

**Integration of HIV/STI
Prevention, Sexuality, and
Dual Protection
in Family Planning
Counseling:
A Training Manual**

Volume 1 - Manual

Working Draft
June 2002



ENGENDERHEALTH
Improving Women's Health Worldwide

Acknowledgements: EngenderHealth would like to thank the following staff and consultants for their contribution to the draft version of this supplement: Elizabeth Leitman, Elizabeth Schroeder, Julie Becker, Peter Twyman, Fabio Saini, Asiwa Obishai, A.S.A. Masud, Sukanta Sarker, Akua Ed-Nignpense, Amy Shire, Marie Rose Charles, Jill Tabbutt-Henry, Andrew Levack, Manisha Mehta and Maaza Seyoum.

©2002 EngenderHealth
440 Ninth Avenue
New York, NY 10001, U.S.A.
Telephone: 212-561-8000; Fax: 212-561-8067
e-mail: info@engenderhealth.org; www.engenderhealth.org

DRAFT: Not for publication, duplication, quotation, or citation without prior permission of EngenderHealth. This publication was made possible through support provided by the Office of Population, U.S. Agency for International Development (USAID), under the terms of cooperative agreement HRN-A-00-98-00042-00. The opinions expressed herein are those of the publisher and do not necessarily reflect the views of USAID.

Printed in the United States of America. Printed on recycled paper.

CONTENTS

VOLUME 1 – TRAINING MANUAL

INTRODUCTION

I. Background	vi
A. What is Integration?	
B. What is Dual Protection?	
C. Who is the Intended Audience for this Manual?	
D. What is the Content of this Training Manual?	
E. What is the Philosophy of this Training Resource Manual?	
II. How to Use this Training Resource Manual	x
A. Overview of Adult Learning and Participatory Training	
B. Format of the Training Resource Manual	
C. Preparation for the Facilitator	
D. Types of Exercises	
E. Cross-Cultural Adaptability	
III. Tips for Facilitators	xiii
A. Considerations for Developing a Training Agenda	
B. Creating a Positive Learning Environment	
C. Evaluating Training Workshops	

SECTION ONE: UNDERSTANDING SEXUALITY AND GENDER

A. Understanding Sexuality and Gender

Exercise 1. Defining Sex, Sexuality and Sexual and Reproductive Health	1
Exercise 2. Why Address Sexuality?	3
Exercise 3. Defining Gender	7
Exercise 4. Sexuality, Laws, Customs, Rights and Health	11
Exercise 5. Exploring Sexualities: Sexual Orientation, Sexual Identity and Sexual Behavior.....	15

B. Values and Comfort

Exercise 1. Early Learning About Sexuality: A Trip Down Memory Lane	19
Exercise 2. How do We Learn About Sex?.....	24
Exercise 3. Values and Sexual Behavior: That’s OK for Me!.....	26
Exercise 4. Talking About Sex: Finding a Comfort Zone for You and Your Clients.....	33
Exercise 5. Gender Roles: I’m Glad I’m a... but if I Were a... ..	37
Exercise 6. Gender Roles: Act Like a “Lady; Act Like a “Man”	41

C. Knowledge

Exercise 1. Sexual Anatomy, Physiology and Erogenous Zones: Body Mapping44
Exercise 2. Sexual Pleasure.....47
Exercise 3. Introduction to Sexual and Reproductive Sexual Problems.....50
Exercise 4. Sexual Development Throughout the Life Cycle.....53
Exercise 5. Uncovering Clients’ Underlying Concerns About Sexuality.....55

SECTION TWO: INTRODUCTION TO HIV/STI PREVENTION AND DUAL PROTECTION

A. Values and Attitudes about HIV/STIs

Exercise 1. The Impact of HIV/AIDS on our Personal and Professional Lives...61
Exercise 2. When Someone Says AIDS, I think...I feel...65
Exercise 3. Values Clarification: Where do You Stand on the Issues?.....67

B. HIV/STI Knowledge

Exercise 1. Myths about HIV/STIs.....73
Exercise 2. Essential Knowledge about HIV/AIDS and STIs.....77
Exercise 3. HIV/STI Information Game.....81
Exercise 4. HIV/STI Risk Continuum.....88
Exercise 5. Contraceptive Methods: Link to HIV/STI Prevention and Sexuality..94
Exercise 6. HIV Voluntary Counseling and Testing (VCT) Overview.....103
Exercise 7. Mother-to-Child-Transmission (MTCT) of HIV Overview.....107

C. HIV/STI Risk and Vulnerability

Exercise 1. Social Vulnerability to HIV/STIs.....111
Exercise 2. Women’s Vulnerability to HIV/STIs.....121
Exercise 3. Sexual Negotiation and Gender-Based Violence.....125

D. Condoms, Dual Protection and Safer Sex Negotiation

Exercise 1. Defining Safer Sex.....134
Exercise 2. Comfort With Condoms: Personal and Professional Considerations.....137
Exercise 3. Condoms and Sexuality.....141
Exercise 4. Condom Demonstration.....144
Exercise 5. The Female Condom: An Introduction.....149
Exercise 6. Condom Negotiation: Why is it Difficult for Women?.....154
Exercise 7. Condom Negotiation: Excuses game.....158
Exercise 8. What’s Dual Protection and Why Talk About It?.....161
Exercise 9. Dual Protection Messages.....168
Exercise 10. Dual Protection counseling: Case Studies.....170

SECTION THREE: INTEGRATED COUNSELING SKILLS BUILDING

A. Overview of an Integrated Counseling Model

Exercise 1. Integration to Dual Protection Counseling: Introduction to a Framework.....	175
Exercise 2. Using the GATHER to Address Sexuality.....	179
Exercise 3. Integrated Dual Protection Counseling Case Studies.....	182

B. Counseling Skills: Helping Clients Explore their Risk for HIV, STIs and Unintended Pregnancy

Exercise 1. Exploring Clients' Sexual and Reproductive Health Needs, Risks and Social Context.....	185
Exercise 2. Talking With Clients About Sensitive Subjects: Overcoming Fears... ..	188
Exercise 3. Broaching the Subject of Sexuality and HIV/STIs with Clients: Approaches to Putting the Client at Ease.....	192
Exercise 4. Providing Information on HIV/STIs	197
Exercise 5. Assessing Risk and Improving Clients' Risk Perception.....	202

C. Counseling Skills: Helping Clients Improve their Partner Communication and Sexual Negotiation Skills

Exercise 1. Personal Reflections on Behavior Change	205
Exercise 2. Introduction to the Stages of Behavior Change Model	208
Exercise 3. Behavior Change: What Stage am I In? Client Case Studies.....	210
Exercise 4. Helping Clients Make Decisions and Plan for Action.....	221

D. Counseling Skills: Helping Clients Improve their Partner Communication and Sexual Negotiation Skills

Exercise 1. Client Barriers to Communicating With Partners: I Can't Say That!	223
Exercise 2. Helping Clients Communicate with their Partners.....	225

E. Putting it All Together

Exercise 1. Integrated Dual Protection Counseling Role Plays	229
Exercise 2. Approaches to Counseling Specific Populations.....	235
Exercise 3. Counseling About HIV: Issues to Consider	240
Exercise 4. Counseling HIV-Positive Women	244
Exercise 5. Counselor Well-Being and Dealing with Stress.....	247
Exercise 6. Applying What was Learned: Provider Self-Assessment	249

APPENDIX

Sample Training Agendas

INTRODUCTION

INTRODUCTION

I. BACKGROUND

This counseling training resource manual is designed to train reproductive health and other providers to approach their interaction with clients in a new, more *integrated manner*. The overall focus of this new approach is integrating sexuality concerns, HIV/STI prevention and dual protection in family planning counseling. The ultimate goal of integrating these areas is to provide *better quality services* that are tailored to each client's individual sexual and reproductive health needs. This approach is "*client centered*" because it places the specific needs, risks, concerns and circumstances of each client at the center of every counseling session. Within this framework, the interaction between client and provider is a *two-way dialogue* that enables clients to understand and perceive their own risks of HIV/STI transmission and unintended pregnancy, explore their options for protecting their health, make decisions that are realistic, based on individual needs and the social context in which they live, and develop the skills to effectively carry out those decisions.

This manual contains a collection of participatory training exercises from which individualized training curricula can be developed. Some exercises are original, whereas others have been adapted from published sources. Where possible, citations have been provided. This is not the case for those based on well-known exercises that have been used in various forms throughout the world and for which original sources are difficult to identify. Exercises can be used in different ways and adapted locally for audiences from different cultures and with varied levels of background knowledge. The manual is not intended to be followed exercise by exercise, in strict order. Rather, facilitators are encouraged to select exercises to create training workshops that reflect the varied needs of participants. In order to help facilitators develop these individualized workshops, this manual contains the following tools:

- Fifty-nine (59) training exercises with comprehensive instructions for facilitators
- Sample 1-5 day training agendas that feature different topics
- Participant handouts and educational aids
- Suggestions and tips for facilitators on planning and conducting successful workshops

A. What is integration?

This training resource manual focuses on *integration* of HIV/STI prevention in family planning counseling. Integration of HIV and reproductive health programs, more generally, involves the provision of family planning and HIV/STI prevention and care services and programs as part of a unified coordinated strategy to address clients' risks of unintended pregnancies and HIV/STI transmission, as well as pregnancy and HIV-related care and support. The starting point of integration can be either family planning services or HIV/STI services. Essential to this definition is the goal of enhancing the quality of programs and services by altering the *way* in which they are provided. An integrated approach to counseling is often a key component of integrated programs and services, yet an integrated approach to counseling can also be used within more vertical services. This more comprehensive, client-centered approach to counseling

has become critically important in light of the growing HIV/AIDS epidemic. Not only do family planning clients need to understand their risks of HIV and make decisions about their sexual and reproductive health that take these risks into account; HIV positive women also have pregnancy prevention needs. Client needs related to HIV and family planning are often inextricably linked, and addressing sexuality is fundamental to both.

B. What is “dual protection”?

This training resource manual focuses on *dual protection counseling*, which is one component of integrated programs and services.

Dual protection can be defined as a strategy to prevent both HIV/STI transmission and unintended pregnancy through the use of condoms alone, the use of condoms combined with other methods (dual method use), or the avoidance of risky sexual activity. More specifically, dual protection can include:

1. The use of condoms alone:

The use of a condom (male or female) alone for both purposes.

2. Dual method use:

- The use of a condom plus another contraceptive method for extra protection against pregnancy.
- The use of a condom plus emergency contraception, should the condom fail.
- Selective condom use plus another family planning method (for example, using the pill with a primary partner and using the pill plus condoms with secondary partners).

3. The avoidance of risky sex:

- Abstinence
- Avoidance of all types of penetrative sex
- Mutual monogamy between uninfected partners while using a contraceptive method to avoid pregnancy
- Delaying sexual debut (for young people)

While condoms are an important component of dual protection, the term encompasses much more than condom use. Dual protection is primarily about *risk reduction*, which can also be accomplished through means other than condom use (e.g., non-penetrative sex, etc.).

Given that unintended pregnancy and the transmission of HIV/STIs are two possible outcomes of sexual activity, client needs in these two areas cannot be separated whenever risk is present.

C. Who is the intended audience for this manual?

This training resource manual is primarily designed for training of health care providers who offer counseling services, but the exercises can be used with a wide range of people who work in the area of sexual and reproductive health, including for example:

- Family planning staff (counselors, medical providers, frontline staff, managers, cleaners, etc)

- Health outreach workers
- HIV/STI educators, counselors and frontline staff
- Community groups

For family planning staff

Some of the exercises are geared to the staff of family planning clinics who are already trained and competent in family planning counseling. Staff members of family planning clinics may benefit from participating in some of the other exercises, even if they do not provide counseling directly to clients.

For reproductive health providers

If this manual is being used to train people who do not work primarily in family planning (such as HIV/STI counselors, educators and other staff), it is recommended that facilitators first familiarize participants with key family planning concepts. A basic training in family planning can be developed with EngenderHealth's family planning training manual, *Family Planning Counseling: A Curriculum Prototype* (AVSC International, 1995).

Number of participants

Ideally, most of the exercises are designed to accommodate between 10 to 30 participants, although there may be cases in which participation is less than 10 or greater than 30.

D. What is the content of this training manual?

The training manual is divided into three sections, with each subsequent section building on the previous, as follows:

Section One: Understanding Sexuality and Gender

This section helps participants to explore and clarify their values and attitudes about sensitive issues related to sexuality and gender. It also increases their knowledge of sexual anatomy, physiology, sexual response and sexual problems, psychosexual development and the life cycle, sexual orientation, sexual health and rights, and gender roles and gender stereotypes. This first section is predicated on the belief that an understanding of and comfort with issues related to sexuality and gender are fundamental building blocks to addressing clients' sexual and reproductive health needs.

Section Two: Introduction to HIV/STI Prevention and Dual Protection

The second section provides participants with basic information about HIV/STI prevention, safer sex and dual protection; and explores values, attitudes and biases related to HIV/STIs, people with HIV/AIDS and condoms.

Section Three: Developing Integrated Counseling Skills

The third section provides a framework for integrated, dual protection counseling, a process for adapting the “GATHER” counseling model for those who currently use this approach and wish to continue doing so. It also provides an opportunity for participants to practice a range of essential skills for integrating HIV/STI concerns, sexuality, dual protection, and family planning counseling.

E. What is the philosophy of this training resource manual?

Goals of the training resource manual

As a result of the training, participants will gain the knowledge and skills necessary for addressing a broad range of clients’ sexual and reproductive health concerns. They will also increase their level of comfort in addressing sensitive issues related to sexuality, gender and HIV/AIDS, clarifying values and overcoming biases necessary to do so. They will be able to assist clients to identify their own risks for HIV/STIs and unintended pregnancy, and to develop strategies and skills for protecting themselves.

