English

# Sexual Orientation, Gender Identity and Expression (SOGIE)

# TRAINING MANUAL

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isean
islands of southeast asia network on male and transgender sexual health

apcom.org

AFRO

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ISEAN is the first sub-regional grouping of community representatives and organisations from Brunei Darussalam, Indonesia, Malaysia, the Philippines, Singapore and Timor Leste. This sub-regional grouping was envisaged at the 'Risks & Responsibilities' International Consultation on Male Sexual Health and HIV in Asia and the Pacific, held in New Delhi in late 2006, which led to the formation of Asia Pacific Coalition on Male Sexual Health (APCOM), and later ISEAN.

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# PREFACE

As a network that focuses on male and transgender sexual health issues, one of ISEAN vision is to make societies within ISEAN are more accepting of sexual orientation and gender identity within the context human rights.

ISEAN realizes that disseminating comprehensive information about sexual orientation and gender identity and expression (SOGIE) to our community is the most important and urgent thing that must be done prior to implementing the next program. Encouraging LGBTI community to obtain a higher level of health would be difficult to do if there is no support from the social environment for the community. Internalization of fallacious believes about sexuality in LGBTI community itself has led them to low self-acceptance and contributed to their closure on being actively involved in the activities, including in accessing health services.

Consider the situation shown above, ISEAN has developed SOGIE package that can be applied by organizations that focus on the issue of sexuality and sexual health as well as by other organizations that consider this issue is important to be institutionalized in their organizations.

The first document of this SOGIE Package is the SOGIE Assessment Tool that is used to measure the sensitivity level of an organization and its personnel to the issue of SOGIE. This tool can be used as a database for organizations that want to mainstream SOGIE issue in organization's activities.

The second document is the SOGIE Training Manual which is can be used as a guide in organizing capacity building on the basic knowledge of SOGIE. This manual consists of five modules that discuss the terms related to gender and sexuality; introduction to gender and sexuality; the process of identity formation and its challenges; stigma and discrimination, including homophobia and transphobia; and psychological issues related to gender and sexuality.

Even though the main target of this package is the community-based organizations (CBOs) and other civil society organizations (CSOs), but it can also be used by other institutions such as health service providers or government institutions. Some adjustments and further discussions with ISEAN team are required.

In the process of developing these documents, we found a challenge in choosing terms and abbreviations. The first one is the use of term/abbreviation of SOGIE (Sexual Orientation, Gender Identity and Expression).

The second one is the use of the term/abbreviation of LGBTI (Lesbian, Gay, Bisexual, Trans* and Intersex). It is not our purpose to break human sexuality into certain classifications, but it is to refer to the diversity of human sexuality, not only heterosexual and cisgender. The use of LGBTI term in this package is not limited to people who identify themselves as lesbian, gay, bisexual, trans* and intersex, but also to the other human sexuality diversities that may have not been accommodated in the existing term.

Finally, ISEAN hopes this SOGIE package can be used widely by organizations in Indonesia, Malaysia, Timor Leste, the Philippines and even other countries. Therefore ISEAN considered the materials and terms to not too complicated yet easy to apply. ISEAN would be very happy to receive inputs, especially from organizations that have already applied the package, to make it possible to improve this package in the future.

**Jakarta, September 2015**

# ACKNOWLEDGEMENT

ISEAN would like to take this opportunity to acknowledge the contributions of those who helped in taking the process.

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# ABBREVIATIONS

| | |
|---|---|
| AFAO | : Australian Federation of AIDS Organizations |
| AIDS | : Acquired Immuno Deficiency Syndrome |
| APCOM | : Asia Pacific Coalition on Male Sexual Health |
| ASEAN | : Association of South East Asian Nation |
| CBO | : Community-Based Organization |
| CSO | : Civil Society Organization |
| FGD | : Focused Group Discussion |
| HIV | : Human Immunodeficiency Virus |
| HR | : Human Rights |
| ICPD | : International Conference on Population and Development |
| ISEAN | : Islands of Southeast Asia Network on Male and Transgender Sexual Health |
| LGBTI[1] | : Lesbian, Gay, Bisexual, Trans* and Intersex |
| MSM | : Men who have Sex with Men |
| NGO | : Non-Government Organization |
| SOGIE | : Sexual Orientation and Gender Identity and Expression |
| SOP | : Standard Operational Procedure |
| SRHR | : Sexual and Reproductive Health and Rights |
| STD | : Sexual Transmitted Disease (Sexual Transmitted Infection) |
| WHO | : World Health Organization |

[1]In this document, LGBTI is being used to refers not only those who identified themselves as lesbian, gay, bisexual, trans* and intersex, but also to the other variance and range of gender and sexuality.

# About the SOGIE Training Manual

## Background

The result of the review of the SOGIE advocacy carried out by ISEAN under the support of AFAO through the 2014 APCOM shows that the LGBTI community is extremely in need of strengthening the organization and programmatic in HIV, Human Rights, and wider Sexual and Reproductive Health and Rights (SRHR) issues.

SOGIE is one of the important issues which are part of the mentioned issues which have in truth become a necessity, but has not yet received enough attention and support. Gender inequality and the human rights violations against the LGBTI community have prevented them to obtain optimal health for themselves, their families, and their communities.

These gender inequality and human rights violation issues against the LGBTI community contributes to the rejection, avoidance or delay of the individual/ community's involvement in health programs or services such as the HIV program (starting from prevention, care and support, to treatment and impact mitigation), which contributes to the spreading of HIV as well as the mortality and morbidity rate that is essentially avoidable.

One criticism on gender mainstreaming in Indonesia is the reproduction of gender division that is still binary and the boundaries of heteronormativity. However, in reality, there are more than two gender varieties in human beings. Male, female, transgender, and other genders have different health care needs, and thus require specific programs and services that are aware and sensitive of their different needs and are trained to meet these specific needs. Integrating SOGIE and the rights- based approach in HIV programs and services as well as SRHR programs will contribute in the quality of the services and the protection of the LGBTI community.

In relation to the commitment of the board of ISEAN at the fifth board meeting to promote SOGIE, also ISEAN's own mission to promote SOGIE and health in the ASEAN region, this assessment tool for CBO and CSO is developed.

## What and for whom is the manual made for?

This manual is made to assist CBOs and CSOs in order to carry out the capacity building activities on the basic knowledge of SOGIE. This manual consists of five modules each focused on terms related to gender and sexuality (module 1), introduction to gender and sexuality (module 2), the process of identity realization and the challenges (module 3), stigmas and discrimination including homophobia and trans phobia (module 4), as well as psychological issues related to gender and sexuality (module 5).

The purpose of this manual is to provide basic knowledge of SOGIE which is needed by the board of organizations involved in HIV issues (both CBO and CSO), the management, and the staff such as outreach personnel and peer educators in order to perform their duties with sensitivity as to insure that no stigma or discrimination against issues related to SOGIE is made.

Other than the board and staff members of organizations involved in HIV issues, this manual may also be used by a wider audience such as programmers or health service providing institutions (both government and non-government institutions) or other organizations that want to strengthen their performance to be more sensitive and inclusive regarding SOGIE issues.

Aside from this SOGIE module, ISEAN has also prepared SOGIE Assessment Tools which can be used to determine how these SOGIE issues are reflected through attitude, values and practices of individuals and institutions.

## What is participatory method and why is it used?

The methods in this manual were chosen with the special consideration for the ease of the users in situations where resource is limited. The materials in this module are designed to be delivered using the participatory method, where the main objective is not only to deliver the information, but also to stress the involvement of the participants in the discussion and the learning process.

Numerous proofs have shown that the use of this method is effective in improving the participant's knowledge and the retention of information between them post training. The participatory approach also has the concept of utilization and equality, since the participants are considered as people with knowledge and experience, and encourages them to share what they have and builds their confidence.

## How to Use the Manual

This manual consists of several components which are designed to ease facilitators in preparing learning activities. Preparation is crucial in determining the success of the training process. Therefore, facilitators must have full understanding of the objectives of each session, the means of delivery, the tools and materials needed in carrying out the learning activity, the reading materials needed to help manage the discussion, and the key messages that need to be emphasized in each session.

Each module consists of the following sections:

### Outcome

Explains what is to be achieved in this session, be it changes of knowledge, change of attitude, or change of skills. Knowing and remembering the objective or purpose of the session will help facilitators to focus on the outcome of learning itself. In other words, this will help us avoid the tendency to talk and discuss about things that are out of topic and are not a priority or is not important to discuss.

## Method

Method means the way we choose to deliver the learning materials in order to achieve the objectives of the session that we want. Depending on the outcomes we want to accomplish, there is a variety of methods that can be used in these training sessions such as brainstorming, group discussions, plenary discussions, case studies, role play, demonstrations, simulations, or field trips.

- Brainstorming

  Facilitators propose questions to the participants which aim to encourage them to discuss ideas, concepts, and solutions related to the topics proposed by the facilitator.

- Discussion or Group Work

  Discussions are held in small groups typically consisting of 4-5 people. Facilitators provide questions to be discussed by participants in small groups. Facilitators observe the process of discussion in each group. Therefore, for this discussion or group work process, having more than one facilitator (co- facilitator) will be better. After the small group tasks are accomplished, the summary or the result of the discussion will be presented by one of the members of each group to the whole group (all participants). After each small group has presented their findings, the facilitator will conclude, structure or summarize the agreement of the whole group.

- Case study

  Case study provides detailed description or stories of people, groups, or situations. It is used when there is a need to invite participants to understand and analyze a problem or its solution. Facilitators initially provide questions to guide the participants' discussions in the study of case study.

- Role Play

  In this method facilitators help participants learn to understand the problem by putting themselves in the position of the person facing the challenge/ problem. Participants are asked to play the role of the other person in front of all the other participants. Role play brings the real situations faced by certain people to the participants (both the role player and the audience) of the training.

- Interactive Presentation

  This is the most frequently used method in trainings. Facilitators present structured ideas or information through power point presentations (or using other presentation tools such as flipcharts and white boards). Presentations need to be done interactively as to avoid on way communication or the presentation will become boring for the participants.

