FACILITATION MANUAL

2017

CHALLENGING ORGANIZATIONAL STIGMA

Providing safer and more inclusive sexual health, harm reduction and STBBI-related services

Calgary
Sexual Health
Centre

CANADIAN PUBLIC HEALTH ASSOCIATION

ACKNOWLEDGEMENTS

All of the resources for the workshop *Challenging organizational stigma: Providing safer and more inclusive sexual health, harm reduction and STBBI-related services*, 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.*

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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 *Challenging organizational stigma: Providing safer and more inclusive sexual health, harm reduction and STBBI-related services* workshop to explore stigma and STBBIs, the multiple factors that contribute to stigma, and the role that organizations can play in preventing and reducing stigma. This workshop provides participants the opportunity to critically reflect on organizational practices and policies that perpetuate stigma and gives them tools and strategies to address stigma at an organizational level.

To develop the workshop content, CPHA conducted literature reviews (peer-reviewed and grey literature) to distinguish 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.

The workshop incorporates the [Organizational assessment tool for sexually transmitted and blood-borne infections (STBBIs) and stigma](#) to help participants identify the policy, environmental and cultural factors that contribute to stigma and discrimination, as well as priority areas for action. CPHA developed the tool following a review of the literature and consultation with several health and social service providers.

Frontline service providers (e.g., nurses, nurse practitioners, social workers, physicians, health educators, peer workers) and program planners/decision-makers pilot tested and evaluated the workshop in several Canadian cities throughout 2016. Overall, the workshop was well received and a large majority of participants reported an increased awareness and comfort level related to STBBIs, sexuality and harm reduction. The content was revised based on the evaluation findings to meet the learning needs of health and social service professionals in Canada.

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. *Moving beyond the basics: An advanced workshop about sexual health, substance use and stigma* – Offers frontline service providers in sexual health, harm reduction or other STBBI-related services an opportunity to enhance their discussion skills around sexuality, substance use and STBBIs, and provides several strategies and tools to mitigate stigma within health and social service settings.

The facilitation manuals, participant workbooks and slides for these workshops can be found at [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.

THIS WORKSHOP WILL HELP PARTICIPANTS IDENTIFY THE POLICY, ENVIRONMENTAL AND CULTURAL FACTORS THAT CONTRIBUTE TO STIGMA AND DISCRIMINATION, AS WELL AS PRIORITY AREAS FOR ACTION.
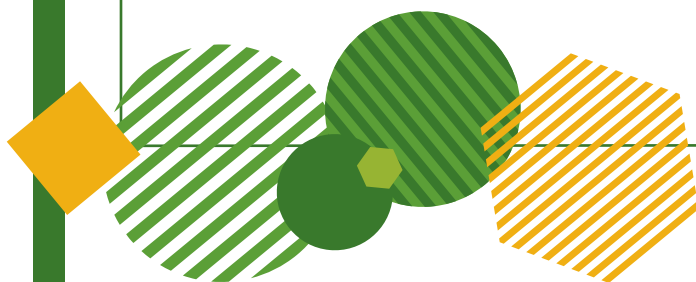
SECTION 2
WORKSHOP PREPARATION AND EVALUATION

TARGET AUDIENCE

This workshop is for administrators, managers, policy makers, and frontline staff currently working in the areas of substance use, STBBIs or sexuality, including nurses, nurse practitioners, physicians, health educators, social workers, outreach workers, etc. Participants should have a basic 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 many factors that contribute to STBBI-related stigma, including attitudes, values and beliefs as well as organizational policies and practices;
- increased ability to identify organizational strengths and challenges in addressing stigma; and
- enhanced skills in developing strategies to decrease stigma at an organizational level and to create safer and more inclusive environments for clients.

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)
- Organizational assessment tool for sexually transmitted and blood-borne Infections (STBBIs) and stigma (one for each participant; listed as a supplementary resource in Appendix F*)*
- *Pre- and post-workshop questionnaires* (one for each participant; see Appendix C)

Additional resources

- *Sample recruitment poster* (see Appendix D)
- *Glossary* (see Appendix E)
- *Supplementary resources* (see Appendix F)

WORKSHOP TIMELINES

This workshop may be offered as a 3-hour or 90-minute session. Identify the best format for your group based on size, learning needs, potential resource and time constraints, and prepare accordingly using 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 D to support your efforts. Consider reaching out to the health and social service organizations in your community for help in recruiting participants (e.g., forwarding the recruitment poster to their networks, promoting the workshop on their social media).

It is strongly recommended that you complete the Facilitating adult learning online course before the workshop, particularly if you do not have a lot of facilitation experience. The course takes approximately 30 minutes to complete and offers several strategies to help you facilitate workshops to adult learners focused on sexual health, harm reduction and STBBIs.

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

Ensure that the Organizational assessment tool for STBBIs and stigma **is sent to participants in advance of the session, and encourage them to review it prior to the workshop.**
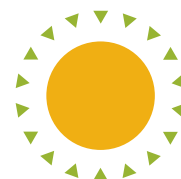
ROOM SET-UP

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

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

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

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

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

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

WORKSHOP EVALUATION

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

There is also a reflection sheet for facilitators to complete following the workshop (see Appendix C). Facilitating adult education requires consistent self-reflection, on-going learning and improvement. Use your reflection sheets and evaluation results to continue to develop your facilitation skills.
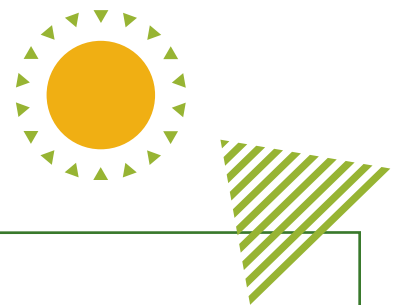
EVALUATION OF YOUR WORKSHOP IS IMPORTANT. IT CONFIRMS THAT LEARNING OBJECTIVES ARE MET, AND THAT THE CONTENT AND FACILITATION ARE EFFECTIVE FOR CONTINUOUS PROFESSIONAL DEVELOPMENT.

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 C)

Challenging organizational stigma:
Providing safer and more inclusive sexual health, harm reduction and STBBI-related services

Created in Partnership with

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)

welcome

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.

   The workshop supports the use of the _Organizational assessment tool for sexually transmitted and blood-borne infections (STBBI) and stigma_ to assist organizations in identifying the policy, environmental and cultural factors that contribute to stigma and discrimination, and to identify their priority areas for action.

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:

- "You will learn about strategies that your organization can employ to address stigma."
- "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

Workshop overview

1. Introduction
2. Exploring stigma and factors that contribute to stigma
3. Strategies to reduce stigma and create more inclusive and safer services
4. Closing

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 want to get out of the workshop.

MATERIALS: n/a

Learning objectives

- Increase knowledge of the various forms of stigma and the many factors that may contribute to STBBI-related stigma, including personal values and beliefs as well as organizational policies and practices.
- Increase ability to identify organizational strengths and challenges in addressing stigma.
- Enhance skills in developing strategies to reduce stigma on an organizational level and to create safer and more supportive environments for clients.

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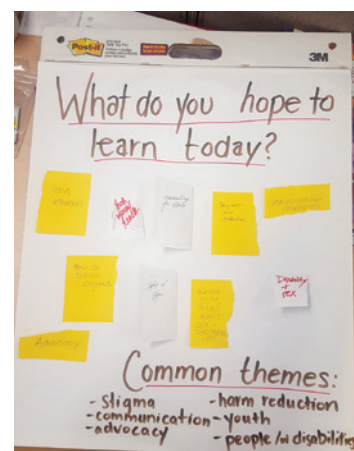
Sample image of "What do you hope to learn today?"

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.