General principles behind the development of the training resource manual

- **Informed choice**

Voluntary and informed choice refers to the right of all clients to make decisions about their fertility, free from coercion, with full information about the nature, risks and benefits of available family planning options. Informed choice has been long recognized as a critical element of quality family planning services. With the growth of the HIV/AIDS epidemic, it is apparent that in many contexts, the nature of informed choice must extend beyond family planning. Clients who receive family planning services need to understand their risks of both pregnancy and disease so that they can make *informed decisions* about their sexual and reproductive health. Similarly, HIV/STI clients need accurate and individualized counseling about their family planning options in order to make truly informed health-related decisions. In this way, integrated dual protection counseling upholds the concept of informed choice by assuring that clients are knowledgeable and aware of their risks for HIV/STI transmission and unintended pregnancy. The approach to informed choice used in this manual emphasizes not only the importance of helping clients make choices, but also exploring the implications of choices based on their social context and relationships. It recognizes that sometimes the most protective choices are not realistic or safe for a particular individual, but other types of incremental steps to reduce risk can be taken. For example, providers will learn to recognize and assess situations in which encouraging women to use condoms or to confront partners could put the client at risk of relationship problems, or worse yet, gender-based violence or loss of economic support. Providers learn to challenge historical biases against the condom as an inferior method of family planning, and to legitimize the condom as a valid option, alone, or in conjunction with other methods or risk reduction behaviors.

- **Client-centered counseling**

Client-centered counseling explores the personal meaning a client gives to the issues being discussed in a two-way dialogue between client and provider. The ultimate direction and outcome of the session flows out of the client’s individual needs, risks, concerns and social

context. The provider's job is assist clients to develop practical and feasible strategies for protecting themselves that reflect their own realities.

- **Focus on social context and social vulnerability**

This manual emphasizes the importance of understanding client vulnerability to HIV/STIs and unintended pregnancy due to social forces that are often beyond the control of individual clients. Understanding the social context of clients' lives is essential to providing effective integrated dual protection counseling. Social, economic and cultural factors such as gender relations, power dynamics, partner violence, access to financial and other resources, access to health care, and religious and community norms and values, affect clients', particularly women's, abilities to control and negotiate the terms of their sexual relationships.

- **Focus on risk reduction and partner communication**

The goal of integrated dual protection counseling is to support clients to develop and clarify their own strategies for taking preventive actions to reduce risk. An important component of effective risk reduction is enhanced partner communication. As part of the training process, participants learn how to work with clients to improve their communication skills, to broach sensitive subjects with partners and to negotiate the terms of their sexuality. Participants also explore how the sociocultural context and the nature of relationships may limit clients' abilities to communicate directly with partners about their need and concerns.

- **Addressing values and attitudes**

This training resource manual helps participants to explore and clarify their values and attitudes related to sexuality, gender, HIV/STIs, condoms and other sensitive issues so that they learn to provide *non-judgmental, neutral counseling* to clients. As part of the training process, participants learn to identify and acknowledge their own values, attitudes and biases, and to keep them from interfering with their ability to counsel clients effectively. They also participate in exercises designed to increase their comfort and ease with addressing sensitive issues with clients.

II. HOW TO USE THIS TRAINING RESOURCE MANUAL

A. Overview of adult learning and participatory training

Participatory training

This training resource manual has been designed using participatory training approaches, which means that the exercises require the active involvement of all participants. The role of the facilitator is to guide participants through learning activities rather than to lecture or just provide information to a passive audience. Underlying this approach is the belief that every participant has abilities, ideas and experiences that are invaluable to the learning experience.

Successful adult learning

Participatory methods, such as brainstorming or role play exercises (for an explanation see *Types of exercises* below), have been shown to be a critical feature of successful adult learning. In general, it is desirable to have as much interactivity as possible, both to reduce the amount of

x

WORKING DRAFT

Not for publication, duplication, quotation or citation without prior permission of EngenderHealth.

lecture time and to engage the participants more fully. The facilitator can employ principles of adult learning by relying on the participants to discuss issues and generate solutions based on their own experiences.

Prerequisites for facilitators

The training manual has been developed for use by skilled, experienced facilitators who are familiar with the content and goals of each exercise. While the training manual contains information to walk facilitators through each exercise, it is assumed that the facilitator understands adult learning concepts, employs a variety of training methods and techniques and knows how to adapt materials to meet the participants' needs.

B. Format of the training resource manual

Layout of the exercises

For ease of use, each exercise follows a standardized format with seven basic components. The number of accompanying resources, such as participant handouts (which are contained in a separate binder), varies by exercise. A brief description of each component follows below:

1. **Objectives:** A short description of the learning objectives for the exercise.
2. **Time:** A guideline for the anticipated length of the exercise to help a facilitator plan a workshop.
3. **Materials and advance preparation:** A list of materials needed to carry out the exercise and preparation steps prior to conducting the exercise.
4. **Steps:** Detailed directions that walk the facilitator through the order of activities within the exercise.
5. **Key discussion points:** A series of questions that the facilitator can raise with participants to promote productive discussion. In some cases, possible responses are listed after key questions in order to illustrate some ways that people might respond to a particular question. These, however, are purely illustrative and by no means exhaustive.
6. **Considerations for the facilitator/training options:** Notes and suggestions about how to conduct activities, different versions of exercises to try and things to keep in mind while conducting an exercise.
7. **Essential ideas to convey:** A summary of relevant points that participants should take away from the exercise. They should be conveyed during the course of the exercise and discussion, and the facilitator can use these points to summarize at the end of each exercise.
8. **Accompanying resources:** Materials such as handouts for participants (for future reference or for a specific activity) case studies, role play suggestions or additional resources for the facilitator that accompany an exercise.

Note: For ease of reference, participant handouts are contained in a separate binder. The handouts are clearly labeled so that it is readily apparent to which exercise they belong.

Adaptability to meet participants' needs

As mentioned previously, the training resource manual is not intended to be followed in order, but rather serves as a resource with an assortment of exercises from which facilitators may choose. Depending on the needs of the participants, facilitators may design a training to focus

more exclusively on one or two of the sections, or they may incorporate a number of exercises from all three sections.

Focus on knowledge, skills, attitudes

The exercises are designed to enhance participants' knowledge, skills and attitudes, with some exercises focusing more exclusively on one area and others addressing two or three areas. Enhanced knowledge, skills and attitudes will ultimately improve providers' abilities to interact with clients and to deliver sexual and reproductive health services that are tailored to the individual needs of clients.

C. Preparation for the facilitator

It is recommended that facilitators read or skim the entire training resource manual (including the handouts and other accompanying materials) to get an idea of what types of exercises are offered and to understand the purpose, content and approach of the training resource manual.

Facilitators can then select the specific content areas and exercises that are most appropriate to the needs of their training participants.

Sample agendas

Facilitators may find it helpful to examine the Sample Agendas contained in the Appendix III. These Sample Agendas illustrate a sequence of exercises that might be used in workshops of varying lengths (i.e., 1-day, 3-day, 5-day) and with varied training objectives (i.e., a focus on sexuality and gender). These Sample Agendas are merely reference guidelines, and facilitators are encouraged to develop their own agendas and to adapt the exercises to local settings and requirements.

Training materials, supplies and equipment

Most of the exercises require flipchart paper, markers and tape. It is important to make sure that these materials are available for training. In cases where flipchart paper is unavailable, facilitators might consider using a chalkboard or other large writing surface. Some exercises may call for props, cards, paper or other materials. If these items are not available, facilitators are encouraged to find suitable substitutes or to conduct the exercise in a slightly different way so that they are not needed.

D. Types of exercises

A short description of some of the main training techniques used in this training resource manual is provided below.

Brainstorming

Participants respond to a specific question or idea creatively and freely without fear of being judged or criticized by others. The point of brainstorming is to unearth as many ideas as quickly as possible, without worrying about how important or relevant they are. In a brainstorming session, all of the suggestions are written down until the group runs out of ideas. The group can

then sort the ideas into groups or categories and eliminate repetitions. Brainstorms can be useful for introducing topics and for stimulating new ideas and debate about topics already addressed.

Role plays

Role plays are short dramatic scenarios in which participants serve as actors. Role plays actively engage participants in learning because in order to act they must understand the perspective of the character they are playing. In most cases, role plays will involve a “client” and a “provider” role. In other cases, a role play will call for a variety of parts. Sometimes the training resource manual will suggest scenarios that participants can use to develop their own role plays. In other exercises, participants will come up with their own scenarios. Occasionally, a role play will be scripted, meaning that a script has been written out in advance for participants to follow.

Small group work

Many exercises call for participants to be divided into small groups of generally 3-5 people to work on activities together. Breaking up the larger group allows participants to work more intimately with each other and provides them with more time to clarify and express ideas. Additionally, participants who are less inclined to speak in a larger group may feel more comfortable doing so in a small group setting.

Large group discussion

Discussion in a large group is useful for learning from the experiences of all the members of the group and for concluding activities. Facilitators may need to encourage equal participation among all group members by drawing out quieter members and reigning in more vocal participants.

Case studies

Case studies present hypothetical situations based on real issues that participants might confront in the course of their work. They provide material for participants to examine and analyze, usually in a small group.

E. Cross-cultural adaptability

This training resource manual is intended to be adaptable across different cultures. Therefore, facilitators are encouraged to adapt the exercises, including case studies and role play suggestions, to reflect the needs of participants and the norms of the local setting. These adaptations could be as simple as changing case study characters’ names or as complex as developing a new series of role play suggestions or even a brand new exercise.

III. TIPS FOR FACILITATORS

A. Considerations for developing a training agenda

When developing a training agenda, the facilitator should take the following factors into consideration:

- The ultimate goals of the training (i.e., to institute integrated dual protection counseling within a facility; to familiarize staff with sexuality, gender and HIV/STI issues; to address stigma and discrimination within a facility, etc.)
- The participants' perceived needs, special interests and concerns
- The participants' level of familiarity with the training topics
- The composition of training participants by role within a facility – i.e., health care providers, counselors, frontline staff, cleaners, CBD workers, and other types of staff
- The amount of time and resources available for training
- The training location and physical space available for activities
- The facilitator's teaching style and preferred mode of activities

Sample agendas

The Sample Agendas provided in Appendix III can serve as a model or jumping off point for facilitators as they develop their own training agendas. By selecting from the training exercises, the facilitator can adapt the training agenda for different workshop lengths, types of participants, levels of experience, and different workshop goals.

Training time

In general, three to five days would be an ideal length of time to address some of the essential concepts explored in this training resource manual. A shorter training workshop might address one or two essential concepts in depth (for example, a two-day workshop on *improving participants' understanding of and comfort in addressing sexuality and gender issues with clients*).

The times in the sample agendas and exercises are approximate. The actual length of time needed and the number and type of training activities used to teach the content will depend on several factors, including the participants' level of knowledge and experience, and their work responsibilities. Therefore, the facilitator will need to adapt the workshop carefully by reviewing the agenda after the first day of training to see if the time allocated for exercises still seems sufficient, and modifying it, if needed.

Participant scheduling constraints

The facilitator should consider participant scheduling constraints when developing the agenda, including the following factors:

- The times that staff arrive at and leave work
- The time period during which clients are seen
- The client load during the days of training
- The participants' need to see clients and do their other work during the course of the training

When developing the agenda, the facilitator should attempt to cause the least disruption possible to the staff's work schedule. After all, if the participants are unhappy and inconvenienced by the training, they are less likely to be enthusiastic, active participants and to learn the information. On the first day of the training, the facilitator should discuss the schedule with participants and make adjustments, as necessary, rearranging the agenda to suit participants' needs.

B. Creating a positive learning environment

Many factors contribute to the success of a training workshop. The list of “tips” below enumerates some ways in which a facilitator can create a positive and effective learning environment for participants:

Respecting each participant: Facilitators should recognize the knowledge and skills that participants bring to the workshop. They can show respect by remembering and using the participants’ names, encouraging them to contribute to the discussions, and requesting their opinions about the training content and agenda.

Acknowledging and respecting diversity within the group: Facilitators should be sensitive to the different needs and experiences of participants within the group. For example, facilitators should not assume that all members of the group have the same sexual orientation, values, experiences or beliefs. The facilitator should recognize and acknowledge that some people in the group may have HIV, some people may identify as homosexual, bisexual or heterosexual, participants will have different attitudes about gender roles, and that there may be differences in the values and attitudes of participants of different age groups. Furthermore, there may be tensions between participants of different socio-economic status or class, or occupational status.

Presenting sensitive content carefully and addressing prejudice within the group: The facilitator may face situations in which participants hesitate to join in discussions, are judgmental, or inhibit others from expressing themselves freely. To create an environment in which participants feel comfortable discussing and absorbing new content and ideas, particularly about sensitive issues such as sexuality and HIV/STIs, the facilitator may use the following techniques:

- Acknowledge that it is normal to feel nervous, anxious or uncomfortable discussing sensitive topics.
- Begin with less-sensitive content, and build up to content that is more sensitive.
- Use small group work to allow the participants to express their feelings in front of a smaller audience.
- Gently confront and challenge members of the group who demonstrate prejudice or are insensitive to the experiences of others in the group. Acknowledge that people are entitled to their own opinions, but invite others in the group to express opposing ideas, or present these ideas yourself. Help participants to see how their comments may be offensive to others.
- **Using warm-ups and icebreakers:** It is important to incorporate short warm-up activities and “icebreakers” throughout a training workshop. Such activities can engage and energize participants after breaks, or can make them feel more comfortable with one another at the beginning of a workshop. Icebreakers are particularly important when participants are working on sensitive subjects related to sexuality and HIV/STIs.
- **Summing up and reinforcing objectives:** It is recommended that facilitators develop their own ways to ensure that participants have absorbed the relevant concepts and information after completing a particular exercise. Facilitators might consider asking participants to summarize the key concepts that they have learned at the end of the activity. Facilitators

might also summarize the “Objectives” and “Essential Ideas to Convey” in their own words to conclude an activity, or they might make their own participant handouts with key points on a particular topic. Please note that the *Objectives* and *Essential Ideas to Convey* contained in each exercise are not intended to be read out loud word for word. Rather, they are included as guidelines for facilitators to make sure that they have addressed relevant information.

