FACILITATION MANUAL

2017

# MOVING BEYOND THE BASICS

An advanced workshop about sexual health, substance use, STBBIs and stigma

Calgary Sexual Health Centre

CANADIAN PUBLIC HEALTH ASSOCIATION

# ACKNOWLEDGEMENTS

All of the resources for the workshop *Moving beyond the basics: An advanced workshop about sexual health, substance use, STBBIs and stigma*, including the facilitation manual, participant workbook and slide deck, were developed in partnership by the Canadian Public Health Association (CPHA) and the Calgary Sexual Health Centre (CSHC) as part of the project *Impacting attitudes and values: Engaging health professionals to decrease stigma and discrimination and improve STBBI prevention.*

This project would not have been possible without the support and involvement of the many organizations and professionals who reviewed project resources and provided expert feedback through key informant interviews and community consultations. We are also indebted to the members of the project's Expert Reference Group who offered expert guidance and support throughout various stages of the project. CPHA and CSHC would also like to thank the organizations that helped coordinate and organize pilot workshops across the country, as well as the professionals who helped inform the development of workshop resources through their participation in the pilot workshops. Finally, we would like to acknowledge the individuals from various communities who participated in local focus groups and shared their stories, insight and wisdom.

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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 advanced workshop, *Moving beyond the basics: An advanced workshop about sexual health, substance use, STBBIs and stigma*, to explore stigma and STBBIs, the multiple factors that contribute to stigma, and its potential impacts on clients and public health interventions. This workshop gives participants an opportunity to enhance their skills in discussing STBBIs, sexuality and substance use with their clients and introduces several strategies and tools that can help mitigate stigma within service settings.

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.

This workshop incorporates the Discussing sexual health, substance use and STBBIs: A guide for service providers (referred to below as discussion guide) as a tool to help participants have safer, more inclusive conversations with clients about STBBIs, sexual health and substance use. CPHA developed the discussion guide based on a literature review covering sexual health and substance use-related interactions among service providers and clients, and key informant interviews with a range of frontline service providers as well as clients. The resulting promising practices covered in the discussion guide informed the development of the stigma-reduction strategies presented in this workshop.

**THIS WORKSHOP GIVES PARTICIPANTS AN OPPORTUNITY TO ENHANCE THEIR SKILLS IN DISCUSSING STBBIS, SEXUALITY AND SUBSTANCE USE WITH THEIR CLIENTS AND INTRODUCES SEVERAL STRATEGIES AND TOOLS THAT CAN HELP MITIGATE STIGMA WITHIN SERVICE SETTINGS.**

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

1. *Exploring STBBIs and stigma: An introductory workshop for health and social service providers* – Offers health and social service providers an introduction to STBBI-related stigma and stigma-reduction strategies that can be used in 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 (e.g., in-service, staff orientation, community professional development).

### 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 advanced workshop is for frontline service providers currently working in the areas of sexual health, harm reduction or STBBI-specific services, including nurses, nurse practitioners, physicians, health educators, social workers, addictions counsellors, outreach workers, etc. Participants should have a basic to advanced understanding of STBBIs (including prevention, transmission, testing and treatment) as well as sexual health and harm reduction.

## 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 reflect on societal values and beliefs related to STBBIs, substance use and sexuality;
- enhanced skills in discussing STBBIs, sexual health and harm reduction while using the *Discussing sexual health, substance use and STBBIs: A guide for service providers* (including enhanced skills in using a trauma- and violence-informed care approach in a non-stigmatizing, empowering and authentic manner); and
- increased awareness of how to develop a personal action plan for the delivery of safer and more inclusive STBBI-related 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)
- *Name that substance activity* (one copy to be read to the group; see Appendix C)
- *Discussing sexual health, substance use and STBBIs: A guide for service providers* (one for each participant)
- *Clinical and non-clinical practice scenarios* (one for each participant; see Appendix D)
- *Pre- and post-workshop questionnaires* (one 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 may be offered as a 90-minute, 3-hour or 5-hour session. 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.

## 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 their assistance 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 STBBIs.

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.

Ensure that the *Discussing sexual health, substance use and STBBIs: A guide for service providers* (referred to below as discussion guide) is sent to participants in advance of the session and encourage participants to review it prior to the session.

# ROOM SET-UP

Ensure 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 (consider, for example, room temperature and lighting) and set-up needs 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 avoid lecture-based learning.

## 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

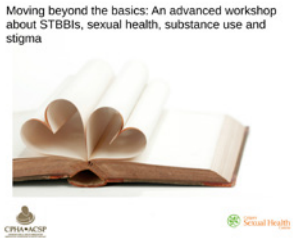
# WORKSHOP CONTENT

# 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:

1. Distribute participant workbooks to each participant.
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.

    This workshop supports the use of *Discussing sexual health, substance use and STBBIs: A guide for service providers* (referred to below as discussion guide). It is based on literature reviews and key informant interviews and has been reviewed by sexual health and harm reduction professionals as well as clients from across the country.
4. Describe why your community or agency sees this training as important. Ask participants to share why they think this training is important for their practice.

## DISCUSSION POINTS:

**Provide concrete examples of the workshop's value for participants, such as:**

- "After this workshop, you may feel more comfortable and confident talking about sexuality, substance use and harm reduction with your clients."
- "You'll likely have a greater understanding of stigma and how it affects your clients."
- "You will leave the workshop with tools that you can use in your practice as well as share with your colleagues."

## SLIDE 3: WORKSHOP OVERVIEW

**OBJECTIVE:** To discuss the workshop format.

**MATERIALS:** n/a

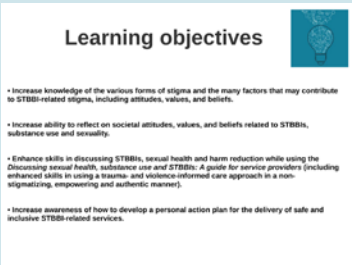

### STEPS/DISCUSSION POINTS:

1. Tell the group that the workshop begins with a brief discussion of the learning objectives and key terms, followed by activities exploring stigma and strategies to contribute to safer, more inclusive services.

## SLIDE 4: LEARNING OBJECTIVES

**OBJECTIVE:** To present the learning objectives, clarify the focus, and identify what participants hope to learn from their participation in the session.

**MATERIALS:** n/a

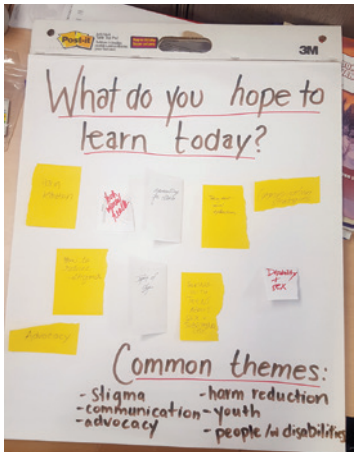



### STEPS/DISCUSSION POINTS:

1. Describe how the group will work together, sharing experiences and learning from one another through a series of self-reflections, discussion and practice activities.
2. Read each of the learning objectives.
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 identity their professional role and the length of time they have worked in their field. To save time, ask for a show of hands from 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 to share 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.

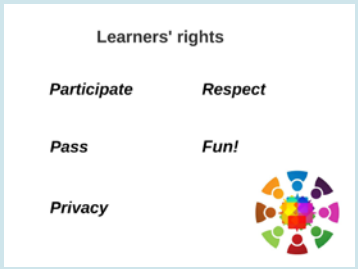



**Sample image of "What do you hope to learn today?"**

## SLIDE 5: 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 does not respect the rights of others or creates a potentially unsafe environment throughout the course of the workshop.




### 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.

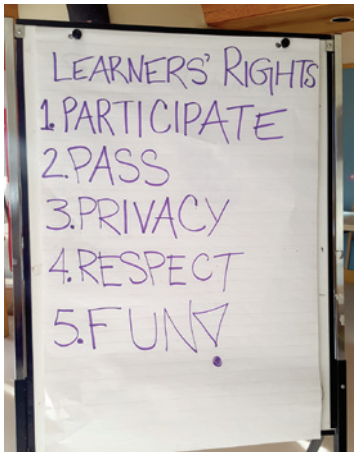
## DISCUSSION POINTS

- 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 unsafe.
- 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 you hope to make the session a positive experience and, as a group, you will be participating in activities that add enjoyment to the learning experience.

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

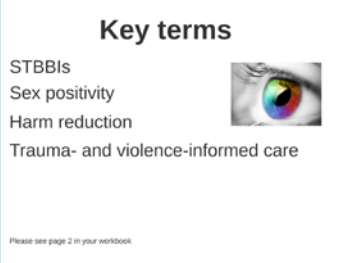



**Sample image of the learners' rights:**

# SLIDE 6: 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)




## STEPS/DISCUSSION POINTS:

1. Direct participants to the definitions of key terms 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 15-17 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

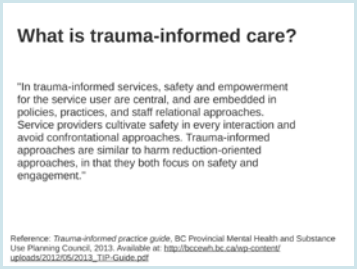
- STBBIs: To measure the group's level of prior knowledge, ask participants to call out various STBBIs (e.g., genital herpes or herpes simplex virus, hepatitis B and C, HIV, human papillomavirus or HPV, chlamydia, gonorrhea, syphilis, pubic lice, scabies, trichomoniasis).
- Harm reduction: To measure 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 associated 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.