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.
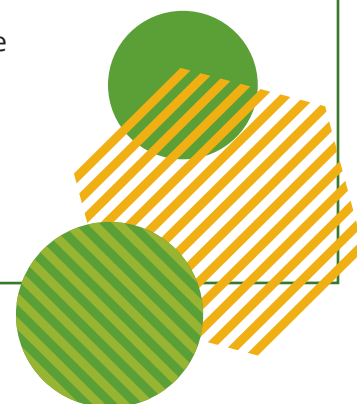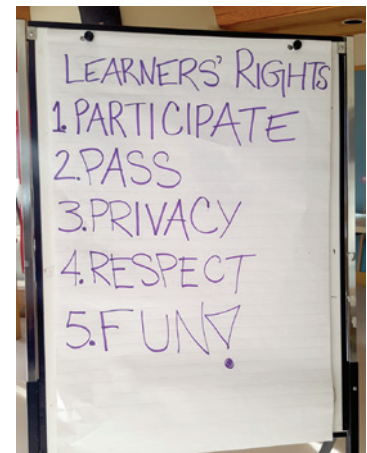
DISCUSSION POINTS

- Explain how learning rights help ensure that all people feel safe when exploring their attitudes, values and beliefs during the workshop.
- Tell participants that they may feel uncomfortable during the session, which is not necessarily a bad thing. Feeling some discomfort can facilitate learning by questioning one's own 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 voice and encourage them to share the strategies that work for them. This approach will create a more inclusive and welcoming space.

LEARNERS' RIGHTS

- **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 participants 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 learners' 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 they are respectful learners. However, encourage participants 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. So tell participants that today you hope to make this a positive experience and, as a group, you will be choosing activities to 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.

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)

Key terms

STBBIs

Harm reduction

Sex-positivity

Trauma- and violence-informed care

STEPS/DISCUSSION POINTS:

1. Direct participants to the term definitions on pages 2 and 3 of the workbook and provide time to review. Read the definitions aloud to accommodate different learning styles.

2. Ask for questions or comments about the terms.

3. Direct participants to the glossary of terms found on pages 20-22 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 (see slides 7-9).

NOTE: For questions about gender and sexual diversity, refer participants to the supplementary resources listed in Appendix F 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)

What is trauma-informed care?

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

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

What is trauma-informed care?

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

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

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

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

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

Reference: Varcoe CM, 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.

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, residential schools, 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 they are 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 understand 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: DRAWING ACTIVITY

OBJECTIVE: To consider the impact of organizational policies, practices and culture on stigma.

Drawing activity

MATERIALS: Large markers, chalk, white out, pens, pencils, crayons and paper of various sizes; participant workbook (page 4)

STEPS/DISCUSSION POINTS:

1. Distribute one piece of paper (ranging from extremely small to large) and one writing tool (e.g., large markers, chalk, white out, pens, pencils, crayons) to each participant.

2. Tell participants to write their signatures using the paper and writing tool provided to them.

3. Allow several moments for the group to complete this task, and then ask them if it was an easy or difficult task.

4. Ask them to turn over their papers and now draw a cat (or other simple image). Give the group 1-2 minutes to complete their drawings.

5. Ask participants to show each other their cat drawings.

6. Debrief the activity using the points below. Direct participants to page 4 of their workbooks if they would like to take notes.

DEBRIEF QUESTIONS AND DISCUSSION POINTS

Ask participants to share what that experience felt like for them.

For some, it may have felt awkward, difficult, embarrassing or frustrating. Some people may have been unable to write their signature or draw the cat, given the size of the paper or the writing tool provided to them. Some may say they felt lucky because they had an easier writing tool or a larger piece of paper. This likely made the activity fairly easy. Some participants may say they felt guilty or badly for having a better writing tool or larger paper, as compared to others. They may have felt extra pressure to draw well given they had the clear advantage.

Ask participants why the activity was so difficult? Remind them that everyone had a writing tool and a piece of paper. They had "equal access" to the basic tools needed to complete the activity.

Participants may say that even though they were all provided with a writing tool and a piece of paper, they did not receive tools that were equally effective. For those lucky enough to receive pens or pencils and larger pieces of paper, they had less challenges and probably used these tools fairly easily.

Explain that although everyone was provided with equal access to a piece of paper and a writing tool, they were not provided with equitable access to the tools. Refer to the Public Health Agency of Canada (2007) definition of equity to further the discussion:

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[1].

Ask participants if organizations ever create services that, similar to this analogy, contribute to inequity among clients. For example, "Do organizations ever create programs or policies that are not the right fit for the clients that they serve? If so, what are some examples?"

Examples include:

- policies that restrict access to clients who do not have identification (e.g., health care cards), or that do not fit within a certain demographic or group;
- hours that are inaccessible to groups of clients (e.g., 9 to 5 hours only);
- intrusive forms or questions at intake;
- fees for service;
- clinical or sterile facilities, or environments that seem to cater to only one type of demographic (visible by way of posters, pamphlets, artwork, etc. in the lobby, or by the lack of diversity in the staff); and
- "cookie cutter" services that do not reflect the unique needs of individuals who are accessing those services or programs.

Finally, ask participants if they felt uncomfortable with the activity. They may say yes. Ask them if clients are ever asked to do things that may make them feel uncomfortable.

Participants may say that clients are often asked potentially stigmatizing questions when they access services, without being told the rationale for this line of questioning. Further, clients may have to 'work around' the policies and procedures of organizations or services, ultimately creating barriers to service access and uptake.

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1   Public Health Agency of Canada. *Public health practice: Glossary of terms.* 2007. Available at: http://www.phac-aspc. gc.ca/php-psp/ccph-cesp/glos-eng.php#e (Accessed September 6, 2015).

SLIDE 11: ACTIVITY - HEALTH PROMOTION/PREVENTION MESSAGING

OBJECTIVE: To consider the impact of health promotion/prevention campaigns and how they can perpetuate stigma.

MATERIALS: Participant workbook (page 4)

Activity

Think about the early public health messages you received about STBBIs, sexuality and substance use. Consider:

- the common themes;
- how you felt in response to these messages; and
- whether our approach to health promotion/prevention has evolved over time.

STEPS/DISCUSSION POINTS:

1. Ask participants to form groups of 2 or 3. Ask them to think back to the early messages they received about STBBIs, sexual health and substance use through health promotion/prevention campaigns (e.g., through posters, commercials, social media campaigns, or educational presentations). Ask them to think about whether these campaigns had positive or negative impacts on their understanding of sexual health and harm reduction.

2. Encourage participants to reflect on the following:

- common themes across the health promotion/prevention campaigns (e.g., abstinence from sex, healthy relationships, fear-based messaging related to substance use);
- how they felt in response to these health promotion/prevention campaigns (e.g., confusion, fear, informed); and
- whether the approach to health promotion/prevention campaigns has evolved over time (e.g., possible shift away from fear-based messaging).

Direct participants to page 4 of their workbooks if they would like to take notes. Allow participants 5-10 minutes to discuss as a small group.

3. Invite participants to share their thoughts with the larger group and write them down on a flipchart or white board for reference. Ask participants to reflect on the following:

- Despite best intentions, how might health promotion/prevention campaigns perpetuate stigma about sexuality, STBBIs or substance use?
- How would a person living with an STBBI or using substances feel if they were the target of the health promotion/prevention campaigns?
- How might health promotion/prevention campaigns about STBBIs, sexuality and substance use influence a service provider's attitudes, values and beliefs?
- **NOTE: To maintain a safe space for learning and dialogue, it is important that participants refrain from speaking negatively about any campaigns created by an organization in the community. Focus on common themes and not specific campaigns. Alternatively, encourage participants to reflect on campaigns from other regions or from the past.**

4. Ask participants to reflect on some strategies that would ensure that health promotion/prevention campaigns do not perpetuate stigma. Write these strategies on a flipchart/white board for reference.

5. Encourage participants to think about the potential to inadvertently perpetuate stigma when providing health promotion/prevention messaging. How can the public health community ensure that its messaging does not further stigmatize or stereotype a group of people or a set of behaviours? For example, in the field of sexual health, many public health campaigns aim to reduce the transmission of STBBIs. To avoid perpetuating stigma among people living with an STBBI, campaigns could focus on routine testing as an important part of one's overall health and well-being as opposed to focusing solely on the potential negative repercussions of an STBBI diagnosis.

DISCUSSION POINTS

Ask participants to reflect on the primary themes found within health promotion/prevention campaigns. They may discuss:

- campaigns that focused on abstinence from sex and/or substance use altogether, with little discussion of healthy sexuality or harm reduction;

- messaging that was not inclusive of gender and/or sexual diversity (e.g., campaigns that reinforced dominant gender norms or heteronormative/cisnormative beliefs);

- messaging that invoked fear and shame related to sexuality and substance use, or that focused only on the potential negative repercussions of sexual activity and substance use (e.g., STBBIs, pregnancy and addiction);

- campaigns targeted to specific population groups, reinforcing inaccurate yet dominant rhetoric that only "certain" types of people use substances or contract STBBIs ; and

- campaigns that were empowering and effective in teaching about STBBIs, sexual health and substance use (these campaigns were likely age-appropriate and were evidence-based rather than values-driven).