- **Inviting outside experts to speak on various topics:** It is recommended that facilitators invite outside speakers to present information on different topics. Including outside speakers not only keeps participants interested and engaged, but also allows the group to learn from the expertise of individuals who may be better versed in a particular topic than the facilitators. For example, facilitators might consider inviting experts on family planning, HIV/STI prevention, MTCT, VCT, sexual problems and dysfunctions, or on any other topic that may benefit the group. Additionally, if appropriate and feasible, facilitators might consider inviting a person living with HIV to speak about his or her experiences.
- **Giving frequent positive feedback:** Positive feedback increases people’s motivation and learning ability.
- **Keeping participants involved:** The facilitator should use a variety of training methods that increase participant involvement, such as questioning, case studies, role plays, discussions and small group work.
- **Making sure that participants are physically comfortable:** The physical training space should be well lit, well ventilated, and quiet and should be kept at a comfortable temperature. Breaks for rest and refreshment should be scheduled.
- **Inviting participant feedback:** The facilitator should set aside time at the beginning of each training day to invite the participants to raise issues that can interfere with learning, such as those related to personal situations, logistics, or content. At the end of the day, the facilitator can encourage participants to share their learning insights and their assessment of what did and did not go well for them that day. This assessment will enable the facilitator to make any needed adjustments to the agenda and give participants the opportunity to comment on the way the workshop is progressing.
- **Adjusting the training:** As the workshop progresses and facilitators get to know the participants’ learning styles and levels of knowledge, they may need to make adjustments to the workshop content or agenda. Adjustments to the agenda should not compromise the quality of the training. Facilitators should cover all of the important content areas and allow sufficient time for discussion.
- **Ensuring follow-up:** Learning about integrated dual protection counseling, HIV/STIs and sexuality does not end at the completion of the workshop. Follow-up is an important part of training and should be a planned part of any workshop. Participants should know who will be conducting follow-up and when and how it will occur.

C. Evaluating training workshops

Evaluation is a critical part of training. Evaluation gives the facilitator and participants an indication of what the participants have learned and helps the facilitator determine which training strategies were effective. The true test of how successful an integrated dual protection counseling training has been is whether the quality of counseling and services has improved for clients. This emphasizes the importance of good follow-up training workshops and long-term impact evaluation.

More immediate evaluation is also needed, including an evaluation of the facilitator's performance and the participants' perceptions of the workshop itself. Because the training exercises address knowledge, attitudes and skills, the participants' progress will be measured in large part by assessing changes in these areas.

The facilitator should include appropriate evaluation options to:

- **Assess the participants' progress during the training.** For example, the facilitator may ask questions of individuals or groups of participants to test their knowledge and comprehension.
- **Assess the participants' cumulative knowledge, skills and attitudes at the beginning and end of the training.** For example, the facilitator could administer written or oral pre-tests and post-tests, or observe participants during role play exercises, depending on the literacy level of participants. If some participants have poor literacy skills, observing them during oral discussion is likely to be a better assessment tool than written exercises.
- **Assess the outcome or results of the workshop after the training.** For example, the facilitator should follow-up with the participants to learn how they have applied the knowledge and skills developed during the workshop, and to determine if their attitudes have changed. If a supervisor performs follow-up, the facilitator could contact the supervisor to see how the quality of counseling has changed at the facility.
- **Assess how participants' perceive the overall process and results of the training.** An end-of-training evaluation is an important tool to assess how participants perceived the training. This should include an assessment of the facilitator's performance.

VOLUME 1

SECTION ONE: UNDERSTANDING SEXUALITY AND GENDER

(EXERCISES AND RESOURCES)

DEFINING SEX, SEXUALITY AND SEXUAL AND REPRODUCTIVE HEALTH

Objectives

1. To explore participants' understanding of the terms "sex," "sexuality," "sexual health" and "reproductive health."
2. To arrive at a common understanding of these key concepts.

Time

30-45 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
 - Participant Handout: *What is Sexuality?*
 - Participant Handout: *Sexual and Reproductive Health*
-

Steps

1. Divide participants into small groups of 2-4 people. Give each group 4 pieces of flipchart paper and a marker. Ask the participants to spend 15 minutes creating definitions for the terms "sex," "sexuality," "sexual health," and "reproductive health." Each definition should be written on a separate piece of paper. Encourage participants to avoid using the words "sex," "sexual" or "reproduction" in their definitions.
2. Invite the participants back into the larger group and post each groups' definitions on the wall, sorted by term rather than by group (i.e. all definitions of "sex" from all groups posted together, all definitions of "sexuality" together, etc). Facilitate a discussion on each group's understanding of the terms, focusing on similarities and differences. (See key discussion points below).
3. Distribute the participant handout entitled *What is Sexuality?* Ask for a participant to read the definitions from the handout aloud. Discuss the definitions, comparing with those of the small groups. Note any part of the definition that was missed and clarify any remaining questions.

Key Discussion Points

- ↪ Which of these terms was the most difficult to define? Why?
- ↪ How do these four concepts overlap? Where do they differ? Does one term encompass the others?
- ↪ Are some aspects of these definitions related to sexual health but not necessarily related to reproductive health? Is all sex related to reproduction? Why do people have sex?
- ↪ In what ways might your clients' definitions of these terms differ from yours?
- ↪ Given your definition of sexual health, what is your assessment of the sexual health of your clients and of the community in which you work?

Essential Ideas to Convey

- Sexual and reproductive health involves much more than physical health, but is a broad concept involving a state of health and well-being, social and emotional aspects of sexuality and reproduction and a variety of services to meet people's broad needs.
- Sexual health includes aspects of sexuality not necessarily related to reproduction. This recognizes the fact that people have sex for the purposes of pleasure, not just reproduction, and that people have health needs related to such sexual activity.
- Sexual health and reproductive health are overlapping and intertwined concepts. Thus, the combined term "sexual and reproductive health" has emerged to include all aspects of sexuality, reproduction and health.
- The term sexuality encompasses sexual behaviors, sexual orientation, gender roles and gender identity, which are all influenced by society and culture.
- A common understanding of these terms helps us to better address our clients' sexual and reproductive health needs and to better communicate with colleagues about sexual health.

WHY ADDRESS SEXUALITY?

Objectives

1. To communicate how and why a focus on sexuality can improve the quality of sexual and reproductive health services.
2. To describe the role of reproductive health service providers in addressing clients' sexuality and sexual health needs and concerns.

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
-

Steps

1. Lead a large group brainstorm on the following question: *Why is it important to address sexuality as a part of reproductive health counseling?*

Possible responses that can be used to prompt participants:

- *Pregnancy and STIs are both possible outcomes of sexual activity.*
- *The impact of reproductive health programs will be limited if the context in which people make decisions about their sexual lives and reproduction is not considered. Sexuality, and sexual practices can have implications for a client's decisions about contraceptive method use and HIV/STI risk reduction as well as the client's ability to make decisions and to negotiate with his or her partner.*
- *People may stop using a contraceptive method if they perceive it to interfere with the sexual act.*
- *People may stop using a contraceptive method if it decreases sexual pleasure.*
- *Clients may feel reluctant to try a certain method (e.g., vasectomy, condom, oral contraceptives) out of fear that it will affect sexual pleasure or response (for self or partner or both).*
- *It is difficult to discuss STI prevention without discussing the specific sexual practices that place a person at risk as well as the range of sexual practices that are safer.*
- *When providers make assumptions about the sexual practices of their clients, they may provide inappropriate services. For example, providers might promote family planning methods because they incorrectly assume that a client is having sex with people of the opposite sex; a provider might assume that a woman only engages in vaginal sex and not anal sex and therefore may fail to provide sufficient information about HIV/STI risks; a provider might misdiagnose a vaginal infection as an STI when it may, in fact, be an RTI that is not transmitted sexually).*
- *Clients may have underlying concerns about sexuality that may be the real reason for the clinic visit or more important than the stated reason.*
- *A client's needs may be related to sexual abuse or coercion, rape or incest –*

issues that need to be addressed in order to provide effective services.

- *Offering counseling about sexuality may help improve client satisfaction and help to attract clients.*

2. List participant ideas on flipchart paper. Post each sheet to the wall as it is completed.
3. Make sure that the main ideas are identified and discussed by the group. Continue the session by facilitating a discussion based on the key discussion points.

Key Discussion Points

- ↪ Despite all the benefits to addressing sexuality within reproductive health counseling, it can often be difficult to broach the subject with clients. What are some of the **barriers** or **challenges** providers might experience in addressing clients' sexuality?

Possible responses:

- *Providers may feel uncomfortable addressing sexuality with clients.*
- *Providers may feel that it is culturally inappropriate to address sexuality with clients.*
- *Clients may feel uncomfortable discussing sensitive subjects such as sexuality with providers.*
- *Providers may not know how to initiate a discussion about sexuality with clients.*
- *Providers may feel that there is not enough time to address sexuality issues in a counseling session.*
- *If the client and provider are of different sexes it may be awkward to talk about sexuality.*
- *If there is a significant age difference between provider and client it may be awkward to talk about sexuality.*
- *Providers may fear that clients will be offended if asked about their sexual lives.*
- *Clients may bring up topics or have questions that providers feel unprepared to address.*

- ↪ How can providers feel more comfortable and better equipped to address issues related to sexuality?

Possible responses:

- *Practice talking about sexuality with clients and try using language that is comfortable for you and understandable to the client.*
- *Focus on the importance of sexuality to the client's health – assure the client that you are not asking out of your own curiosity.*
- *If the provider is of the opposite sex of the client, ask another staff person of the same sex to be present during the discussion.*
- *Learn more about sexuality so you will feel more comfortable talking about it.*
- *Talk with other providers about their experiences speaking with clients about sexuality.*
- *Conduct focus groups or interviews with community members or clients to ask them what their sexuality concerns and service needs are.*

Considerations for the Facilitator/Training Options

An alternative way to conduct this exercise is as a “message” or “graffiti” wall, whereby responses are written on large pieces of paper posted throughout the room. The steps are as follows:

1. Create three large banners of flipchart paper by taping together 3 or 4 sheets of flipchart paper horizontally. On the top of each banner write one of the following questions in marker:
 - *Why is it important to address sexuality in family planning counseling?*
 - *Why is it challenging to address sexuality in family planning counseling?*
 - *What aspects of sexuality are important to address in family planning counseling?*

Note: If the participants provide other reproductive health services, substitute the term “reproductive health” for “family planning” in each of the above questions.
2. Post each banner on the wall.
3. Distribute markers to participants and encourage them to walk around and to stop at each banner to contribute either a written phrase, slogan or a picture in response to each of the questions posed on the “message wall.” Encourage participants to write on any part of the banner, in any direction or angle – it is not necessary to line up the responses as a list.
4. Once all of the participants have contributed something to each banner, reconvene the group in front of the banners. Ask them to take a few moments to view each banner to see what the others have written or drawn.
5. Facilitate a discussion based the key discussion points above.

Essential Ideas to Convey

- Discussing sexuality with clients is an important aspect of sexual and reproductive health services. It is critical to the provision of effective HIV/STI prevention, and can improve the quality of reproductive health services overall.
- Providers are better able to help clients make informed choices about contraceptive methods and HIV/STI risk reduction approaches if they have discussed the client's sexuality concerns, practices and relationships.
- Providers often shy away from discussions of sexuality because they fear it may be culturally inappropriate or may offend clients, but many who try find that it improves the quality of services, and clients appreciate the opportunity to discuss their sexuality concerns in a safe, confidential setting.
- Discussing sexuality can foster comfort and trust between clients and providers and can improve both client and provider satisfaction.
- Discussing sexuality may reveal underlying issues and concerns that affect clients' needs and decisions related to their sexual and reproductive health.

DEFINING GENDER*

Objectives

1. To provide participants with an understanding of the concept of gender.
2. To distinguish between the concepts of “sex” and “gender.”

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
 - Prepared slips of paper, each with a sex characteristic (e.g., penis, beard, vagina, etc.), a personality trait (e.g., strong, weak, gossipy, caring, etc.) or occupational role (e.g., doctor, farmer, teacher, nurse, laborer, etc.) written on it (see Facilitator Resource: *Sample sex characteristics, personality traits and occupational roles*).
 - Prepared pieces of flipchart paper labeled “man” or “woman” posted on different sides of the training room.
 - A prepared piece of flipchart paper labeled “both” to post in the center of the room after the first part of the exercise is completed.
 - Facilitator Resource: *Sample sex characteristics, personality traits, occupational roles*
-

Steps

1. Distribute prepared slips of paper with a sex characteristic, a personality trait or an occupational role to each participant (2 or 3 slips per person, depending on the number of participants and the number of slips that are prepared in advance).
2. Explain to the group that for this exercise there are two sides to the training room, the “man” side and the “woman” side. Make sure that blank flipchart paper labeled “man” or “woman” is posted on the appropriate side of the room.
3. Ask each participant, in turn, to read aloud his or her slip, to determine whether it applies to a “man” or a “woman,” to go to the appropriate side of the room, and to write what is written on his or her slip on the flipchart paper (or to tape the written slip to the wall). Explain to participants that they must choose to designate their slip either “man” or “woman,” even if they think if what is written could apply to both. After writing on the flipchart paper (or taping the slip to the wall), participants should return to their seats in the middle of the room.
4. After all the participants have written their information on the flipcharts (or taped their slips to the wall), ask them to review all the characteristics, traits and roles and to determine whether any of them could apply to both men and women.