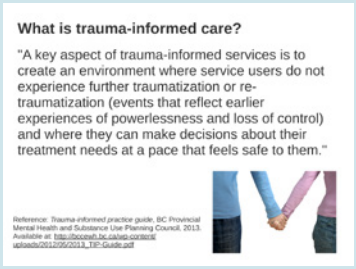
**NOTE:** For questions about gender and sexual diversity, you can refer participants to the supplementary resources listed in Appendix H and to the online learning course Introduction to LGBT developed by Rainbow Health Ontario and the University Health Network

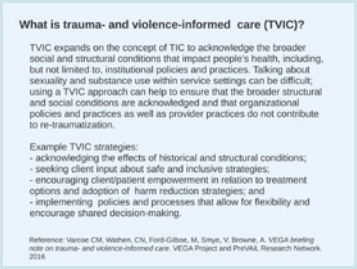
# SLIDES 7, 8, AND 9: TRAUMA- AND VIOLENCE-INFORMED CARE

**OBJECTIVE:** To present basic information about trauma- and violence-informed practice.

**MATERIALS:** Participant workbook (page 3)




## 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 10: ACTIVITY - THE LANGUAGE OF SEX

**OBJECTIVE:** To consider the social construction of sexuality and identify the impacts of heteronormativity and gender scripts.

**MATERIALS:** Participant workbook (page 4)


### STEPS/DISCUSSION POINTS:

1. Tell participants that this activity focuses on the dominant cultural construction of sexuality by exploring our use of language.
2. Direct participants to page 4 of the workbook. Ask them to work with a partner to identify all terms (including adult and childhood slang terms) and synonyms used for sexual activity. Give 2-5 minutes for participants to create their lists.
3. Write all terms on a flipchart or white board and, as a group, explore the common themes.

### DISCUSSION POINTS

**Begin by discussing the terms identified for sexual activity.**

- It is likely that the majority (or all) of the terms will relate to vaginal sex.
- Ask the group what this focus tells us about how we define sexual activity as a society.
- What types of sexual activity are most often discussed as a society? Possible response: heterosexual sex, namely penis penetration of the vagina.

**Discuss and define heteronormativity and its impact on stigma and STBBI prevention, testing and treatment.**

- Heteronormative assumptions (based on the belief that every person is heterosexual until proven otherwise) can be perpetuated through language, including the language used in conversations with clients as well as the language used on intake forms, resources and other information products provided to clients.
- When heteronormative assumptions are made, even unintentionally, service providers may ask questions that damage their rapport with the client or result in a missed opportunity for care.
- Heteronormativity can make clients feel they cannot be honest with professionals about their sexual practices or sexual orientation.

**Ask the group:**

- "Are the words that we use to describe sexual activity mostly positive or mostly negative? How does this link with stigma?"
- Possible response: The prevalence of violent or non-consensual language indicates that, as a society, we have confused notions about consent. This confusion can feed into the high prevalence of sexual assault and sexualized violence in our society. As service providers, we can start addressing this issue by speaking about the right to consent with all clients, by not assuming that consent has been given in all cases, and by working from a trauma- and violence-informed perspective.

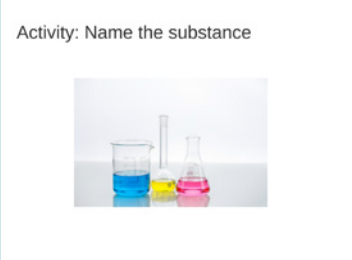
**Discuss some strategies to confront the negative social construction of sexuality.**

- It is important to welcome and normalize clients' disclosures of sexual and gender diversity so they feel safe and comfortable. Ask about all types of sexual activity (i.e., anal, vaginal, digital, masturbation and oral), explain the rationale for your line of questioning and affirm that these questions are asked of everyone.
- Respect a client's use of pronouns and names, and consistently use gender-neutral terms (e.g., partners).
- Service providers need to be aware of common yet misguided stereotypes about who is a sexual being. For example, people with disabilities or older adults are often excluded from routine discussions about sexual health.
- Use a trauma- and violence-informed approach.

In closing, reiterate that the negative social construction of sexuality can lead to the use of stigmatizing language as well as stigmatizing attitudes, values and beliefs. **Our ideas about sexuality can also influence myths about who is at risk for STBBIs, about how people acquire STBBIs and, in turn, how we as health or social service professionals communicate about harm reduction practices with clients.**

## SLIDE 11: ACTIVITY - NAME THE SUBSTANCE

**OBJECTIVE:** To consider one's assumptions about substance use, to explore the dominant messaging around substance use, and to unpack how our society views the use of different substances.




**NOTE: THIS IS A SHORT ACTIVITY THAT CAN BE USED WITH GROUPS THAT HAVE LIMITED EXPERIENCE IN HARM REDUCTION.**

**MATERIALS:** Participant workbook (page 4) and *Name the substance activity* (one copy to read aloud to the group; see Appendix C)

## STEPS/DISCUSSION POINTS:

1. Without providing the name of the substance, read the information about each substance found in the *Name the substance activity*. Ask participants to call out the name of the substance as it is described.
2. Once the activity is complete, ask the group if they were surprised by any of the answers. Ask if they noticed that several of the legal substances were as harmful as the illegal substances or even more so.
3. Ask which substances are considered more permissible in our society. Encourage participants to reflect on some of the commonly held beliefs that our society perpetuates about people who use substances.
4. Ask the group how misinformation about substances can influence service provider's attitudes, values and beliefs.
5. Ask how this misinformation can influence clients and their attitudes, values and beliefs, as well as their interactions with providers.

## DISCUSSION POINTS

**Responses to this activity from past workshops:**

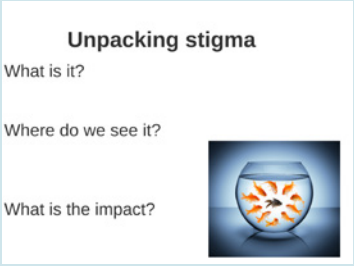
- **Were you surprised by the answers?** Yes, many substances are very similar, and many of the most harmful substances are actually legal.
- **Which substances are considered to be more permissible in our society?** Substances prescribed by doctors or purchased over the counter are regarded as more acceptable. Also, there is greater social acceptance of some substances such as alcohol. Some substances are discussed only as harmful, ultimately perpetuating stigma and hindering harm reduction efforts.
- **How does misinformation about substances influence service provider's attitudes, values and beliefs?** Beliefs about which substances are most harmful or about who uses substances are two examples. Service providers may not talk about substance use with all clients, based on their misguided assumptions about who could benefit from those conversations. They may focus harm reduction efforts on those traditionally seen as most 'at risk' and exclude those from the population at large who may also benefit from substance use discussions.
- **How does misinformation influence clients' attitudes, values and assumptions about substance use?** Some people who use substances may not identify as somebody who "uses." Some may have internalized or perceived stigma and, in turn, avoid disclosing their substance use for fear of discrimination.

Direct participants to the definition of harm reduction in the workbook on page 3. **Harm reduction is a just and evidence-based approach that recognizes clients as the experts in their own lives. Conversations about substance use with clients should be client-centred and focused on reducing potential harmful consequences of using substances, rather than focusing solely on reducing use or promoting abstinence. A harm reduction approach recognizes that not all individuals who report substance use will need or desire help.**

# SLIDE 12: 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)




## 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 an 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 or 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]
- 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 you indicate a reason for people to get tested for HIV? Is there a list of checkboxes that includes population groups deemed as 'high risk'?

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).

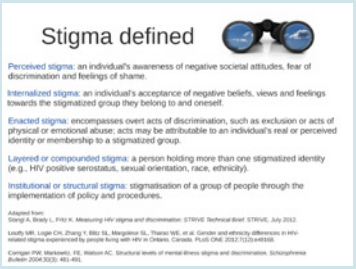
8 Kinsler JJ, Wong MD, Sayles JN, Davis C, Cunningham WE. The effect of perceived stigma from a health care provider on access to care among a low-income HIV-positive population. *AIDS Patient Care STDs* 2007;21(8):584-92.

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 13: 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 defintions 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 14: 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 highlight 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 5 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 (see Appendix B).
3. Ask participants to spend a few minutes reading the scenario and then to form groups of 3 or 4.
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. Time permitting, write down a few suggestions.

## 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 judgement 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.[13,14,15]
- 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.

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.

15 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.

- 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.
    - 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 15: 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:** Participant workbook (page 9)


### STEPS/DISCUSSION POINTS:

1. Refer participants to page 9 in their workbook.
2. 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.
3. Allow participants time to share their experiences.
4. Ask why service providers often assume that clients do not want to discuss their sexual health and/or substance use.

## DISCUSSION POINTS

**Both the grey and academic literatures note that individuals expect service providers to ask questions about their sexual health.[16,17]**

- 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.
- 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.[18]

**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.[19]**

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 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.

17 Sargant NN, Smallwood N, Finlay F. Sexual history taking: A dying skill? *Journal of palliative medicine* 2014;17(7): 829-831.

18 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.

19 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 16: PRACTICE TOOLS

**OBJECTIVE:** To introduce the last module of the workshop.

**MATERIALS:** n/a

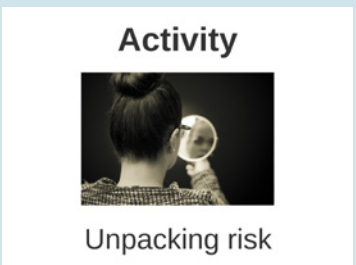

### STEPS/DISCUSSION POINTS:

1. Tell participants that you have reached the third and final module of the workshop, which focuses on strategies and tools that can be used to ensure that service providers have safer, more inclusive conversations with their clients.
2. Encourage participants to continue to reflect on what they learned earlier in the workshop as they move into the practice tools and strategies.