Ask participants to reflect on how they remember feeling in response to these health promotion/prevention campaigns.

Given the breadth of campaigns that your participants were likely exposed to, they will likely report a range of emotions, including:

- confusion (messaging was not age appropriate or properly explained)
- fear (shame-based tactics were used)
- empowered (messaging was affirming or provided easy-to-understand facts)
- internalized stigma (messaging perpetuated stereotypes about people with whom the participant identified)

How might health promotion/prevention campaigns contribute to stigma?

Messaging that reinforces shame or portrays STBBIs and substance use using a fear-based approach can contribute to stigma. Further, population-specific campaigns that use fear or shame to elicit behaviour change can trigger internalized stigma, as this type of messaging reinforces inaccurate, yet dominant stereotypes about people who use substances or are affected by STBBIs.

For individuals who engage in substance use or are affected by an STBBI, public health messaging can reinforce stigma and create silence and shame. This silence can prohibit people from accessing services, or lead them to refrain from honest conversations about STBBIs with their service providers or sexual partners.

How might early public health campaigns about sexuality, substance use and STBBIs influence service providers' attitudes, values and assumptions?

As service providers, we are not immune to bias. The early messages we receive about sexuality and substance use have a lasting impact on our attitudes, values and beliefs, and may in turn affect how we speak about sexuality and substance use as professionals with our clients. For example, service providers may not talk about substance use or sexuality with all clients based on misguided beliefs about who might benefit from these conversations. As a result, they may focus their harm reduction efforts on clients traditionally deemed most at risk for using substances or contracting an STBBI, and may exclude others from the population at large who need to talk about substance use and sexuality. It is therefore imperative that we deliberately and regularly reflect on our attitudes, values and beliefs related to STBBIs, sexuality and substance use.

How do public health campaigns influence clients and their attitudes, values and assumptions about substance use and sexuality?

If public health campaigns, even inadvertently, perpetuate stigma, they can impede clients' access to and uptake of health and social services. For example, some clients who use substances may not readily ask for information from their service providers for fear of being labelled a "substance user". Further, clients who use substances may experience internalized stigma, and, in turn, believe some of the dominant and negative messaging about people who use substances.

Sample image of a group debrief for this activity
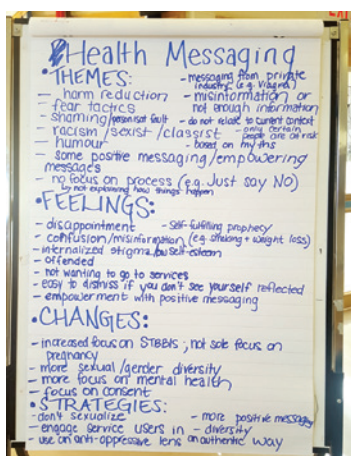
How have health promotion/prevention campaigns evolved over time?

Participants may say that health promotion/prevention campaigns have improved over time, with more positive campaigns that reinforce healthy relationships, sex-positivity and harm reduction. Participants may also say that more needs to be done, as we have not yet moved away from messaging that employs shame-based approaches to prevention. Further, some participants may acknowledge the need to address the broader social and structural factors that impact vulnerability to STBBIs through our health promotion/prevention campaigns, rather than focusing exclusively on behaviour change.

SLIDE 12: ASSUMPTIONS TO AVOID

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

MATERIALS: n/a

Assumptions to avoid

All people are heterosexual/cisgender.

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

All people are sexually active or not sexually active.

All sexual activity is consensual.

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

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

STEPS/DISCUSSION POINTS:

1. Give participants a minute to read the slide.

2. Ask if anyone would like to share an immediate reaction to the common assumptions presented on the slide.

3. Discuss the dominant social construction of sexuality and substance use, which emphasizes heterosexism, gender scripts, shame, sex-negativity, etc. Many of our assumptions are rooted in the social construction of sexuality and substance use.

DISCUSSION POINTS

- The dominant social construction of sexuality reinforces ideas about who has permission to be sexual (e.g., the media often portray young, able-bodied, heterosexual people as sexual beings, while largely excluding older adults or people with disabilities), as well as ideas about which sexual acts are permissible (e.g., sexual promiscuity is seen as morally reprehensible). Further, as a society, many of our ideas are heterosexist or cissexist or are predicated on a limited understanding of sexual and gender diversity.

- There are many social beliefs about substance use. For example, some substances are regarded as more socially permissible (e.g., prescription drugs or alcohol as compared to illegal substances). Further, there are many negative stereotypes about people who use substances.

- The dominant social construction of sexuality and substance use can shape our implicit attitudes, values and beliefs and, in turn, the assumptions we make about our clients. As service providers, it is therefore imperative that we engage in regular self-reflection to help counter stigma.

SLIDE 13: UNPACKING STIGMA

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

MATERIALS: Participant workbook (page 5)

Stigma

What is it?

Where do we see it?

What is the impact?
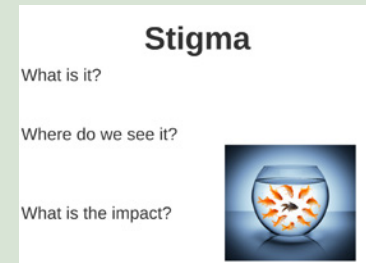
STEPS/DISCUSSION POINTS:

1. Direct participants to page 5 of their workbook (ask them to refrain from looking at page 6 until they have brainstormed some ideas).

2. Ask participants to break into small groups to brainstorm a definition of stigma.

3. Ask them to discuss where it occurs and its impact on an individual's:

   - 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.

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

4. 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 our services? How may this impact a client's willingness to discuss their sexuality or substance use with health or social service professionals?

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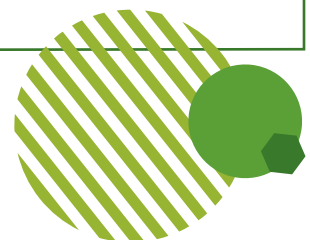
DISCUSSION POINTS

- 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." [2]

- Service providers working in STBBI prevention, testing and treatment need to understand the far-reaching impacts of stigma.[2,3,4]

- Stigma can lead to harmful outcomes for individuals living with or affected by STBBIs such as psychological stress, fear of disclosure and avoidance of prevention, testing and treatment services.[3,5,6,7,8] 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.[9]

- 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.[10] 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.

2   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).

3   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.

4   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.

5   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).

6   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.

7   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.

8   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).

9   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.

10   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 14: 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)

Stigma defined

Perceived stigma: an individual's awareness of negative societal attitudes, fear of discrimination and feelings of shame.

Internalized stigma: an individual's acceptance of negative beliefs, views and feelings towards the stigmatized group they belong to and oneself.

Enacted stigma: encompasses overt acts of discrimination, such as exclusion or acts of physical or emotional abuse; acts may be attributable to an individual's real or perceived identity or membership to a stigmatized group.

Layered or compounded stigma: a person holding more than one stigmatized identity (e.g., HIV positive serostatus, sexual orientation, race, ethnicity, etc.).

Institutional or structural stigma: stigmatisation of a group of people through the implementation of policy and procedures.

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 discussed, 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.[11]
   - **Internalized stigma:** An individual's acceptance of negative beliefs, views and feelings towards themselves and the stigmatized group to which they belong.[11]
   - **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).[11]
   - **Layered or compounded stigma:** A person holding more than one stigmatized identity (e.g., HIV positive serostatus, sexual orientation, race, ethnicity).[11]
   - **Institutional or structural stigma:** Stigmatisation of a group of people by way of policies and procedures.[12]

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.[13]

3. For each of the 5 types of stigma, ask participants to think of an example they have witnessed within health and social service settings or within the community.

11 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.

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

13 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 stigma forms.

- 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 lifestyle choices.