  There are several things that need to remember in order to make a presentation run interactively:

  1. Speak in a fairly loud voice, with clear articulation and intonation that is according to the message given. This will make our presentation lively and not bring.
  2. Use simple language so that it is easy for the participants to understand.
  3. Maintain eye contact with the participants throughout the presentation. Eye contact will encourage interaction. In contrary, lack of eye contact will make participants feel left out.

4. Encourage interaction and discussion by asking questions.
5. Do not read the presentation word by word, the participants are able to do that already. Likewise, do not read all the notes written on your "cheat sheet". Cheat sheets are meant to help facilitators remember the important points and the flow of the discussion that should be given.
6. Walk towards the participants, move from one place to another, and avoid standing in one place for a long period of time. Approach participants who ask questions or those who do not pay attention to the presentation. Ask them questions to engage them in the discussion.
7. Use images in the presentation, but not too many. One image for each slide is enough.
8. Detailed information can be given to participants in reading texts or handouts.

## Tools and Materials

This section indicates the tools and materials needed in the facilitation of the sessions, which is closely related to the method used. The audio and visual method, for example, will need a laptop, LCD projector and screen, speakers, or a television and video player, as well as movies/ clips or music that will be shown.

In the brainstorming method, markers (rather large ones) will be needed, as well a whiteboard or a flipchart. While in the case study method, scenarios and cases that will be discussed and analyzed by the participants need to be prepared.

## Process

This is the series of processes that need to be guided by the facilitators in order for the sessions to go according to the steps based on the method that has been chosen to achieve the outcome of the session. These processes are designed to make it easier for facilitators to plan the sessions they need to give step by step, and to ensure that they do not miss any steps. For new facilitators, these steps of the sessions will help them have a picture of what needs to be done in each session.

## Key Messages

This section reminds and emphasizes the messages from each session that should be 'taken home' by the participants.

## Reading Materials

This is the minimum reading materials that need to be understood by the facilitators before giving a session. This section should also be copied to be given to the participants to take home, as further reading material and records to be studied at home.

# Preparations

## Preparations for the Facilitator

- In order to be effective facilitators, we need to have adequate knowledge on materials related to SOGIE, sexual and reproductive health, and human rights.
- In addition, we need to keep learning and continue to train our communication skills and our facilitative skills.
- We also need to learn about topics connected to SOGIE such as HIV, sexual and reproductive health, as well as a broader knowledge of gender and sexuality.
- We need to know who the participants who will be attending the training are, their background, and their expectations of the training that we will carry out or the sessions we will facilitate.
- Limit the participants to be no more than 15 people, especially if we plan to hold them alone. Too many participants will make facilitators unable to manage the process of the session, which will make the session ineffective and some participants may feel 'left out' or unattended to by the facilitator. The minimum amount of participants is 8 people, in order to allow sufficient interaction between the facilitator and the participants and among the participants themselves. With 8 people, it is possible work in small groups (either threesome or dyad) and to role play.
- When we are not yet accustomed to giving new materials or we are giving a new session, we can use 'cheat sheets' which contain brief notes on the process and the activities, including the messages that need to be emphasized in each step (depending on our needs).
- Get plenty of rest the night before the session/ training. Many studies show that lack of sleep increase nervousness, decrease concentration, composure, and creativity. As a facilitator, we have an important role and responsibility to ensure that we are in good physical condition.

## Preparation of Room, Tools and Materials

- Always visit the training classroom before the training takes place, even if there is another person who prepares the room for us. By doing this we can know the positions of the seats, the whiteboard, flipchart, and we can change the positions if necessary. We can also check whether the speakers function or not, if there is disturbing echo from the speakers which needs to be fixed.
- It is recommended to arrange the participant's seats into a semicircle/ horse shoe without using the tables. This is to ensure that the facilitator is able to see all of the participants, and vice versa. The tables can become psychological barriers and create a boundary between the facilitator and the participants. Physically, the table can also restrict the participants' movements especially if we are using the participatory approach in our sessions.

There are many 'little things' that need to be prepared properly so that it does not disrupt the learning process and affect our comfort (and the comfort of the participants!) in attending every session. Prepare the following tools and materials that support the learning process:

- Whiteboard markers
- Flipchart (paper sheets)
- Index card
- Tape
- Flipchart board
- Whiteboard
- Eraser
- Laser pointer
- Laptop, LCD projector and screen
- Stationery for participants (notebook and pen)

- Make sure we have made copies of forms and sheets which will be used during the training such as pre and post- tests, answer sheets, evaluation sheets, case study sheets, etc.
- Also make sure that all the forms and sheets used are printed clearly, easy to read, and do not have any parts missing.
- Always arrive earlier than the set time for the training. Even if we (or others) have prepared the day before, there are still several things that might have escaped our attention or needs readjustment.
- Never assume that electricity will always be available during our sessions. Always prepare a backup plan such as by writing the learning points on a notepad.

**Note**

**What should be done and what shouldn't be done (do's and don'ts)**

### Do the followings:

1. Start with something interesting (ice- breaker). Use images, poems, songs, or quizzes to attract the participant's attention. If we are able to get their attention at the beginning of the session, it tends to be easier for them to keep paying attention throughout the whole process.
2. Balance participation and control. Encourage and give participants opportunities to share their stories, and express their opinions and views. However, we need to take control if the discussion becomes too broad takes up too much time. We can direct the discussion by limiting the number of participants and how much time they have to speak.
3. Make use of questions. Use closed questions, open questions, clarification questions to encourage discussion, overcoming stiffness in class, or to move the flow of the discussion.
4. Be sensitive towards what participants show (or do not show). There are messages that participants convey orally/ verbally through their words and there are messages that they convey non-verbally (i.e. through facial expressions, position or posture). Often, these non-verbal messages are the most honest. Recognize the signs that participants show when they start to get bored, their energy starts to decline, they don't understand the discussion, sleepy, feeling too hot or too cold, etc. respond to these situations adequately and discuss what can be done together if necessary.

5. Manage sophists. Remember that time keeps going and these sophist debates usually never finish no matter how much time there is. Be firm to return to or continue the discussion or the talk of the topic being studied. Voice out that there is an objective that needs to be achieved in this session for the common interest in learning.
6. Keep the participants moving and laughing. The intense learning process may be very draining and tiring for those who are accustomed to following classes moreover for those who are not accustomed to studying for a relatively long period of time (i.e. from 9 a.m. to 5 p.m.). Have the participants move around through activities in the sessions or through energizers. Use humor to make participants more relaxed and refreshed. Feel free to laugh at yourself.
7. Prepare a "parking lot". Prepare a blank sheet of planner paper posted to the wall with "parking lot" written on it. At the beginning of the training session, explain to the participants that the "parking lot" can be used as a place to write down the things they still do not understand or are still unclear of and needs further explanation on or needs solutions from other participants and especially facilitators. Make use of these "parking lots" if there are questions we cannot answer. Do not forget to fulfill our promise to find the answers (on the next day, the next session, or through telecommunications/ social media/ email).
8. Move and approach participants. Give attention to the participants by approaching them when they speak or give their opinions. Be relaxed and change your position once in a while and move from one place to another from time to time.

**Do not do the followings:**

1. Continuously pressing the cap of your pen. Sometimes we unconsciously do this, especially when we are nervous. The sound it creates is not pleasant to hear and is a distraction.
2. Be aware of our habits related to paralinguistic such as "eehhh", "ennggg", "okay", "alright", etc. that we use too often (or use out of place) hence making it a distraction for the participants and obstructs theirs understanding of what we deliver.
3. Playing with coins in our pockets. Just as the pressing of the pen cap, this is also something we do unconsciously. This will bother the participants' concentration and is also unsightly for some people.
4. Holding too many objects. Sometimes we unconsciously pick things up and forget to put them down, and by the time we realize we are already holding the microphone, a blue marker, and a black marker all in one hand. For some participants this will be very disturbing and makes our presence seem incomplete to them.
5. Turning your back to the participants for too long. Do not turn your backs to the participants for too long when you are writing on the whiteboard or the flipchart, as this will give the impression that you are leaving them out.
6. Using colored markers to write sentences on the whiteboard/ flipchart. Colored markers (such as red, yellow, and green) must only be used to underline, make bullet points, arrows, and circling the point of focus in the discussion.
7. Continuously standing in one position. Staying in a static position during the whole session will lessen the interaction that occurs in the class.
8. Moving too much or too quickly. Moving too much or too quickly can also make participants feel distracted and tired (because their attention usually follows your position). Some participants may also become dizzy when they see you move around too fast and too frequently.

## Icebreaker and Energizer

Literally, icebreaker means something to break ice or to break something stiff/ frozen, while energizer can be defined as a spirit or energy booster.

Icebreakers are typically used at the beginning of the training, where the participants are usually unacquainted and are still foreign with each other and the facilitator and to the dominant classroom atmosphere. With an icebreaker, we help the participants to be more relaxed and calm. Remember, discomfort and tension will make training sessions ineffective.

Energizers are typically used at the turn of sessions, in the middle of long sessions, or at the beginning of sessions after a lunch break. Energizers are also used when participants seem to be tired or sleepy. With energizers, we make participants move and laugh thus they feel refreshed to continue the learning process.

So, icebreakers and energizers have different functions. However, the materials/ used for both may be the same, such as:

- Games
- Quizzes
- Singing songs
- Riddles
- Songs or short videos
- Exercises or simple gymnastics, etc.

## Evaluation

### Why do we evaluate?

Evaluations provide us with information on whether or not we have reached/ achieved the target/ outcome of the training (or the purpose of the session) as planned.

With evaluations we can also receive feedback about the good qualities of our sessions (that we need to maintain) and the bad qualities (that we need to improve on the next training activities).

### What aspects do we evaluate?

Evaluations will tell us to what extent the participants understand the materials given, which methods need to be adapted or changed, which materials are most needed, added, or which are considered irrelevant and unimportant with the participant's needs, what is liked and considered important by the participants in relation to the learning process, and the changes that happen in the participants throughout the training sessions conducted.