## SLIDE 17: ACTIVITY - UNPACKING RISK

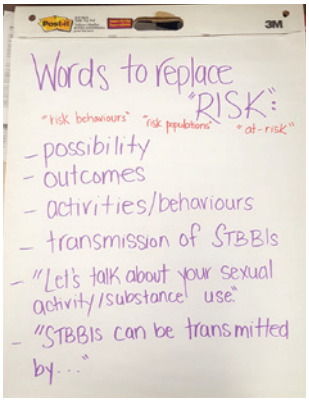
**OBJECTIVE:** To consider the language used by service providers when discussing STBBIs with clients and, specifically, to deconstruct the term 'risk' and consider its impacts.

**MATERIALS:** White/black board or flipchart paper



## STEPS/DISCUSSION POINTS:

1. Remind the group that service providers can have a major impact on STBBI prevention, diagnosis and treatment efforts during their interactions with clients. Discussing sexuality, substance use and STBBIs can be challenging, so providers need to continuously practice to improve their confidence, comfort and skill. Questioning one's practices, attitudes, values and beliefs should be an ongoing exercise as well.
2. Ask participants to brainstorm all of the words they associate with the term "risk" in the context of one's health.
3. On a flipchart or whiteboard, record the responses.
4. Ask participants for their initial reactions to the list. Examples from previous workshops include dangerous, scary, bad, something to avoid and negative consequences.
5. Ask participants if they ever use the word risk in their practice. It is likely that many participants will respond that they do. Some examples include risk behaviours, risk reduction or risk populations.
6. Ask participants how they would feel if their personal practices or identities were spoken about in the context of risk. This type of language can lead to internalized and perceived stigma.
7. Ask participants to brainstorm some potential strategies to remove risk-based language from their repertoire. For example, is it possible to remove the word risk by simply focusing on behaviours or activities?




# SLIDE 18: A NOTE ABOUT PRIVACY AND CONFIDENTIALITY

**OBJECTIVE:** To highlight the importance of privacy and confidentiality as mechanisms to reduce stigma.

**MATERIALS:** Participant workbook (page 11)


## STEPS/DISCUSSION POINTS:

1. Ask participants to share how they think the protection of confidentiality and privacy can help address stigma in health and social service settings.

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. Be prepared to discuss the criminalization of HIV non-disclosure, the potential limits to confidentiality and the duty to report. Refer to the discussion points below taken from CPHA's resource *Reducing STBBI-related stigma and discrimination through the protection of privacy and confidentiality*. You may also refer participants to page 14 of their workbooks for more information on the criminalization of HIV non-disclosure or to the legal resources listed in Appendix H.

## DISCUSSION POINTS

- Respecting clients' rights to privacy and confidentiality can help reduce stigma and discrimination in health and social service settings.
- While the scope and degree of the legal duty of confidentiality may vary from one provider to another, it remains a legal obligation of all service providers involved in STBBI counselling, care and treatment.
- When discussing the duty of confidentiality with clients, be clear about how their personal information will be used and with whom it will be shared (now and in the future). Providers' duty of confidentiality is not limited to clients' STBBI status or other health conditions, but extends to any personal information a provider may receive in the context of counselling, care and treatment. Any information about a client's sexual activity, substance use, sexual orientation, gender identity or challenges surrounding disclosure to partners is to be kept confidential.
- It is also important to discuss the potential limits of confidentiality, including, for example, the duty to report, STBBI reporting requirements and sharing of information amongst care providers. Some providers may worry that telling clients about the limits of confidentiality will create more fear, but being open and honest about the potential limits follows a trauma- and violence-informed approach because it allows the client to have informed consent and control over what information they decide to share.
- Explain to clients why certain questions are being asked and reiterate that all responses will be kept confidential. Service providers need to consider their own attitudes, values and beliefs to determine if their questions are rooted in personal assumptions or are pertinent to the client's care needs.
- Each province has its own STBBI reporting requirements. As the facilitator, make sure that you are familiar with the local reporting requirements (or know where to refer participants).
- Under criminal law in Canada, people living with HIV have a legal duty to disclose their HIV-positive status to their sexual partner(s) when they engage in sex that poses a "realistic possibility of HIV transmission" (which is interpreted by the courts). The current criminalization of HIV perpetuates stigma and discrimination

against people living with HIV and may further isolate them from health and social services. Further, criminalization can reinforce internalized and perceived stigma and may in turn contribute to a client's unwillingness to discuss their sexual or substance use practices with providers. These are important considerations for service providers when working with people living with HIV or seeking HIV testing.

**NOTE:** While service providers cannot provide legal advice to their clients, they should not shy away from conversations about HIV and related disclosure issues. If participants have any questions about privacy, confidentiality, the criminalization of HIV non-disclosure, or other legal issues, instruct them to the supplementary resources listed in Appendix H.

## SLIDE 19: DISCUSSING SEXUAL HEALTH, SUBSTANCE USE AND STBBIS: A GUIDE FOR SERVICE PROVIDERS

**OBJECTIVE:** To practice using the *Discussing sexual health, substance use and STBBIs: A guide for service providers*.

**MATERIALS:** Participant workbook (page 12), copies of the *Discussing sexual health, substance use and STBBIs: A guide for service providers* (listed as a supplementary resource in Appendix H)


**NOTE: SEND THE DISCUSSING SEXUAL HEALTH, SUBSTANCE USE AND STBBIS: A GUIDE FOR SERVICE PROVIDERS TO PARTICIPANTS IN ADVANCE OF THE WORKSHOP FOR THEIR REVIEW. HAVE EXTRA COPIES AVAILABLE AT THE WORKSHOP.**

### STEPS/DISCUSSION POINTS:

1. Direct participants to page 12 of their workbooks. Participants can follow along in their workbooks for slides 19-26.
2. Ensure all participants have a copy of the *Discussing sexual health, substance use and STBBIs: A guide for service providers* (referred to below as discussion guide).
3. Provide an overview of the discussion guide:

   This discussion guide is a tool that can be used by service providers to facilitate safer and more respectful discussions with clients about sexuality, substance use and STBBIs (e.g., during sexual health counselling, when taking a sexual health and substance use history, when discussing different STBBI testing options). A broad range of service providers (e.g., nurses, physicians, health educators, social workers, etc.) working in sexual health and/or harm reduction services or in general health and social services can use this guide.

The discussion guide is based on the Center for Disease Control and Prevention's Guide to taking a sexual health history and was modified to reflect Canadian language and context, and to incorporate substance use as well as stigma and discrimination reduction. The discussion guide drew on peer-reviewed and grey literature reviews, as well as several key informant interviews with service providers and clients living with or affected by STBBIs. It is organized as follows:

**a.** creating a safe and respectful environment;

**b.** the 5Ps or the five broad categories of issues that may arise when discussing sexual health, substance use and STBBIs with clients (practices, partners, protection from STBBIs, past history of STBBIs and pregnancy); and

**c.** wrapping-up the discussion.

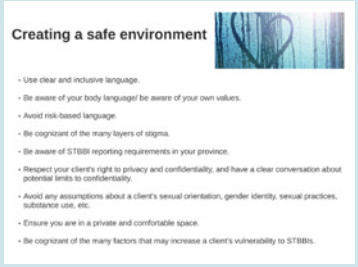
The discussion guide should not be used as a standard for diagnosis or a data collection tool, nor should the sample dialogue be used as a script. Rather, it is meant to facilitate safer and more respectful discussions about sexuality, substance use and STBBIs between service providers and clients. Providers should practice incorporating the 5Ps into client conversations. The questions and the manner in which they are asked (e.g., the order in which the 5Ps are discussed, the use of closed-ended versus open-ended questions) can be modified depending on the nature of the visit, the relationship between provider and client, the client's understanding of STBBIs, etc. It is unlikely that all of the questions in the sample dialogues will apply to every interaction; in many instances, the use of all questions would be interpreted as inappropriate and invasive. The line of questioning will vary depending on whether providers are taking a formal history prior to STBBI testing or having a general conversation about sexuality and substance use during a counselling or education session.

**4.** Tell participants that you will begin by discussing each of the sections of the discussion guide, and then move into a role-playing activity to practice using this tool.

## SLIDE 20: CREATING A SAFE ENVIRONMENT

**OBJECTIVE:** To provide a quick review of the "Creating a safe environment" section of the discussion guide.

**MATERIALS:** Participant workbook (page 12), copies of the *Discussing sexual health, substance use and STBBIs: A guide for service providers* (listed as a supplementary resource in Appendix H)



## STEPS/DISCUSSION POINTS:

1. As a group, review the recommendations for "Creating a safe environment".
2. Time permitting, ask the group to share some of challenges they face (if any) in creating a safer and more inclusive environment for their clients. What strategies do they employ to overcome these challenges (or brainstorm potential solutions as a group)? Sample challenges:
    - lack of time to form a rapport with the client so they feel safe and comfortable;
    - difficulty explaining possible limits to privacy and confidentiality;
    - lack of time to engage in exercises of self-reflection and to unpack one's own implicit attitudes, values and beliefs;
    - perception that clients do not want to discuss their sexual health and/or substance use:
        - fear of offending or upsetting the client;
        - perceived differences in age, gender or sexual orientation between the provider and the client, ultimately creating a sense of discomfort; and
    - addressing internalized stigma for individuals experiencing marginalization and resultant health inequities.