- 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 15: 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 demonstrate 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, classism, colonization, ableism, etc. The diagram highlights the socio-ecological levels at which clients experience stigma and at which organizations can mount stigma-reducing actions and interventions. Some effects of STBBI-related stigma are shown including poor mental health, adoption of unhealthy behaviours, withdrawal and fear of disclosure, and limited use of available services.

2. Pass out the stigma case scenario to each participant (Appendix B).

3. Ask participants to spend a few minutes reading the scenario and then to form groups of 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. Participants can take notes on page 8 of their workbooks. Some participants may choose to work individually.

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 or 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. [14,15,16]

■ Be solution-focused in the discussion. Allow participants the space to share their stories and experiences, but also try to keep the discussion strengths-based and encourage the group to brainstorm solutions.

■ If the group becomes marred in hopelessness about the structural or systemic nature of stigma and the oppression of groups of people through policies and institutions, discuss how change occurs through collective action.

   • The purpose of our jobs as service providers is to work towards creating more socially just conditions. We have the ability to work together to advocate and create positive change. Even participating in this discussion can be a start towards action.

14 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.

15 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.

16 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.

- 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 16: WHY IS IT IMPORTANT TO ADDRESS STIGMA?

OBJECTIVE: To consider why organizations should address stigma.

MATERIALS: Flipchart or white board

Why is exploring stigma important for organizations that provide STBBI-related services, including sexual health and harm reduction services?

STEPS/DISCUSSION POINTS:

1. Ask participants to share why they believe it is important to address stigma within their organizations. Write down their responses on the flipchart or white board for reference.

DISCUSSION POINTS

- STBBIs are important public health issues. However, stigma and discrimination within health and social service settings complicate public health efforts by acting as barriers to clients who try to access and use STBBI-related services. At the organizational level, stigma and discrimination can lead to ineffective program planning, such as health promotion campaigns that inadvertently reinforce stereotypes.

- The reduction of stigma within health and social service settings requires a multi-faceted approach. Stigma and discrimination arise from the attitudes, values, beliefs and practices of individuals as well as from the policies, procedures, culture and environment of service organizations.

- Refer to CPHA's Core competencies for STBBI prevention, which cite "awareness of the impact that organizational policies and practices have on access to STBBI prevention services" as a core competency.[17]

- Describe the development of the core competencies. CPHA conducted 17 focus groups with client groups in 6 communities in which participants reflected on past interactions with service providers and considered the factors that impact their overall health and access to health services. They noted several barriers to services, many of which operate at the organizational level, including lack of physical space for confidentiality and privacy, body language that portrays judgement, lack of service providers with diverse lived experiences, dismissive attitudes, shame or fear-based approaches to STBBI prevention efforts, and no visual cues to indicate safety and inclusivity.

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

■ Remind participants that culture, policies and practices of organizations affect clients and staff/volunteers alike. Creating safer spaces will not only improve outcomes for those accessing services, but will also create a more respectful environment for staff.

SLIDE 17: INTERNALIZED AND PERCEIVED STIGMA

OBJECTIVE: To reflect on the potential impact of internalized and perceived stigma.

MATERIALS: n/a

Even if your organization is actively working towards the provision of safer and more inclusive services, it is important to consider the impact of internalized and perceived stigma on client health and well-being.

People experiencing internalized and perceived stigma may have been subject to trauma within health and social service organizations in the past. It is imperative that organizations counteract the impacts of historical marginalization through ongoing reflection and action.

STEPS/DISCUSSION POINTS:

1. Read the slide aloud to accommodate different learning styles. Ask participants if they have anything they want to add.

DISCUSSION POINTS

It is important to acknowledge that some groups have been historically stigmatized and marginalized by society. Members of these groups may feel they have little reason to trust public institutions (including health and social service organizations) due to a lack of support from these institutions in the past, or due to experiences of stigma or discrimination. As a result, organizations need to proactively demonstrate their commitment and earn the trust of these individuals, rather than assuming members of marginalized groups will trust in them.

SLIDE 18: FACTORS THAT CONTRIBUTE TO STIGMA

OBJECTIVE: To consider the organizational factors that can perpetuate stigma.

MATERIALS: Participant workbook (page 9)

What are the organizational factors that contribute to stigma?

- Lack of knowledge
- Lack of comfort in speaking about substance use and sexuality
- Service providers' unconscious values or beliefs that may be harmful to clients
- Restrictive or discriminatory policies
- Inaccessible services
- Restrictive forms
- Communications materials that do not reflect the diversity of the community
- Lack of diversity within the staff team
- Lack of resources

STEPS/DISCUSSION POINTS:

1. Ask participants to form groups of 2 or 3 to brainstorm the organizational factors that can perpetuate stigma. Give groups 3 to 5 minutes to discuss, and come back together as a large group to debrief.
   NOTE: Do not show all of the responses on the slide to the group until participants have brainstormed and debriefed. The responses will appear individually as you click through the presentation.

2. Ask participants to share their thoughts.

3. After the debrief, display the responses on the screen. Highlight any factors that were not discussed during the debrief. Refer participants to page 9 of their workbooks for a list of factors that contribute to stigma.

4. Ask participants to once again refer to the stigma framework on page 7. Ask them to consider the socio-ecological levels at which these factors operate. For example, do the factors operate at the individual, interpersonal, community, institutional or policy/legal level? It is likely that many factors will operate at multiple levels. Use this exercise to highlight the need for a multi-pronged approach to stigma reduction.

DISCUSSION POINTS

As part of the development of this workshop, CPHA conducted a series of focus groups and key informant interviews with service providers as well as clients living with or affected by STBBIs from across the country. A number of factors that perpetuate stigma and discrimination were identified, including:

- lack of knowledge of different STBBIs, including transmission modes, infection and disease progression, and treatment options, which could result in an inappropriate fear of contagion;
- lack of comfort in discussing sexuality and/or substance use;
- negative attitudes/values (often unconscious or implicit) towards sexuality/substance use;
- interaction with other forms of oppression (e.g., racism, classism, heteronormativity);
- lack of culturally competent care for different population groups (often due to lack of training/exposure to different population groups);
- discriminatory (often unintentionally) policies and procedures within organizations:
  - fees for missed appointments
  - forms that assume that all clients are heterosexual and/or cisgender
  - intake practices that force clients to prove they are eligible for services (e.g., need to provide income level to receive services)
  - lack of safe space for clients to speak about substance use and sexuality in privacy
  - lack of policy to protect clients' confidentiality when accessing services
- structural drivers of stigma (e.g., criminalization of HIV non-disclosure, inappropriate focus on "at-risk" populations); and
- lack of financial or human resources to adequately meet clients' individual needs.

MODULE 3: STRATEGIES TO REDUCE STIGMA AND CREATE MORE INCLUSIVE AND SAFER SERVICES

SLIDE 19: WHAT CAN YOU DO?

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

MATERIALS: *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBI) and stigma* (listed as a supplementary resource in Appendix F)

What can you do?

How do we create safer and more supportive services?

STEPS/DISCUSSION POINTS:

1. Inform participants that you will now begin looking at the concrete and possibly minor changes that can be made to reduce stigma at the organizational level. Inform participants that as a group you will reflect on what clients see, feel and hear when they enter a service organization as a means of reflecting on some of the factors that may perpetuate stigma. Participants will then develop a concrete action plan to identify priority areas for action within their organization.

DISCUSSION POINTS

- Participants should focus on concrete changes their organizations can make to create safer and more inclusive spaces, rather than becoming dispirited through discussion of the structural and systemic barriers to change.

- It can be very challenging to work within organizational structures that, often inadvertently, perpetuate stigma. However, participation in this workshop can serve as a catalyst for change. For example, encourage participants to share the workshop resources with their colleagues or to forward the *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBI) and stigma* to their management.

- **To ensure a safe learning environment, participants should refrain from criticizing or naming specific organizations in the community.**

- Encourage participants to reflect on the things that their organization is doing well in addition to those things that require improvement. Ask them to share promising practices with the group.

SLIDES 20 AND 21: SEE

OBJECTIVE: To explore what clients might see when they access services, and to brainstorm potential areas for change.

MATERIALS: Participant workbook (page 10)

STEPS/DISCUSSION POINTS:

1. Direct participants to page 10 of their workbooks.

2. The physical space of an organization is often the first indicator of whether or not services are truly safe and inclusive spaces for clients.