In other words, depending on the evaluation questions we ask, we can receive any information we need to improve the effectiveness of the sessions and trainings, meet the needs of the participants, and ensure that the process is carried out in a fun way and not boring or intimidating for the participants.

## When do we evaluate?

We can make an evaluation at the end of every session, at the end of the day, or at the end of the whole training session. Usually, we conduct a short evaluation at the end of every session and every day, and a longer and more thorough evaluation at the end of the training. Information on the evaluations can be delivered before the session (or sessions) starts so that the participants are ready to give feedback and pay more attention to the process and the substance of assessment of the evaluation.

## Examples of Evaluation Tools

There are several simple tools that can be used during the training session. The following are some examples:

**Written evaluation using forms**

We can use the forms that we have prepared and make multiply/ make copies for the participants to fill. A simple questionnaire with a corresponding scale (for example one to five, with one being irrelevant and five being very relevant) can be used to know how the participants feel, how they enjoyed our session, whether or not our session has fulfilled their needs and expectations, whether or not the session has given them knew knowledge, etc.

For a more elaborate explanation, we can give open questions to the participants. These open questions are usually used to further understand the reason participants chose the number on the scale. An example can be seen in Annex 1.

**Evaluation using emoticon**

We can also use an even simpler form of evaluation, for example by preparing three emoticon images ( for happy/ love; for normal; and for unhappy/ dislike) and a list of the subjects assessed (the list of aspects we want the participants to evaluate). The way to use this tool is as the following:

1. Place/ post three emoticons in three different places.
2. Ask all participants to stand.
3. Read the first evaluation point (for example 'how would you evaluate the materials today?')
4. Ask the participants to move to the emoticons according to their evaluation of the question.
5. Take note of how many participants stand near each emoticon.
6. Read the next evaluation point and repeat the process #4 and #5 for all the remaining evaluation points.

**Evaluation using the 'Dart' method**

1. This method uses the analogy of playing dart. The closer the arrow that we throw is to the center of the circle, the higher our points will be. However, in this evaluation, we do not throw darts, but we ask participants to draw a dot using markers. The dots represent the participant's evaluation on certain aspects.
2. Draw a large circle on the flipchart. Divide the circle into slices like a cake, either three or four or more, according to how many aspects you want to evaluate.
3. Prepare this circle before class and hand out markers to each participant. At the end of the session/ the end of the day/ the end of the training have the participants draw a dot on the circle according to their evaluation: one dot for each aspect.

4. The more satisfied they are of an aspect the closer their dot should be drawn to the center of the circle. The more they are unsatisfied, the closer it should be drawn to the outside of the circle.
5. After every participant has drawn a dot for each aspect of evaluation, we will be able to have a general picture of each aspect's evaluation. For example, if in one aspect, say material, we see that there are a lot of dots drawn near the center of the circle. This shows that in general, the participants give a high score on the material given in the session. If the dots are spread, this means that the participants' thoughts on the aspect vary. While if the dots are mostly drawn in the outer area of the circle, near the outer line, this shows that the participants find this aspect of the session to be unsatisfying.


The example tools above can be used at the end of each session, the end of the day, or the end of the whole training. As previously mentioned, the evaluation aspects given at the end of each session should only be a few and used to find out the things we really need to know (example: the participants understanding on the materials given and the method used in that session). For the end of the day, we can use a more elaborate evaluation. Example: the participants feelings, the relevance of the topics/ materials to the participant's needs, food/ snack, the facilitators, the benefit for the participants, etc. for end of training evaluation, we can use all the evaluation aspects that we need.

## Pre- and Posttest

Pre- and post-test evaluations are used to assess the participant's understanding of the materials learned throughout the training. Normally, 'pre- and post- test' is used to evaluate the changes in the participant's knowledge, even though it can also be used to assess the changes in their attitudes.

If the majority of participants show development in their results on the pre- test to the post- test, it means that there is an increase in their knowledge which they gained from the training sessions that have been given. On the other hand, if there is no development in their results, or there is a decrease, then there is something wrong that we need to find out about. Maybe the problem lies in the materials given, way or method that was used, or there may be other causes.

Try to make a pre-test and post- test assessment and make a comparison list of the results as soon as the post-test is carried out. Even though we can always do this after the training is finished, the participants will be happier to see their results, and this is also a type of achievement for the participants in the training.

All of the types of evaluations previously explained will give us information on the things that we have done and give us feedback in order to make improvements in our next sessions. Positive feedback will also give us encouragement and a sense of appreciation for us (as facilitators and as organizers) for the things we have done well.

# Module 1
# Terminology of Gender and Sexuality

## Outcomes

1. Participants recognize the various terms related to gender and sexuality;
2. Participants understand the terms related to gender and sexuality.

## Time

90-120 minutes.

## Tool and materials

1. Power point slides
2. LCD Projector
3. Flipchart paper (paper sheets)
4. Index cards (with the terms such as given in the following example)

| | | | |
|---|---|---|---|
| Feminine | Gender Identity | Sexual Orientation | Cisgender |
| Masculine | Gender Based Violence | Transgender | Homosexual |
| Gender | Bisexual | Gender Expression | Androginy |
| Heterosexual | Intersex | Asexual | Heteronormative |
| MSM | Transsexual | Lesbian | Internailzed Homophobia |
| Transition | Transwomen | Transphobia | Homophobia |
| Transvestite | Conversion/ Reparative Thearapy | Transmen | Gender Dysphoria |

5. Whiteboard
6. Whiteboard markers and erasers
7. Flipchart board

## Methods

1. Group Work
2. Interactive Presentations
3. Quizzes (alternative)

### Alternative Method

If the location of the training process is unlikely for there to have a power point presentation, facilitators need to arrange a presentation using flipchart boards and paper which has been previously prepared, by writing the meanings and definitions of the terms from the power point presentation on the paper.

An alternative choice to use is the quiz method. Every correct definition explained by a small group will receive a point. A wrong answer will not receive a point. The remaining index cards will be used as extra points. The group with the most points is the winners.

## Process

1. The facilitator presents the objectives of the session to the participants.
2. The facilitator starts the session by distributing the index papers which have the terms on them to the participants. One paper for each participant. If there are any remaining index cards, then the facilitator should distribute them randomly to the participants who have previously received index cards. Or the facilitator can tape the remaining cards on the whiteboard or the flipchart board where it can be seen by all the participants.
3. The facilitators then form small groups, each group consisting of 4-5 people. in these small groups, they are asked to discuss the definition or meaning of the terms they received. Give the groups enough time to discuss each term. After they are finished, have a representative from each group explain to the class about the terms they have discussed.
4. The facilitator starts an interactive presentation (a two- way presentation followed by discussion) on the mentioned definitions and terms using power point or flipchart presentation which has been previously prepared.
5. The facilitator clarifies be there any incorrect/ inappropriate answers from the groups on specific terms.
6. When finished, the facilitator gives participants an opportunity to ask questions if there are any things that are still unclear.
7. The facilitator ends the session by summarizing the key points of the materials in the session, then thank the participants.

## Key Messages

Facilitators need to remind the participants that the terms studied in this session are the key points of the study. There are still many other terms related to the topic of gender and sexuality. There are many more local terms that differ depending on the ethnic, culture, or even period/ time. Participants are encouraged to keep learning and to read relevant books and articles related to gender and sexuality.

Emphasize to the participants that they do not need to memorize all of the terms. The more they learn about SOGIE, the more terms they will know and remember.

## Reading Materials

**Sexual orientation** is the emotional, romantic, and/ or sexual attraction someone feels towards the opposite sex (**heterosexual**), the same sex (**homosexual**), or both (**bisexual**).

The term **lesbian** describes a woman who is romantically, emotionally, and sexually attracted to other women. The term **gay** describes a man who is romantically, emotionally, and sexually attracted to other men, and the term **bisexual** describes an individual who is emotionally, romantically, and sexually attracted to both men and women.

**Asexual** refers to the lack of sexual attraction or absence of arousal or the desire for sex.

**Gender** is the diversity of characteristics, nature, role and identity which is constructed socially based on the masculinity or femininity that is unfixed and can change depending on the time, group and society where the individual lives.

**Gender identity**[2] is the experience that an individual feels very deeply about internally related to their gender, which can be related or unrelated to their sex at birth.

A **cisgender** is an individual who identifies themselves as the sex they were born with, for example a person who was born with a penis identifies themselves as a man. Or, a person born with a vagina identifies themselves as a woman.

**A transgender** (transwomen, transmen) is and individual identifies themselves different from the sex they were born with. For example, a person who was born biologically as a male (has a penis) and identifies themselves as a female (**transwoman**). Or, an individual who was born biologically as a female (has a vagina) and identifies themselves as a male (**transman**). Unlike gender expression (see explanation below), gender identity cannot be seen by others.

**MSM** (Men who have sex with men) is a technical term that emphasizes sexual intercourse between two men. This term is used in the medical world which only refers to sexual behavior, not gender identity or sexual orientation. An MSM could be a heterosexual, homosexual, bisexual, or transgender male.

[2]Yogyakarta Principles

**Gender expression** is an external manifestation of gender, i.e. how an individual physically expresses themselves (through appearance, how they dress, their haircut, voice, body language, or other physical behavior or characteristics) based on their gender identity and sexual identity, whether it shows manly characteristics (**masculine**), or womanly characteristics (**feminine**) or does not clearly show either masculine or feminine characteristics, which is called **androgyny**. A transgender will normally express themselves according to their gender identity, not their biological sex.

An individual may be born with two genitals (usually one or both do not fully develop). This biological condition is called **intersex**.

Gender identity also includes personal feelings regarding the body which can also, if freely chosen, involve the modification of bodily appearance or functions through medical means (such as hormone therapy), surgery, and other means. A transgender who has undergone sex change surgery (or is going to and is in the process of physical change) in order to match their gender identity is called a **transsexual**.

Not all transgender undergo surgery because many of them, both transwomen and transmen, decide not to have a sex-change surgery because they still feel comfortable remaining in their biological body due to one reason or another.

**Transvestite** is an individual who wears clothes of the opposite sex for various reasons and do not have any intention of changing or making any modifications to their bodies.