* Adapted from: *Gender, Adolescents and Reproductive Health: Skills Building Workshop, Curriculum Part 3*, IPAS, June 2000.

5. Post the flipchart paper labeled “both” in the center of the room, and as agreement is reached by the group on particular characteristics, traits and roles, cross them out on the “man” or “woman” flipcharts and re-write them on the “both” flipchart (or move the slips of paper to the “both” category). For example, if someone had placed the personality trait “weak” under “woman,” and the group agrees that it could apply to either men or women, cross it out from the “woman” flipchart and re-write it under “both”.
6. Continue assessing and moving the terms until only the sex characteristics (those that define sex) remain on the “man” and “woman” sides. If some of the personality traits, characteristics and roles remain, point them out to the group and ask them if it would be possible for someone of the opposite sex to display that characteristic. For example, if the occupational role of “midwife” remains on the “woman” side, ask the group if it would be physically possible for a man to perform the role of midwife. Challenge the group until they distinguish between gender roles and biological sex.
7. Ask participants to try to describe which types of words remain on the “man” and “woman” sides. After a brief brainstorming session, indicate that the words that are left under “man” and “woman” refer to sex characteristics. The words under “both” are gender-based. Personality traits, characteristics and occupational roles are often determined by gender roles and social expectations regarding what it means to be male or female.
8. Ask the participants to brainstorm definitions for the terms “gender,” “sex” and “stereotypes.”
9. Provide the group with the following definitions:
 - *Gender is how an individual or society defines “male” or “female.” Gender roles are socially and culturally defined attitudes, behaviors, expectations and responsibilities for males and females. Gender identity is the personal, private conviction each of us has about being male female, or some combination.*
 - *Sex refers to the biological characteristics that make us male or female (anatomical, physiological and genetic).*
 - *Stereotypes are standardized or conventional ideas or characters that are often based on generalizations. Some examples of gender role stereotypes include:*
 - *Men should be sexually experienced.*
 - *Women do not enjoy sex and do not experience sexual desire.*
 - *Women are supposed to be mothers, and their primary function is to reproduce.*
 - *Women who were raped were probably “asking for it.”*
10. Facilitate a large group discussion based on the key discussion points.

Key Discussion Points

- ↔ Which characteristics, traits or roles did you find it difficult to place on the “man” or “woman” sides? Why?
- ↔ Which characteristics, traits or roles did you find it easy to place on the “man” or “woman” sides? Why?

- How were stereotypes of men and women shown in this exercise?
- How did it feel to see stereotypes about members of your own sex? What feelings did you experience? What can you learn from that experience?
- Why do you think people sometimes get confused about the difference between sex and gender?

Possible responses that can be used to prompt participants:

Sometimes gender roles are so ingrained in a society that people automatically assume they are determined by sex rather than society. For example, caring for children is a role that society often assigns to people who are female (gender role), but there is no biological or anatomical reason (sex characteristic) that men could not do this as well (beyond breastfeeding).

Considerations for the Facilitator/Training Options

Facilitators should expect participants to debate the meaning of some of the characteristics, traits and roles. One of the goals of this exercise is to demonstrate that people assign different meanings to characteristics, traits and roles that are gender-based.

It is important to reach conclusions on each term that is addressed. For example, if some participants argue that men have breasts while other say that only women do, ask them to specify if they are referring to breasts in terms of mammary glands or breastfeeding, in that case, breasts can be put in the “woman” list as a sex characteristic.

Facilitators should be ready to address discussion about different types of sexuality, if participants bring this up. It may be necessary to distinguish sexual orientation (erotic or romantic attraction to members of the same, different or both sexes) from gender.

Essential Ideas to Convey

- Gender roles are socially and culturally determined, while sex characteristics are anatomically, physiologically or genetically determined.
- When gender-based characteristics, traits or roles are confused with sex characteristics, stereotypes may result. For example, if the attribute of “good at mathematics” is applied to men, this is a stereotype because both men and women can be “good at mathematics.” Being “good at mathematics” is not an innate sex characteristic, but relates to gender if boys and men are socially or culturally encouraged to pursue mathematics and given better training in it and women are discouraged from pursuing it, etc.

**FACILITATOR RESOURCE:
SAMPLE SEX CHARACTERISTICS, PERSONALITY TRAITS AND
OCCUPATIONAL ROLES**

Sex characteristics:

Penis
Vagina
Breasts
Beard
Semen
Vaginal fluid
Breastfeeding
Testicles
Ovaries
Uterus
Giving birth
Father
Mother

Personality traits:

Strong
Weak
Gossipy
Caring
Analytical
Sensitive
Aggressive
Passive
Nurturing
Strict
Lazy
Sweet
Tough
Wise

Occupational roles:

Doctor
Nurse
Farmer
Teacher
Laborer
Miner
Scientist
Midwife
Lawyer
Shopkeeper
President/prime minister
Market vendor
Athlete

SEXUALITY, LAWS, CUSTOMS, RIGHTS AND HEALTH

Objectives

1. To identify ways in which laws and customs regarding sexuality can restrict rights and freedoms and lead to adverse health outcomes.
2. To introduce participants to the concept of sexual and reproductive rights.

Time

45 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
 - Tape two pieces of flipchart paper together side by side to create a large rectangle. Label the top of the paper “Laws and Customs influencing Sexual Health and Rights.” Create a chart with two columns, one labeled “law or custom” and the other labeled “impact on sexual health and rights” (see Facilitator Resource: *Sample chart on laws and customs influencing sexual health and rights*).
 - Participant Handout: *Declaration of Sexual Rights*
 - Participant Handout: *IPPF Charter on Sexual and Reproductive Rights*
 - Facilitator Resource: *Sample chart on laws and customs influencing sexual health and rights*
-

Steps

1. Introduce the activity by saying that we are going to discuss local laws and customs and how they affect human rights and sexual health. Begin the exercise by facilitating a brainstorm on the definition of **sexual rights** and **reproductive rights**. Summarize the brainstorm by distributing and reviewing the handouts: *Declaration of Sexual Rights* and *IPPF Charter on Sexual and Reproductive Rights*.
2. Next, ask participants to brainstorm a list of local laws or customs related to sexual rights and sexual and reproductive health. Write their responses on the prepared flipchart paper under the “law or custom” column in the chart. Prompt participants with some examples such as legal age requirements to obtain contraceptives for youth, age of consent for having sex, rape and sexual abuse laws, laws against same-sex sexual activity, prostitution laws, female genital cutting, male circumcision, laws regarding sexuality education in schools, etc. (see Facilitator Resource: *Sample chart on laws and customs influencing sexual health and rights*).
3. After participants have identified some laws or customs, ask them to brainstorm how each one may impact, positively or negatively, sexual and reproductive rights. Write their responses in the “impact on sexual health and rights” column directly opposite the law or custom being discussed. For example, for “legal age requirements to obtain contraceptives for youth,” an impact on sexual health and rights would be “lack of access or ability to

protect themselves against unintended pregnancy and/or HIV/STIs.”

4. Facilitate a group discussion based on the key discussion points.

Key Discussion Points

- ↔ What types of violations of sexual and reproductive rights have you witnessed in your community and in your work setting?
- ↔ How might a lack of understanding and respect for sexual and reproductive rights affect different groups of people in different ways (for example, sex workers, men who have sex with men, poor women, adolescents)?

Possible responses:

- *Sex workers are often discriminated against in communities and health centers and may be the targets of violence.*
- *Men who have sex with men may face legal discrimination (i.e., laws against same-sex behavior), torture and violence in communities, the family, the workplace, and other settings.*
- *Poor women often lack resources to protect themselves from rape or abuse within marriage due to their precarious financial situation and may find themselves the targets of coercion at health centers (i.e., forced sterilization or contraceptive choice).*
- *Children and adolescents can be vulnerable to sexual abuse by adults who are in a position of power over them, etc.*

- ↔ How can we respect clients’ rights and freedoms in our work setting?

Possible responses:

- *Promote informed choice – do not coerce clients into accepting certain methods or into making certain choices about their sexual and reproductive health*
- *Provide clients with complete, accurate information and education.*
- *Provide counseling that informs, educates and empowers the client to make his or her own decisions.*
- *Do not discriminate against clients based on sexual orientation, ethnicity, occupational status (e.g., sex work), gender, HIV-status, or other factors.*
- *Respect client confidentiality.*
- *Support linkages with groups and programs that promote sexual and reproductive rights.*
- *Promote dialogue about sexual and reproductive rights issues among peers and colleagues.*

- ↔ How can we promote understanding and respect for sexual and reproductive rights outside of work setting?

Essential Ideas to Convey

- As providers, we must be aware of the ways in which laws and customs can affect peoples' sexual and reproductive rights and freedoms. In order to provide high-quality services, we must ensure that our work environment respects and promotes clients' sexual and reproductive rights.
- As providers, we must be aware of our own personal biases against particular groups of people and work to increase our acceptance of people who are different or are discriminated against by the community. We must also increase our awareness of how the sexual and reproductive rights of different individuals and groups in the community may be affected by certain laws and customs.
- Health providers can become important advocates to promote sexual and reproductive rights and to improve access to health services (and quality of services) for all individuals and groups in the community.

**FACILITATOR RESOURCE:
SAMPLE CHART ON LAWS AND CUSTOMS INFLUENCING
SEXUAL HEALTH AND RIGHTS**

Laws and Customs influencing Sexual Health and Rights

Law or custom	Impact on sexual health and rights
No sexuality education in schools	Girls and boys have no access to information about sex and sexual health and are at higher risk for pregnancy, HIV/STIs, etc
No laws against rape within marriage	Women have no right to refuse sex in marriage – physical and emotional health of women at risk, including risk of HIV/STI infection, psychological trauma, bodily harm, etc.
Female genital cutting/infibulation	Increased risk of infection, complications during labor and delivery, reduced sensation/sexual pleasure
Laws against same-sex sexual behavior	Sexual activity becomes secret and underground with people living double lives; people are not aware of how to protect themselves from HIV/STIs; people are jailed for expressing their sexuality; people experience violence, intimidation, discrimination within the community and by law enforcement personnel
Coercive HIV testing/lack of confidentiality regarding test results	People may fear stigma and discrimination if found to be HIV-positive and perceive health services as hostile and punitive. This can lead to people not accessing services. For those who do access services and experience coercive HIV and/or lack of confidentiality, they may be at risk of ostracism and violence by the family and community if they test positive for HIV, or even for testing at all.

EXPLORING SEXUALITIES: SEXUAL ORIENTATION, SEXUAL IDENTITY AND SEXUAL BEHAVIOR

Objectives

1. To define sexual orientation and sexual identity.
2. To examine societal attitudes about sexual orientation.
3. To explore how sexual behaviors relate to sexual orientation and sexual identity.

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
-

Steps

1. Begin a discussion by asking the group to define the term **sexual orientation** and **sexual identity**. Provide the following definitions after the discussion:
 - **Sexual orientation** is the erotic or romantic attraction to or preference for:
 - People of the opposite sex (heterosexuality)
 - People of the same sex (homosexuality)
 - People of both sexes (bisexuality)
 - Sexual identity refers to how people view themselves sexually, which includes four main elements: (1) how a person identifies as male, female, masculine, feminine, or some combination (i.e., gender identity); (2) the individual's sexual orientation; (3) gender roles; and (4) biological sex.
2. Divide the participants into small groups of 3 or 4 people. Provide each group with flipchart paper and markers and ask them to brainstorm how various sexual orientations and identities are expressed in their culture.
3. After 10 minutes, invite the groups back into the larger group and instruct each group to present its ideas to the larger group.
4. After all the groups have presented their ideas, facilitate a larger group discussion based on the key points (below).

Key Discussion Points

- ↪ Do all the groups seem to have a similar interpretation of how sexual orientation and identity is expressed in this culture? If yes, how would you describe the general view of the groups? If no, what are the different interpretations?
- ↪ How are people who have sex with members of the same sex treated by this community? Is there discrimination or prejudice against people who have same-sex sexual relationships? If so, how is this expressed in different settings (i.e., in schools, in health care facilities, in the

family, in the work place, etc.)?)

- Why is it important to understand sexual orientation when working on issues of sexual and reproductive health?

Possible responses:

- *Clients may have questions or concerns about their own sexual orientation or that of partners, friends or family members.*
- *It is important to understand the social context of a client's sexual life when providing counseling on sexual and reproductive health issues.*
- *Understanding how clients view and perceive their own sexuality is critical to helping them protect themselves from unintended pregnancy and/or HIV/STI transmission.*
- *Clients may want to discuss issues related to sexual orientation but may be afraid to do so unless the provider asks directly and makes them feel comfortable.*

- Are there situations in which people engage in sexual behaviors that do not appear consistent with their sexual orientation?

Possible responses:

- *Sometimes people engage in same-sex sexual behavior in certain situations but do not consider their sexual orientation to be homosexual, for example, in prisons, migrant workers on farms or plantations, adolescent experimentation, people who exchange sex for money, women who have "close friendships", etc.*
- *Sometimes people engage in sexual behavior with people of the opposite sex but do not consider their sexual orientation to be heterosexual, for example, a man who self-identifies as homosexual, but gets married to a woman to conform to society.*

- Why is it so important to discuss specific sexual behaviors with clients as well as sexual orientation?