3. Use the discussion points below to brainstorm potential areas for change related to what clients see when they access services.

DISCUSSION POINTS

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

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

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

SLIDES 22 AND 23: HEAR

OBJECTIVE: To explore what clients might hear when they access services, and to brainstorm potential areas for change.

MATERIALS: Participant workbook (page 11)

Hear

- What do people hear within a safe space?
- Is the language used within your workplace inclusive and respectful?
- Is there space for private conversations?

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

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

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

(CPHA Focus Group, 2012)

STEPS/DISCUSSION POINTS:

1. Direct participants to page 11 of their workbooks.

2. Point out that the language used by service providers, administrators and volunteers, as well as the language found on forms and policies can help create safer spaces. Language sends a message to clients about organizational attitudes and beliefs around sexual and gender diversity, sexuality, culture, substance use, etc.

3. Use the discussion points below to brainstorm potential areas for change related to what service users hear when they access services.

DISCUSSION POINTS

1. What questions appear on your forms about gender identity? Which pronouns are listed on your forms?

2. If you do pre-/post-test counselling for STBBIs, do you ask questions that could be seen as stigmatizing, such as participation in "risky behaviours"? Is routine STBBI testing offered to everyone?

3. Are the people accessing your services consistently asked about their pronouns/names?

4. Are questions about relationships inclusive? For example, asking about partners, spouse or parents as opposed to husband, wife, mother or father?
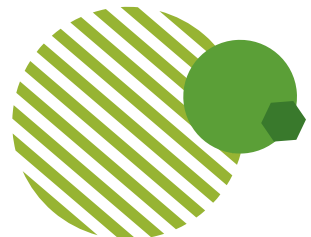
5. Do staff respect clients' right to privacy and confidentiality (e.g., do they refrain from speaking about clients with their colleagues unless it is required for care)?

6. Is respectful language used when talking about your organization's clientele (e.g., "a person who uses substances" rather than a "junkie" or "addict")?
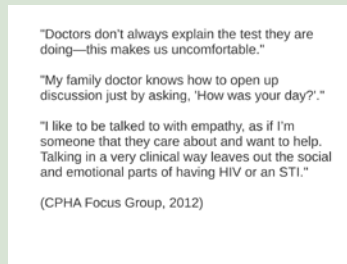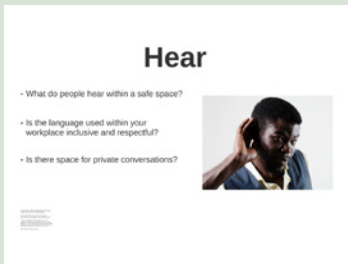
Consider sharing the responses below from the focus groups conducted by CPHA in 2012 as part of the development of the *Core competencies for STBBI prevention*.

■ "Doctors don't always explain the test they're doing — this makes us uncomfortable."

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

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

SLIDES 24 AND 25: FEEL

OBJECTIVE: To explore what clients might feel when they access services, and to brainstorm potential areas for change.

MATERIALS: Participant workbook (page 12)

Feel

- Are services provided in a way that is considerate of the impacts of stigma?
- Are the unique experiences of individuals honored and recognized?
- How do people feel within your service setting?
- How do you know how your clients are feeling?

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

"People don't want to go into a health office because they feel they are going to be judged and discriminated against. Don't want to get tested because they are scared. When I go to the [clinic] to get tested, I feel like people imagine all sorts of weird circumstances about me."

(CPHA focus group, 2012)

STEPS/DISCUSSION POINTS:

1. Direct participants to page 12 of their workbooks.

2. Share with participants the guidance in the *Core competencies for STBBI prevention*, which recommends that service providers offer non-judgmental, culturally safe and supportive services. This means honouring the people accessing our services and making them feel welcome and safe so they can be their authentic selves.

   • Creating a safe space involves fostering a feeling among clients that their personal experiences, beliefs and identities are heard, acknowledged and respected.

3. Use the discussion points below to brainstorm areas for change related to what clients feel when they access services.

DISCUSSION POINTS

- Does your organization have an advisory board that includes clients?
- Does your organization have feedback forms? If so, do you follow-up if someone shares information?
- Do staff receive training on trauma- and violence-informed care? Cultural safety?
- Does your organization provide training that includes self-reflection on personal and organizational attitudes, values and beliefs about substance use and sexuality?

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

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

SLIDE 26: PERSONAL REFLECTION

OBJECTIVE: To reflect on the services participants provide and to consider the communities that are drawn to their services.

MATERIALS: Participant workbook (page 13)

Reflection activity

Go to page 11 in the workbook. Spend a couple of minutes writing down your responses to the 3 questions.

STEPS/DISCUSSION POINTS:

1. Direct participants to page 13 in their workbooks and encourage them to think about the services they provide and the communities that access them.

2. Allow participants a few minutes to write down their responses.

3. Come back as a large group and ask participants to share their responses.

DISCUSSION POINTS

- A wide range of people engage in substance use or sexual behaviours that may lead to the transmission or acquisition of an STBBI. This means that if your services typically attract only 1 or 2 groups from your community, there may be an opportunity to expand your reach. If your services are tailored to specific groups of people, you should still consider intersecting

sources of identity. Even within a targeted population, there will be diversity in terms of class, gender, sexual orientation, race, ability, religion, etc.

- **If there are groups in your community who are not seeking services from your organization, they may be choosing to access services elsewhere, they may be experiencing or perceiving some form of stigma, or they may not be accessing services at all. While it is unlikely your organization will be able to access everyone, continual reflection is important to ensure that you are addressing the changing needs of the community.**

- It is important to celebrate what your organization is doing well and to apply these promising practices to expand reach. Talk with clients from different groups to find out what can be done to improve services and make sure this engagement is authentic and not tokenistic. Engage with other organizations that do work with these groups and collaborate where feasible.

SLIDE 27: ORGANIZATIONAL ASSESSMENT TOOL FOR STBBIS AND STIGMA OVERVIEW

OBJECTIVE: To present the goals of the *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBIs) and stigma.*

MATERIALS: Participant workbook (pages 14-16), *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBIs) and stigma* (listed as a supplementary resource in Appendix F)

Organizational assessment tool for STBBIs and stigma

Long-term goal: clients can easily access and receive safe and inclusive sexual health, harm reduction or STBBI-related services.

What needs to happen for this goal to be reached?

☐ supportive organizational policies, procedures, culture and environment;

☐ providers have developed the core competencies that are relevant to their professional role; and

☐ clients feel comfortable and supported through the whole process of dealing with the organization.

STEPS/DISCUSSION POINTS:

1. Distribute a copy of the *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBIs) and stigma* to each participant.

2. Direct participants to pages 14-16 of their workbooks.

3. Explain that the tool is predicated on 3 preconditions to be met by organizations in order to achieve the long-term goal of providing sexual health, harm reduction or STBBI services in a supportive and safe environment. They are:

   - supportive organizational policies, procedures, culture and environment;
   - providers have attained relevant core competencies for their professional roles; and
   - clients feel comfortable and supported during their interactions with the organization.

4. The goal of the tool is to facilitate critical reflection within organizations to assess their own strengths, challenges and capacity to meet the preconditions.

5. It is important to work with the strengths of the group and to keep the tone positive. If participants express they are dealing with too many policy restrictions to provide services that are fully supportive of each client, remind them that everything is a work in progress and that this tool can help create small and incremental changes within organizations. It can also be an important tool to bring to management to elicit change at the policy level.

SLIDE 28: ORGANIZATIONAL ASSESSMENT TOOL - GETTING STARTED

OBJECTIVE: To present the steps involved in completing the *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBIs) and stigma*.

MATERIALS: Participant workbook (page 14), *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBIs) and stigma* (listed as a supplementary resource in Appendix F)

Organizational assessment tool for
STBBIs and stigma

Getting started:

1. Identify who should participate in the organizational assessment.

2. Identify how this tool fits within larger organizational policies and procedures.

3. Ask staff to consider their own attitudes, values and beliefs about substance use and sexuality.

STEPS/DISCUSSION POINTS:

1. Direct participants to page 14 in their workbooks. Explain the 3 steps of the tool:

- getting started by identifying the stakeholders needed to engage in the assessment process;
- completing the tool and discussing the responses; and
- developing an action plan based on the assessments by stakeholders.