**Transition** is the process of an individual's gender presentation to match their gender identity. For a transgender, this could include sex adjustment surgeries, but not all transgender do this.

Many people assume that gender identity aside from man and woman (i.e. transwomen and transmen), as well as sexual orientation other than heterosexual (i.e. homosexual and bisexual) is not normal or even ill. This is a false assumption, because the sexual diversity explained previously is not a matter of normal or abnormal or healthy or sick.

Throughout our lives we were not raised with heteronormative values, hence we unconsciously consider groups outside of heterosexuality are not normal. Again, this is a false assumption.

**Heteronormative** refers to the social and cultural practices where men and women are made to believe that that heterosexuality is the only sexuality that may exist. This implies that heterosexuality is the only way to be 'normal' and as the main source of social status[3].

These heteronormative values are the main source of the stigma and discrimination against those who have different gender identities and sexual orientation than the mainstream. Aside from that, these stigma and discrimination are also influenced by the '**Phallocentric**' (from the word Phallus or Penis) culture. The view of phallocentric focuses on masculinity as the source of power and strength so as to amplify the needs and desires of men (heterosexual) while at the same time reducing or even ignoring the needs and desires of men (homosexual), women, and other genders into subordinates.

**Gender based violence** refers to violence that perpetrated on a person because of their gender (male, female, or transgender). For the LGBTI community, violence is directed towards them because of their sexuality, gender identity, gender expression, or their appearance.

[3]Definition from ILGA

**Homophobia** is the irrational fear of homosexual feelings, thoughts, and behavior (or person) which leads to bias, accusations, and discrimination against homosexuals. Whereas **transphobia** is the irrational fear of transgender or of those who do not fit the norm of traditional gender (someone biologically male must be masculine, identifies himself as a man and heterosexual. While someone biologically female must be feminine, identifies herself as a woman and heterosexual).

In many cultures, homophobia and transphobia is so strong that homosexuals and transgender experience **internalized stigma**, which is when a homosexual or transgender internalizes the hatred, anger, and shame towards themselves.

What has been described previously is different from gender dysphoria. **Gender dysphoria** is a medical term used to describe the condition where an individual experiences disconnectedness between the gender they have and the gender they want. Most transgender do not agree with the term gender dysphoria as a medical term because it seems to be based on which gender is 'normal'. In 2013, the American Psychiatric Association/ APA in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) used the rem Gender Dysphoria to replace the term gender identity disorder' as well as changes in the diagnosis.

**Conversion therapy**, also known as reparative therapy, is an action/ effort of a homophobic which aims to change the sexual orientation of a homosexual or bisexual into a heterosexual through certain types of therapy.

# Module 2
# Introduction to Gender and Sexuality

## Outcomes

1. Participants understand what sex, gender, and sexuality is;
2. Participants understand what is meant by sexual orientation, gender identity, and gender expression and the examples;
3. Participants understand the different kinds of sexual behavior

## Time

90-120 minutes.

## Tool and materials

1. Power point slide
2. LCD Projector
3. Flipchart paper (paper sheets)
4. Whiteboard markers
5. Whiteboard and erasers
6. Flipchart board
7. # set of index cards with the terms of sexual diversity and # set of index cards with the terms of sexual behaviors.

**For Part III:** index cards need to be prepared prior to the session. The amount required depends on the number of groups, for example, if we are planning to make the participants work in four groups, then there will need to be four sets of index cards with the terms of sexual diversity as the following:

| | | | |
|---|---|---|---|
| **Feminine** | **Gender Identity** | **Biological woman (vagina)** | **Sexual Orientation** |
| **Masculine** | **Female** | **Transgender** | **Homosexual** |
| **Biological Sex** | **Gender Expression** | **Bisexual** | **Androginy** |
| **Heterosexual** | **Intersex** | **Male** | **Biological man (penis)** |

**For Part IV:** index cards need to be prepared prior to the session. The amount required depends on the number of groups, for example, if we are planning to make the participants work in four groups, then there will need to be four sets of index cards with the terms of sexual behaviors/ activities as the following:

| | | | |
|---|---|---|---|
| Wet petting | Anal Sex | Oral Sex | Mammary Intercourse |
| Masturbation | Fingering | Fisting | Intercrural Sex |
| Axilism | Jerking off | Threesome | BDSM |
| Quickie | 69 | Mutual Masturbation | Rimming |
| Golden shower | Cunilingus | Dry petting | Anilingus |
| Blow job | Fellatio | Vaginal Sex | Orgy |

## Method

1. Brainstorming
2. Interactive Presentations
3. Group Work (alternative)

### Alternative Method

If the location and facilities where the training is held is not possible to have a power point presentation, the facilitator needs to prepare a presentation using flipcharts that have been previously prepared, by writing the definitions of the terms and the image of a 'person' from the power point.

## Process

### Part I Sex and Gender

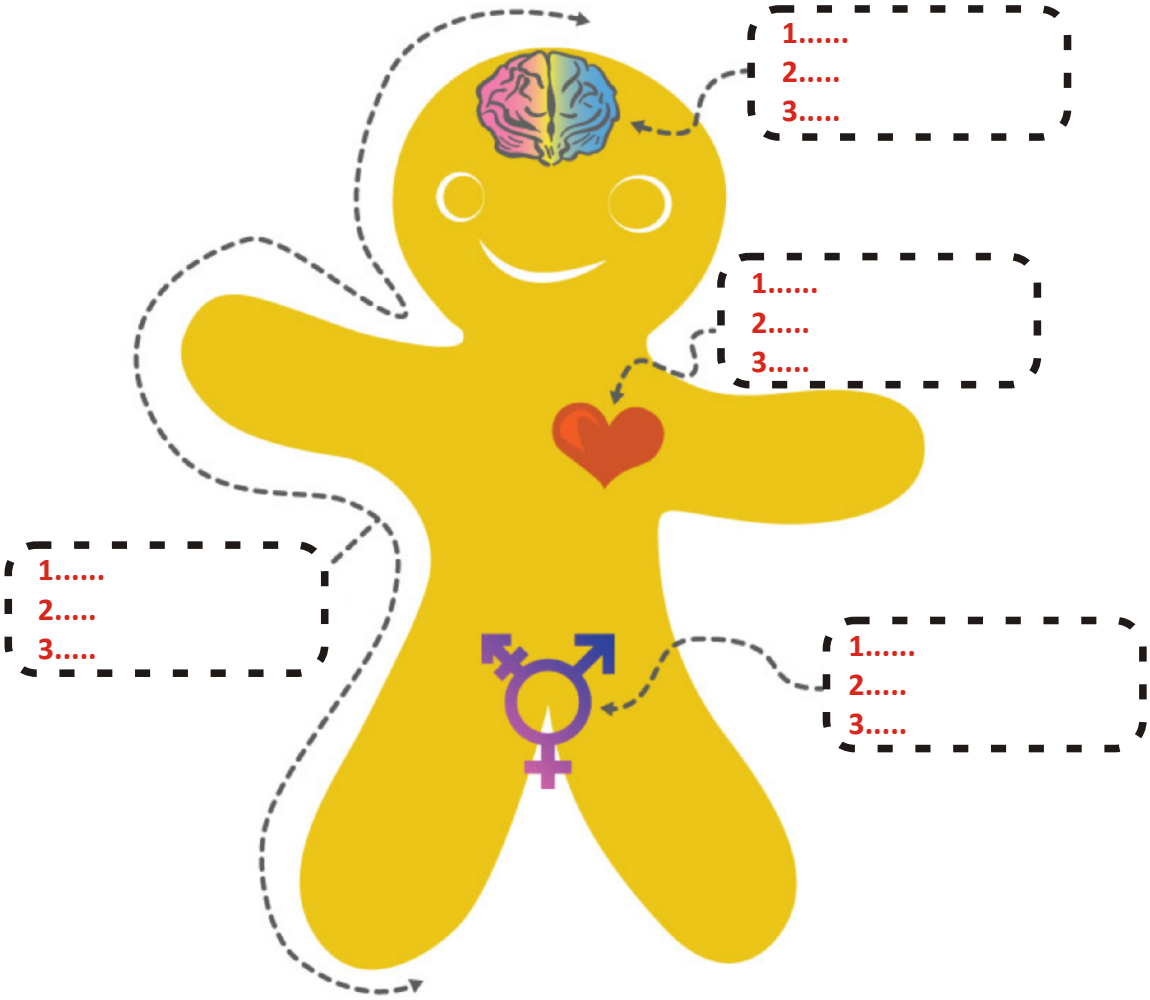
1. The facilitator presents the objectives of the session to the participants.
2. The facilitator starts the session with brainstorming. Ask the question, "if sex refers to genitals, hen what is gender?" to the participants.
3. The facilitator notes the participants' answers on the whiteboard or the flipchart. After the participants are finished answering, the facilitator then explains what gender is. Gender is a social construction.
4. If there were any incorrect answers from the participants, show the notes previously written on the whiteboard (as in #3) and clarify the answer. Give a simple reminder to the participants, "sex is what is between our thighs. Gender is what is between our ears (in our brain/ our mind)".

### Part II Sex and Sexuality

1. The facilitator asks the participants, "what is the difference between sex and sexuality?"
2. The facilitator notes their answers on the white board or the flipchart. After the participants are finished answering, the facilitator explains about sex and the biological characteristics and sexuality as a broad term which consists of various components such as anatomy or parts of the body, identity, and behavior.

### Part III Gender Diversity and Sexuality

1. The facilitator divides the participants into small groups (4-5 people). give a whiteboard marker, flipchart paper, and a set of index cards which already have the terms written on them such as the above.
2. The facilitator asks the participants to draw a 'person' in a large scale on the flipchart paper similar to the display shown in the power point presentation (or the sample image the facilitator has drawn on the flipchart), making sure that it the picture has a brain, heart, and sex. The facilitators tell the participants that the knowledge received in the gender and sexuality terminology session will be used as the 'base' to complete the group task.