Possible responses:

- *If a provider inquires only about a person's sexual orientation this will not necessarily reflect the person's sexual behaviors (for example, a person who identifies as heterosexual but has sex with people of the same sex, or a person who identifies as homosexual but has sex with both men and women, etc.).*
- *It is important to know about specific sexual behaviors of clients in order to help them protect themselves from the risk of unintended pregnancy and HIV/STI transmission. Knowing about their sexual orientation will help you understand how they view themselves and their relationships but it will not necessarily provide a complete picture of their sexual practices.*
- *It is important to distinguish between sexual identity and sexual orientation and sexual behaviors because same-sex behaviors do not always mean that someone is homosexual, nor does sex with people of the opposite sex mean that someone is heterosexual.*
- *It is important to discuss specific behaviors because sometimes the way people define sex varies. For instance some people may only define penile–vaginal intercourse as sex. With this definition, a man could be having anal or oral intercourse with another man, but not consider it to be sex.*

- How comfortable are you talking with clients about same sex sexual behaviors?

- What can you do to feel more comfortable talking with clients about same sex sexual behaviors?

Considerations for the Facilitator/Training Options

Make sure to acknowledge that many people may have strong feelings and opinions about sexual orientation. Emphasize that it is important for providers to be aware of their personal values and attitudes about sexual orientation and to remain non-judgmental when counseling clients.

A facilitator may consider adding a short reflection period after the group discussion where participants respond silently to themselves to a series of questions read by the facilitator. Some of the questions might include:

- If you were a client who has sex with people of the same sex, would you be able to discuss this with a health care provider? What do you think would make you feel comfortable doing so?
- As a provider, how would you feel if clients confided in you that they have sex with people of the same sex?
- How would you feel if you found out that a co-worker's sexual orientation was different than you assumed (for example, a man that you assumed identified as heterosexual was homosexual)? How would this information affect how you felt about working with this person?

Facilitators should be sensitive to the variation of sexual orientation among members of the training group, as well as that of clients. If participants make discriminatory or derogatory statements about homosexuality, for example, acknowledge that while everyone is entitled to his or her own private opinions and values, voicing them in this way can be offensive and hurtful to other people.

Alternative: Instead of the small group activity described above (or in addition to it), you might consider providing participants with confidential surveys on same-sex sexual activity that they can read and respond to on their own. Distribute the confidential surveys to participants (see Participant Handouts: *Attitudes about people who engage in same-sex activity* and *Attitudes about providing services to clients who engage in same-sex activity*) and ask them to read each statement and check the box that corresponds to their opinion about it. Tell them not to write their names on the handouts and that you will not be collecting them; no one will see their answers and they should feel free to respond honestly. Allow ten minutes for completion. Then facilitate a discussion based on the questions below:

- How did it feel to express your opinion about these statements?
- How do you think that your attitudes about same-sex activity might affect your ability to provide professional and respectful services to clients?
- What are your fears, if any, about working with clients who have same-sex partners?
- What is similar about working with clients who have same-sex partners and working with clients who have opposite-sex partners?
- What are some ways that providers can act in a professional and respectful manner with clients whose sexual orientation or sexual behavior differs from their own?

Essential Ideas to Convey

- A person's sexual behavior does not always indicate his or her sexual orientation. Not all individuals who have had same-sex sexual experiences would define themselves as homosexual. Similarly, not all individuals who have had sexual experiences with members of the opposite sex would define themselves as heterosexual. For example, individuals who have same-sex sexual activity might not be exclusively attracted to members of their own sex. Some married people have same-sex sexual activity outside of marriage and consider themselves to be heterosexual. People who have sex with both men and women might consider themselves to be bisexual, homosexual or heterosexual.
- Sexual orientation is not something a person can change at will. No scientifically valid studies have indicated that people can change their sexual orientation by wanting to do so. An individual's sexual orientation, however, might change over time.
- It is important for providers to examine and understand their own values and attitudes about sexual orientation in order to provide neutral, non-judgmental counseling to clients.
- It is important to know about specific sexual behaviors of clients in order to help them protect themselves from the risk of unintended pregnancy and HIV/STI transmission. Knowing about their sexual orientation will help you understand how they view themselves and their relationships but it will not necessarily provide a picture of their sexual practices.
- It is important to distinguish between sexual identity and sexual orientation and sexual behaviors because same-sex behaviors do not always mean that someone is homosexual; nor does sex with people of the opposite sex mean that someone is heterosexual.

EARLY LEARNING ABOUT SEXUALITY: A TRIP DOWN MEMORY LANE

Objectives

1. To enable participants to reflect upon how their personal experiences of sexual development affect their current views and feelings about sexuality issues.
2. To reflect upon how participants' own views and feelings about sexuality might influence their approach to counseling clients on these issues.

Time

30 minutes

Materials and Advance Preparation

- Facilitator Resource: *A Trip Down Memory Lane: Guided Visualization Script*
 - Make sure that the training room is quiet and closed to outsiders. No interruptions should be allowed during this session.
-

Steps

1. Introduce this activity to the participants by reviewing the objectives. Explain that we will be taking a few moments to individually reflect on our own experiences learning about sexuality so that we can think about how these experiences may affect our work as counselors.
2. Tell the participants that this exercise is only for them – to think and reflect for themselves. They will not be asked to share their personal thoughts or experiences with the larger group.
3. Ask the participants to make themselves comfortable and close their eyes. In a slow, reassuring voice read aloud the Facilitator's Resource, *A Trip Down Memory Lane: Guided Visualization Script*, to the participants, pausing between questions to enable them to reflect on memories and images.
4. When participants are ready, ask them to discuss how they felt during the exercise and how this experience could be helpful to their work as counselors. There are two options:
 - **Option 1:** Facilitate a large group discussion about how the participants felt during this exercise. Emphasize that people should not share their personal sexual life experiences, but rather how it felt to think about them. Ask participants how this kind of reflection can be helpful to their work as counselors.
 - **Option 2:** Divide participants into pairs to discuss how they felt during the visualization and how their learning experiences contributed to their present feelings and understanding about sexuality, saying only as much as they feel comfortable sharing.

Key Discussion Points

Ask as many of the following questions as you have time for:

- ↔ How did you feel during this exercise? Did anything I said make you feel uncomfortable or surprised?
- ↔ Do you think the questions asked during this exercise touched upon the key stages and

elements of your sexual development?

- Why do you think I asked if anyone had ever assured you that your thoughts and feelings were normal and that many people have them?
- How are girls' and boys' experiences of sexual development and learning different? Do boys and girls get different messages about their bodies and sex?
- What messages does society give about when women are supposed to have sex for the first time and with whom (e.g., after marriage with her husband)?
- What messages does society give about when men are supposed to have sex for the first time and with whom (e.g., before marriage with a prostitute)?
- How do our own sexual experiences and learning about sexuality affect our ability to counsel clients about issues related to sexuality?
- How do you think your experiences might be similar and different from those of your clients?
- How does this exercise help us understand how clients might feel talking about their sexual life with providers?
- How can providers overcome barriers to talking about sexuality with clients?
- How can you help clients to be more comfortable discussing sexuality issues with you?

Note: If participants first discuss in pairs, incorporate the following questions when the larger group is reconvened:

- How did you feel talking about these issues with another person?
- What made it easy or difficult for you to share your thoughts or memories with another person?
- In what ways did talking to someone else about the visualization give you insight into how a client might feel talking about her or his sex life with a provider?

Considerations for the Facilitator/Training Options

Maintaining a comfortable, quiet and private environment in the training room is critical to this exercise. Depending on the cultural context, participants may feel comfortable remaining seated or may prefer to lie down as they listen to the script.

This exercise may bring up strong emotions among participants, particularly among those with a history of sexual abuse or bad experiences. Be prepared to address these issues if they arise.

Discussion can be held in the larger group or in pairs as described above.

Alternative Exercise: An alternative to this exercise is: *How do we learn about sex?*

Essential Ideas to Convey

- Our own inhibitions and attitudes about sexuality and sexual practices might affect the way we talk to our clients about sex, as well as our comfort in doing so. Understanding where our own feelings and beliefs stem from can help us empathize with the experiences of clients, and the difficulties we all have in talking about our sexuality.
- Sexual practices and relationships are affected by the way we feel about sex, what we think is proper and improper, and what it means to relate to another person in a sexual way. These types of thoughts and feelings are often filled with emotions, including, for example, pleasure, but also sometimes fear, guilt, shame or embarrassment. These feelings come from our personal experiences and also from the meanings that our society and culture attach to sex.
- This exercise alone might not help us to feel more comfortable discussing sexuality with our clients, but it can be a helpful step in the process.

FACILITATOR RESOURCE: A TRIP DOWN MEMORY LANE: GUIDED VISUALIZATION SCRIPT

In this activity, you will spend time alone reflecting as I guide you through memories and thoughts about growing up and sexuality. You will then consider how these experiences shaped your own sense of sexuality. We will not be looking at you. We won't try to read what is on your faces. You will be alone with your thoughts. Nobody will be asked to share personal material with the larger group. We are not concerned with knowing your sexual feelings and experiences. But we do think that it is important that you know them and are comfortable with your own sexuality. This will help you to help others.

Imagine yourself as a child and see what memories come up as I ask you the following questions:

- 1. Reach back into your memories, and imagine yourself as a child of 5. What was your life like then? Who were the important people in your life?*
- 2. Remember yourself at the age of 10. Where did you live? Who were the important people in your life?*
- 3. As you were growing up as a young child, what types of messages did you receive from other people about touching your own body?*
- 4. What messages did you receive about the opposite sex? As you grew older, how did these messages change?*
- 5. Think about when you first learned where babies come from. How old were you? How did you feel about it?*
- 6. For women, how did you first learn about menstruation? How old were you? How did you feel about it?*
- 7. For men, how did you first learn about wet dreams (nocturnal emissions)? How old were you? How did you feel about it?*
- 8. When you were 12, how did you feel about your body?*
- 9. Think back to when you first learned about sex. Where did you hear about it first? Did you talk about it with a parent or an adult? With a friend?*
- 10. Think about the first time you tried to talk to someone about sex. What was it like? How did the person respond? How did it make you feel?*
- 11. How did you feel about the idea of having sex yourself one day?*
- 12. Did you ever have thoughts about sex that you wished you did not have?*

13. *Did anyone ever assure you that these thoughts and feelings are normal and that most people have them? Do you still worry about these thoughts?*
14. *Think about your first sexual experience. How did you feel beforehand? How did you feel afterwards? Did it feel good? Did it feel wrong? Did it feel shameful?*
15. *How did the messages that other people gave you about sex affect your feelings?*
16. *As you've grown older, have you become more comfortable with sex? If yes, what has helped you feel more comfortable? If no, what would have made you feel more comfortable over the years?*

When you are ready, open your eyes.

HOW DO WE LEARN ABOUT SEX?*

Objectives

1. To enable participants to examine their own process and sources of learning about sexuality in order to become more sensitive to the needs and perspectives of clients.
2. To explore the ways in which participants' own learning and experience affect their approach to counseling.

Time

45 minutes

Materials and Advance Preparation

- Participant Handout: *How do we learn about sex?*
 - Pencils or pens for participants
-

Steps

1. Distribute a worksheet and a pen or pencil to each participant. Ask participants to write answers to the questions on the worksheet by themselves. Encourage them to keep their answers short, listing a few main points for each question.
2. Divide the participants into small groups, asking each group to discuss their answers and whether they now agree or disagree with the ideas that they were taught from each source.
3. Reconvene the larger group and lead a discussion about what we learned about sex as children and how these ideas influence our work as counselors. (See key discussion points below).

Key Discussion Points

- ↔ Based on your small group discussions, what do you think are the most common negative ideas that we are taught about sex? Which are the most common positive ideas?
- ↔ How does our society give us messages about sex?
- ↔ How are the ideas conveyed or the messages received about sex different for boys and girls?
- ↔ What messages does society give about when women are supposed to have sex for the first time and with whom (e.g., after marriage with her husband)?
- ↔ What messages does society give about when men are supposed to have sex for the first time and with whom (e.g., before marriage with a prostitute)?
- ↔ Do you think your clients learned about sex in the same ways you did? What are the similarities? What are the differences?
- ↔ Why is it important for us to consider how our clients learned about sex and sexuality? How does it apply to our work as providers?

* This exercise was adapted from, *Challenges in AIDS Counseling: A training guide for counselors*, J Macks and L Liskin, MOH Zambia, AED, Johns Hopkins and USAID.

- ↔ How do our own sexual experiences and learning about sexuality affect our ability to counsel clients about issues related to sexuality?
- ↔ How can you help clients to be more comfortable discussing sexuality issues with you?

Alternative Exercise: An alternative to this exercise is: *Early learning about sexuality: A trip down memory lane.*

Essential Ideas to Convey

- Our own inhibitions and attitudes about sexuality and sexual practices might affect the way we talk to our clients about sex, as well as our comfort in doing so. Understanding where our own feelings and beliefs stem from can help us empathize with the experiences of clients, and the difficulties we all have in talking about our sexuality.
- Sexual practices and relationships are affected by the way we feel about sex, what we think is proper and improper, and what it means to relate to another person in a sexual way. These types of thoughts and feelings are often filled with emotions, including, for example, pleasure, but also sometimes fear, guilt, shame or embarrassment. These feelings come from our personal experiences and also from the meanings that our society and culture attach to sex.
- This exercise alone might not help us to feel more comfortable discussing sexuality with our clients, but it can be a helpful step in the process.

