of people that look like them; this makes them feel singled out and more anxious. By the time the smiling service provider comes into the room, they are quite tense. The service provider calmly asks the questions on the form and waits patiently for them to answer. They answer some of the questions, but have trouble with some and do not understand why they are being asked these questions. So, they just say no in response. During the visit, the service provider is patient and explains what could happen if they get a positive result for an STBBI. They feel comfortable knowing what test results could be reported to the government and feel they have been provided with enough information to make an informed choice. They decide to go ahead with the testing.

As they leave the clinic, they think more about the HIV test that they just took. They once heard from a friend that if you are diagnosed with HIV, you have to tell all of your new sexual partners. The thought of disclosing to everyone makes them very anxious, and they begin to feel confused about all the information they received at the clinic. They once again begin to feel guilty about their behaviours and are sure they will test positive for an STBBI. They start to wonder if they really want to go back for those test results...

FACILITATOR GUIDE FOR THE STIGMA CASE SCENARIO

An individual interested in STBBI testing takes the bus to the closest clinic, which is located on the other side of town. When they arrive, they realize the clinic is closed and is only open weekdays from 9 am to 4 pm. They work every day from 9 am to 5 pm and do not have paid leave. Several weeks later, they take a day off and return to the clinic **[institutional stigma]**.

On arrival, they begin to feel uneasy about getting tested. This is the first time they have been tested, and they are not sure what to expect. They notice that all of the staff are busy, working and rushing about the office. They approach the front desk and are asked by reception the reason for their visit. But there is no privacy to explain their situation **[institutional stigma]**. They worry about other people in the waiting room overhearing and so give a vague response. They are immediately given a form to complete without further instruction. They feel that perhaps the person at the front desk is already judging them **[perceived stigma]**.

They complete the form but are confused about some of the questions. For many of the questions, only one or two response options are listed and they do not reflect their lived experience **[enacted and institutional stigma]**. After a long time, they hear their name called. They are now feeling more nervous and wishing they had not come at all. They go to the front desk and are asked about their health care card. They are told that they missed an appointment in the past and, that if they miss another appointment, they will have to pay a fee **[institutional stigma]**. They are now extremely confused and say sorry. They go back to their seat and wait.

Finally, they are called to meet the service provider. They are nervous about explaining why they need to get tested, as they are ashamed of their behaviours and are certain they have an STBBI **[internalized stigma]**. They are taken into a small room to wait for the service provider where they notice many posters targeted at groups of people that look like them; this makes them feel singled out and more anxious **[perceived stigma]**. By the time the smiling service provider comes into the room, they are quite tense. The service provider calmly asks the questions on the form and waits patiently for them to answer. They answer some of the questions, but have trouble with some and do not understand why they are being asked these questions. So, they just say no in response **[perceived and institutional stigma]**. During the visit, the service provider is patient and explains what could happen if they get a positive result for an STBBI. They feel comfortable knowing what test results could be reported to the government and feel they have been provided with enough information to make an informed choice. They decide to go ahead with the testing.

As they leave the clinic, they think more about the HIV test that they just took. They once heard from a friend that if you are diagnosed with HIV, you have to tell all of your new sexual partners **[institutional stigma]**. The thought of disclosing to everyone makes them very anxious, and they begin to feel confused about all the information they received at the clinic. They once again begin to feel guilty about their behaviours and are sure they will test positive for an STBBI **[internalized stigma]**. They start to wonder if they really want to go back for those test results....

POSSIBLE STRATEGIES TO ADDRESS STIGMA:

- Work with a broad base of stakeholders to determine accessibility of services and the level of inclusion in those services.
- Provide organization-wide training to all staff on stigma and the impacts of stigma.
- Consider the physical environment. Are there many different posters and information materials?
- Review intake forms to ensure they are inclusive of all clients.
- Tell all clients why questions are asked and why they are important.

POSSIBLE DISCUSSION QUESTIONS:

1. How did it feel to read through the scenario?

POSSIBLE ANSWERS: Familiar, as many conventional health care models work in this fashion. Participants may say they felt sad and experienced empathy for the client.

2. What elements of this story felt familiar?

POSSIBLE ANSWERS: Location of the clinic, hours, forms, rushed service providers, inaccessible language on the forms, and a perceived lack of empathy from staff.

3. What is the overall impact of stigma on the client?

POSSIBLE ANSWER: Stigma can keep clients from accessing care and treatment, create more barriers for services, and perpetuate perceived and internalized stigma. Stigma can lead to poor outcomes for individuals living with or affected by STBBIs, including psychological stress; fear of disclosure; and avoidance of prevention, testing and treatment services.^{19,20, 21, 22, 23}

Stigma within health service settings is particularly concerning as it can impact the quality of care and an individual's engagement in the health care process.²⁴ Stigma can also have a negative impact on public health interventions in the community at large (e.g., denial of a problem within a community can lead to misguided health promotion or public health interventions; communities as a whole may avoid services for fear of others finding out; stigma may lead to mistrust of service providers or support services within a community).