3. The facilitator then ask each group to put one index card on each arrow on the drawing of which they think is most appropriate. Give the participants enough time to discuss and finish the group task. If they have come to an agreement, they can tape the according index cards on the places they consider most appropriate, then the result of their group is posted on the wall in front of the class.
4. The facilitator asks each group to present their results. After every group has presented their results, the facilitator starts the interactive presentation to re-emphasize the previous presentation in the terminology session about gender identity, sexual orientation, biologic sex, and gender expression and their examples. The facilitator can use a power point presentation or one of the groups work and change the positions of the index cards that are incorrect while explaining them to the participants.

Genderbread Person from http://itspronouncedmetrosexual.com/

## Part IV Sexual Behaviors

1. Again, the facilitators ask the participants to return to their small groups. A whiteboard marker, flipchart paper, and a set of index cards with the terms of sexual activities as the example above are given to each group. Give the participants time to discuss and agree on the meaning of the terms. After they are finished, ask them to present the result of their discussion in front of the class.
2. The facilitator then asks each group to give a short presentation of their results to the class. Then, discuss the terms whose meaning is still unclear to the groups.
3. The facilitator gives the participants a chance to ask questions if there are still points that are unclear to them.
4. The facilitator ends the session by summarizing the main points of the materials in the session and then thanking the participants.

## Key Messages

This session is the longest session compared to all the other sessions in this module. Therefore, it is important that the facilitator emphasizes several important points at the end of the session:

The difference between sex and gender: sex is the sex we have had since birth, gender is a social construction. Gender is not a nature; it is formed, learned and taught after we are born into the world.

Many people often fail to distinguish between sexual orientation and gender identity and expression. One of the purposes of the part III activity is to clarify the differences between gender identity ('between our ears', invisible to others), sexual orientation (matter of the heart', invisible to others), biologic sex (between our thighs'), and gender expression (physical appearance that is visible to others). Ensure that all participants understand the differences of each term classified as gender identity, sexual orientation, biologic sex, and gender expression.

Many people also connect certain sexual activities or behaviors to certain sexual orientations or certain gender identities. For example, anal sex is often associated to homosexual males and transgender. In fact, many heterosexual and bisexual males engage in anal sex, as well as females (regardless of their sexual orientation and gender identity and expression). Stress to the participants that the various sexual behaviors discussed in this session can be done by different people and is not based on sexual orientation, gender identity, or gender expression.

## Reading Materials

### Sex and Gender

Sex refers to the biologic sex (which is written on our birth certificate). However, sex is actually a combination of biological characteristics such as chromosome, hormone, genitals, and the reproduction system (outer and inner), and the characteristics of secondary sex. Although physically, sex can be altered (i.e. sex change surgery), but the function of their reproduction system will not change.

While sex is something obtained from birth, gender is formed, taught, and learned. Let us try to remember, what color presents do baby girls usually receive? How about baby boys? Baby girls usually receive gifts that are pink, while boys receive blue gifts.

Who determines this division? This is social construction, a result of the heteronormative- patriarchy culture and phallocentric views. This is what we call gender, a diversity of characteristics, nature, role, and identity based on masculine and feminine qualities given to an individual by the society. Because it is not inborn, gender is then flexible; it can change depending on the time and place, and can be exchanged.

Gender roles indicate how the society identifies an individual as a male, female, or transgender (or any other gender). The difference with gender identity is that it is how an individual identifies themselves as a male, female, transgender (or any other gender). While gender expression is how an individual displays themselves as masculine, feminine, or neither masculine nor feminine, or even displaying both at the same time (called androgynous).

**Sex and Sexuality**

If sex can be simplified genitals, sexuality is a term that describes something complex. According to WHO, sexuality is:

*"… the main aspects of being a human being in his/ her life, consisting of sex, gender identity and gender role, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed through various dimensions such as thoughts, fantasies, sexual arousal, beliefs, attitudes, values, behavior, intimacy, and reproduction. Sexuality is composed of all of the mentioned dimensions, but not all of these dimensions can be experienced or expressed. Sexuality is influenced by interactions of biological, psychological, social, economic, political, cultural, legal, historical, and religious and spiritual factors."*

Women, young people, and the LGBTI community are groups that are typically unable to carry out or express their sexuality comfortably and freely without fear and pressure.

**Reproductive health**

Sexual and reproductive health rights is part of the human rights that applies to everyone regardless of their gender identity, sexual orientation, disabilities, ethnic, race, and social class. The definition of reproductive health and its rights, according ICPD (1994) is:

"*a state of complete physical, mental and social well-being ... in all matters related to the reproductive system and not merely meaning the absence of disease or dysfunctions, in all matters relating to the reproductive system and its connection with the functions and processes*."

**Sexual health**

According to the World Health Organization, sexual health is a state of complete physical, emotional, and social in relation to sexuality; not merely free from disease or dysfunction. Sexual health requires a positive approach to sexuality and sexual relations, including the possibility to have a sexual experience that is safe, pleasant, and free of coercion, discrimination, violence and threats. So that

sexual health can be obtained and maintained, the sexual rights of all people must be respected, protected and fulfilled.

From the above definition we can see that 'Sexual Health' is not only a matter of being free from illnesses or diseases and the dysfunction of the body. But it also includes having safe sexual experience that is enjoyable and pleasurable for us and our partners (without coercion, discrimination and violence). This last point is yet to be fulfilled or enjoyed by sexual minority groups in general.

**Diversity of Gender and Sexuality**

Many people assume that every person is heterosexual. This is a false assumption that is based on heteronormative values. This is also what underlies the supposition that a man must be masculine and a woman must be feminine. A man must like and be sexually attracted to a woman and vice versa. An individual who was born with a penis must identify themselves as a male. An individual who was born with a vagina must identify themselves as a female.

These assumptions have been so deeply-rooted that people believe those with a gender identity and expression as well as sexual orientation that is different from the ideal heteronormative concept is abnormal, deviant, or ill. This is what has influenced the efforts to fix, treat, or cure those people who are not included in the ideal heteronormative boxes of men and women, including by using the corrective rape practice which is done in many places and cultures in the world.

In the medical world, in Diagnostic and Statistical Manual of Mental Disorders published in 1973 has excluded homosexuality from the list of mental disorders. In Indonesia, a similar guideline, the Guidelines for Classification and Diagnosis of Mental Disorders or PPDGJ II & III, which was published by the Ministry of Health of the Republic of Indonesia in 1993 has also declared homosexuality as a variant of human sexuality and not as a mental disorder.

In DSM V (2013), the term ‘Gender Identity Disorder’ which was previously used in DSM IV has been changed to ‘Gender Dysphoria’. This change or revision from DSM IV to DSM V was done to eliminate any stigma against those whose gender identity is different from their biologic sex, because the word disorder implies a negative connotation. People who do not confirm their gender (gender non-conformity) are also not referred to as a disorder.

The word dysphoria in ‘Gender Dysphoria’ which is used in the DSM V refers to the strong and continuous feeling of rejection and discomfort in a certain period of time (6 months) experienced by an individual towards their his/ her gender identity, which causes a deep negative stress as well as creating dysfunction socially, at work, or in other aspects. This means that, not every transgender experiences gender dysphoria. If they do not go through very heavy stress and persistent dysfunctions (or in other words they feel comfortable and accept their gender identity) then they do not have gender dysphoria.

DSM V also adds a discussion on post- transition, which is for those who will or have lived in accordance with the gender they desired/ identified with.

Thus, this ensures the possibility of access to continue hormone therapy, counseling, or surgery to support the gender transition process.

Sexual orientation and gender identity and expression is not a choice. Many people use this argument to blame the LGBTI community who are considered to have made the wrong choice. Just as someone

who was born a heterosexual will feel uncomfortable when asked to imagine having to change and become homosexual or bisexual (or be born as a cisgender and must change into a transgender), the same goes for the LGBTI community when asked (and forced!) to change their gender identity, sexual orientation, and gender expression.

Because sexual orientation as well as gender identity and expression is not an illness, therefore it is a useless attempt to try to cure it. Sexual orientation, gender identity and expression are also not contagious and cannot be transmitted. Attempts to 'treat and fix' or 'prevent transmission' will make individuals from the LGBTI community even more ostracized and are unable to enjoy the degree of physical, psychological, and social health as the heterosexual and cisgender community.

**Sexual Behavior**

Sexual behavior includes all the sexual activities and practices done by one or more (either two, three, or more) individuals, regardless of the individual's (or individuals') sexual orientation, gender identity, and gender expression.

For those of us still confused with the number above, we can learn the definitions of the following sexual behavior terms. First there is masturbation which is carried out by one person, penetrative sexual intercourse through the anus, mouth, or vagina that is carried out by two people, there is penetrative sexual intercourse through the anus, mouth, or vagina that is carried out by three people (which is called a threesome), and there is also penetrative sexual intercourse through the anus, mouth, or vagina that is carried out by more than three people (called an orgy).

The following is an explanation of some of the many terms of sexual behavior, and additional information on the risks of the transmission of HIV and other STDs. This information is important because there are still a lot of people who have the wrong assumption and belief about the risks of sexual practices. Most people are stuck with the heteronormative mindset of how to avoid unplanned pregnancies from happening. Therefore there is a false assumption that sexual practices other than penetrative sexual intercourse through the vagina are safe. For example, many heterosexual teenage couples have anal penetrative sexual intercourse to avoid pregnancy, without knowing the risk of transmitting HIV and other STDs.

**Petting / humping/ frottage**

This is a sexual activity where two people rub their genitals (or the penis and the anus) while using their clothes (dry petting/ humping/ frottage) or without their clothes (wet petting/ humping/ frottage), without penetration. In this context the term penetration refers to 'the penis entering the vagina' or 'the penis entering the anus'. Dry petting does not have a risk of transmitting HIV or any other STDs. While wet petting still has a risk of transmitting several kinds of STDs such as genital warts, genital lice, Herpes, Gonorrhea, and chlamydia.

**Oral sex**

Oral means mouth. Oral sex means stimulating the male or female genitals or anus by using the mouth and tongue. Oral sex where the mouth and tongue stimulates the penis is called **Fellatio**. We also often call it Blow job. Oral sex where the mouth and tongue stimulate female vagina is called **Cunnilingus**. Another term for this is vagina licking. Oral sex where the mouth and tongue stimulate the anus is called **Rimming** or **Analingus**, which some call 'toilet cleaning'.