VALUES AND SEXUAL BEHAVIOR: THAT'S OK FOR ME!

Objectives

1. To enable participants to acknowledge their own biases and value judgments about particular sexual behaviors.
2. To raise awareness about differences in individual and cultural perspectives about sexual behavior, including differences in what is considered “normal” or “acceptable.”
3. To highlight the importance of being non-judgmental about sexual behaviors when counseling clients about sexual and reproductive health.
4. To improve participants’ level of comfort in discussing a range of sexual behaviors.

Time

45 – 60 minutes

Materials and Advance Preparation

- Prepare sheets of letter-sized, colored paper (use heavy paper or card stock if available) by writing one sexual behavior on each piece of paper (see Facilitator Resource: *Different types of sexual behaviors*) for list of sample behaviors. Print using a large marker and large letters, or print the pages using a computer in large, bold font so that the words can be read from a distance. Write the phrases “OK for me,” “OK for others, but not OK for me,” and “Not OK” in small letters at the bottom of each card (so participants can circle their response – see sample below).

<h1>Vaginal Sex</h1>		
OK for me	OK for others but not for me	Not OK

- Prepare three additional sheets, one with the phrase “OK for me,” a second with the phrase “OK for others, but not OK for me,” and a third with the phrase “Not OK” written in large print. Use a different color paper for these three sheets if possible. Post them high on the wall, ensuring there is sufficient space between them to place 3-5 vertical rows of cards beneath each.
 - Markers
 - Small pieces of tape (it is helpful to prepare many small pieces ahead of time, enough to affix all of the prepared sheets to the wall).
 - Facilitator Resource: *Different types of sexual behaviors*
-

Steps

1. Introduce the exercise saying that we will be exploring the range of sexual behaviors people engage in and the attitudes and values we have about those behaviors. It is an interactive exercise that will allow us to examine our own personal values about different sexual behaviors, but in a completely confidential way.
2. You have two options:

Option A: Begin the exercise by asking participants to brainstorm a list of all of the sexual behaviors that they can name (**Note:** this will take an extra 15-20 minutes). Ask them to think broadly and include those behaviors that are not very common or are taboo in their community. The list should include both sexual acts (e.g., vaginal sex, oral sex, anal sex, etc.) and sexual dynamics or situations (e.g., sex with a commercial sex worker, sex with someone older, etc.). Write all the responses on flip chart paper. If there are two facilitators, while one is leading the brainstorm, the second should write each of the sexual behaviors on a piece of paper or card as they are mentioned. (**Note:** be sure to write the phrases “OK for me,” “OK for others, but not OK for me,” and “Not OK” in small letters at the bottom of each card so participants can circle or check their response). The facilitator could also ask for one or two volunteer participants to handle this task. If after the brainstorm, the list of behaviors does not represent a wide range of sexual behaviors, add some of the pre-made cards from the list of sexual behaviors (see below) to the pile of cards before they are distributed.

Option B: Use the pre-written sexual behavior cards only. Be sure to review the Facilitator Resource, *Different types of sexual behaviors*, first and add new behaviors or omit others, based on the local situation. (**Note:** it is important to include some behaviors that are outside of the mainstream or that are taboo, even if these behaviors are not generally acknowledged in the local setting.)
3. Tell participants that you will give each person one or more cards with a sexual behavior written on each. Instruct them to determine how they personally feel about the particular behaviors written on their cards and to indicate this by circling one of the phrases:
 - “OK for me”: meaning it is a behavior I personally would engage in
 - “OK for others, but not for me”: meaning it is a behavior I personally would not engage in, but I have no problem with other people doing it;
 - “Not OK”: meaning it is a behavior that no one should engage in because it is morally, ethically, or legally wrong.
4. Be sure to remind participants that this exercise is meant to be completely confidential, so they should not share the behavior on the card or their response with anyone. To ensure confidentiality, before distributing the cards you may want to ask participants to rearrange their seats or spread around the room so no one can see their cards and responses.
5. Distribute the sexual behavior cards to participants, attempting to give each person the same number of cards, until all of the cards have been distributed. Repeat the meaning of “OK for me”, “OK for others, but not for me”, and “Not OK” again, and ask if everyone understands.

6. Tell the participants to mark their responses by circling one of the phrases (“OK for me”, etc). Instruct them not to write their names on the cards and to place the cards with their circled responses face down in a pile in the center of the room.
7. Mix up the cards, and ask all participants to take as many cards as they put down.
8. Have the participants take turns, one by one, reading aloud each card and then taping their cards on the wall under the appropriate category ("OK for me," "OK for others, but not OK for me," or "Not OK"), according to what is indicated on the card. Remind them to put the card in the category that is circled, even if they personally do not agree with it. Encourage them to stay standing, line up (queue) to read their card, and move quickly one after the other.
9. Once all of the cards are posted, instruct participants to gather around the wall and give them a few minutes to observe the placement of the cards.
10. Facilitate a group discussion based on the points below. Do not move the cards if there is disagreement; simply acknowledge the difference of opinion and leave the cards as they are.

Key Discussion Points

- ↪ Are you surprised by the placement of some of the cards? Which ones surprised you and why?
- ↪ How would you feel if someone had placed a practice that you engage in yourself in the "Not OK" category?
- ↪ How would you feel if someone placed something you felt was wrong or immoral in one of the "OK" categories?
- ↪ Does the placement of the cards imply that some behaviors are “right” and others “wrong”? How do you feel about that?
- ↪ Are there behaviors that are “Not OK” under any circumstances?
Possible responses:
 - *Rape*
 - *Pedophilia*
 - *Incest*
 - *Behaviors that violate human rights*
- ↪ How did you feel placing someone else’s response card on the wall? Would you have felt comfortable placing your own responses in front of the group?
- ↪ What does this exercise tell us about how clients might feel when providers ask them about their sexual practices?
Possible responses:
 - *Clients may fear being judged negatively*
 - *Clients may be embarrassed or ashamed to admit that they engage in particular behaviors*
 - *Clients may fear that their behaviors are not “normal”*
- ↪ How do you think providers’ and educators’ values and attitudes about different sexual practices affect their work?

↔ How can providers and educators feel more comfortable in addressing sexuality issues with clients?

Possible responses:

- *Over time and with practice you will feel more comfortable*
- *Talk about your fears and concerns with colleagues*
- *Recognize what makes you uncomfortable and why to desensitize yourself*

↔ How can providers and educators make clients feel more comfortable discussing sex?

Possible responses:

- *Create a welcoming and non-judgmental environment*
- *Assure clients of confidentiality*
- *Explain that you discuss these issues with all clients in order to provide them with high quality sexual and reproductive health services*
- *Reassure them that many clients are initially uncomfortable discussing sexuality*

Considerations for the Facilitator/Training Options

There may be behaviors on the cards that participants do not understand. If necessary, you can stop to define the behaviors for participants, or ask other participants to do so.

It is helpful to continually remind participants that this exercise is not about HIV risk, but about values and judgements around sexual behaviors. Sometimes participants have difficulty separating their ideas about disease risk from their value judgements about behaviors.

If some participants indicate that a particular sexual practice does not exist in their culture (e.g. anal sex), ask other participants to verify whether this is true. Sometimes there are participants who are more aware of the variations in sexual behavior who can help their colleagues understand.

Do not ask participants to identify who placed any particular response in a particular category. If a participant would like to volunteer such information to explain their answer, they may do so, but to ask might make participants uncomfortable and take away the anonymity of the exercise.

Essential Ideas to Convey

- Although reproductive health providers have offered services for many years with success, rarely do they discuss sexual practices with clients. HIV has heightened reproductive health providers' awareness of the need to address sexuality more frankly and directly.
- This exercise is meant to help us not only see the difficulty of discussing sexual practices, on the part of both the client and the provider, but also to understand how biases on the part of the provider might affect a client's feelings about discussing such intimate issues.
- The term "sex" is often thought to refer to penile-vaginal sex only, but sexual behaviors can be defined much more broadly. If providers assume that sex only means penile-vaginal intercourse, they may be missing important information.
- We all have value judgments when it comes to sexual behaviors and the circumstances under which people engage in sexual practices, but in order to be effective providers we must not impose our own values on clients as we explore their individual needs and situations.
- If a provider does not address the issue of sexual practices, clients may receive inadequate or inappropriate information, and consequently may be unable to protect themselves from infection or unintended pregnancy. Assumptions and misunderstandings about clients' sexual practices can leave them without the information, skills or methods that they need to protect themselves.

FACILITATOR'S RESOURCE: DIFFERENT TYPES OF SEXUAL BEHAVIORS

Note: These behaviors represent a wide range of sexual activity. Add new behaviors or omit those on the list, based on the local situation.

Hugging
Kissing
Giving oral sex
Receiving oral sex
Group sex
Anal sex
Sex with someone of the same sex
Using objects or toys during sex
Sex with someone of the opposite sex
Getting paid for sex
Sex in public places
Being faithful to one partner
Sex with a person who is much younger
Masturbation
Manually stimulating your partner (using your hand)
Sex with a person who is much older
Vaginal sex
Watching pornographic movies
Sex with many partners
Sex with people who you do not know
Sex with your spouse
Initiating sexual encounters
Sadism and masochism
Sex between teacher and a student
Oral-anal sex
Engaging in "dry sex" [omit if not practiced in your culture]
"Cleansing" Rituals (sex with a relative of a deceased husband) [omit if not practiced in your culture]
Sex between a child and an adult relative
Sex with someone other than your spouse (adultery)
Rape
Paying someone for sex
Pre-marital sex
Sex with animals (bestiality)
Sex with a relative considered too close (incest)
Swallowing semen
Sex with children (pedophilia)
Telling someone a lie just to have sex
Sex with someone of another race or ethnicity

Having sex whenever your partner wants it
Sex with someone who is married
Sex with a disabled person
Sex under the influence of drugs or alcohol
Watching other people have sex
Sharing sexual fantasies with others
Being celibate
Having sex in exchange for money to support your children
Having sex without pleasure
Having sex with your spouse because it's your duty
Agreeing to have sex with someone who won't take no for an answer
Using a vibrator for sexual pleasure
Placing objects in the rectum
Placing objects in the vagina
Placing devices on the penis to maintain an erection
Tying up your partner
Being tied up by your partner

TALKING ABOUT SEX: FINDING A COMFORT ZONE FOR YOU AND YOUR CLIENTS *

Objectives

1. To increase participants' comfort using sexual terminology with clients.
2. To identify the differences between words that clients and providers use in referring to sexual acts and body parts.
3. To explore ways in which cultural attitudes towards sexuality are revealed in language.
4. To identify sexual terminology that is appropriate for providers to use and understandable to clients.

Time

45–60 minutes

Materials and Advance Preparation

- Prepare sheets of flipchart paper with headings related to sexuality (body parts or sexual activities – see suggested topics below). Use one heading per sheet of paper.
 - Distribute markers or pens to participants.
-

Steps

1. Explain that as providers working on sexual and reproductive health we often must address issues that make people, clients and providers alike, feel uncomfortable, such as sexual activities or body parts:
Sometimes clients may use different words than providers to discuss sexual acts or concerns. If clients do not know the “medical” terms for what they are trying to describe, they may use slang or common terms that may make some providers feel uncomfortable, or they may avoid saying the words altogether. In counseling clients about matters related to sexuality, it can be a challenge to find the right words. In this exercise, we are going to try to identify all the terms that we can think of for various sexual acts and body parts, including both “medical” (or “scientific”) terms as well as slang or common terms so that we can discuss the relevance of various terms to counseling.
2. Divide participants into 3–6 groups (at least 4 people per group) and give each group a flipchart sheet headed with one of the following (if there are fewer groups, it is suggested that the first three headings be used, or each group can receive two flip chart sheets with different headings):
 - *Penis*
 - *Vagina*
 - *Penile/vaginal intercourse*
 - *Penile/anal intercourse*
 - *Men who have a lot of sex partners*

* Adapted from *Sexualities: An advanced Training Resource*, EM Armstrong, P Gordon; Family Planning Association, London, 1992.

- *Women who have a lot of sex partners*
3. Ask participants to brainstorm and to choose a “reporter” to write down all the words and phrases that the group members have heard of (both medical and slang) to describe the heading on the sheet they have been given.
 4. After a few minutes, instruct each group to pass their sheet to another group (or move the groups to another flip chart sheet) to add words or phrases. Additional blank sheets should be added under each heading as the space is used up. Instruct the groups to continue passing their sheets until every group has had a chance to add words/phrases under all of the headings. Post the completed sheets on the wall.
 5. Ask participants to examine the sheets posted on the wall. Give them permission to seek clarification of any terms that they find unfamiliar.
 6. Ask participants to choose one word or phrase that makes them uncomfortable or which they dislike for whatever reason. Then instruct them to walk around the room and ask other participants the following questions:
 - *What does (selected term) mean to you?*
 - *How do you feel saying (selected term)?*
 Let participants know that they should try to get as many short replies as possible, without getting involved in a conversation.
 7. After a few minutes, ask the participants to return to their seats and lead a large group discussion based on the following questions:

Key Discussion Points

- ↪ What was it like for you to hear and say these words?
- ↪ What do these words reveal about our cultural attitudes towards sexuality and gender?
- ↪ Which terms suggest negative views of women? Which terms have positive connotations for women?
- ↪ Which terms suggest negative views of men? Which terms have positive connotations for men?
- ↪ For which sexual behaviors or parts of the anatomy can we list the most number of words/phrases? Why do you think this is the case?
- ↪ Which words/phrases would you use in your work with different types of people? For example: adolescents, small children, younger female clients, men, older female clients.
- ↪ Are there “medical” terms on the list that you think some clients might not know?
- ↪ Are there common terms (non-medical or slang) that you think providers might be able to use in some circumstances with clients in order to communicate more effectively?
- ↪ How do you determine which terms are appropriate for a provider to use and are understandable to a client?
- ↪ How could you respond if a client used a term that you consider crude or inappropriate?
- ↪ How can this exercise help us to communicate better with clients?