2. Discuss the primary steps involved in "getting started".

1. Identify who should participate in the organizational assessment process. In some cases, only one part of the organization (e.g. sexual health clinic) will do the assessment, and in others the whole organization will be involved.

2. Engage the entire "chain" of staff and volunteers with whom clients come in contact.

3. Identify where/how this assessment process fits with your organizational policies and processes. Ideally, the tool can be incorporated into regular quality improvement practices as a way of reinforcing a welcoming and supportive culture throughout the organization, rather than being seen as an "extra" process.

4. Encourage all staff and volunteers involved in the assessment process to complete the *Self-assessment tool for STBBIs and stigma* and reflect on their own attitudes, values and beliefs related to STBBIs.

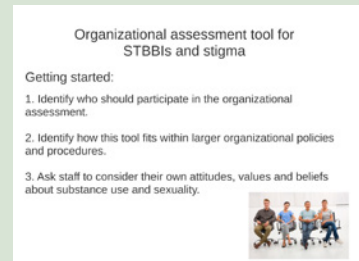# SLIDE 29: ORGANIZATIONAL ASSESSMENT TOOL - COMPLETING THE ASSESSMENT PROCESS

OBJECTIVE: To describe the main sections of the *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBIs) and stigma* as well as the main steps involved in completing the assessment.

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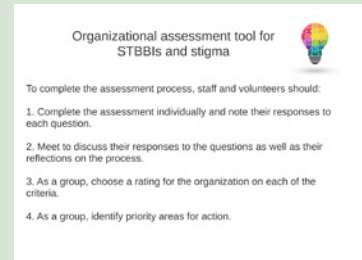

Organizational assessment tool for STBBIs and stigma

To complete the assessment process, staff and volunteers should:

1. Complete the assessment individually and note their responses to each question.

2. Meet to discuss their responses to the questions as well as their reflections on the process.

3. As a group, choose a rating for the organization on each of the criteria.

4. As a group, identify priority areas for action.

STEPS/DISCUSSION POINTS:

1. Explain that the assessment tool is organized into 3 sections, with each section offering background on the criteria, examples of how the criteria have been applied successfully, and a series of questions. The 3 sections are based on the conditions necessary to achieve the long-term goal of providing sexual health, harm reduction or STBBI services in a supportive and safe environment. They are as follows:

    - supportive organizational policies, procedures, culture and environment;
    - providers have attained relevant core competencies for their professional roles; and
    - clients feel comfortable and supported during their interactions with the organization.

2. Discuss the primary steps involved in completing the assessment:

    1. Staff and volunteers complete the assessment individually and note their responses to each question. Managers should ensure a supportive, constructive environment, so that staff and volunteers feel they can respond openly to the questions.

    2. Staff and volunteers meet to discuss their responses to the questions as well as their reflections on the process. This is an important learning opportunity and should foster frank and constructive discussion of organizational challenges and strengths.

    3. As a group, staff and volunteers choose a rating for the organization on each of the criteria.

    4. As a group, staff and volunteers identify priority areas for action.

3. When working through the various questions in the assessment tool, encourage participants to consider what their clients see, feel and hear when they come to their organizations seeking services.

SLIDES 30-40: ACTIVITY - ORGANIZATIONAL ASSESSMENT TOOL FOR STBBIS AND STIGMA

OBJECTIVE: To use the *Organizational assessment tool for sexually transmitted and blood-borne infections (STBBIs) and stigma* to critically reflect on organizational strengths and challenges.

MATERIALS: Post-it notes **(all of the paper must be the same colour to protect anonymity)**; have 2 facilitators for this activity (if not possible, ask for a volunteer from the group to assist)

Activity: Organizational assessment tool for STBBIs and stigma

Questions from the assessment tool will be read aloud. After you hear the question, use the following rating system to respond:

☐ Y - Yes, we have addressed this issue
☐ R - We have recognized this issue and are starting to work on it
☐ N - No, we have not yet addressed this issue
☐ NR - This issue is not relevant to our work

You will answer each question privately on an individual paper. Once you have answered, the facilitator will collect your answer. Your answer will remain anonymous. As a group, we will look at the collective responses.

1. Does your organization have a complaints mechanism for clients who have experienced discrimination or a violation of their privacy/confidentiality rights?

Consider: are clients made aware of this mechanism?

2. Does your leadership reinforce the organization's commitment and implementation of these policies (via staff meetings, communications materials, day-to-day interactions)?

3. Do clinical staff receive training on the factors that make individuals more vulnerable to STBBIs (including individual, community and systemic factors)?

4. Do all staff and volunteers (clinical and non-clinical) receive training to support safe and respectful service provision (e.g., training on language, communications, cultural safety, stigma reduction, inclusivity, etc.)?

5. Has your organization developed relationships with other organizations in the community that offer specialized services (both clinical and non-clinical) and/or deal with issues frequently faced by traditionally marginalized communities?

6. Do the images and language used in your organization's communications (e.g., ads, posters, pamphlets, websites) include positive images of the population groups you serve?

7. Does your organization provide other assistance to address accessibility issues (e.g., childcare services, assistance with transportation)?

8. Is your organization's public space (reception area, waiting rooms) welcoming of people from different population groups? For example, do posters, pamphlets, artwork, brochures, magazines, etc. depict different types of relationships, sexual orientations, ethno-cultural groups in a positive way?

9. Do the intake forms use language that is clear and inclusive (e.g., using gender-neutral terminology)?

10. Are confidentiality and privacy respected through the intake process (e.g., a safe, private space for completing the intake process)?

STEPS/DISCUSSION POINTS:

1. Tell participants they will now begin to critically assess the strengths and challenges their organizations face in providing safer and more inclusive services.

2. Explain that several questions will be read aloud.

3. After each question is asked, participants will write down their responses to that question on a post-it note. They should respond using the following answer key:

   - **Y** - Yes, we have addressed this issue.
   - **R** - We have recognized this issue and are starting to work on it.
   - **N** - No, we have not yet addressed this issue.
   - **NR** - This issue is not relevant to our work.

4. After each question is read aloud, the second facilitator or volunteer will collect all of the responses, mix them up and then sort them by the answer given. Then, they will post them somewhere so that they are clearly visible to the whole group (see sample image below).

5. After all of the questions and the responses have been displayed, go through the answers and note where the group as a whole is actively addressing stigma and areas where more work may be needed. Ask participants to consider why certain areas may be easier than others, and what steps need to be taken to address the issues where improvement is needed.

6. Encourage them to share some of the strategies they have used within their organizations to improve service delivery. This may help others brainstorm small steps that can be made within their organizations to expedite change.

QUESTIONS FROM THE ORGANIZATIONAL ASSESSMENT TOOL FOR STBBIS AND STIGMA:

1. Does your organization have a complaints mechanism for clients who have experienced discrimination or a violation of their privacy/confidentiality rights? Consider: Are clients made aware of this mechanism?

2. Does your leadership reinforce the organization's commitment and implementation of these policies (via staff meetings, communications materials, day-to-day interactions)?

3. Do clinical staff receive training on the factors that make individuals more vulnerable to STBBIs (including individual, community and systemic factors)?

4. Do all staff and volunteers (clinical and non-clinical) receive training to support safe and respectful service provision (e.g., training on language, communications, cultural safety, stigma reduction, inclusivity, etc.)?

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

5. Has your organization developed relationships with other organizations in the community that offer specialized services (both clinical and non-clinical) and/or deal with issues frequently faced by traditionally marginalized communities?

6. Do the images and language used in your organization's communications (e.g., ads, posters, pamphlets, websites) include positive images of the population groups you serve?

7. Does your organization provide other assistance to address accessibility issues (e.g., childcare services, assistance with transportation)?

8. Is your organization's public space (reception area, waiting rooms) welcoming of people from different population groups? For example, do posters, pamphlets, artwork, brochures, magazines depict different types of relationships, sexual orientations, ethno-cultural groups in a positive way?