Some people engage in oral sex as sex precursor (foreplay) before vaginal or anal sex. While some others may perform oral sex until their partner reaches orgasm and ejaculation or ejects semen.

It is advisable to use a condom when performing felatio (karaoke / Ngesong), or dental dams when performing cunnilingus (jimek) or rimming (toilet cleaning), especially if we have mouth sores, or sore teeth / gums, or are experiencing bleeding gums. Be careful not to tear the condom with your teeth when performing oral sex.

The risk of HIV transmission is very low in oral sex. However, STDs such as herpes, genital lice, syphilis, gonorrhea, chlamydia and genital warts can be transmitted through oral sex without a dental dam. While doing rimming, avoid contact with feces that may be present around the anus (to be safe, use a dental dam over the surface of the anus during rimming, or attach a condom on the tongue). We can be infected with Hepatitis A or digestive diseases. While doing cunnilingus or jimek, the low risk of HIV transmission can rise higher when the woman is menstruating and the man has mouth sores, cavities, or bleeding gums.

We can still get herpes and syphilis despite the use of condoms or dental dams, through direct contact with the parts around the genitals or anus that are not covered by the condoms or dams.

**Quickie or fast sex**

Stressing on the duration of sexual intercourse (be it anal, vaginal or oral sex) which is done quickly. The risks of quickies are blisters and sores if done without a condom and lubricant, especially in anal and vaginal sex. In the context of vaginal intercourse between men and women, women who are not sexually aroused (not ready physically) may experience pain and blisters on the surface of the canal and vagina.

**Anal sex**

Sexual activity that stimulates the anus and rectum (inside the anus) with the penis. In anal sex, there are two roles: the receptive role (which receives the penis) and the insertive role (which inserts the penis). The higher risk of HIV transmission is for the receptive role, because HIV more easily enters the body through blistered mucous membranes on the wall of the rectum. Anal sex also has the risk of transmitting various kinds of STDs such as genital warts, herpes, lice, chlamydia, gonorrhea and syphilis.

Anal sex is not only done by transgender or homosexual men. Some clients of female prostitutes also asked them to engage in anal sex. Some heterosexual couples also engage in anal sex. For those of us who are not accustomed to it, we need to learn how to do it if we want to do.

Such as in the vagina, a penis that is directly inserted in the anus will cause pain. By reflex, the anus will close if the penis comes inside when the receptive is not ready. Therefore, communication with sexual partners is indispensable in order to control and guide the penis into the anus when the receptive is ready. You need to relax. By inviting your sexual partner to talk casually, the penis can slowly be inserted into the anus. Try not to insert the penis in a hurry. The anus will further adjust and give way for the penis to enter.

It is highly not recommended to use drugs that make you drunk in order to suppress the pain of

anal sex, because when we are drunk we are very vulnerable to violence. In the context of sex work, sexual partners (client) can also leave us without paying, if they do not pay in advance.

Always use a new condom and sufficient lubricant when performing anal sex. Add lubricant at any time when the condom begins to dry, or replace it with a new condom.

**Mammary intercourse/ motor boating**

This is when a man rubs his penis between a woman's or transgender's breasts. If the man performs mammary intercourse until ejaculation (semen comes out), then you should turn your head the other way so that the semen does not enter your eyes, because HIV or germs that cause other STDs can enter your body through the membranes of your eyes. If there are cuts, abrasions, acne, or boils that have recently popped on the breast or the surrounding body parts, cover them with a Band-Aid. Herpes and Moluccas contagiosum can be transmitted through direct contact of two bodies.

**Intercrural sex**

In intercrural sex, a man rubs his penis between the thighs of his partner. If the man performs intercrural sex until ejaculation, ask him to ejaculate on the stomach, thigh, or any part other than the vagina, because if the semen contains virus or germs, then those virus and germs may enter the woman's body through the membranes of the vagina. The risk from this activity is the same as that of mammary intercourse.

**Axillism**

This is when a man rubs his penis between his partner's armpits. The risk from this activity is the same as that of mammary intercourse.

**Masturbation**

This is a sexual activity that is carried out alone to obtain sexual pleasure, usually by stimulating the genitals using your own fingers or an instrument. This activity is also commonly referred to as Onan, supermarket sex, 501, or coli (jerking off).

Mutual masturbation is an activity where you and your partner masturbate together. Mutual masturbation can also mean that you and your partner masturbate each other (you stimulate your partner's sex and vice versa). Masturbation is not harmful for your health, and does not give any risk of transmission of HIV or any other STD.

**Golden Shower**

Golden shower is a sexual activity where an individual lets out urine (urinates) on their sex partner which causes sexual pleasure for one or both parties.

**69 (Sixty-nine)**

This refers to a sex position: two people are in the position where the mouth of one individual is near the other individual's sex or anus and both perform oral sex to each other, so that it looks like the number 69.

**Threesome**

This is a sexual activity that is carried out by three people together. The sexual activities carried out in a threesome varies, such as oral sex, anal sex, vaginal sex, kissing, etc. The risk of HIV transmission depends on the kind of sexual activity done. In general, the risk of HIV transmission in order of higher risk and lower risk is anal sex - vaginal sex – oral sex.

As for the transmission of other sexual infections, in a threesome it is possible to have body contact and contact with genital fluids, so there is a risk of transmitting bayur lice, genital warts, gonorrhea, chlamydia, syphilis, etc. always use a condom and lubricant when having a threesome.

Threesome emphasizes on the number of three people. For a higher amount of people, the term sex party or orgy is used.

**Fingering and Fisting**

This is the term for the activity when you insert your finger into the anus or vagina (fingering) or when you insert your fist into the anus or vagina (fisting).

Injury to the vagina or anus of the receiver of fingering or fisting can easily occur, so always use sufficient lubricant and ask your partner to be careful when performing fingering or fisting to prevent injuries and small tears in the anus or vagina.

Use a latex glove (or a condom) when doing fingering or fisting to you partner or vice versa. Be careful when taking off the latex glove (or condom) after you have finished fingering or fisting so as to not have any contact with the genital fluid or feces. Wash your hands with water and soap until it is thoroughly clean after fingering or fisting.

**BDSM**

BDSM is an acronym for Bondage & Discipline, Sado-Masochism (Domination & Submission). In BDSM, a couple will feel aroused by physical bondage, the use of pain, both physically and psychologically (i.e. intimidation). There are two roles in BDSM, the dominant (master) and the subordinate (slave).

Masochism is sexual pleasure that an individual feels from pain or feeling demeaned and humiliated by their sexual partner (from attitude or words). In contrary, Sadism is sexual pleasure that an individual feels from giving pain, and demeaning or humiliating their sexual partner. There are many forms of BDSM activities, ranging from 'mild' such as using handcuffs, rope, silk cloth, or other binders, slapping and humiliating your partner. There are many scenarios that can be played in BDSM, and many story settings in the form of decorating the room where BDSM is played out, and costumes that can be used accordingly to the scenarios.

All BDSM activities from mild to severe must be accompanied with consent, which means that there must be approval and an agreement from both (or more) parties who will be performing these BDSM activities. BDSM should be safe (there needs to be a key word or password that an individual says when they can no longer continue his/ her role) and there needs to be an emotion recovery period post BDSM activity. BDSM without consent is no longer BDSM but sexual violence and coercion which are a crime.

A more in-depth knowledge on BDSM and training on BDSM are required before engaging in a more severe BDSM activity.

# Module 3
# Identity Process and Its Challenges

## Outcomes

1. Participants understand the process of gender identity and sexual identity formation
2. Sharing of the participant's knowledge and experience in the development of their identity formation
3. Participants understand the challenges that the minority community experiences when they open up about their gender/ sexual identity to other people or the general public.

## Time

90-120 minutes.

## Tools and Materials

1. Power point slide show
2. LCD Projector
3. Flipchart paper
4. Index cards
5. Whiteboard markers
6. Whiteboard and erasers
7. Flipchart board
8. List of Statements for the game:

**Take one step forward, if you...**

are wearing black pants.
have more than one mobile phone.
are single (do not have a partner).
are wearing red underwear.
have debt of over a hundred dollar.
have secretly farted in this session.
have ever masturbated in a public toilet.
have cheated on your partner.
have been cheated on.
have ever done phone sex.
have ever (or your partner has ever) had an abortion.
have ever had and STD.
have ever (even just once) had unprotected sex.
still have unprotected sex until now.
have ever hit your partner.
have ever been hit by your partner.
have ever used drugs.
have ever had silicon implementation.
have ever had a sexual dream with a person of the same sex.
are attracted to people of the same sex.
feel entrapped in a body with the wrong sex.
actually want to express yourself femininely but has always suppressed it.
are sexually attracted to both men and women.

## Method

1. Game 'One Step Forward'
2. Interactive Presentations
3. Group discussions
4. 'Lifetime Line' activity (alternative)

### Alternative Method

If the location and facilities where the training session is held is not possible to use power point presentation, the facilitator needs to prepare a presentation using the flipchart which has previously been prepared, by writing the key points from the power point presentation.

Another method that can be used in the training is to ask the participants to draw their own 'life line'. Each participant is asked to draw a line, which starts from their birth to the present, on a flipchart sheet. Have them draw important events that have happened on that line (for example when they first entered kindergarten, when they first learned to ride a bicycle, moved houses, were in an accident, hospitalized, received a memorable gift, entered junior high school/ high school/college, got their first job, their first kiss, etc.). After they are finished, discuss together what the participants felt when drawing their 'life line'. Ask them if they have listed all of the important events in their live? Are there any important events that they have not listed in their 'life line'? (participants do not have to 'open up' about what is not listed, they only have to answer yes or no). Facilitate a discussion such as the #3 process in the following activities.