## DISCUSSION POINTS

- Create a space where clients feel comfortable talking about their sexual health, substance use, gender identity, sexual orientation, etc. without fear of judgement, and where harm reduction strategies can be tailored to their needs.
- Make sure to ask clients for their permission before moving into a discussion of their sexual health and substance use. Tell clients they do not have to answer any questions with which they are not comfortable, and encourage them to ask questions to clarify any issues.

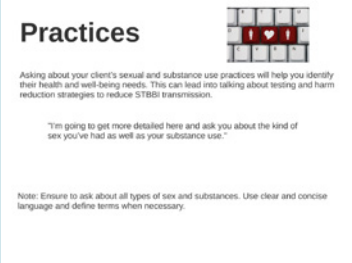
Many factors impact an individual's vulnerability to STBBIs, including health literacy and the ability to navigate health and social service systems, the ability to negotiate harm reduction practices, the need for intimacy and pleasure, experiences of stigma and discrimination, etc. All of these factors are influenced by the social determinants of health, which include housing, education, income, employment and working conditions, social support networks, gender, etc.

**While STBBIs, sexual health or harm reduction may be the primary focus of your discussions with clients, make sure to acknowledge all the factors that may impact your client's vulnerability to STBBIs and tailor any harm reduction strategies to their unique lived experiences. If necessary, refer your client to other support services available in their community.**

# SLIDE 21: PRACTICES

**OBJECTIVE:** To discuss the main points of the first of the 5Ps: Practices.

**MATERIALS:** Participant workbook (page 12), copies of the *Discussing sexual health, substance use and STBBIs: A guide for service providers* (listed as a supplementary resource in Appendix H)




## STEPS/DISCUSSION POINTS:

1. Explain to the group that the 5Ps represent the primary issues that may arise when discussing sexuality, substance use and STBBIs with clients. Though presented as distinct categories, it is not necessary to discuss the "5Ps" in any given order; it is likely that the conversation will move from one "P" to the next. Conversations must be tailored to the client's care needs.
2. Ask the group to share some of the strategies they use to ask clients about their sexual and/or substance use practices. Notice if the word "risk" is present in their dialogue. Remind participants of the earlier activity (slide 17) and the potential impact of value-laden language such as risk. Encourage participants to explore the use of other terms (e.g., practices, behaviours).
3. Time permitting, ask the group to share the challenges they face when discussing sexual and substance use practices with clients, and the strategies they use to overcome them (or brainstorm potential solutions as a group). Sample challenges:
    - discussing sexual consent with clients in a safe, respectful way;
    - discomfort related to a client disclosure of sexual trauma or sexualized violence;
    - the ability to provide follow-up if a client discloses they have had unwanted sexual contact, or they have assaulted another person;
    - engaging in pre- and post-test counselling with clients who come for frequent STBBI testing; and
    - dealing with clients experiencing internalized and perceived stigma who are uncomfortable or uninterested in discussing their sexual and substance use practices.

## DISCUSSION POINTS

- Use sex-positive and harm reduction approaches and recognize that clients may engage in different sexual and substance use practices for many reasons, including pleasure, health literacy and availability of information, the need for intimacy, broader social and structural factors including stigma and discrimination, etc.

**NOTE** that asking about past sexual and substance use practices may be difficult for some; employ a trauma- and violence-informed care approach.

- It is unlikely that all of the questions will be relevant to all interactions with clients. Some questions may only be appropriate after a rapport with the client has been established. Use your discretion and follow the client's cues (e.g., body language, verbal responses).

### SAMPLE DIALOGUE:

**"I'm going to get more detailed here about the kind of sex you've had as well as your substance use practices."**

**"What kind of sex do you have (or have you had in the past):**

**a.** Vaginal sex (penetration of the vagina)?
**b.** Anal sex (penetration of the anus)?
**c.** Oral sex (mouth on penis, vagina, or anus)?
**d.** Manual stimulation of the penis, vagina, anus?"

**"Do you now use or have you ever used any of these substances?**

**a.** tobacco
**b.** alcohol
**c.** marijuana
**d.** prescription drugs for non-medical purposes
**e.** street drugs (e.g., heroin, cocaine, ecstasy, etc.)?"

## SLIDE 22: PARTNERS

**OBJECTIVE:** To discuss the main points of the second of the 5Ps: Partners.

**MATERIALS:** Participant workbook (page 12), copies of the *Discussing sexual health, substance use and STBBIs: A guide for service providers* (listed as a supplementary resource in Appendix H)

## STEPS/DISCUSSION POINTS:

1. It is helpful for service providers to gather some information about a client's sexual and substance use partners to help guide their discussion of harm reduction strategies.
2. Ask participants to share the language they use to ask about clients' sexual and substance use partners. Remind participants of the need to use language that is respectful of sexual and gender diversity (e.g., use of the term partner instead of husband/wife/boyfriend/girlfriend; refraining from making assumptions about a person's physiology, gender identity, sexual orientation, etc. based on their appearance). **Clients who have experienced stigma within health or social service settings in the past, as well as clients who identify with groups that have been subject to historical marginalization, may be hyperaware of language.**
3. Time permitting, ask the group what challenges they face (if any) when talking with clients about their partners, and the strategies they use to overcome them (or brainstorm potential solutions as a group). Sample challenges:
    - discussing sexual consent with service users;
    - discussing criminalization of HIV non-disclosure; and
    - use of sexual health or substance use history forms that necessitate asking various questions that do not reflect clients' care needs

## DISCUSSION POINTS

Where possible, use open-ended questions. Depending on the nature of the visit as well as your relationship with the client, some closed-ended questions may be necessary. Inform your client that these questions are asked of everyone and explain the rationale for your line of questioning (e.g., to identify STBBI testing sampling sites, to assist with contact tracing, etc.). Remind clients that they are not required to answer any or all of the questions if they are not comfortable.

## SAMPLE DIALOGUE:

**"How many different people have you had sex with in the past 2 months? In the past year?"**

0? 1-2? 3-10? 10+?

**NOTE:** Asking clients about the number of sexual partners may be interpreted as immaterial and invasive. This line of questioning should only be used when necessary (e.g., in the context of STBBI testing or partner notification). Alternatively, ask individuals whether they have had sex with multiple people.

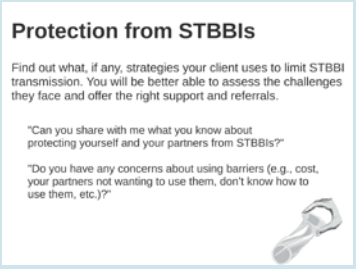
**"Do you ask about the STI or sexual health history of your sexual partners?"**

**"Who do you normally use substances with? How do you typically use together?"**

# SLIDE 23: PROTECTION FROM STBBIS

**OBJECTIVE:** To discuss the main points from the third of the 5Ps: Protection from STBBIs.

**MATERIALS:** Participant workbook (page 12), copies of the *Discussing sexual health, substance use and STBBIs: A guide for service providers* (listed as a supplementary resource in Appendix H)




## STEPS/DISCUSSION POINTS:

1. The third P provides service providers with an opportunity to identify the harm reduction strategies (if any) the client is currently using, and to discuss other harm reduction strategies that may work for them.
2. Ask participants to share how they ask their clients about protection from STBBIs. Remind participants that harm reduction should be discussed with all clients and that any suggested harm reduction strategies should be tailored to the client needs.
3. Time permitting, ask the group to share the challenges they face (if any) when discussing protection from STBBIs with clients and the strategies they use to overcome them (or brainstorm some potential solutions as a group). Sample challenges:
    - use of sexual health or substance use history forms that necessitate asking questions that do not reflect the clients' care needs;
    - ensuring that harm reduction strategies are tailored to clients' needs;
    - ensuring access to low-cost barrier methods for sexual activity as well as harm reduction supplies (e.g., condoms, dental dams, safe inhalation equipment, sterile injection equipment) when community support services are scarce;
    - working with clients who are not interested in adopting harm reduction strategies due to internalized stigma, feelings of low self-worth, etc.; and
    - assisting clients who cannot negotiate harm reduction practices with their partners because of power imbalances in the relationship and/or a fear of reprisal or violence.

## DISCUSSION POINTS

Asking clients what they know about protection from STBBIs can be a helpful starting point to a conversation. Use open-ended questions. Based on the responses, you can see what direction your dialogue should take and what harm reduction information to give.

Remind participants to acknowledge the many factors that affect a client's willingness and capacity to engage (or not engage) in harm reduction strategies.

**NOTE:** Facilitators are strongly encouraged to review the *Factors impacting vulnerability to HIV and other STBBIs*, Canadian Public Health Association, 2014 prior to facilitating this session.

### SAMPLE DIALOGUE:

**Can you share with me what you know about protecting yourself and your partners from STBBIs?**

**Do you or your (regular and non-regular) partner(s) use any barriers (i.e., condoms, dental dams or split condoms/gloves) during sex? When do you use them (i.e., all the time, sometimes, never) and for what kind of sex (i.e., vaginal sex, oral sex, anal sex)?**

**Do you have any problems related to the use of barriers (e.g., cost, your partners not wanting to use them, not knowing how to use them, etc.)?**

**NOTE:** Demonstrate how to properly use and dispose of various barriers, if needed.

**What questions (if any) do you have about different barriers?**

**Do you know where to get low-cost or free barrier methods in your community?**

**Have you been vaccinated for HPV? Hepatitis A? Hepatitis B?**

**Are there any other things you do to protect yourself from STBBIs (e.g., using sterile injection equipment, not sharing substance use equipment, not using when you're alone, taking your antiretroviral medication regularly)?**

## SLIDE 24: PAST HISTORY OF STBBIS

**OBJECTIVE:** To discuss the main points from the fourth of the 5Ps: Past history of STBBIs.

**MATERIALS:** Participant workbook (page 12), copies of the *Discussing sexual health, substance use and STBBIs: A guide for service providers* (listed as a supplementary resource in Appendix H)


### STEPS/DISCUSSION POINTS:

1. Discussing an individual's past STBBI history is an excellent means to start talking about routine STBBI testing as well as the STBBIs that are not included in testing.
2. Ask participants if they usually discuss past STBBI history with clients and, if so, what questions do they ask.