Considerations for the Facilitator/Training Options

This activity can be structured in two other ways:

- The activity can also be conducted in the form of a race, with each small group or “team” listing synonyms for each heading simultaneously, switching headings after 2-3 minutes. Teams are identified by their use of a distinctive colored pen (i.e., the “red team” or the “blue team”). The team with the most total number of words or phrases listed on the sheets of paper wins.
- In another version, small groups can be assigned one or more headings and the results can be shared in the larger group, without a race or passing the flipchart paper to other groups.

The purpose of this activity must be explained clearly to participants, as some might feel as if the facilitators are just trying to get them to say “dirty” words, especially if the objectives are not carefully articulated. It is important to be clear about how this exercise applies to service delivery and communication with clients. Similarly, it is important to note that some participants may experience discomfort during this exercise if they respond emotionally to the words and feel offended. If there are any participants who seem very upset by the activity or who feel unable to participate, you may wish to discuss this with them privately later in the day to help them overcome their uneasiness.

It is important to acknowledge issues that may arise when this exercise is conducted with a mixed gender group. In some circumstances, participants may not feel comfortable saying sexual terms in front of members of the opposite sex. While one goal of this exercise is to help participants get beyond this discomfort, it is important to start this process in a sensitive and non-threatening way. If necessary, facilitators should consider conducting the exercise in single sex groups or ensuring the facilitator is female, when the participants are predominantly female.

Participants can be asked to brainstorm “medical terms” and “common or slang terms” for each category. This can be facilitated by drawing a line to divide each piece of flipchart paper in half, and by writing “medical terms” on one side and “common terms” on the other side, under each heading.

Essential Ideas to Convey

- One of the challenges that people confront in discussing matters related to sexuality is choosing the words to use. Sometimes the words that come to mind seem either too clinical or too vulgar. This exercise gives us the opportunity to explore different words and to consider their relevance in counseling on sexual and reproductive health matters.
- An important part of this exercise is saying the words out loud so that we begin to feel more comfortable using them or hearing them from clients. As providers, it is essential to use sexual terms without embarrassment.
- Even when people are speaking the same language, the way they speak and the words they choose can lead to misunderstandings. In order to meet their clients' needs, providers must find ways of communicating about sex that are respectful and that make their clients feel comfortable and understood.

GENDER ROLES: I'M GLAD I'M A...BUT IF I WERE A...*

Objectives

1. To develop a better understanding of the enjoyable and difficult aspects of being male or female.
2. To explore gender roles within the context of sexual and reproductive health issues.
3. To gain sensitivity to how gender role expectations can influence clients' abilities to protect themselves from infection or unintended pregnancy.

Time

60 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
-

Steps

1. Separate the participants into same-sex groups of no more than eight. If the participants are all the same sex, simply divide them into smaller groups. If there are only a few participants of one sex, have them form a very small group of their own.
2. Instruct the participants to pick one person to serve as the "reporter" who will write for the group.
3. Provide each group with a sheet of flipchart paper and a marker. Ask the participants to come up with as many endings as they can for the following sentences:
 - Male group: "I'm glad I'm a man because..." (If there are no male groups, do not include this question).
 - Female group: "I'm glad I'm a woman because..." (If there are no female groups, do not include this question).
4. After about 10 minutes, provide the groups with another sheet of flipchart paper, and ask the participants to come up with as many endings as they can to the following sentences:
 - Male group: "If I were a woman, I could..." (If there are no male groups, do not include this question).
 - Female group: "If I were a man, I could..." (If there are no female groups, do not include this question).
5. Once the groups have finished, post all the completed sheets of paper on the wall, grouping them by male and female responses.
6. Allow time for the participants to view other groups' responses.

* This exercise is adapted from: *Life Planning Education*, Center for Population Options, Washington, DC, 1985

7. Facilitate a discussion based on the key discussion points.

Key Discussion Points

- Questions if there are groups of men and women:
 - ↪ Were any of the responses the same for male groups and female groups?
 - ↪ Was it more difficult for members of the male groups or female groups to come up with reasons that they were glad to be men or women? Why do you think this is?
- Questions for a single sex group:
 - If the group is all men:
 - ↪ How do you think a woman would finish the sentence, “I’m glad I’m a woman because...”?
 - ↪ How do you think a woman would finish the sentence, “If I were a man, I could...”?
 - If the group is all women:
 - ↪ How do you think a man would finish the sentence, “I’m glad I’m a man because...”?
 - ↪ How do you think a man would finish the sentence, “If I were a woman, I could...”?
- Questions for either group:
 - ↪ What did you find challenging about discussing the advantages of being the other gender?
 - ↪ Which of these responses are stereotyped? Why do these stereotypes exist? Are they fair?
 - ↪ Which of these responses relate to male and female sexuality? How do gender roles influence the way people feel about their sexuality and behave sexually?
 - ↪ How can gender roles facilitate and limit what men and women can and cannot do in sexual relationships?
 - ↪ How can gender roles affect women’s and men’s abilities to protect themselves from HIV and other STIs and unintended pregnancy and to negotiate issues related to sexuality with their partners? How can gender roles contribute to risky sexual behavior?
 - ↪ How might gender stereotypes have a negative impact on how we as providers relate to men and women as clients?
 - ↪ Based on gender stereotypes, what messages does society give about men’s and women’s roles in determining aspects of a sexual relationship (i.e., Who makes decisions about how to have sex? Who makes decisions about when to have sex?)
 - ↪ As providers, how can we help clients when pressure (internal or external) to conform to gender role expectations potentially threatens their sexual or reproductive health? (An example of this could be a young man who believes that to “act like a man” he must have many sexual partners without using condoms. Another example would be a young woman who places herself at risk of unintended pregnancy because if she were to use a contraceptive method it would show that she “planned” to have sex, instead of just getting caught up in the moment of passion.)
 - ↪ How do you think an awareness of gender roles can help us in our work providing counseling on sexual and reproductive health?

Considerations for the Facilitator/Training Options

Encourage participants to be creative and open in their responses. For example, they could include statements that celebrate aspects of their own gender as well as those that center on not

having to experience something the other sex experiences. For example, men in the group could include statements like “I’m glad I’m a man because I don’t menstruate,” as well as statements like “I’m glad I’m a man because I’m strong.”

Facilitators should make the participants aware that many of the statements prepared by the group will be generalizations and will not necessarily reflect the thoughts or feelings of all members of the group. Furthermore, facilitators should be sensitive to the diversity of opinion, thoughts, feelings and experiences among participants. Participants will have different ways of expressing their sexuality, gender identity and sexual identity. For example, do not assume universal heterosexuality among participants, which can lead to and perpetuate isolation and alienation among those members of the group who do not define themselves as heterosexual.

If there are enough women and men in the group, another way of conducting this exercise is in the form of a “fishbowl,” which consists of an inner and outer circle of participants, divided by sex. The outer group (e.g., men) silently observes the inner group (e.g., women) discussing their answers to “I’m glad I’m a…” and “If I were a…” After an agreed time, the groups switch places and then the facilitator leads a larger group discussion (see key discussion points above).

Alternative Exercise: An alternative to this exercise is *Act Like a Lady, Act Like a Man*, which is a large group brainstorm in which participants identify gender stereotypes apparent in societal messages about how men and women should think, feel and behave.

Essential Ideas to Convey

- Gender refers to what a person, society, or legal systems define as “female” or “male.” A gender role refers to the set of socially or culturally defined attitudes, behaviors, expectations, and responsibilities that is considered appropriate for women (feminine) and men (masculine).
- Gender roles may vary according to culture, class and social and economic status within a society.
- Gender messages and stereotypes are often internalized and thought of as “natural,” due to powerful messages that we received as children from many sources, including family, school, religion, tradition, the media.
- Gender roles are not fixed – they can change over time as the society changes.
- Gender roles and expectations influence the way people express their sexuality, form and negotiate partnerships, and engage in sexual behaviors.
- In order to understand the individual circumstances and specific sexual and reproductive health needs of clients, counselors need to be aware of how gender role expectations may influence clients’ abilities to protect themselves from infection and unintended pregnancy. For example, due to gender roles, many women lack control over when, where and how they have sexual relations.
- Gender roles which result in lack of power in relationships can make it nearly impossible for some women to discuss sexual matters with their partners, including infidelity and condom use.

GENDER ROLES: ACT LIKE A “LADY” ACT LIKE A “MAN”

Objectives

1. To recognize that it can be difficult for both men and women to fulfill the gender roles that society establishes.
2. To identify gender stereotypes apparent in societal messages about how men and women should think, feel and behave.
3. To examine how messages about gender can affect human behavior, particularly sexual behavior and intimate relationships.

Time

45 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
-

Steps

1. Conduct a large group brainstorming session by asking the participants if they have ever been told to “act like a man” or “act like a lady” based on their sex. Ask participants to share some experiences in which someone has said this or something similar to them. Why did the individual say this? How did it make the participant feel?
2. Tell the participants that we are going to look more closely at these two phrases. By looking at them, we can begin to see how society can make it very difficult to be either male or female.
3. In large letters, print the phrase “act like a man” on a piece of flipchart paper. Ask the participants to share their ideas about what this means. These are society’s expectations of who men should be, how men should act, and what men should feel and say. Draw a box on the paper, and write the participants’ ideas about “acting like a man” inside this box. Some responses might include the following:
 - *Be tough*
 - *Do not cry*
 - *Show no emotions*
 - *Take care of other people*
 - *Do not back down*
4. Once the participants have finished their list of what it means to “act like a man,” initiate a discussion by asking the following questions:
 - How can it be limiting for a man to be expected to behave in this manner?
 - Which emotions are men not allowed to express?
 - How can “acting like a man” affect a man’s relationship with his partner and children?

- How can social norms and expectations to “act like a man” have a negative impact on a man’s sexual and reproductive health?
 - How can pressure to “act like a man” influence how a man behaves sexually and how he feels about his sexuality?
 - Do men need to conform to these social norms? Is it possible for men to challenge and change existing gender roles?
5. After the discussion of men’s roles is complete, print the phrase “act like a lady” on a piece of flipchart paper. Ask the participants to share their ideas about what this means. These are society’s expectations of who women should be, how women should act, and what women should feel and say. Draw a box on the piece of paper, and write the participants’ ideas about “acting like a lady” inside this box. Some responses may include the following:
- *Be passive*
 - *Be the caretaker*
 - *Put others first*
 - *Act sexy, but not too sexy*
 - *Be quiet*
 - *Listen to others*
 - *Be the homemaker*
6. Once participants have finished their list, initiate a discussion by asking the following questions:
- How can it be limiting for a woman to be expected to behave in this manner?
 - Which emotions are women not allowed to express?
 - How can “acting like a lady” affect a woman’s relationship with her partner and children?
 - How can social norms and expectations to “act like a lady” have a negative impact on a woman’s sexual and reproductive health?
 - How can pressure to “act like a lady” influence how a woman behaves sexually and how she feels about her sexuality?
 - Do women need to conform to these social norms? Is it possible for women to challenge and change existing gender roles?
7. After analyzing the situation of women, wrap up the activity by discussing the key points.

Key Discussion Points

- ↪ How can gender roles facilitate and limit what men and women can and cannot do in sexual relationships?
- ↪ How can gender roles affect women’s and men’s abilities to protect themselves from HIV and other STIs and unintended pregnancy and to negotiate issues related to sexuality with their partners? How can gender roles contribute to risky sexual behavior?
- ↪ How might gender stereotypes have a negative impact on how we as providers relate to men and women as clients?
- ↪ Based on gender stereotypes, what messages does society give about men’s and women’s roles in determining aspects of a sexual relationship (i.e., Who makes decisions about how to have sex? Who makes decisions about when to have sex?)

- Are stereotypes ever useful? Why are they used so frequently?
- As providers, how can we help clients when pressure (internal or external) to conform to gender role expectations potentially threatens their sexual or reproductive health? (An example of this could be a young man who believes that to “act like a man” he must have many sexual partners without using condoms. Another example would be a young woman who places herself at risk of unintended pregnancy because if she were to use a contraceptive method it would show that she “planned” to have sex, instead of just getting caught up in the moment of passion.)
- How do you think an awareness of gender roles and stereotypes can help us in our work as providers in sexual and reproductive health?

Considerations for the Facilitator/Training Options

Alternative Exercise: An alternative to this exercise is:

Gender roles: I’m glad I’m a... but if I were a...

Essential Ideas to Convey

- Gender refers to what a person, society, or legal systems define as “female” or “male.” A gender role describes the set of socially or culturally defined attitudes, behaviors, expectations, and responsibilities that is considered appropriate for women (feminine) and men (masculine).
- Gender roles may vary according to culture, class and social and economic status within a society.
- Gender messages and stereotypes are often internalized and thought of as “natural,” due to powerful messages that we received as children from many sources, including family, school, religion, tradition, the media.
- Gender roles are not fixed – they can change over time as the society changes.
- Gender roles and expectations influence the way people express their sexuality, form and negotiate partnerships and engage in sexual behaviors.
- In order to understand the individual circumstances and specific sexual and reproductive health needs of clients, counselors need to be aware of how gender role expectations may influence clients’ abilities to protect themselves from infection and unintended pregnancy. For example, due to gender roles, many women lack control over when, where and how they have sexual relations.
- Gender roles which result in lack of power in relationships can make it nearly impossible for some women to discuss sexual matters with their partners, including infidelity, condom use.