9. Do the intake forms use language that is clear and inclusive (e.g., using gender-neutral terminology)?
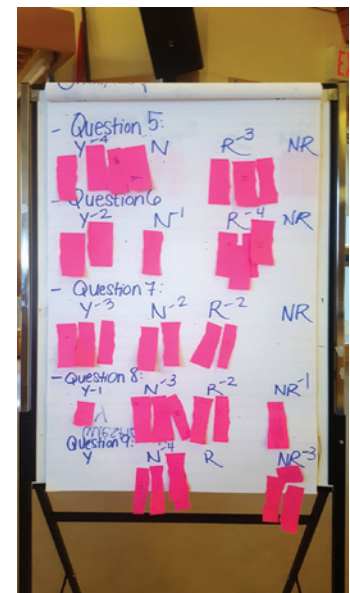
10. Are confidentiality and privacy respected through the intake process (e.g., a safe, private space for completing the intake process)?

DISCUSSION POINTS

1. **Ask participants if they were surprised by the group's collective responses.**
You will likely hear mixed responses. You may find that people from the same organization have different responses and different views on what is working well and what needs improvement. This is normal and may reflect the fact that people are working within different departments or at assorted levels of the organization (e.g., management versus direct service delivery). Larger organizations can use this activity as an opportunity to learn from one another about what is working well within different departments.

2. **Ask participants how this activity felt for them.**
Some participants may say that it was discouraging as there are a lot of areas that need work. Remind participants that change takes time and that even small, incremental changes can have a large impact on clients' health and well-being.

Others may say that due to resourcing and funding issues, some of the recommendations are not possible. This is a very real challenge for many organizations and may require advocacy. Remind participants that they can use the suggestions within this workshop to identify the small and easy changes that can be made. Implement the "easy wins" first and then move on to tackle the larger issues as opportunities arise.

SLIDE 41: ACTIVITY - DEVELOPING A POLICY STATEMENT

OBJECTIVE: To practice creating a policy or values statement that addresses stigma or discrimination.
NOTE THAT THIS IS AN OPTIONAL ACTIVITY DEPENDENT ON TIMING AND GROUP LEARNING OBJECTIVES.

MATERIALS: Participant workbook (page 17)

Activity: Developing a policy statement

STEPS/DISCUSSION POINTS:

1. Tell participants that institutional support is a necessary precondition to sustainable change within an organization. Policies and values statements formally acknowledge an organization's commitment to the reduction of stigma and discrimination, and can be used by clients to hold organizations accountable. Simply having a policy or a values statement is not enough; clients must be made aware of them and of their right to report staff/volunteer behaviours that do not align with the policy or values statement.

2. Ask participants to turn to page 17 of their workbooks to see a sample policy statement.

3. Instruct participants to form small groups of 2 to 3 (preferably with colleagues from the same organization).

4. Ask the groups to write a simple policy statement that could be implemented by their organization.

5. After 5 minutes, bring the group together and ask several volunteers to share the sample policies.

6. Brainstorm what would need to occur to ensure that a policy is implemented and monitored on an ongoing basis.

SLIDE 42: NEXT STEPS

OBJECTIVE: To reflect on what the participants have learned and how they can move forward in the future

MATERIALS: Participant workbook (pages 16 and 18)

Next Steps

The most important outcome of the organizational assessment process is that issues are identified and action is taken. Organizations have many and possible conflicting demands, so it is very helpful to identify clear priorities for action and to identify the resources available so a reasonable plan can be developed.

Brainstorm one or several things that you can do differently to improve service delivery and reduce stigma within your organization. As a group, we will discuss our collective action plans.

STEPS/DISCUSSION POINTS:

1. Direct participants to pages 16 and 18 to the recommended steps for creating an organizational improvement plan following the assessment process.

2. Give participants a few minutes to read the steps, and then brainstorm what they could do differently to improve service delivery and reduce stigma within their organizations. There are no right or wrong answers. They may choose to focus on small changes within their own practice or advocate for larger changes to policies or procedures. Participants can work individually or in groups if other members of their organization are present. Instruct participants to identify at least 2-3 changes that could be made within their organizations to create safer and more inclusive services.

3. Ask participants to share at least one element of their action plan. If time allows, do this activity as a roundtable so that everyone has an opportunity to share.

4. Encourage participants to bring their ideas back to their colleagues as well as to management. Also encourage participants to bring the assessment tool to their organizations.

5. Remind them that given the pervasiveness of stigma within society, all organizations, regardless of the quality of their services, should conduct regular exercises of self-reflection.

NOTE: Individuals may say that in their current roles they have no power to make larger changes. Allow participants to focus on what they can do within their current roles. Also, ask them to think about individuals within their organizations who can act as change agents and to consider advocating in partnership with them.

MODULE 4: CLOSING

SLIDE 43: CLOSING AND QUESTIONNAIRE

OBJECTIVE: To thank participants for their participation and to give them an opportunity to complete the post-workshop evaluation questionnaire.

MATERIALS: Post-workshop evaluation questionnaire (Appendix C)

Thank you for your participation!

Questions or comments?

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

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STEPS/DISCUSSION POINTS:

1. End the workshop on a positive note. Make sure to thank the participants for all of their comments and feedback. Share with the group 1 or 2 things that you learned from them.

2. Remind participants of additional resources such as the *Organizational assessment tool for STBBIs and stigma* and the *Discussing sexual health, substance use and STBBIs: A guide for service providers*. Refer to Appendix F for a list of supplementary resources.

3. In some communities, this workshop may stimulate collective action among several organizations. If the group is inspired to continue working together to implement strategies from the workshop, then future actions and next steps should be discussed at this point. Time permitting, participants can connect with others in the room with whom they can collaborate.

4. Finally, ensure that all participants complete the post-workshop questionnaire. Remind them that their feedback is anonymous, confidential and important.

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APPENDIX A: SAMPLE WORKSHOP AGENDAS

The workshop content can be delivered over 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.

3-HOUR SESSION

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

Module/slide title	Timeframe
Module 1: Introduction	**25 minutes (excluding breaks)**
Slide 1: Welcome and questionnaire	5 minutes
Slide 2: Background	2 minutes
Slide 3: Workshop overview	1 minute
Slide 4: Learning objectives	2 minutes
Slide 5: Learners' rights	5 minutes
Slides 6- 9: Key terms	10 minutes
Module 2: Exploring stigma and factors that contribute to stigma	**68 minutes (excluding breaks)**
Slide 10: Drawing activity	12 minutes
Slide 11: Activity - Health promotion/prevention messaging	15 minutes
Refreshment break	10 minutes
Slide 12: Assumptions to avoid	2 minutes

Module/slide title	Timeframe
Slide 13: Unpacking stigma	8 minutes
Slide 14: Stigma defined	3 minutes
Slide 15: Activity - Stigma case scenario	20 minutes
Slide 16: Why is it important to address stigma?	1 minute
Slide 17: Internalized and perceived stigma	2 minutes
Slide 18: Factors that contribute to stigma	3 minutes
Module 3: Strategies to reduce stigma and create more inclusive and safer services	**62 minutes**
Slide 19: What can you do?	1 minutes
Slides 20-21: See	3 minutes
Slides 22-23: Hear	3 minutes
Slides 24-25: Feel	3 minutes
Refreshment break	10 minutes
Slide 26: Personal reflection	6 minutes
Slide 27: Organizational assessment tool for STBBIs and stigma overview	2 minutes
Slide 28: Organizational assessment tool for STBBIs and stigma– Getting started	2 minutes
Slide 29: Organizational assessment tool for STBBIs and stigma– - Completing the assessment process	2 minutes

Module/slide title	Timeframe
Slides 30-40: Activity - Organizational assessment tool for STBBIs and stigma	20 minutes
Slide 41: Optional activity: Developing a policy statement	10 minutes
Slide 42: Next steps	10 minutes
Module 4: Closing	**5 minutes (excluding breaks)**
Slide 43: Closing and questionnaire	5 minutes
Total	**3 hours (including breaks)**

90-MINUTE SESSION

Note that a 90-minute session is not recommended given the limited time for discussion and reflection. If you only have 90-minutes available, skip several activities and keep group discussions short. The 90-minute session will serve as a basic introduction to STBBI-related stigma at the organizational level. Note that the sample agenda for the 90-minute session does not include any refreshment breaks.