3. Time permitting, ask the group to share the challenges they face (if any) in discussing past STBBI history with clients, and the strategies they use to overcome them (or brainstorm some potential solutions as a group). Sample challenges:
    - discussing potential limits to confidentiality (e.g., partner notification, STBBI reporting requirements);
    - providing a positive STBBI test result; and
    - discussing sexuality after a client has received a positive diagnosis (e.g., how a client should disclose to their sexual partners that they have been diagnosed with herpes).

## DISCUSSION POINTS

- Conversations about symptomology should emphasize that many STBBIs are asymptomatic and highlight routine testing as an important way for the client to maintain overall health.
- When discussing STBBI testing, be very clear with clients about which STBBIs they will (and will not) be tested for. Give the client clear information on what they can expect if they choose to go forward with testing. Be prepared to discuss partner notification and treatment options as well as support services available in the community in case of a positive test.
- If the client discloses a past STBBI diagnosis, normalize their experience and give non-judgemental information. Some STBBIs are common, such as herpes, yet carry a great deal of stigma.

## SAMPLE DIALOGUE:

- **Have you ever had a Pap test (or Pap smear) and/or pelvic exam?**
  If yes, when was your last Pap test? Do you know if you were screened for HPV?
- **Have you ever had an STBBI?**
  If yes, when? Were you treated? Do you know how you were treated? Did you retest after you finished treatment? Do you have any ongoing problems or concerns?
- **Do you know if any of your current or past sexual partner(s) have had an STBBI?**
  If yes, were you tested? Were you treated? Do you know how you were treated? Did you retest after you took the treatment?
- **Do you have any signs or symptoms that worry you – any lumps, bumps, discharge, pain?**
- **Would you like to be tested?**
- **(If yes): Do you have any questions before we do the testing?**

# SLIDE 25: PREGNANCY

**OBJECTIVE:** To discuss the main points from the fifth of the 5Ps: Pregnancy.

**MATERIALS:** Participant workbook (page 12), copies of the *Discussing sexual health, substance use and STBBIs: A guide for service providers* (listed as a supplementary resource in Appendix H)


## STEPS/DISCUSSION POINTS:

1. Ask participants to reflect on whether they normally ask all clients about pregnancy. Participants may say that generally they do, but that they are more likely to ask people they assume could be pregnant (generally, heterosexual, cisgender females). In fact, all clients may be considering pregnancy or may be engaging in behaviours that could result in a pregnancy regardless of their physiology or sexual orientation.
2. Ask participants to share with the group how they normally discuss pregnancy with their clients.
3. Time permitting, ask the group what challenges they face (if any) in discussing pregnancy with clients, and the strategies they use to overcome them (or brainstorm some potential solutions as a group). Sample challenges:
    - discussing pregnancy with all clients, regardless of sexual orientation or gender identity, in a safe and respectful way; and
    - referring clients to other organizations for further pregnancy-related support.

## DISCUSSION POINTS

- Discuss pregnancy with those who want to become pregnant now or in the future, with those who do not want to become pregnant, and with those who are currently pregnant and want to discuss their options. Also discuss pregnancy with individuals whose sexual partner(s) are currently pregnant, are interested in becoming pregnant or are not interested in getting pregnant.
- Consider which/whether these questions should be posed if the client identifies as trans or gender diverse. Do not assume a person's physiology based on their gender identity or expression, and never make assumptions about a person's desire or capacity to get pregnant.

### SAMPLE DIALOGUE:

**Are you pregnant now?**

**NOTE:** Depending on the client's needs, be prepared to discuss different options for unintended pregnancy, or to refer as needed for prenatal care.

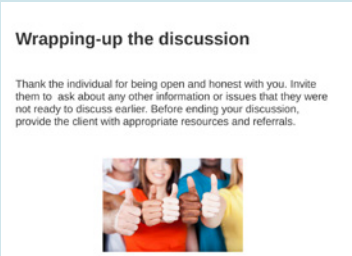
**Are you or your romantic or sexual partner(s) trying to get pregnant? Are you or your romantic or sexual partner(s) interested in becoming pregnant in the future?**

**NOTE:** Be prepared to discuss various contraceptive methods.

## SLIDE 26: WRAPPING-UP THE DISCUSSION

**OBJECTIVE:** To discuss the final step in the discussion guide: Wrapping-up the discussion.

**MATERIALS:** Participant workbook (page 12), copies of the *Discussing sexual health, substance use and STBBIs: A guide for service providers* (listed as a supplementary resource in Appendix H)




### STEPS/DISCUSSION POINTS:

1. Tell participants that at the end of any conversation or counselling session about STBBIs, sexuality or substance use, it is important for service providers to show authentic appreciation for their client's honesty. In wrapping up the discussion, affirm and recognize the client's strengths and provide an opportunity for the client to ask questions.
2. Ask participants to share whether and how they ask clients about the factors that influence vulnerability to STBBIs. For example, do they ask about housing or access to support services?
3. Time permitting, ask the group to share some of the challenges they face (if any) in wrapping-up a discussion about sexual health, substance use and STBBIs with clients, and the strategies they use to overcome the challenges (or brainstorm some potential solutions as a group). Sample challenges:
    - lack of time to cover the factors that impact STBBI vulnerability and the social determinants of health; and
    - referring clients to other organizations for more support (e.g., may be limited access to other resources, hard to find services that meet client needs).

## DISCUSSION POINTS

Thank clients for coming in and talking with you. Acknowledge that it can be difficult to talk openly about sexuality and substance use, and cite the strength it took for them to come in.

## SAMPLE DIALOGUE:

**"Is there anything else you'd like to discuss that's impacting your health or well-being?"**

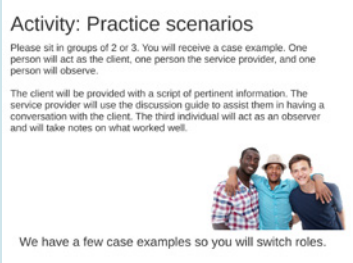
**"Is there anything that we discussed earlier that you'd like to revisit?"**

**"What other questions do you have for me?"**

# SLIDE 27: ACTIVITY - PRACTICE SCENARIOS

**OBJECTIVE:** To practice using the *Discussing sexual health, substance use and STBBIs: A guide for service providers*.

**MATERIALS:** Participant workbook (page 12), copies of the *Discussing sexual health, substance use and STBBIs: A guide for service providers* (listed as a supplementary resource in Appendix H) and *Practice scenarios* (see Appendix D)




## STEPS/DISCUSSION POINTS:

1. Ask participants to form groups of 2 or 3 for a small group role-playing activity. Inform the group that they will be provided with a practice scenario that reflects either a clinical or non-clinical practice setting; each group should select the version that best aligns with their professional roles, so it is best for small groups to form around professions.
2. Each group should choose an individual to play the role of a service provider, a client and a recorder. There are 3 practice scenarios, so each group member will have an opportunity to take on the three roles.
3. Pass out the service provider scenario to the volunteer service provider and the client scenario to the volunteer client. **Instruct participants that they are only to read the scenario that corresponds to their assumed role.**
4. Tell participants that the volunteer service provider has been provided with only a small element of the client's story. The client has received a separate script. Instruct the service provider to use the *Discussing sexual health, substance use and STBBIs: A guide for service providers* to work through the scenario and to discuss the 5Ps with the client. Instruct the client to use the instructions contained within the practice scenario to guide their responses.

5. Instruct the recorder to take notes on what worked well during the interaction (e.g., questions that were free of judgement, affirming statements, etc.). The recorder should not give negative feedback to the volunteer service provider or volunteer client.
6. Remind participants to recall the strategies that help create safer spaces, the importance of plain and simple language, the role of body language and the need to discuss confidentiality. Participants may also need to define terms like STBBIs or sexual activity.
7. Allow the group 10-15 minutes to work through the first scenario.
8. Come back together as a group to debrief.
    a. Ask the volunteer service providers how it felt to use the discussion guide.
    b. Were they surprised by any of the client's responses?
    c. Ask the volunteer clients how it felt to play that role.
    d. Ask the volunteer recorders to share what they observed during the activity. What worked well during the interaction?
    e. Encourage participants to share their own strategies for discussing STBBIs, sexuality and substance use.
9. Repeat steps 1-8 for the remaining 2 scenarios.

**NOTE that key discussion points for each scenario are available in Appendix D.**

# MODULE 4: CLOSING

## SLIDE 28: NEXT STEPS

**OBJECTIVE:** To debrief and make concrete plans for the future.

**MATERIALS:** n/a


### STEPS/DISCUSSION POINTS:

1. End the workshop on a positive note. Thank participants for all of their comments and feedback, and share what you learned from the group.
2. If time permits, provide participants with a few minutes to discuss in small groups the changes they intend to make to their practice or the strategies they intend to share with

their colleagues following their participation in the workshop. Participants can also use this time to connect with others in the room regarding collective action to improve services at the community level. After several minutes, bring the group back together and ask participants to share one thing they intend to do differently or one thing they intend to share with their colleagues.