4. Why is it important to understand and acknowledge internalized and perceived stigma?

POSSIBLE ANSWER: Even service providers and organizations actively addressing stigma and offering safe and inclusive services are not immune to the effects of internalized and perceived stigma. In the sample scenario, the client experiences internalized and perceived stigma and, as a result, considers not getting their test results, despite the service provider's safe and respectful approach when discussing STBBI testing. It is important to recognize factors that may contribute to internalized and perceived stigma and be proactive in how services are designed and how we talk about sexuality, substance use and STBBIs with clients.

19 Balfe M, Brugh R, O'Donovan D, O'Connell E, Vaughn D. Young women's decisions to accept chlamydia screening: influences of stigma and doctor-patient interactions. *BMC Public Health* 2010;10(425).

20 Fortenberry DJ, McFarlane M, Bleakley A, Bull S, Fishbein M, Grimley DM, Malotte KC, Stoner, BP. Relationships of stigma and shame to gonorrhea and HIV screening. *Am J Public Health* 2002;92(3): 378-81.

21 Mahajan AP, Sayles JN, Patel VA, Remien RH, Ortiz D, Szekeres G, et al. Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. *AIDS* 2008;22(Suppl 2): S67-S79.

22 Mill J, Edwards N, Jackson R, Austin W, MacLean L, Reintjes F. Accessing health services while living with HIV: intersections of stigma. *Can J of Nurs Res* 2009;41(3): 168-85.

23 Rusch M L, Shoveller JA, Burgess S, Stancer K, Patrick DM, Tyndall MW. Preliminary development of a scale to measure stigma relating to sexually transmitted infections among women in a high risk neighbourhood. *BMC Womens Health* 2008;8(21).

24 Kinsler JJ, Wong MD, Sayles JN, Davis C, Cunningham WE. The effect of perceived stigma from a health care provider on access to care among a low-income HIV-positive population. *AIDS Patient Care STDs* 2007;21(8):584-92.

APPENDIX G: SELF-ASSESSMENT TOOL FOR STBBIS AND STIGMA

Below is a list of concepts about people who have different types of sexually transmitted and blood-borne infections (STBBIs). You may share some of these concepts wholeheartedly, while others you may agree or disagree with to varying degrees. Answer the questions for each type of STBBI as honestly as possible. This self-reflection exercise can help you identify your own attitudes, values and beliefs related to STBBIs.

| 1 | 2 | 3 | 4 | 5 | 6 |
|-------------------|----------|-------------------|----------------|-------|----------------|
| Strongly Disagree | Disagree | Somewhat Disagree | Somewhat Agree | Agree | Strongly Agree |

| | Hepatitis C | | | | | | HIV | | | | | | Other viral STIs: e.g., genital herpes, human papillomavirus (HPV) | | | | | | Bacterial STIs: e.g., chlamydia, gonorrhea, syphilis | | | | | |
|--|-------------|---|---|---|---|---|-----|---|---|---|---|---|--|---|---|---|---|---|--|---|---|---|---|---|
| 1. I believe most clients with _____ acquired the virus through risky behaviour. | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. I think clients with _____ have engaged in risky activities despite knowing these risks. | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. I believe I have the right to refuse to work with clients with _____ for the safety of other clients. | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 |

| | Hepatitis C | HIV | Other viral STIs: e.g., genital herpes, human papillomavirus (HPV) | Bacterial STIs: e.g., chlamydia, gonorrhea, syphilis |
|--|-------------|-------------|--|--|
| 4. I think people would not get _____ if they had sex with fewer people. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 5. Clients with _____ present a threat to my health. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 6. Clients with _____ present a threat to the health of other clients. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 7. I believe I have the right to refuse to work with clients with _____ if other staff members are concerned about safety. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 8. I would avoid certain tasks with clients with _____. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 9. I think if people act responsibly they will not contract _____. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |

| | Hepatitis C | HIV | Other viral STIs: e.g., genital herpes, human papillomavirus (HPV) | Bacterial STIs: e.g., chlamydia, gonorrhea, syphilis |
|---|-------------|-------------|--|--|
| 10. Clients with _____ tend to have numerous sexual partners. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 11. I believe I have the right to refuse to work with clients with _____ if I feel uncomfortable. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 12. I would rather not come into physical contact with clients with _____. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 13. I believe I have the right to refuse to work with clients with _____ to protect myself. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 14. I would not be comfortable working alongside another provider who has _____. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 15. I think many clients with _____ likely have substance abuse problems. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |

| | Hepatitis C | HIV | Other viral STIs: e.g., genital herpes, human papillomavirus (HPV) | Bacterial STIs: e.g., chlamydia, gonorrhea, syphilis |
|--|-------------|-------------|--|--|
| 16. I believe I have the right to refuse to work with clients with ____ if I am concerned about legal liability. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 17. I would rather see a client without ____ than a client with this infection for non-STBI concerns. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 18. Clients with ____ should accept responsibility for acquiring the infection. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 19. I worry about contracting ____ from clients with ____. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 20. I often think clients with ____ have caused their own health problems. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 21. Clients with ____ make me uncomfortable. | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 | 1 2 3 4 5 6 |