## Process

1. The facilitator presents the objective of the session to the participants.
2. The facilitator starts the session by inviting the participants to play the game 'one step forward'. First, the facilitator explains the rules of the game. All participants stand in a starting line (the room needs to be prepared before the game starts, such as by moving the chairs and putting tape the floor to create a starting line), so that there are no participants standing in front of or behind other participants. Tell them that the facilitator will read out 25 questions one by one. They are asked to pay close attention to the statements being read out. Explain to the participants that they may deny or not step forward if the statement is something they have gone through or are going through but do not want to admit in front of other participants. Ask the participants whether or not they have fully understood the rules of the game. If all of the participants are clear about the rules, start reading the statements one at a time. Give them enough time to understand each statement that is being read.

3. After all of the statements have been read, have the participants return to their seats and ask them about their general impression of the game. Ask them what they thought and how they felt during the game. If a participant shares their personal story, let them do so. However, never force a participant to share their personal story if they do not want to. Then (if this has not yet arisen in the participant's feedback) ask them what the relation between this game and LGBTI is. Discuss this with the participants then emphasize that many LGBTI groups have to live in secret, and sharing their secret to other people may endanger their lives.

4. Show the power point presentation (or the points which have been previously written if not using the power point presentation) about the 'stages of Identity formation' and use points as a guideline for an interactive presentation. Explain the stages that gays, lesbians, and bisexuals go through before deciding to reveal the truth about themselves to other people (coming out). Emphasize that this is a long process, it is not instant, and there is no age limit. There are some people who will never experience 'coming out' because it is too dangerous or because of many other reasons.

5. The facilitator continues the learning process by dividing the participants into two groups. All participants are asked to imagine that they are a part of the LGBTI community and is about to 'come out'. The first group is asked to make a list of the positive consequences of 'coming out', while the other group is asked to make a list of the negative consequences of 'coming out'. After both groups are done with their lists, ask a representative of teach group to present their ideas in front of the class. Then, invite the participants to discuss the various aspects to think about when going to 'come out'. Emphasize to the participants to really imagine if this was happening to them. What will they do? Why? Is 'coming out' an easy thing to do? In the game 'one step forward' or 'life line', was it easy to reveal/ share secrets with other people? what secret was the easiest to reveal/ share? What was the hardest?

6. The facilitator gives participants an opportunity to ask questions about things they are still unclear about.

7. The facilitator ends the session by summarizing the key points of the materials in the session, then thank the participants.

## Key Messages

The process in this session reflects the things that people are forced to keep hidden from the people closest to them, their family, and the general public because of various reasons. In the game 'one step forward', the emphasis is on the process of reflection. It is when many participants do not take a step forward on statements relevant with themselves, that it becomes a good matter to reflect on about the challenges faced by the LGBTI community regarding revealing their gender identity, sexual orientation, and other things related to their sexuality.

Also make sure that participants understand that 'coming out' is a choice, not an obligation.

## Reading Materials

There are several theories on identity formation. The following will briefly explain the simplified stages of identity formation (Troiden, 1989)[4]. Though the following information is based on western concepts and knowledge, it is a good start to learn to understand the process of identity formation.

**Stage 1: Sensitization.**

This stage usually occurs just before puberty. In this stage an individual believes that they are heterosexual and or cisgender. They feel the same as most other people, aside from a few aspects such as choice of clothing, ways of expression, haircut, or a difference in the sexual orientation perceived.

**Stage 2: Confusion.**

This stage is when an individual will feel confused about their identity. This occurs in the adolescence period where people start to feel attracted to other people (for example sexual attraction or the feeling of liking someone of the same sex). The lack of knowledge on sexuality, the heteronormative values learned from the society and culture, as well as the new/ never before experience of feelings and attraction makes that individual experience identity confusion.

**Stage 3: Assumption.**

In this stage, an individual starts to accept that their identity is different from others. This process varies and happens in different ages. There is no specific or standard age for this. The 'coming out' process may happen in this stage or it may not. The person involved may not be comfortable with themselves and may still feel isolated, alone, or depressed, but at one point in this stage they have already found their identity.

**Stage 4: Commitment.**

Here, an individual feels comfortable with their identity and their life with that identity.

The stages mentioned do not take place quickly and is a complex process. An individual may have felt doubtful and confused numerous times before finally accepting and feeling comfortable about their identity permanently. This is what needs to be remembered by those working with the LGBTI community/ group, such as the outreach staff, peer teachers, healthcare staff, or advocates for LGBTI rights related issues.

Coming out or revealing information about gender identity and sexual orientation is not an easy thing to do for everyone. There are many processes that take place simultaneously, inside oneself (internal process) and outside (external process).

Both of these processes are influenced by many factors 9for example the heteronormative culture and the phallocentric view, belief, customs, social class, the education level of an individual or society, conservatism and fundamentalism, the law, etc.), and the external processes also influence the internal process (i.e. stigma or phobia that is internalized).

[4]Pehchan Training Curriculum 2013

Coming out is not the purpose of LGBTI individual or group assistance. Keep in mind that every person is unique and cannot be compared, so our experience with one person cannot be associated with another person, even if they are from the same group (such as LGBTI). Forcing, directing, or imposing someone to come out without that person's own judgment or decision must be avoided because of the many negative impacts that may happen to that individual on various levels.

Something that can be done by a field officer, a peer teacher, or a healthcare staff regarding the issue of coming out is to develop empathy and to give support with a client centered approach. By doing so, the client can consider the outcomes that may happen (both advantageous and disadvantageous) and can make their own plans to manage the consequences that may arise.

# Module 4
# Stigma, Discrimination, Homophobia and Transphobia

## Outcomes

1. Participants are able to identify the forms of discrimination against the LGBTI community
2. Participants understand the impacts of discrimination and the acts of hate crime
3. Participants can identify the forms of support that can be given to the sexual minority groups.

## Time

90-120 minutes.

## Tools and Materials

1. Power point slide show
2. LCD Projector
3. Flipchart paper
4. Index cards
5. Whiteboard markers
6. Whiteboard and erasers
7. Flipchart board
8. Scenario cases 1-5 *

***Scenario #1***

I am a first year junior high school student who was born as a male biologically but I identify myself as a female. When I leave my house, there is a group of people who often shout out, "sissy!"

The first time this happened I did not feel anything. However, when this incident repeated, I felt scared and hurt. There is a sharp pain in my heart when I remember their words. Now I am afraid to leave the house and I stay at home in solitude. Sometimes I want to search for information about my condition, but I am too scared.

***Scenario #2***

I am a woman, only in my second year of college. I have a girlfriend. We have been secretly dating for the past year. But one day my family found out about our relationship. I was relentlessly scolded. One night, not long after that, a man who is a distant relative came into my room and told me he would help me become a normal woman. Then he raped me.

***Scenario #3***

I am a 28 year old man, I am married to a woman and we have a child together. When I went to the clinic to check a lump I have near my genitals, the nurse asked about my sexual intercourse history and I told her that I had had sex with a man the week before. The next day, when I came back to get my results, I was kicked out of the clinic. The nurse who had spoken to me the day before told me I was ungrateful and disgusting. I was very embarrassed.

***Scenario #4***

I am a transgender and I always dress as a woman. Once I went to a clinic. On the front door of the registration room there was an announcement which read: 'only serving those who dress accordingly to their nature'.

***Scenario #5***

I am a 23 year old gay male. In a physical examination at the hospital, the doctor who examined me said that I must wear a condom when having sex with 'my girlfriend'. I tried telling him that I don't have sex with girls. But he seemed to pretend to not hear me and repeated his words over and over that I must always wear a condom when having sex with 'my girlfriend'.

## Method

1. Case studies
2. Interactive presentations
3. Group work

**Alternative Method**

If the location or facilities of the training session is not possible to use power point presentation, the facilitator needs to prepare a presentation using a flipchart which has previously been prepared with the main points of the power point presentation.
It is advised to have group work in this session.

## Process

1. The facilitator presents the objectives of the course to the participants.
2. The facilitator starts the session with brainstorming. Ask questions to the participants, "what is the difference between stigma and discrimination?" the facilitator gives the participants the opportunity to answer, the answers are written on the flipchart or whiteboard. The facilitator then shows the power point presentation or the previously prepared main points written on the flipchart about stigma and discrimination.
3. The facilitator then invites the participants to study the cases, by displaying scenario #1 - #5 on the power point presentation (or the flipchart presentation). As a guideline for discussion, ask the participants to discuss the following points:
   a. **What problems or issues exist in the scenario?**
   b. **What will you do if you experience this kind of situation at work, in your community, etc.?**
   c. **What will you do in our job (both regarding health issues and as part of the society) to respond to the situation as such in the scenario?**
4. Give an opportunity to the participants to discuss and write down the results of their discussion and the agreement of the group; have them present to the class.
5. After all the groups have presented their results, the facilitator then leads a discussion on the result of the group discussion related to the topic of the session.
6. The facilitator gives the participants an opportunity to ask questions on things they are still unclear about.
7. The facilitator ends the session by summarizing the main points of the materials in the session and saying thanks to the participant.

## Key Messages

Sometimes we show stigma (or even discrimination) against certain groups, including minority groups, unconsciously. This session is an opportunity to reflect on our words, attitude, and behavior towards those certain groups thus far. As much as we feel uncomfortable when we experience stigma or discrimination in any form or context, so does everyone else who experiences it.

## Reading Materials

Stigma is negative prejudice given to a certain individual or group. Discrimination is specific negative treatment done to an individual or group based on a stigma. Thus, sometimes discrimination is called 'executed stigma'.

Homophobia and transphobia is an irrational and un-based fear towards the homosexual and transgender. Homophobia and transphobia involve a set of negative attitudes and feelings towards the homosexual and transgender community. Though not as much, there are forms of negative attitudes and feelings among the gay, lesbian, and transgender community itself.

These negative feelings can manifest into physical violence, verbal abuse, neglect, and social exclusion. Many transgenders experience various forms of discrimination and violence from their family or the general public who link their gender identity to homosexuality.

Internalized homophobia is the negative feelings an individual has towards oneself due to their own homosexuality. While internalized transphobia is the negative feelings an individual has towards themselves because of their gender identity as a transgender. Lately, the term used for these conditions is internalized stigma. Research shows that most gay men and lesbian women had negative attitudes and feelings towards themselves in the early days of their identity formation.