## SLIDE 29: CLOSING AND QUESTIONNAIRE

**OBJECTIVE:** To share final thoughts, comments or questions.

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


### STEPS/DISCUSSION POINTS:

1. Remind participants that they can access additional resources such as the *Self-assessment tool for sexually transmitted and blood-borne infections and stigma* or the *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBIs) and stigma*. Refer participants to the list of additional resources found in their workbook on page 18.
2. 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 some of the 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.
3. Finally, ensure all participants complete the post-workshop questionnaire. Remind them that their feedback is anonymous, confidential and important.

# REFERENCES


Baker JR, Arnold-Reed D, Brett T, Hince DA, O'Ferrall I, Bulsara MK. Perceptions of barriers to discussing and testing for sexually transmitted infections in a convenience sample of general practice patients. *Australian Journal of Primary Health* 2013;19(2): 98-101.

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).

Beagan BL, Fredericks E, Goldberg L. Nurses' work with LGBTQ patients: "They're just like everybody else, so what's the difference?". *Canadian Journal of Nursing Research* 2012; 44(3):44-63.

Boekeloo BO. Will you ask? Will they tell you? Are you ready to hear and respond?: Barriers to physician-adolescent discussion about sexuality. *JAMA pediatrics* 2014;168(2):111-113.

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/core-competencies-stbbi-prevention (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/factors-impacting-vulnerability-hiv-and-other-stbbis (Accessed May 6, 2014).

College of Registered Nurses of British Columbia. *STI assessment.* 2015. Available at: https://www.crnbc.ca/Standards/CertifiedPractice/Documents/ReproductiveHealth/719STIAssessmentDST.pdf (Accessed March 2, 2105).

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.

French K. How to improve your sexual health history-taking skills. *Practice Nurse* 2010;40(2):27-30.

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.

Knight RE, Shoveller JA, Carson AM, Contreras-Whitney J. Examining clinicians' experiences providing sexual health services for LGBTQ youth: considering social and structural determinants of health in clinical practice. *Health education research* 2014;29(4):662-670.

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.

Maes CA, Louis M. Nurse Practitioners' Sexual History-Taking Practices with Adults 50 and Older. *Journal for Nurse Practitioners* 2011;7(3):216-222.

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.

Masaro CL, Johnson J, Chabot C, Shoveller J. STI service delivery in British Columbia, Canada; providers' views of their services to youth. *BMC Health Serv Res* 2012;12(240).

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.

Public Health Agency of Canada. *Canadian guidelines on sexually transmitted infections.* Ottawa, Ontario: 2006. Available at: http://www.phac-aspc.gc.ca/std-mts/sti-its/index-eng.php (Accessed March 2, 2015).

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).

Sargant NN, Smallwood N, Finlay F. Sexual history taking: A dying skill? *Journal of palliative medicine* 2014;17(7): 829-831.

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.

Szewchuk, A. *Providing appropriate STI care for transgender and gender-diverse clients*. 2014. Available at: http://smartsexresource.com/health-providers/blog/201408/providing-appropriate-sti-care-transgender-and-gender-diverse-clients (Accessed March 2, 2015).

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 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 45-minute lunch break.

| Module/slide title | Timeframe |
|---|---|
| **Module 1: Introductions** | **37 minutes (excluding breaks)** |
| Slide 1: Welcome and questionnaire | 5 minutes |
| Slide 2: Background | 3 minutes |
| Slide 3: Workshop overview | 2 minutes |
| Slide 4: Learning objectives | 2 minutes |
| Slide 5: Learners' rights | 10 minutes |
| Slides 6-9: Key terms | 15 minutes |
| **Module 2: Exploring stigma and factors that contribute to stigma** | **76 minutes (excluding breaks)** |
| Slide 10: Activity - The language of sex | 20 minutes |
| Slide 11: Activity - Name the substance | 10 minutes |
| Refreshment break | 10 minutes |
| Slide 12: Unpacking stigma | 10 minutes |

| Module/slide title | Timeframe |
|---|---|
| Slide 13: Stigma defined | 6 minutes |
| Slide 14: Activity - Stigma case scenario | 25 minutes |
| Slide 15: What do clients think? | 5 minutes |
| **Module 3: Strategies to reduce stigma and discuss sexual health, substance use and STBBIs** | **107 minutes (excluding breaks)** |
| Slide 16: Practice tools | 2 minutes |
| Slide 17: Activity - Unpacking risk | 15 minutes |
| Slide 18: A note about privacy and confidentiality | 5 minutes |
| Lunch break | 45 minutes |
| Slides 19-26: Discussing sexual health, substance use and STBBIs: A guide for service providers | 25 minutes |
| Slide 27: Activity - Practice scenarios | 60 minutes |
| Refreshment break<br>*Note: This break may be offered in the middle of the Activity – Practice scenarios.* | 10 minutes |
| **Module 4: Closing** | **15 minutes (excluding breaks)** |
| Slide 28: Next steps | 10 minutes |
| Slide 29: Closing and 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** | **20 minutes (excluding breaks)** |
| Slide 1: Welcome and questionnaire | 4 minutes |
| Slide 2: Background | 1 minute |
| Slide 3: Workshop overview | 1 minute |
| Slide 4: Learning objectives | 1 minute |
| Slide 5: Learners' rights | 5 minutes |
| Slides 6-9: Key terms | 8 minutes |
| **Module 2: Exploring stigma and factors that contribute to stigma** | **64 minutes (excluding breaks)** |
| Slide 10: Activity - The language of sex | 18 minutes |
| Slide 11: Activity - Name the substance | 8 minutes |
| Slide 12: Unpacking stigma | 5 minutes |
| Slide 13: Stigma defined | 3 minutes |
| Refreshment break | 10 minutes |
| Slide 14: Activity - Stigma case scenario | 25 minutes |
| Slide 15: What do clients think? | 5 minutes |

| Module/slide title | Timeframe |
|---|---|
| **Module 3: Strategies to reduce stigma and discuss sexual health, substance use and STBBIs** | **66 minutes (excluding breaks)** |
| Slide 16: Practice tools | 1 minute |
| Slide 17: Activity - Unpacking risk | 8 minutes |
| Slide 18: A note about privacy and confidentiality | 2 minutes |
| Slides 19-26: Discussing sexual health, substance use and STBBIs: A guide for service providers | 15 minutes |
| Refreshment break | 10 minutes |
| Slide 27: Activity - Practice scenarios | 40 minutes |
| **Module 4: Closing** | **10 minutes (excluding breaks)** |
| Slide 28: Next steps | 5 minutes |
| Slide 29: Closing and 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. Note that the 90-minute sample agenda does not include any refreshment breaks.

| Module/slide title | Timeframe |
|---|---|
| **Module 1: Introductions** | **19 minutes** |
| Slide 1: Welcome and questionnaire | 5 minutes |
| Slide 2: Background | 1 minute |
| Slide 3: Workshop overview | 1 minute |
| Slide 4: Learning objectives | 1 minute |
| Slide 5: Learners' rights | 3 minutes |
| Slides 6-9: Key terms | 8 minutes |
| **Module 2: Exploring stigma and the factors that contribute to stigma** | **31 minutes** |
| Slide 10: Activity - The language of sex<br>*Note: Discuss as large group, rather than in smaller breakout groups.* | 8 minutes |
| Slide 11: Activity - Name the substance | 5 minutes |
| Slide 12: Unpacking stigma<br>*Note: Discuss as large group, rather than in smaller breakout groups.* | 3 minutes |
| Slide 13: Stigma defined | 3 minutes |
| Slide 14: Activity - Stigma case scenario<br>*Note: Allow participants several minutes to read the case scenario. Discuss as a large group, rather than in smaller breakout groups.* | 10 minutes |
| Slide 15: What do clients chink? | 2 minutes |

| Module/slide title | Timeframe |
|---|---|
| **Module 3: Strategies to reduce stigma and discuss sexual health, substance use and STBBIs** | **32 minutes** |
| Slide 16: Practice tools | 1 minute |
| Slide 17: Activity - Unpacking risk | 5 minutes |
| Slide 18: A note about privacy and confidentiality | 1 minute |
| Slides 19-26: Discussing sexual health, substance use and STBBIs: A guide for service providers | 5 minutes |
| Slide 27: Activity - Practice scenarios<br>*Note: You will likely only have time for 1-2 scenarios.* | 20 minutes |
| **Module 4: Closing** | **8 minutes** |
| Slide 28: Next steps | 4 minutes |
| Slide 29: Closing and questionnaire | 4 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. 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 they 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 behaviors 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 behaviors 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 behaviors 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 got at the clinic. They once again begin to feel guilty about their behaviors 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:

- 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 lots of 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.[20,21,22,23,24]

   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.[25] 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.

20 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).

21 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.

22 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.

23 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.

24 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).

25 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 C: NAME THE SUBSTANCE ACTIVITY

- Side effects may include difficult or troubled breathing; irregular, fast or slow, or shallow breathing; pale or blue lips, fingernails, or skin; and shortness of breath.
- When taken in large doses, this substance can cause liver damage. Although rare, very large doses can lead to liver transplantation and death.
- Long-term use can lead to constipation.
- Signs of an overdose include dark urine; difficult or troubled breathing; irregular, fast or slow, or shallow breathing; nausea or vomiting; pain in the upper stomach; pale or blue lips, fingernails or skin; pinpoint pupils of the eyes; or yellow eyes or skin.

## Answer: Acetaminophen (Tylenol)

Adapted from *Acetaminophen and codeine*, Mayo Clinic, 2016. Available at: http://www.mayoclinic.org/drugs-supplements/acetaminophen-and-codeine-oral-route/description/drg-20074117 (Accessed January 3, 2016).