| | Hepatitis C | | | | | | HIV | | | | | | Other viral STIs: e.g., genital herpes, human papillomavirus (HPV) | | | | | | Bacterial STIs: e.g., chlamydia, gonorrhea, syphilis | | | | | |
|--|-------------|---|---|---|---|---|-----|---|---|---|---|---|--|---|---|---|---|---|--|---|---|---|---|---|
| 22. I would feel uncomfortable knowing one of my colleagues has ____. | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 |
| 23. I tend to think that clients with ____ do not share the same values as me. | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 |
| 24. It would be hard to react calmly if a client tells me they have ____. | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 |

DOWNLOAD THIS SELF-ASSESSMENT TOOL

NOTE that, in collaboration with Dr. Anne Wagner, this tool was adapted from the *Health Care Provider HIV/AIDS Stigma Scale (HPASS)*. For more information on HPASS, refer to Wagner A, Hart T, McShane K, Margoliese S, Girard T. Health care provider attitudes and beliefs about people living with HIV: Initial validation of the health care provider HIV/AIDS stigma scale (HPASS). *Journal of AIDS and Behaviour* 2014;18(12):2397-408.

APPENDIX D: SAMPLE CHALLENGING SCENARIOS/QUESTIONS

The following scenarios were generated from feedback received during pilot testing of the workshop across the country.

Feel free to use these scenarios during your workshop (slides 20-26) rather than having participants submit their own scenarios/difficult questions. For each of the sample scenarios, the first page gives sample responses for each step of the practice model, and the second page provides an empty template to pass out to participants. Use the sample responses provided when you debrief the scenarios/questions in the large group.

Scenarios 1-4 may be used with both clinical (e.g., nurses, doctors, and other health care professionals) and non-clinical (e.g., counsellors, social workers, health educators) groups. Modify the sample responses to match the professional role(s) of your group. Scenarios 5-6 should only be used with groups working in clinical care.



FACILITATOR GUIDE - SCENARIO #1

Scenario: A client comes to you to talk about how to tell a new partner that they have herpes.

1. Check-in: What are my personal values and assumptions? What are my professional obligations in this situation? What might my body language be communicating?

A service provider should consider their own values, assumptions and beliefs about herpes. They should also consider how much information they have about herpes, and if they are able to provide an accurate response based on their role, knowledge and experience.

2. Affirm: What can I say to make this person feel comfortable, safe and respected?

"I'm really happy you're asking me about this." Alternatively, "It's great that you're thinking about talking to your partner about this. This is a really common question."

3. Clarify: What additional information do I need to understand the client's needs? What does the client require from me?

"What support or information do you need to be able to talk to your partner?"

4. Answer: What are the facts, resources and information that could be of benefit to the client?

The answer will depend on how the client responds to the clarifying question. However, it is important to stress that many people have the herpes virus and that it is very common, and to provide them with resources for more information about herpes. It can also be helpful to offer to role-play with the individual so they can practice disclosing to their partner.

WORK SHEET - SCENARIO #1

Use this worksheet to plan a response.

Scenario: A client comes to you to talk about how to tell a new partner that they have herpes.

1. Check in: What are my personal values and assumptions? What are my professional obligations in this situation? What might my body language be communicating?

2. Affirm: What can I say to make this person feel comfortable, safe and respected?

3. Clarify: What additional information do I need to understand the client's needs? What does the client require from me?

4. Answer: What are the facts, resources and information that could be of benefit to the client?

FACILITATOR GUIDE - SCENARIO #2

Scenario: You work on a mental health unit that does not allow people to use their preferred names. An individual who identifies as trans asks you why other staff continue to use a name with which they no longer identify.

1. Check in: What are my personal values and assumptions? What are my professional obligations in this situation? What might my body language be communicating?

Think about your own understanding of gender identity. Do you have enough information? Would you like more information on this topic? How do you feel about this policy? How might you feel if you could not be called by the name with which you identify? What can you do as a professional in this situation? What might your body language be communicating?

2. Affirm: What can I say to make this person feel comfortable, safe and respected?

You could tell this person: "I'm really glad you came to me. That must be a difficult thing for you to be dealing with right now."

3. Clarify: What additional information do I need to understand the client's needs? What does the client require from me?

"It sounds like your preferred name is not being used. What can I do to help you?"

4. Answer: What are the facts, resources and information that could be of benefit to the client?

In this situation, you may say, "I can see how this is an issue for you. Since you told me that you'd like me to talk to the other staff about this, I'm going to do that. In the meantime, I'll only call you by the name that you identify with." Consider talking with and offering resources to your organization about the importance of honouring the experiences of trans and gender-diverse people. You can serve as an ally to the client and advocate for training on lesbian, gay, bisexual, trans and questioning (LGBTQ) diversity, cultural safety, stigma reduction, etc.

WORK SHEET - SCENARIO #2

Use this worksheet to plan a response.