Module/slide title	Timeframe
Module 1: Introduction	**20 minutes (excluding breaks)**
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	4 minutes
Slides 6- 9: Key terms	8 minutes
Module 2: Exploring stigma and factors that contribute to stigma	**37 minutes**
Slide 10: Drawing activity	5 minutes
Slide 11: Activity - Health promotion/prevention messaging **NOTE: DO THIS ACTIVITY AS A LARGE GROUP DISCUSSION, RATHER THAN IN SMALLER BREAKOUT GROUPS**	5 minutes
Slide 12: Assumptions to avoid	1 minute
Slide 13: Unpacking stigma	5 minutes
Slide 14: Stigma defined	10 minutes

Module/slide title	Timeframe
Slide 15: Activity - Stigma case scenario **NOTE: DO THIS ACTIVITY AS A LARGE GROUP DISCUSSION, RATHER THAN IN SMALLER BREAKOUT GROUPS**	5 minutes
Slide 16: Why is it important to address stigma? **NOTE: SIMPLY READ THE SLIDE RATHER THAN ENGAGING IN GROUP DISCUSSION**	1 minute
Slide 17: Internalized and perceived stigma **NOTE: SIMPLY READ THE SLIDE RATHER THAN ENGAGING IN GROUP DISCUSSION**	1 minute
Slide 18: Factors that contribute to stigma	5 minutes
Module 3: Strategies to reduce stigma and create more inclusive and safer services	**28 minutes**
Slide 19: What can you do?	1 minute
Slides 20-21: See	2 minutes
Slides 22-23: Hear	2 minutes
Slides 24-25: Feel	2 minutes
Slide 26: Personal reflection	Skip this activity
Slide 27: Organizational assessment tool for STBBIs and stigma overview	1 minute
Slide 28: Organizational assessment tool for STBBIs and stigma– Getting started	1 minute
Slide 29: Organizational assessment tool for STBBIs and stigma– - Completing the assessment process	1 minute

Module/slide title	Timeframe
Slides 30-40: Activity - Organizational assessment tool for STBBIs and stigma	12 minutes
Slide 41: Optional activity: Developing a policy statement	Skip this activity
Slide 42: Next steps	6 minutes
Module 4: Closing	**5 minutes (excluding breaks)**
Slide 43: Closing and questionnaire	5 minutes
Total	**90 hours**

APPENDIX B: STIGMA CASE SCENARIO

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

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

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

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

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

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

FACILITATOR GUIDE FOR THE STIGMA CASE SCENARIO

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

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

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

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

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

POSSIBLE STRATEGIES TO ADDRESS STIGMA:

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

POSSIBLE DISCUSSION QUESTIONS:

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

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

2. What elements of this story felt familiar?

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

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

POSSIBLE ANSWER: Stigma can keep clients from accessing care and treatment, create more barriers for services, and perpetuate perceived and internalized stigma. Stigma can lead to poor outcomes for individuals living with or affected by STBBIs, including psychological stress; fear of disclosure; and avoidance of prevention, testing and treatment services. [18, 19, 20, 21, 22 23] Stigma within health service settings is particularly concerning as it can impact the quality of care and an individual's engagement in the health care process. 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.

18 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).

19 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.

20 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.

21 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.

22 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).

23 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;2(8):584-92.

APPENDIX C: PRE- AND POST-WORKSHOP EVALUATION/ FACILITATOR REFLECTION QUESTIONS

PRE-WORKSHOP QUESTIONNAIRE

Date: _____

Challenging organizational stigma: Providing safer and more inclusive sexual health, harm reduction and STBBI-related services

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. Please share any other thoughts before this session begins.

POST-WORKSHOP QUESTIONNAIRE

Date: _____

Challenging organizational stigma: Providing safer and more inclusive sexual health, harm reduction and STBBI-related services

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 various forms of stigma and the factors that contribute to STBBI-related stigma.	1	2	3	4	5
The workshop environment was safe and respectful.	1	2	3	4	5
I am more aware of the organizational strategies I can use to reduce stigma within my workplace.	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? (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?
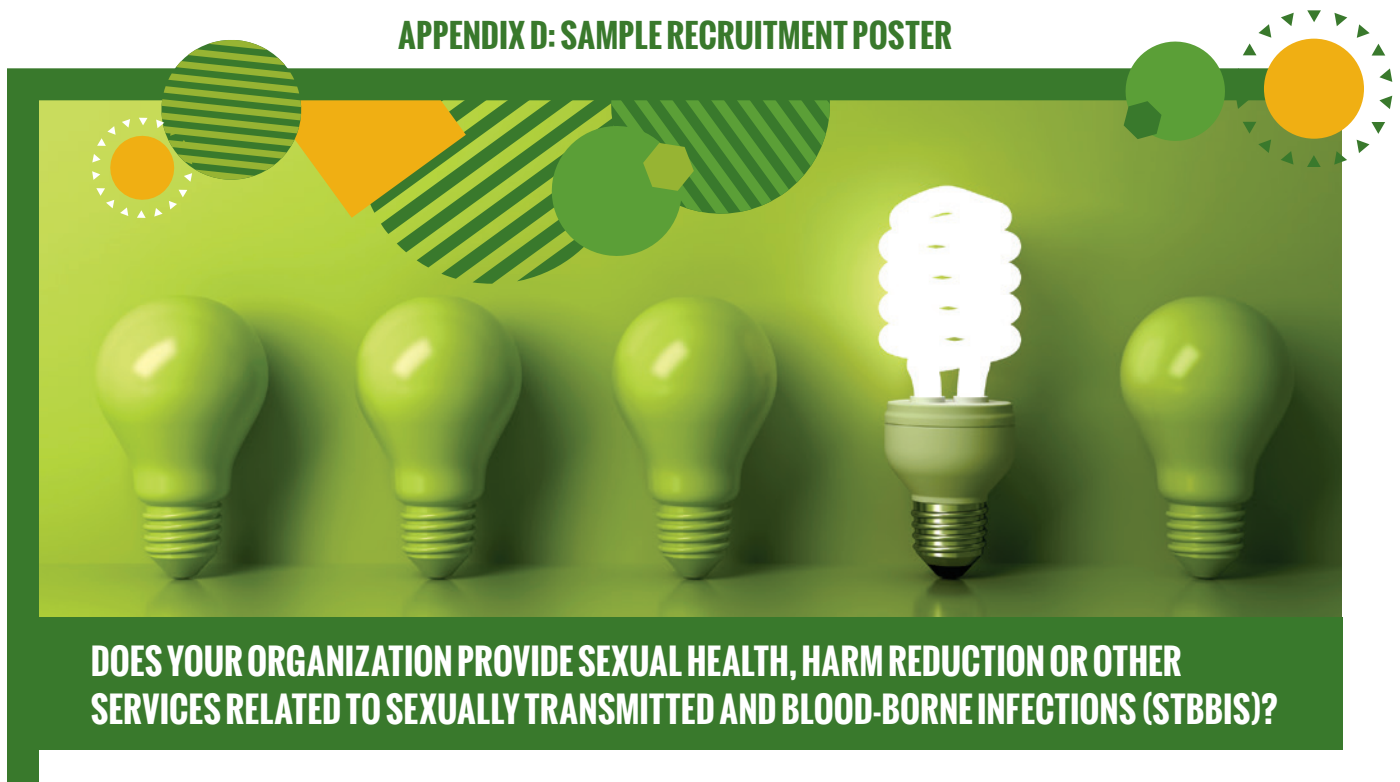
DOES YOUR ORGANIZATION PROVIDE SEXUAL HEALTH, HARM REDUCTION OR OTHER SERVICES RELATED TO SEXUALLY TRANSMITTED AND BLOOD-BORNE INFECTIONS (STBBIS)?

JOIN US FOR A FREE WORKSHOP TO EXPLORE HOW YOU CAN REDUCE STIGMA WITHIN YOUR ORGANIZATION!

During this workshop, we will explore STBBIs, sexuality, substance use and related stigma. You will critically assess the policies, practices and culture of your organization and learn strategies and tools to ensure the provision of safer and more respectful services.

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 E: 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, etc.).

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 F: 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/organizational-assessment-tool-stbbis-and-stigma

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/reducing-stigma-and-discrimination-through-protection-privacy-and-confidentiality

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 DISCLOSURE AND THE LAW

Canadian HIV/AIDS Legal Network, http://www.aidslaw.ca/
National organization committed to promoting the human rights of people living with and vulnerable to HIV and AIDS, in Canada and internationally

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