- Higher amounts can cause extreme agitation, tremors, and very rapid or irregular heartbeat.
- Consumption of more than 5,000 mg over a short time can be fatal.
- Long-term use of large amounts may be associated with loss of bone density, increasing the risk of osteoporosis.
- Long-term use is also associated with irregular heartbeat and may raise cholesterol levels.

## Answer: Caffeine

Adapted from *Caffeine*, Centre for Addiction and Mental Health, 2011. Available at: http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/Caffeine/Pages/default.aspx (Accessed January 3, 2016).

- Use of this substance causes:
  - the blood vessels to thicken and constrict, reducing the flow of oxygen to the heart;
  - the heart muscle to work harder, thereby increasing the risk of heart attack or stroke; and
  - increased blood pressure.
- Use of this substance is associated with risk-taking and violent behaviours. It is also linked to poor concentration and judgment, increasing chance of injury and sexually transmitted infections.
- A person can overdose on even a small amount of this substance. Overdoses can cause seizures and heart failure. It can also cause breathing to slow or stop altogether.
- Chronic use can lead to panic attacks and psychotic symptoms, such as paranoia (feeling overly suspicious, jealous, or persecuted), hallucinations (seeing, hearing, smelling things that are not real), delusions (false beliefs) and erratic, bizarre and sometimes violent behaviour.

## Answer: Cocaine

Adapted from *Cocaine and crack*, Centre for Addiction and Mental Health, 2010. Available at: http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/Cocaine/Pages/default.aspx (Accessed January 3, 2016).

- This substance produces a surge of euphoria, followed by a period of sedation or tranquility.
- Other effects include slowed breathing, pinpoint pupils, itchiness and sweating.
- Regular use results in constipation, loss of sexual interest and libido, and an irregular or stopped menstrual cycle in women.
- People who use this substance daily must use every 6 to 12 hours to avoid symptoms of withdrawal. Initial withdrawal symptoms are intense, and include runny nose, sneezing, diarrhea, vomiting, restlessness and a persistent craving for the substance.
- In an overdose, breathing slows down and may stop completely.
- Can result in tolerance and dependence over the long term.

## Answer: Heroin

Adapted from *Heroin*, Centre for Addiction and Mental Health, 2010. Available at: http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/Heroin/Pages/default.aspx (Accessed January 3, 2016).

- Possible side effects may include, among others:
  - drowsiness
  - nausea
  - dry mouth
  - insomnia
  - diarrhea
  - nervousness, agitation or restlessness
  - dizziness
  - sexual problems, such as reduced sexual desire or difficulty reaching orgasm or inability to maintain an erection (erectile dysfunction)
  - headache
  - blurred vision
- People may use this substance to treat anxiety, panic, eating disorders, chronic pain, PTSD, premature ejaculation and depression.
- Abruptly stopping use can lead to general feeling of uneasiness, nausea, dizziness, lethargy and/or flu-like symptoms.

## Answer: Selective serotonin re-uptake inhibitors (or, serotonin-specific reuptake inhibitors) (SSRIs)

Adapted from *Selective serotonin reuptake inhibitors (SSRIs)*, Mayo Clinic, 2016. Available at: http://www.mayoclinic.org/diseases-conditions/depression/in-depth/ssris/art-20044825?pg=1 (Accessed January 3, 2016).

- This substance can cause:
  - depression
  - slurred speech
  - drowsiness
  - slowed reflexes
  - impaired judgement
  - double or blurred vision
  - reduced muscle control
  - loss of consciousness and loss of memory
- Effects of extreme use include inability to stand, vomiting, stupor, coma and death.
- Long-term use increases the risk of brain and nerve damage; high blood pressure and strokes; diseases of the stomach, digestive systems and pancreas; breast cancer and throat cancer; liver disease; low sex hormones; damage to the fetus if used during pregnancy; and dependence.

## Answer: Alcohol

Adapted from: *Alcohol*, Centre for Addiction and Mental Health, 2012. Available at: http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/alcohol/Pages/alcohol.aspx (Accessed January 3, 2016).

# APPENDIX D: CLINICAL AND NON-CLINICAL PRACTICE SCENARIOS

## SCENARIO 1

### INSTRUCTIONS TO SERVICE PROVIDER (CLINICAL)

You are about to see the client. They have arrived at the sexual health clinic to get tested for HIV and other STIs. He is a 26-year-old man who has previously reported that he exclusively has sex with other men. You can see from his file that he has accessed testing numerous times in the past. It has been 8 months since his last visit.

# SCENARIO 1

## INSTRUCTIONS TO CLIENT (CLINICAL)

Your name is Alex. You are 26 years old. You started to self-identify as a gay man 2 years ago and you have come out to some people in your life, though you have not yet come out at work or to your family.

You have had the same family doctor who deals with all of your health needs for as long as you can remember, and your family doctor is shared with the other members of your family. You have not disclosed to her that you are gay because you are concerned that she will judge you and you are worried that she may "out" you to your family. Your family doctor has never questioned you about your sexual activity and has never offered you an HIV or STI test.

For you, sex is a private thing and it is something that you are uncomfortable discussing. You have been sexually active since 18, and all of your sexual partners have been men.

Although you believe it is important to use condoms when having anal sex, you have a hard time asking your sexual partners to use condoms. At 22, a friend suggested that you get tested for STIs and so you came to the local sexual health clinic for the first time. You have continued to receive testing at the sexual health clinic at irregular intervals for the past 4 years.

Every time you have come to the sexual health clinic, you have met with a different nurse. This has been frustrating for you as you have had to "come out" each time. Generally, unless asked specifically, you do not disclose that you are gay.

In the past 4 years, you have had 2 separate positive test results for gonorrhea. In both instances, you returned for treatment and in both instances, you felt like the STI nurse was judging you for engaging in anal sex without a condom, even though you already feel guilty about the inconsistency of your condom use.

After 8 months since your last visit, you are now back at the sexual health clinic to get tested. You had sex without a condom 4 weeks ago with a partner who you did not know and have no way of contacting, and have since noticed some discharge from your penis. You are concerned about your test result and are afraid the nurse will react negatively to your disclosure of having sex without a condom with an anonymous partner. You are unsure what information you want to share with the nurse. If made to feel secure, you will be honest, but if you feel as though you are being judged, you will likely refrain from sharing any details about your sexuality. You just want to get the testing over with and get home.

# SCENARIO 1

## INSTRUCTIONS TO SERVICE PROVIDER (NON-CLINICAL)

You are about to see the client. He has arrived at the sexual health centre to learn more about HIV and other STIs. He is a 26-year-old man who has previously reported that he exclusively has sex with other men. You can see from his file that he has accessed testing numerous times in the past. It has been 8 months since his last visit. In the past, he has only accessed clinical services. This is the first time that he has asked to see a sexual health educator/counsellor.

# SCENARIO 1

## INSTRUCTIONS TO CLIENT (NON-CLINICAL)

Your name is Alex. You are 26 years old. You started to self-identify as a gay man 2 years ago and you have come out to some people in your life, however you have not yet come out at work or to your family.

For you, sex is a private thing and it is something that you are uncomfortable discussing. You have been sexually active since 18, and all of your sexual partners have been men.

Although you believe it is important to use condoms when having anal sex, you have a hard time asking your sexual partners to use condoms. At 22, a friend suggested that you get tested for STIs and so you came to the local sexual health centre for the first time. You have continued to receive testing at the sexual health centre at irregular intervals for the past 4 years.

In the past 4 years, you have had 2 separate positive test results for gonorrhea. In both instances, you returned for treatment and in both instances, you felt like the STI nurse was judging for engaging in anal sex without a condom, even though you already feel guilty about the inconsistency of your condom use.

You have come in today specifically because you had sex without a condom 4 weeks ago with a partner who you did not know and have no way of contacting. You are concerned about how the sexual health educator will react to your disclosure of having sex without a condom with an anonymous partner. You are unsure what information you want to share with the service provider. If made to feel secure, you will be honest, but if you feel as though you are being judged, you will likely refrain from sharing any details about your sexuality.  You would like to discuss the harm reduction strategies that you can use when having anal sex and would like to learn more about negotiating barrier use with your partners. You are feeling very nervous about being at the sexual health centre.

# SCENARIO 1

## DEBRIEF QUESTIONS FOR BOTH CLINICAL AND NON-CLINICAL SCENARIOS

**1. How did the experience feel for the acting service provider and the acting client?**

**POSSIBLE ANSWERS:**

- Playing the role of the client can help build empathy for the people that access our services, as it can be very difficult to answer such personal questions about oneself.
- For service providers, it can be challenging to work with a client that is dealing with both perceived and internalized stigma.
- Creating a safe environment, being considerate of language and ensuring that the client understands why you are asking certain questions can be time-consuming. However, if done properly, these strategies can help foster a trusting rapport with the client and facilitate discussion of the client's health and well-being.

**2. What techniques worked well?**

**POSSIBLE ANSWERS:**

- explaining why each question was being asked
- using a trauma- and violence-informed care approach
- ensuring privacy and confidentiality
- asking open-ended questions
- allowing the client to disclose at their own pace
- allowing the client to identify what services they needed

**NOTE:** Participants may say that it was challenging to use the *Discussing sexual health, substance use and STBBIs: A guide for service providers* or to address all 5Ps in the discussion. Tell participants that with practice, this will become easier and reiterate that not every client interaction will necessitate a discussion of all 5Ps and that the sample questions should only be posed if they are commensurate with the client's care needs.

# SCENARIO 2

## INSTRUCTIONS TO SERVICE PROVIDER (CLINICAL)

You are about to see the client. The only information you were given is that the client is concerned they may have herpes.