Scenario: You work on a mental health unit that does not allow people to use their preferred names. An individual who identifies as trans asks you why other staff continue to use a name with which they no longer identify.

1. Check in: What are my personal values and assumptions? What are my professional obligations in this situation? What might my body language be communicating?

2. Affirm: What can I say to make this person feel comfortable, safe and respected?

3. Clarify: What additional information do I need to understand the client's needs? What does the client require from me?

4. Answer: What are the facts, resources and information that could be of benefit to the client?

FACILITATOR GUIDE - SCENARIO #3

Scenario: You are working with an individual living in residential treatment for addiction. They have just been diagnosed with hepatitis C. One of the staff has told them that they can no longer be sexually active with their long-term partner. They have also been told to be careful in the residence as they may pass this infection on to other residents. They are very worried and confused.

1. Check in: What are my personal values and assumptions? What are my professional obligations in this situation? What might my body language be communicating?

What do you know about the transmission of hepatitis C? Will you need more information? What are your values about people living with hepatitis C? Do you have the knowledge to appropriately answer the client's questions?

2. Affirm: What can I say to make this person feel comfortable, safe and respected?

"Thank you for coming to me, it sounds like this is really upsetting and confusing for you." Or, "Thank you for telling me this. A lot of people have questions about sex and hepatitis C."

3. Clarify: What additional information do I need to understand the client's needs? What does the client require from me?

"What information can I give you to help you answer some of your questions about hepatitis C?" Or, "Can you tell me what you know about hepatitis C?"

4. Answer: What are the facts, resources and information that could be of benefit to the client?

If you do not know a lot about hepatitis C, it is okay to say that you do not know, but add that you are willing to help them find all of the answers to their questions. It is important that the individual receive factual information about hepatitis C transmission and treatment options.

If you feel equipped to talk about hepatitis C, a possible answer is: "Hepatitis C is transmitted mostly through contact with blood, which means that it is not transmitted through casual day-to-day contact, like hugging or shaking hands. The hepatitis C virus can be transmitted through sex, but it is uncommon and it is possible for you to keep an active sex life. If you would like, we can discuss some steps you can take to reduce the chances of passing on the infection to your sexual partners." As a follow-up action, you could advocate for training related to hepatitis C, sexual health, cultural safety, etc. within your organization.

WORK SHEET - SCENARIO #3

Use this worksheet to plan a response.

Scenario: You are working with an individual living in residential treatment for addiction. They have just been diagnosed with hepatitis C. One of the staff has told them that they can no longer be sexually active with their long-term partner. They have also been told to be careful in the residence as they may pass this infection on to other residents. They are very worried and confused.

1. Check in: What are my personal values and assumptions? What are my professional obligations in this situation? What might my body language be communicating?

2. Affirm: What can I say to make this person feel comfortable, safe and respected?

3. Clarify: What additional information do I need to understand the client's needs? What does the client require from me?

4. Answer: What are the facts, resources and information that could be of benefit to the client?

FACILITATOR GUIDE - SCENARIO #4

Scenario: A youth, who had previously told you they were not sexually active, comes to you and says they are worried they got someone pregnant.

1. Check in: What are my personal values and assumptions? What are my professional obligations in this situation? What might my body language be communicating?

What are some of the first assumptions or beliefs that you have about this person? What are your values about this situation? How is your body reacting? You may feel surprised or perhaps confused since this is new information to you; you may also feel a desire to move right into asking questions. Remember to first affirm the client's question and to ensure your body language is supportive and affirming.

2. Affirm: What can I say to make this person feel comfortable, safe and respected?

"Thank you for telling me this. Lots of people have come to me in the same situation."

3. Clarify: What additional information do I need to understand the client's needs? What does the client require from me?

"It sounds like you're worried that someone you had sex with is pregnant. Can I ask you a few questions to make sure I understand the situation? Has this person had a pregnancy test?"

4. Answer: What are the facts, resources and information that could be of benefit to the client?

Your answer will depend on how they respond to your clarifying questions. However, you may want to say, "The only way a person can tell if they're pregnant is by taking a pregnancy test. I can help you get one. Once you find out, we can talk about options."

In some cases, you may need to clarify which types of sexual activity will lead to pregnancy, as there is potential for confusion depending on the sexual health information a person may have received in the past.

WORK SHEET - SCENARIO #4

Use this worksheet to plan a response.

Scenario: A youth, who had previously told you they were not sexually active, comes to you and says they are worried they got someone pregnant.

1. Check in: What are my personal values and assumptions? What are my professional obligations in this situation? What might my body language be communicating?

2. Affirm: What can I say to make this person feel comfortable, safe and respected?

3. Clarify: What additional information do I need to understand the client's needs? What does the client require from me?

4. Answer: What are the facts, resources and information that could be of benefit to the client?

FACILITATOR GUIDE - SCENARIO #5 (CLINICAL SCENARIO)

Scenario: Your heterosexual married male client discloses to you that he has had numerous sexual encounters with other men he has met online. His wife does not know about these encounters. He recently got a call from a public health nurse telling him he had sexual contact with someone recently diagnosed with syphilis. He wants to know if he has to tell his wife about his sexual encounters.