Internalized stigma will force the individual to suppress their feelings associated with homosexuality and transgender. This suppressing is also worsened by internal conflicts (inside a person/ in their mind) caused by the collision of those feelings and the religious values and beliefs. The impact of this situation may either be clinical depression or suicidal thoughts.

Understanding about internalized stigma is important for people who work with the LGBTI community. for example, a counselor must help his/ her client overcome this internalized stigma before discussing how to deal with stigma and discrimination from family or the society. Another example is, an advocate staff needs to understand the levels of stigma (as explained below) to help him/ herself to modify the work such as in sensitizing the service providers or the government to help with overcoming stigma and discrimination at that specific level.

The there are several levels of the forms of stigma and discrimination (either related to homophobia/ transphobia directly or indirectly), such as personal level, social, politic, public, religion and belief, and law. The efforts to raise awareness and advocate work regarding these issues, with the support of the sexual minority group and the society sensitive and in supportive of this community can greatly help to reduce the stigma and discrimination against the LGBTI community.

## Examples of stigma and discrimination in various levels (Kantor, 1998)[5] :

**Medical:**

Therapies to 'cure' homosexuals or transgender.

Comments by healthcare workers who preach and probe the transgender or homosexual patient to repent when patients come for care and treatment for a disease or infection that they have.

Comments given by health care workers who state that anal sex is not normal.

**Religion:** Homosexuality is believed to be a sin. Being transsexual is called unnatural. HIV is appointed as a result of the sins of being a homosexual or transgender.

**Socio-cultural:** The assumption that everyone is heterosexual, pressuring gay men to get married and have a family (having a wife and children).

**Law:** Regulations that criminalize or provide legal sanctions for same sex sexual intercourse.

[5]Pehchan Training Curriculum 2013

# Module 5
# Psychological Issues related to Gender Identity and Sexuality

## Outcomes

1. Participants understand the different types of psychological issues that may arise related to identity, gender, and sexuality;
2. Participants can identify the conditions when an individual from the LGBTI community needs to be admitted to a specialist.

## Time

90-120 minutes.

## Tools and Materials

1. Power point slide show
2. LCD Projector
3. Flipchart paper
4. Index cards
5. Whiteboard markers
6. Whiteboard and erasers
7. Flipchart board

## Method

1. Brainstorming.
2. Interactive Presentations (Q&A)

### Alternative Method

If the location or facilities of the training session is not possible to use power point presentation, the facilitator needs to prepare a presentation using a flipchart which has previously been prepared with the main points of the power point presentation.

## Process

1. The facilitator presents the objectives of the session to the participants.
2. The facilitator starts the session with brain storming. Ask the participants, "from the previous session, what psychological conditions are experienced by an individual or the LGBTI group?" The facilitator briefly notes the participant's answers on the flipchart.
3. The facilitator then starts the interactive presentation using a power point presentation (or the writing on the flipchart which has been previously prepared). During this process, the facilitator connects the discussion with the answers from the brainstorming session before.
4. The facilitator gives the participants an opportunity to ask questions on things that are still unclear to them.
5. The facilitator ends the session by summarizing the main points of the materials in the session and then thanking the participants.

## Key Messages

It is not our part to determine or diagnose a person's medical or psychological condition. The purpose of the information from this session is to help us recognize the psychological issues faced by the sexual minority group so that we can act more sensitively and responsively towards their needs. If we are uncertain or confused, always refer to a person or an organization that works in this issue. We should also know the organizations that have a perspective on the SOGIE issues as much as we can so that the person referred to can get a pleasant service.

## Reading Materials

**I am a homosexual. Am I normal? Are there others like me?**

Medically and psychologically, homosexuality is no longer considered a disease or disorder. Various studies / research carried out globally shows that sexual behavior of the same sex exists in many societies and cultures. Although many old theories classify homosexuality as a disease and should be 'cured' medically, today homosexuality is no longer classified as a disease.

**What about me, who is a transgender? Is there something wrong with me?**

As long as we feel comfortable with our gender identity (being transgender or transmen), there is nothing wrong with us. Currently, the term gender identity disorder has been replaced by the term gender dysphoria. This shows that our condition is no longer categorized as a disorder or illness. If we still feel a certain level of discomfort related to our gender identity (gender dysphoria) then we can consult a psychologist or psychiatrist or counselor who is sensitive with SOGIE issues and open towards the LGBTI community.

If we decide to perform medical procedures (i.e., hormonal therapy) or surgery (i.e. sex adjustment surgery for transsexual or breast elimination surgery for transmen), we need to obtain complete/

thorough information from qualified and trustworthy sources which are accountable. The surgeries that can be performed include testicle removal surgery, scrotum, penis, and vagina construction. Other surgeries also include breast implants and vocal chords surgery, as well as removing the ovaries and uterus/ cervix in women and forming of the penis and scrotum.

**Why do I hate myself?**

When we hate ourselves because of our gender identity or sexual orientation that is different from most people, then it is possible that we are experiencing internalized stigma. It will be very helpful if we can talk to someone who we can trust (such as a social worker, NGO officials, or organization volunteer) or a professional (counselor, psychologist, doctor) who is knowledgeable with LGBTI issues so that we can understand the process that is happening inside ourselves and how we can receive support.

**I often have nightmares, I have trouble sleeping and I am losing weight. I avoid people and shut myself in my room. My appetite has plummeted drastically and lately I have had suicidal thoughts. What is happening to me?**

If we experience one or several of the above situations permanently or comes and goes but is frequent, then it is time to find help. Finding information about gender identity and sexual orientation may be a very difficult thing, therefore it will be very helpful to have someone who can support and assist us through this process. There are many things we do not, or have yet to, understand. However, the most important thing is to look for help, or to let and allow ourselves to receive help. Medical, psychological, and social support is very important to have when facing the above condition.

**What can we do to become an ally and support our friends, relatives, clients or target groups of LGBTI assistance groups?**

An example is when they open up to us about their identity transition process or about their sexual orientation. Find the right place to process our thoughts and feelings. We may feel shocked, afraid or angry, or maybe we have already suspected it for a long time. Whatever the case, find a safe and secluded place to process all of your feelings and thoughts. Do not impose all of your thoughts and ideas to that friend/ relative/ or client, who in general, already have to face the problems inside of their own minds.

Find the right place to process our thoughts and feelings. We may feel shocked, afraid or angry, or maybe we have already suspected it for a long time. Whatever the case, find a safe and secluded place to process all of your feelings and thoughts. Do not impose all of your thoughts and ideas to that friend/ relative/ or client, who in general, already have to face the problems inside of their own minds.

Support groups or organizations engaged in LGBTI issues are a good choice for discussing our thoughts and feelings. Study the information and views that we did not know and we have not seen before to be able to fully understand the issues faced by our friend/ relative/ client.

Respect their identity (including their sexual orientation). Start thinking through their perspective. Do not use the normative values, in contrary, remember that they are living their own life, and we cannot use the common values, or our own values, when discussing the issues they are facing.

Validate their identity and sexual orientation when communicating with them. Use appropriate terms and friendly language. If you are confused, ask questions. Apologize if you incidentally use insensitive language or terms, are not inclusive, or offend them.

Connect them to the services they need.  For example, peer support groups, legal services/ paralegal, professionals (doctors, psychologists), as well as community leaders or religious leaders who support the LGBTI community.  At the same time, show them that we are there for them as their friend to share stories, with respect for confidentiality.

# Link and References

## Link

Below are links to organizations and initiatives with useful information related to SOGIE:

ISEAN (http://isean.asia)
Asia Pacific Coalition on Male Sexual Health or APCOM (apcom.org)
The Asia and Pacific Transgender Network or APTN (weareaptn.org)
International Lesbian, Gay, Bisexual, Trans and Intersex Association or ILGA (http://ilga.org), including ILGA ASIA (http://ilga.org/network/ilga-asia/)
International Day Against Homophobia, Transphobia & Biphobia or IDAHOT (http://dayagainsthomophobia.org)
International Gay and Lesbian Human Rights Commission or IGLHRC (www.ilghrc.org)

## References


Van Dyk, D. Train the Trainer Manual, Understanding Human Sexuality. OUT Wellbeing, 2011

Pehchan Training Curriculum. MSM, Transgender and Hijra. Community System Strengthening, India AIDS Allliance 2013

Jauhola, M. Building back better? – negotiating normative boundaries of gender mainstreaming and post-tsunami reconstruction in Nanggroe Aceh Darussalam, Indonesia. Review of International Studies (2010), 36, 29–50

*Buku Saku Kesehatan Seksual Reproduksi untuk Pekerja Seks* (Sexual Health Booklet for Sex Workers). OPSI, 2015

# Annex

## Annex 1: Sample of Evaluation Form (IHP)

| | |
|---|---|
| **Activity** | |
| **Date and Time** | |
| **Venue** | |

*We would like to know how we can improve succeeding activities (i.e. meetings, workshops, trainings). To do this, may we ask your help by sharing to us your thoughts on how this activity was managed. Please place a check mark ( √ )on the scale table that corresponds to your appraisal per item.*

| No | Statement | Appraisal | | | |
|---|---|---|---|---|---|
| | | Need Improvement | Fair | Good | Very Good |
| 1 | Achievement toward learning goal | | | | |
| 2 | Learning tools support | | | | |
| 3 | Training material/kit | | | | |
| 4 | Class room comfort | | | | |
| 5 | Finance and administration services | | | | |
| 6 | Accomodation service | | | | |
| 7 | Meal and snack service | | | | |
| 8 | Facilitators | | | | |
| 9 | Resource Speaker/s | | | | |

**Please answer the questions below**

| | |
|---|---|
| 1 | In general, was the training well conducted? Why or why not? |
| 2 | Is there any change in your knowledge, skills, or attitudes after the training? If Yes, please describe. |
| 3 | Which topic/session do you think the most useful/beneficial to be used/implemented in your work activities? Why? |
| 4 | Which topic/session do you think the least useful/beneficial to be used/implemented on your work activities? Why? |
| 5 | Please write your additional comments/advises in the area of training process and/or topic. |