# SCENARIO 2

## INSTRUCTIONS TO CLIENT (CLINICAL)

Your name is Skye and you are 35 years old. You have some questions about sexuality and herpes. You are worried that you may have acquired herpes from a past sexual partner and have some symptoms that are disturbing you. You want to know if testing is possible, but are concerned that if you are diagnosed with herpes, you will no longer be able to engage in sexual activity. You are also worried that the clinic will tell your family physician about your diagnosis.

You feel that you deserve to have herpes, that maybe it is a result of you being sexual when you should not have been. You were taught from a very young age that sex is shameful and not to be discussed.

You are quite nervous to talk about herpes with the clinician, as you have never talked to anyone about sex or sexuality.

# SCENARIO 2

## INSTRUCTIONS TO SERVICE PROVIDER (NON-CLINICAL)

You are about to see the service user. The only information you were given is that the client wishes to speak to a counsellor/educator about herpes.

# SCENARIO 2

## INSTRUCTIONS TO CLIENT (NON-CLINICAL)

Your name is Skye and you are 35 years old. You have come in today to ask some questions about herpes.  You were just diagnosed with herpes by your physician and are very worried about telling your sexual partners. You fear you can no longer engage in sexual activity. You feel that you deserve to have herpes and that maybe it is because you engaged in sex when you should not have.

You are quite nervous to talk about herpes with the service provider, as you have never talked to anyone about sex or sexuality.

You were taught from a very young age that sex is shameful and that you should not speak openly about your sexuality. However, you do want to know how this will affect your future sexual partners, and you are open to speaking with a counsellor/educator if made to feel safe and respected.

# SCENARIO 2

## DEBRIEF QUESTIONS FOR BOTH CLINICAL AND NON-CLINICAL SCENARIOS

1. **How did it feel to play the client in this scenario? Do you think this is a common experience for the people accessing our services?**

   **POSSIBLE ANSWERS INCLUDE:**

   - This is a very common scenario within our service settings.
   - It was challenging to play the role of the client, given the shame and fear that the client was experiencing. The service provider had to be open and non-judgmental and allow the client to speak honestly about their needs.

2. **How did it feel to play the role of the service provider? What did you do as the service provider to frame the conversation in a meaningful manner?**

   **POSSIBLE ANSWERS INCLUDE:**

   - It was challenging, but it was also helpful to normalize the experience of herpes and to stress that many people have herpes and have similar fears and concerns about it. If clients are concerned about discussing their herpes diagnosis with their sexual partners, it can be helpful to role-play with them.
   - It can be challenging as counsellors or health educators to provide information about herpes or other STBBIs. It is common for non-clinical professionals to fear they do not have the information that the client is seeking. In this case, it is important to normalize the experience for the client and to look for more information together.

   - For clinical staff, this may be such a common conversation that it can be easy to unintentionally respond to the client in such a way that does not convey empathy. It is important to remember the stigma that is associated with herpes and to consider what a diagnosis may mean for an individual. Even if you are rushed, it is extremely important to address this issue with care. It may be helpful to refer the client to counselling services so that they can process their feelings.

**NOTE:** Participants may say that it was challenging to use the *Discussing sexual health, substance use and STBBIs: A guide for service providers* or to address all 5Ps in the discussion. Tell participants that with practice, this will become easier and reiterate that not every client interaction will necessitate a discussion of all 5Ps and that the sample questions should only be posed if they are commensurate with the client's care needs.

# SCENARIO 3

## INSTRUCTIONS TO SERVICE PROVIDER (CLINICAL)

You are about to see the client. The only information you were given is that the client wishes to speak about birth control options.

# SCENARIO 3

## INSTRUCTIONS TO CLIENT (CLINICAL)

Your name is Tobia and you would like to speak to someone about birth control options. You immediately tell the service provider that you are interested in obtaining an IUD. You are married to a long-term partner. You have no children and generally use condoms when engaging in sexual activity with your partner. You have never been tested for STBBIs and have been told by past service providers that you are "low risk" and therefore do not need to get tested.

You have never been asked about substance use, and so have never disclosed your use to a service provider. You often engage in recreational use of cocaine, MDMA and alcohol. You have previously engaged in sexual activity while using substances and have at times woken up and not been able to remember anything from the night before. You do not feel that your substance use is problematic, and therefore have no interest in reducing your use.  However, you have felt guilty and anxious in the past when you have not been able to remember what occurred the night before.

# SCENARIO 3

## INSTRUCTIONS TO SERVICE PROVIDER (NON-CLINICAL)

You are about to see the client. The only information you were given is that the client wishes to speak about STBBIs.

# SCENARIO 3

## INSTRUCTIONS TO CLIENT (NON-CLINICAL)

Your name is Tobia and you have come in today to talk about STBBIs. You are married to a long-term partner. You have no children and generally use condoms when engaging in sexual activity with your partner. You have never been tested for STBBIs and have been told by past service providers that you are "low risk" and therefore do not need to get tested.

You have never been asked about substance use, and so have never disclosed your use to a service provider. You often engage in recreational use of cocaine, MDMA and alcohol. You have previously engaged in sexual activity while using substances and have at times woken up and not been able to remember anything from while you were intoxicated. You do not feel that your substance use is problematic, and therefore have no interest in reducing your use.  However, you have felt guilty and anxious in the past when you have not been able to remember what occurred the night before.

While you are on birth control and not worried about pregnancy, you are worried about STIs and whether this is a concern for you and your partner. You are, however, very anxious about disclosing to the service provider that you engage in substance use and will likely not disclose too much unless explicitly asked and made to feel comfortable.

# SCENARIO 3

## DEBRIEF QUESTIONS FOR BOTH CLINICAL AND NON-CLINICAL SCENARIOS

1. **How was the *Discussing sexual health, substance use and STBBIs: A guide for service providers* used in this scenario?**

   **POSSIBLE ANSWERS INCLUDE:**

   - It assisted in framing the questions and allowed the conversation to become more open about substance use.
   - Alternatively, the discussion guide was not used in its entirety, and so substance use was not discussed. Since this was not part of the conversation, the interventions proposed may not have matched the client's actual needs in terms of intervention or testing required.

2. **What where some of the strategies that the service provider used to ask the client about their sexuality and substance use in a safe and respectful way?**

   **POSSIBLE ANSWERS INCLUDE:**

   - using open-ended questions
   - explaining the rationale for the various questions posed
   - going through the 5Ps to allow for a richer dialogue
   - refraining from making assumptions about the client based on their age, relationship status, sexual orientation, etc.

**NOTE:** Participants may say that it was challenging to use the discussion guide or to address all 5Ps in the discussion. Tell participants that with practice, this will become easier and reiterate that not every client interaction will necessitate a discussion of all 5Ps and that the sample questions should only be posed if they are commensurate with the client's care needs.

# APPENDIX E: PRE- AND POST-WORKSHOP EVALUATION QUESTIONNAIRE/FACILITATOR REFLECTION QUESTIONS

## PRE-WORKSHOP QUESTIONNAIRE

**Date:** _____

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

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. Thank you. Your feedback is very important to us.

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 societal 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 societal 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?

## APPENDIX F: SAMPLE RECRUITMENT POSTER

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

### DO YOU WORK IN SEXUAL HEALTH, HARM REDUCTION OR OTHER SERVICES RELATED TO SEXUALLY TRANSMITTED AND BLOOD-BORNE INFECTIONS (STBBIS)?

# JOIN US FOR A FREE WORKSHOP TO EXPLORE STIGMA AND STBBIS

During this workshop, you will have an opportunity to enhance your skills in discussing STBBIs, sexuality and substance use with clients. You will learn about several strategies and tools to mitigate STBBI-related stigma within your organization.

**Insert your date and location**

**Insert contact name for registration**

**Add your organization's logo**

**Include information about parking, refreshments, etc.**

**Click here to download your editable poster**

CANADIAN PUBLIC HEALTH ASSOCIATION
ASSOCIATION CANADIENNE DE 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 (SDH):** 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 behavior 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, 2017. Available at: https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/stigmascale_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

*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

## 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-ldcits/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 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

If your client has been charged for HIV non-disclosure or if you require other legal advice, contact the following organizations:

- **Canada:**

  Canadian HIV/AIDS Legal Network, www.aidslaw.ca
  Tel.: +1 416 595-1666
  Fax: +1 416 595-0094
  E-mail: info@aidslaw.ca

- **Ontario:**

  HIV & AIDS Legal Clinic Ontario (HALCO), www.halco.org
  Tel.: +1 416 340-7790 or +1 888 705-8889
  Fax: +1 416 340-7248
  E-mail: talklaw@halco.org

- **Quebec:**

  Coalition communautaire des organismes québécois de la lutte contre le sida (COCQ-SIDA) — Clinique d'information juridique VIH info droits, www.cocqsida.com
  Tel: +1 514 844-2477 (ext. 34)
  Toll-free (when calling from outside Montréal): +1 866 535-0481 (ext. 34)
  E-mail : vih-infodroits@cocqsida.com

- **Prisoner support:**

  Prisoners' HIV/AIDS Support Action Network (PASAN), www.pasan.org
  Toll-free: +1 866 224-9978
  Tel.: +1 416 920-9567
  Fax: +1 416 920-4314

- To find a lawyer, refer to *Legal aid services and lawyer referrals by province*, Canadian HIV/AIDS Legal Network, 2012. Available at: http://www.aidslaw.ca/site/wp-content/uploads/2015/07/Legal_referrals-Jul2012.xls (opens with Microsoft Excel)