1. Check in: What are my personal values and assumptions? What are my professional obligations in this situation? What might my body language be communicating?

What are some of the first assumptions or beliefs that you have about this person? What are your values about sex outside of relationships and anonymous sex? How is your body reacting? How are these values influencing your response? Do you have information to answer the question appropriately?

2. Affirm: What can I say to make this person feel comfortable, safe and respected?

"That's a very good question, and I'm glad you brought this up today."

3. Clarify: What additional information do I need to understand the client's needs? What does the client require from me?

"What kind of support or information can I provide to help you make this decision?"

4. Answer: What are the facts, resources and information that could be of benefit to the client?

Ultimately, this will be the individual's choice as to whether they choose to disclose to their wife. However, it is important to let your client know that if he tests positive for syphilis, he will be asked to discuss his past sexual partners for the purpose of contact tracing. It is important to provide the client with further information so he knows what to expect with respect to STBBI testing and potential limits to confidentiality (e.g., STBBI reporting requirements, contact tracing).

WORK SHEET - SCENARIO #5 (CLINICAL SCENARIO)

Use this worksheet to plan a response.

Scenario: Your heterosexual married male client discloses to you that he has had numerous sexual encounters with other men he has met online. His wife does not know about these encounters. He recently got a call from a public health nurse telling him he had sexual contact with someone recently diagnosed with syphilis. He wants to know if he has to tell his wife about his sexual encounters.

1. Check in: What are my personal values and assumptions? What are my professional obligations in this situation? What might my body language be communicating?

2. Affirm: What can I say to make this person feel comfortable, safe and respected?

3. Clarify: What additional information do I need to understand the client's needs? What does the client require from me?

4. Answer: What are the facts, resources and information that could be of benefit to the client?

FACILITATOR GUIDE - SCENARIO #6 (CLINICAL SCENARIO)

Scenario: Your female patient has tested positive for gonorrhea. After treating her, you attempt to complete a contact tracing interview. She discloses to you that she is a sex worker. She is hesitant to provide any contact details, as many clients are regulars who she fears may stop seeing her if they are named.

1.Check in: What are my personal values and assumptions? What are my professional obligations in this situation? What might my body language be communicating?

What are my values around sex work and those who offer and use these services? How are these values influencing my response and body language with this client? What is my knowledge related to public health reporting requirements, contact tracing, etc.?

2.Affirm: What can I say to make this person feel comfortable, safe and respected?

"I'm really glad you shared this with me, and I can appreciate that this is uncomfortable for you."

3.Clarify: What additional information do I need to understand the client's needs? What does the client require from me?

"What kind of information can I provide to help you complete the contact tracing interview in a way that makes you feel comfortable and safe?"

4.Answer: What are the facts, resources and information that could be of benefit to the client?

Tell the patient that contact tracing is a legal obligation, but also reassure the patient that contact tracing is done confidentially, and no details are given about the informant. Inform the patient that it is beneficial for her and her regular clients to get tested and treated to prevent re-exposure to infection.

WORK SHEET - SCENARIO #6 (CLINICAL SCENARIO)

Use this worksheet to plan a response.

Scenario: Your female patient has tested positive for gonorrhea. After treating her, you attempt to complete a contact tracing interview. She discloses to you that she is a sex worker. She is hesitant to provide any contact details, as many clients are regulars who she fears may stop seeing her if they are named.

1. Check in: What are my personal values and assumptions? What are my professional obligations in this situation? What might my body language be communicating?

2. Affirm: What can I say to make this person feel comfortable, safe and respected?

3. Clarify: What additional information do I need to understand the client's needs? What does the client require from me?

4. Answer: What are the facts, resources and information that could be of benefit to the client?

Date: _____

Welcome to the workshop. Before we begin, we invite you to share your expectations and thoughts about the workshop. At the end, we will ask you to give feedback on your experience and learning. The results will be used to further develop and improve this workshop. Your individual views will be kept confidential.

1. What do you hope to learn from this workshop?
2. What do you hope to contribute to this workshop?
3. In general, how would you rate your awareness of STBBI prevention and treatment issues?

| | Not at all aware | | Neutral | | Extremely aware |
|------------------|---------------------|---|---------|---|--------------------|
| STBBI prevention | 1 | 2 | 3 | 4 | 5 |
| STBBI treatment | 1 | 2 | 3 | 4 | 5 |

Comments:

4. In general, how comfortable do you feel talking about sexual health and harm reduction with service users / clients / patients?

| | Not at all comfortable | | Neutral | | Extremely comfortable |
|---------------------------|------------------------|---|---------|---|-----------------------|
| Sexual health | 1 | 2 | 3 | 4 | 5 |
| Harm reduction strategies | 1 | 2 | 3 | 4 | 5 |

Comments:

5. Please share any other thoughts before this session begins.

POST-WORKSHOP QUESTIONNAIRE

Date: _____

Moving beyond the basics: An advanced workshop about sexual health, substance use, STBBIs and stigma

1. Please rate your experience during this workshop. Circle your level of agreement with the following statements.

| | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |
|---|-------------------|----------|----------------------------|-------|----------------|
| The workshop objectives were clear. | 1 | 2 | 3 | 4 | 5 |
| The content of the workshop was relevant to my needs. | 1 | 2 | 3 | 4 | 5 |
| I am more aware of my values and beliefs about STBBIs, sexuality and sexual behaviour. | 1 | 2 | 3 | 4 | 5 |
| I am more aware of various forms of stigma and the factors that contribute to STBBI-related stigma. | 1 | 2 | 3 | 4 | 5 |
| I am more aware of my values and beliefs about substance use and harm reduction. | 1 | 2 | 3 | 4 | 5 |
| The workshop environment was safe and respectful. | 1 | 2 | 3 | 4 | 5 |
| I will be able to apply what I learned in today's workshop to my practice. | 1 | 2 | 3 | 4 | 5 |
| I will be more comfortable discussing sexuality and harm reduction issues with clients. | 1 | 2 | 3 | 4 | 5 |

Please share your comments on any of your ratings above:

2. What part(s) of the workshop did you like best, and why?

3. What improvements could be made for future workshops?

4. Any other thoughts or comments?

Thank you for participating!

FACILITATOR REFLECTION QUESTIONS

After each workshop, the facilitator is encouraged to spend a few moments reflecting on the workshop. It is anticipated that these reflection notes will contribute to continuous improvement of the workshop content and facilitation process.

1. How many people were at the session? Can you provide any other descriptive information that you think is important (e.g., diversity, professional groups represented, levels of experience, etc.)?
2. What was the level of engagement of the group with the workshop material?

1 2 3 4 5 6 7 8 9 10

PASSIVE

VERY ENGAGED

3. What was your level of comfort in facilitating the session?

1 2 3 4 5 6 7 8 9 10

NOT AT ALL COMFORTABLE

VERY COMFORTABLE

4. In your view, what was the highlight of the session?
5. What worked well during the session? What could be improved? For example, consider the facilitation process, content of the workshop, group engagement, etc.
6. Were there particular moments of friction or challenge? What do you think contributed to these moments of friction or challenge?
7. Were there any questions that were posed by participants that you did not feel you could or were comfortable answering? If yes, why?
8. Any other comments or suggestions that could help improve the workshop in the future?



**ARE YOU A HEALTH OR
SOCIAL SERVICE PROVIDER?**

JOIN US FOR A FREE WORKSHOP TO EXPLORE STIGMA AND SEXUALLY TRANSMITTED AND BLOOD-BORNE INFECTIONS (STBBIS)!

During the workshop, you will review individual attitudes and beliefs related to sexuality and substance use, as well as organizational policies and practices that can contribute to stigma. You will learn practical strategies and skills to reduce stigma and help create safer and more inclusive environments for clients.

Insert your date and location

Insert contact name for registration

Add your organization's logo

Include information about parking, refreshments, etc.

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ASSOCIATION

ASSOCIATION
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SANTÉ PUBLIQUE



Calgary
Sexual Health
Centre

APPENDIX G: GLOSSARY

ALLY: A person who is actively supportive of LGBTQ+ people and their rights. Allies may be gay, straight, transgender, queer, two-spirit, etc.

ASEXUAL: A person whose attraction to others does not include sexuality.

BISEXUAL: A person who is physically and emotionally attracted to their own gender and other genders.

BLOOD-BORNE INFECTION: An infection transmitted by direct blood contact from one individual to another through injured skin or a mucous membrane, or transmitted through drug use and sexual contact (e.g., hepatitis B and C, HIV).

CISGENDER: A person whose gender identity is the same as the sex they were assigned at birth.

CISNORMATIVITY: The assumption that all people are cisgender or that those assigned male at birth grow up to be men and those assigned female at birth grow up to be women. It may also refer to the oppression experienced by transgender people in a society that represents cisgender people as dominant, normal and superior.

DISCRIMINATION: Unjust treatment based on an individual belonging or perceived to be belonging to a traditionally marginalized social group (e.g., by race, gender, orientation, etc.).

EQUITY/EQUITABLE: Equity means fairness. Equity in health means that peoples' needs guide the distribution of opportunities for well-being. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences and various social and economic conditions, or a result of personal lifestyle choices. Inequities occur as a consequence of differences in opportunity, which result, for example in unequal access to health services, nutritious food or adequate housing. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life (Public Health Agency of Canada, 2007).

GAY: A man who is physically and emotionally attracted to other men. Some women attracted to women may also identify as gay.

GAY-STRAIGHT ALLIANCE (GSA): Student-run organizations found in some K-12 schools and universities that create safe and supportive spaces for LGBTQ+ individuals and allies.

GENDER EXPRESSION: The way people communicate their gender identity to others by how they dress, act and/or refer to themselves.

GENDER IDENTITY: A person's internal sense of being a woman or man, or a combination of both, or neither.

GENDER NON-BINARY/GENDERQUEER: Terms for a person whose gender identity is neither woman nor man.

GENDER ROLES: Socially constructed and culturally behavioural norms, such as communication styles, careers and family roles, that are often expected of people based on their assigned sex (Canadian AIDS Society, 2015).

HARM REDUCTION: Harm reduction encompasses evidence-based policies, strategies and services which aim to assist people who use substances to live safer and healthier lives. Harm reduction acknowledges that a reduction of substance use and/or abstinence is not required in order to receive respect, compassion or services (adapted from StreetWorks, 2015).

HETERONORMATIVITY: The assumption or belief that every person is heterosexual until proven otherwise, and by default treating individuals as if they would be in a relationship with somebody of the opposite gender.

HOMOPHOBIA/TRANSPHOBIA: An irrational hatred of people who are, or are perceived to be LGBTQ. Often exhibited by prejudice, discrimination, intimidation or acts of violence.

INTERSEX: A general term used to describe people who are born with reproductive or sexual anatomy that does not fit the typical definitions of female or male.

LESBIAN: A woman who is physically and emotionally attracted to women.

LGBTQ: An acronym to describe the following identities: Lesbian, Gay, Bisexual, Transgender and Queer.

NALOXONE: A medication that reverses the effect of overdose from opiates. Peer administered naloxone programs train people in the community to administer naloxone if they witness an overdose.

NEEDLE EXCHANGE PROGRAMS: This is an evidenced based program to prevent the transmission of STBBIs. People can bring in needles and other paraphernalia that they have used for injecting substances and receive sterile injecting equipment. This is typically offered in a setting where various other psychosocial supports or referrals are available.

ORIENTATION: A person's identity in relation to the gender they are attracted to.

OPIOID DEPENDENCY PROGRAM: This is a program for individuals that would like to stop using opiate based substances. People receive a prescription of methadone or Suboxone® maintenance treatment in an outpatient setting. As part of these programs, people may engage in a wide variety of psychosocial supports to address substance use.

PANSEXUAL: A person who is physically and emotionally attracted to people of any gender.

QUEER: Historically used as a negative term for homosexuality and is still often used as a derogatory term against LGBTQ people. Many LGBTQ people and communities have reclaimed the word and use it in a positive way to refer to themselves and aspects of their identity.

QUESTIONING: A person who is unsure of their sexual orientation or gender identity and experiencing a process of self-discovery.

SAFER INHALATION EQUIPMENT (ALSO KNOWN AS SAFER CRACK PIPE PROGRAMS): Programs where people who inhale substances are provided with new inhalation equipment such as pipes to reduce and prevent the transmission of hepatitis C.

SEX: The category someone is assigned at birth based on their physical body parts and biology.

SEX-POSITIVITY: Adopting a sex-positive approach means respecting the diversity of human sexuality and talking with your clients openly and without judgement about their sexuality. A sex-positive approach respects the sexual rights of all persons, yet also acknowledges that not all persons have learned about or experienced sexuality in a positive and affirming way.

SEXUAL HEALTH: A state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (World Health Organization, 2006).

SEXUALLY TRANSMITTED INFECTION (STI): An infection passed from one person to another through sexual activity, including vaginal, oral or anal sex as well as genital skin-to-skin contact. STIs are grouped into three categories: viral infections (e.g., genital herpes, human immunodeficiency virus (HIV), hepatitis B), bacterial infections (e.g., chlamydia, gonorrhea and syphilis) and parasitic/fungal infections (e.g., trichomoniasis, pubic lice, yeast infection). Note: The term sexually transmitted disease is no longer used.

SOCIAL DETERMINANTS OF HEALTH: The SDH are the social and economic factors that influence people's health. These are apparent in the living and working conditions that people experience every day. The SDH influence health in many positive and negative ways. Extreme differences in income and wealth, for example, have negative health consequences for those who are living in poverty and these effects are magnified when these people are congregated in poor regions. In contrast, those who are well-off and living in well-off regions have better overall health.

STIGMA: Broken down into 5 different types -- (Stangl et al., 2012, Loutfy et al., 2012 and Corrigan et al., 2004)

1. **PERCEIVED STIGMA:** Awareness of negative societal attitudes, fear of discrimination and feelings of shame.
2. **INTERNALIZED STIGMA:** An individual's acceptance of negative beliefs, views and feelings towards the stigmatized group they belong to and oneself.
3. **ENACTED STIGMA:** Encompasses overt acts of discrimination, such as exclusion or acts of physical or emotional abuse (acts may be within or beyond the purview of the law and may be attributable to an individual's real or perceived identity or membership to a stigmatized group).
4. **LAYERED OR COMPOUNDED STIGMA:** A person holding more than one stigmatized identity (e.g., HIV positive serostatus, sexual orientation, race, ethnicity).
5. **INSTITUTIONAL OR STRUCTURAL STIGMA:** Stigmatization of a group of people through the implementation of policy and procedures.

STRAIGHT: A person who is attracted to people of the opposite sex or gender to their own.

SUPERVISED INJECTION SITE: Evidence-based health care settings where people who inject substances can use their own personally acquired illicit substances under the supervision of nurses, social workers and other medical staff and where people can access clean syringes, needles and swabs, and safely dispose used needles. People can also receive health care, counseling and referral to social, health and substance use treatment services (adapted from Health Canada, 2008).

TRANS/TRANSGENDER: People whose gender identity, gender expression or behaviour does not conform to that typically associated with the sex to which they were assigned at birth.

TRAUMA- AND VIOLENCE-INFORMED CARE (TVIC): Trauma-informed care focuses on creating environments where clients do not experience further traumatization or re-traumatization and where they can make decisions about their treatment needs at a pace that feels safe to them (BC Provincial Mental Health and Substance Use Planning Council, 2013). TVIC expands on the concept of TIC to acknowledge the broader social and structural conditions that impact health, including, but not limited to, institutional policies and practices (Varcoe et al., 2016).

TWO-SPIRIT: A spiritual identity for some FNMI (First Nations, Metis, Inuit) people. Implies the embodiment of both masculine and feminine spiritual qualities within the same body. Note that this term is not used in all FNMI communities.

UNIVERSAL PRECAUTIONS: The practice of avoiding contact with all bodily fluids through gloves, face masks and a variety of other barriers, whether we know the health status of said bodily fluid or not.

APPENDIX H: SUPPLEMENTARY RESOURCES

STBBIS AND STIGMA

Discussing sexual health, substance use and STBBIs: A guide for service providers, Canadian Public Health Association, 2017. Available at: https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/discussionguide_e.pdf

Self-assessment tool for STBBIs and stigma, Wagner A and Canadian Public Health Association, Available at: https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/stigmascale_e.pdf

Reducing stigma and discrimination through the protection of privacy and confidentiality, Canadian Public Health Association and Canadian HIV/AIDS Legal Network, 2017. Available at: https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/confidentialitystigma_e.pdf

Organizational assessment tool for STBBIs and stigma, Canadian Public Health Association, 2017. Available at: https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/orgtool_e.pdf

SEXUALITY AND STBBIS

Canadian guidelines on sexually transmitted infections, Public Health Agency of Canada, 2006. Available at: <http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-lcits/index-eng.php>.

CATIE, <http://www.catie.ca/>
Information about HIV/AIDS and Hepatitis C in Canada

Native Youth Sexual Health Network, <http://www.nativeyouthsexualhealth.com/>
Organization by and for Indigenous youth that works across issues of sexual and reproductive health, rights and justice

Sex & U, <http://www.sexandu.ca/>
Information and education on topics related to sexual and reproductive health

LGBTQ

Egale, <http://egale.ca/>
National charity promoting lesbian, gay, bisexual, and trans (LGBT) human rights through research, education and community engagement

Gender Creative Kids, <http://www.gendercreativekids.ca>
Canadian resource for supporting and affirming gender creative kids within their families, schools and communities.

Rainbow Health Ontario, <http://www.rainbowhealthontario.ca/>
Information and support related to the health and well being of LGBTQ people in Ontario

TRAUMA- AND VIOLENCE-INFORMED CARE

Trauma informed practice guide, BC Provincial Mental Health and Substance Use Planning Council, 2013. Available at: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Violence, Evidence, Guidance and Action (VEGA) Project, <https://projectvega.ca/>

A national project developing pan-Canadian public health guidance, protocols, curricula and tools for health and social service providers related to family violence

HARM REDUCTION

Harm reduction training manual: A manual for frontline staff involved with harm reduction strategies and services, BC Harm Reduction Strategies and Services, 2011. Available at: <http://www.catie.ca/en/resources/harm-reduction-training-manual-manual-frontline-staff-involved-harm-reduction-strategies-a>

The best practice recommendations for Canadian harm reduction programs that provide service to people who use drugs and are at risk for HIV, HCV, and other harms: Part 1, Working Group on Best Practice for Harm Reduction Programs in Canada, 2013. Available at: <http://www.catie.ca/sites/default/files/bestpractice-harmreduction.pdf>

The best practice recommendations for Canadian harm reduction programs that provide service to people who use drugs and are at risk for HIV, HCV, and other harms: Part 2, Working Group on Best Practice for Harm Reduction Programs in Canada, 2015. Available at: <http://www.catie.ca/sites/default/files/bestpractice-harmreduction-part2.pdf>

HIV DISCLOSURE AND THE LAW

Canadian HIV/AIDS Legal Network, <http://www.aidslaw.ca>

National organization committed to promoting the human rights of people living with and vulnerable to HIV and AIDS, in Canada and internationally

HIV disclosure and the law: A Resource kit for service providers, Canadian HIV/AIDS Legal Network et al., 2012. Available at: <http://www.aidslaw.ca/site/hiv-disclosure-and-the-law-a-resource-kit-for-service-providers/?lang=en>