SEXUAL ANATOMY, PHYSIOLOGY AND EROGENOUS ZONES: BODY MAPPING

Objectives

1. To explore and build on participants' knowledge of sexual and reproductive anatomy and physiology.
2. To increase participants' comfort with using clinical terms related to sexual and reproductive health.
3. To increase participants' comfort with discussing sexuality and sexual pleasure.

Time

60 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers (several different colors)
 - Tape
 - Participant Handout: *Male sexual and reproductive anatomy and physiology*
 - Participant Handout: *Female sexual and reproductive anatomy and physiology*
-

Steps

1. Divide the participants into small groups – single sex if the group is mixed.
2. Have each small group tape pieces of flipchart paper together to form two large sheets that are big enough to trace a human body outline. Instruct them to choose one or two volunteers to lie down on the paper to have the outline of their bodies traced with marker. Alternatively, the paper can be held against the wall and the participant can be traced while standing. The end result should be two blank life-size human outlines on separate large sheets of paper.
3. Have each group select one outline to represent a woman and the other to represent a man. Then instruct them to draw and label the sexual and reproductive anatomy (internal and external) on their male and female figures.
4. After the groups have drawn and labeled the anatomy, have them select a bright colored pen to mark the erogenous zones (i.e., pleasurable areas on the body) on their male and female figures. Encourage them to work with the whole body, not just the sexual and reproductive organs.
5. Invite each group to present their figures in the larger group. Have participants correct any anatomical errors or misconceptions.
6. Distribute the participant handouts entitled, *Male sexual and reproductive anatomy and physiology* and *Female sexual and reproductive anatomy and physiology* as reference materials. Use these as a guide to solve any disputes over the names or placement of parts

that may have occurred as groups presented their figures.

7. Lead a group discussion based on the following key questions (see below).

Key Discussion Points

- ↪ Where in their bodies do people experience sexual pleasure? What are the differences and similarities in terms of erogenous zones for women and men?
- ↪ How do you feel about the areas identified as erogenous zones on these sketches? Are the sketches complete, or is anything missing?
Note: participants may fail to draw the clitoris. If this is the case, make sure to point it out and discuss why it is so commonly omitted from anatomical models.
- ↪ What do these body maps illustrate about how men and women may think about sexual arousal and behavior?
- ↪ How did it feel to speculate about the erogenous zones of the opposite sex?
- ↪ Was it more difficult for you to draw and label the sexual and reproductive anatomy of one sex or the other? If so, what made it more difficult for you?
- ↪ (*Only ask if working in single-sex groups*) How do the men's depictions of erogenous zones compare with the women's depictions? Do either the male or female sketches seem to have more erogenous zones than the others?
- ↪ If your clients were to do this exercise, how do you think their maps might be similar or different from yours?
- ↪ How does this exercise apply to your work on counseling clients?

Considerations for the Facilitator/Training Options

If feasible, divide participants into small, single-sex groups. If most of the participants are of one sex, then just divide the larger group into smaller groupings.

Depending on the background of the group, this exercise may serve as a review of anatomy or an introduction for staff with a less clinical background.

Depending on the local context, make sure to discuss traditional practices that may have an impact on sexual anatomy and sexual experience, including, for example, female genital cutting or male circumcision. If circumcision or genital cutting is practiced, ask participants to draw and label pre-cut and post-cut anatomy and then lead a discussion on how these practices may affect sexual pleasure.

Instead of using drawing, this activity can be conducted as a creative arts project using clay, string, construction paper, balloons and other locally available materials. Participants can be instructed to create models of the male and female sexual and reproductive health systems using the materials supplied. This approach would take additional time.

Alternative Exercises: Alternatives to this exercise are *Sexual pleasure* and *Sexual development throughout the life cycle*.

Essential Ideas to Convey

- It is important for providers to be familiar with and comfortable discussing the sexual and reproductive anatomy of women and men. This knowledge can help them communicate effectively with clients about their concerns related to anatomical function.
- Similarly, providers must feel comfortable discussing sexual pleasure and erogenous zones with clients, not only to address sexual problems and concerns, but also in helping clients learn how to protect themselves from the risk of infection or unintended pregnancy. Providers must be aware of the ways in which different methods of family planning and safer sex practices may impact a client's experience of sexuality. Learning about and feeling comfortable discussing the pleasurable aspects of sexuality can be a first step in this process.
- Make sure that participants identify the brain and skin in their discussion of sexual pleasure and erogenous zones.

SEXUAL PLEASURE*

Objectives

1. To improve skills related to addressing sexual pleasure and sexual dissatisfaction when counseling clients about sexual and reproductive health issues.
2. To explore social, cultural and biological factors that influence how men and women experience sexuality differently.
3. To increase participants' comfort discussing sexual pleasure and sexual problems.

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
-

Steps

1. Divide participants into small groups. If feasible, when dividing participants into small groups, form all male groups and all female groups. If most of the participants are of one sex, then just divide the larger group into smaller groupings.
2. Ask each group to take four pieces of flipchart paper and to write the following titles (one per each piece of paper): "Things that men find pleasurable," "Things that women find pleasurable," "Things that men don't find pleasurable," "Things that women don't find pleasurable."
3. Ask each group to choose a "reporter" to write down the ideas that the group brainstorms under each of the titles.
4. When the groups have finished writing ideas for each title, have them post their pieces of flipchart paper on the wall, grouping the responses for each title together.
5. Allow participants time to look at the wall and read what other groups have posted.
6. Reconvene the larger group and facilitate a discussion based on the questions below.

Key Discussion Points

- ↪ How much of a difference was there between what you listed for men and for women?
- ↪ Was there more similarity between men and women in the things they find pleasurable or the things they find not pleasurable? Why do you think this is?

* Adapted from: *Training Manual for Community-Based Reproductive Health Programmes*, Volume II, PPAZ/GRZ, Zambia, 1999.

- How can biology and physical factors influence what people find pleasurable or not pleasurable? How can culture and society influence what people find pleasurable or not pleasurable? What other factors might influence how people feel about their sexuality?

Possible responses include:

- *It may not be socially acceptable in certain societies to say or admit that certain sexual acts are pleasurable (e.g. anal sex, oral sex, etc.).*
 - *In many societies, women are expected to control or deny sexual desire and pleasure.*
 - *Individual anatomy can vary, affecting sexual pleasure.*
 - *Practices such as male circumcision or female genital cutting may affect sexual function and pleasure.*
 - *The reasons a person has sex may influence pleasure (e.g. sex for love or desire versus commercial sex or coerced sex).*
 - *Past negative sexual experiences (rape, sexual abuse) might influence a person's ability to derive pleasure from sex.*
- Why is it important to be aware of and talk about sexual pleasure when counseling family planning or other reproductive health clients?

Possible responses include:

- *Since some family planning methods can affect sexual desire and functioning, and this may affect client satisfaction or contraceptive continuation, it is important to discuss sexual pleasure with clients as part of informed choice counseling.*
 - *Sexual dissatisfaction may be the underlying reason a client comes for a clinic visit, so providers need to be comfortable talking about these issues.*
 - *Sexual pleasure is a fundamental part of sexual health.*
- How comfortable do you think clients are talking about sexual pleasure?
- How could you as a counselor help clients to talk with their partners about what they like and dislike sexually?

Possible responses include:

- *Having the client verbalize their likes and dislikes in the counseling session is a good first step.*
- *Role play*
- *If verbal communication with a partner about what the client likes and dislikes is not an option, discuss non-verbal communication strategies.*

Considerations for the Facilitator/Training Options

If for any reason participants are hesitant to begin this activity, acknowledge that it is normal to feel nervous, anxious or uncomfortable discussing issues related to sexuality. Emphasize that the reason for doing this exercise is to increase comfort with addressing sexuality and to improve skills counseling clients on these topics. If some members of a small group seem to be having difficulty starting, sit with the group and help them gain comfort with the brainstorming. You may need to circulate from one group to another until all groups are on task.

Alternative Exercises: Alternatives to this exercise are *Sexual anatomy, physiology and erogenous zones: body mapping* and *Sexual development throughout the life cycle*.

Essential Ideas to Convey

- Helping clients to understand the potential impact of family planning methods on sexual pleasure is critical to contraceptive satisfaction and continuation.
- Helping clients understand and consider issues of pleasure as it relates to safer sexual behaviors is critical to helping clients protect themselves from infection or unintended pregnancy.
- In order to do so, providers must learn how to discuss sexual pleasure and sexual problems with clients without embarrassment.
- Encouraging clients to think broadly about what they might find sexually arousing, beyond genital stimulation, can assist in discussions of safer sexual behaviors.
- Providers can play an important role in helping clients to communicate with their partners about sexuality. Voicing aspects of sexual pleasure and dissatisfaction is an important step in this process.

INTRODUCTION TO SEXUAL RESPONSE AND SEXUAL PROBLEMS

Objectives

1. To introduce participants to physiological and psychological factors that contribute to male and female sexual response and sexual problems.
2. To provide participants with basic knowledge on male and female sexual response and sexual problems that will facilitate their work on counseling clients.

Note: This exercise should be considered an introduction to the topic and not a thorough training on treating sexual dysfunction.

Time

60 minutes

Materials and Advance Preparation

- Flipchart papers
 - Markers
 - Tape
 - Participant Handout: *The sexual response cycle*
 - Participant Handout: *Some common sexual problems, causes and treatments*
-

Steps

1. Divide participants into 2 groups. Provide each group with flipchart paper and markers.
2. List the 5 phases on a piece of flipchart paper and post it in the front of the room (desire, excitement/arousal, plateau, orgasm, resolution). Instruct one group to describe and/or illustrate the physical and physiological changes in the female body during sexual response and the other group to describe and/or illustrate changes in the male body.
3. Reconvene the larger group, post their models on the wall, and have each group present their model to the other. Have participants correct any misinformation.
4. Distribute the handout *The sexual response cycle*. Discuss differences and similarities in male and female response and review the correct terminology.
5. After clarifying and reviewing the information on sexual response, lead a large group brainstorm session on potential sexual problems that men and women can experience.
6. Draw a chart like the one displayed below (*Sample Sexual Problem Chart*) and list the sexual problems mentioned by the participants, indicating potential causes, possible solutions or actions (both traditional and clinical treatments) and whether it is a problem for men, women or both.

Sample Sexual Problem Chart

Problem	Possible causes	Possible solutions/actions (traditional and clinical)	Affects men, women or both?
Maintaining an erection	Drug or alcohol use; aging; medical problem (i.e., diabetes); psychological issues	Cut down on drinking, and/or drug use; work with partner to address psychological issues	Affects men but can have an emotional impact on women
Loss of sexual desire/interest in sex	Physical or medical: hormonal; alcoholism; chronic illness Psychological: stress; relationship problems; rape or sexual abuse; major life changes (for example, loss of employment, etc.)	Depending on cause, address physical or psychological conditions. For physical, may require medical intervention (if available); for psychological may require stressful situation to change, partner communication, counseling (if available).	Both
Etc.	Etc.	Etc.	Etc.

7. Distribute and discuss the handout, *Common sexual problems, causes and treatments*, making sure to address any problems that were not identified by the group during the brainstorming session. Also use this opportunity to clarify any misinformation or doubts that may have been raised.

Key Discussion Points

- ↪ What are the most commonly reported sexual problems reported in your clinic or community?
- ↪ How do people in your community generally deal with sexual problems?
- ↪ Why is it important for family planning/reproductive health providers to understand human sexual response and sexual problems?

Possible responses include:

- *It is important to understand human sexual response to help identify potential sexual problems.*
- *It is important to be able to talk about how family planning methods may or may not impact the normal sexual response cycle (e.g. oral contraceptives may decrease libido in some women, having to put a condom on during the arousal stage may interrupt sexual act).*
- *Some family planning methods may help certain sexual problems (e.g. use of condoms may help with pre-mature ejaculation).*
- *A sexual problem may be the underlying reason a client comes for a clinic visit.*
- *Programs that address sexual problems will better meet clients' needs and may improve client satisfaction.*

Considerations for the Facilitator/Training Options

If available and appropriate, consider inviting a speaker who is expert in the treatment and diagnosis of sexual problems to come in to co-facilitate or lead this exercise with training participants.

Investigate what treatment options for sexual problems are available within the community and enlist participants' assistance in determining this information.

Essential Ideas to Convey

- Providers must be informed about sexual response and sexual problems because these issues impact reproductive health decision-making; clients may present with primary or underlying concerns related to sexual functioning.
- The range of what is considered "normal" within the sexual response cycle is wide, with sexual satisfaction, enhanced intimacy, or both being the desired outcome.
- Sexual problems can be caused by biological, psychological or interpersonal factors. It is common for most women and men at one time or another to have experienced some alteration in sexual response, and an occasional problem in this regard is not an indication of dysfunction.

SEXUAL DEVELOPMENT THROUGHOUT THE LIFE CYCLE

Objectives

1. To familiarize participants with stages of human physical, psychological and social sexual development throughout the life cycle.
2. To examine how gender roles and gender identity may influence sexual development.

Time

45 minutes

Materials and Advance Preparation

- Prepare 5 sheets of flipchart paper by writing a different title on each piece of paper. The titles are “birth to 3 years,” “4 – 12 years,” “13 – 20 years,” “21 – 50 years,” “51 years – death.” Draw a line down the middle of each sheet and label one side “physical” and the other side “emotional.”
 - Markers
 - Tape
 - Participant Handout: *Stages of female and male sexual development*
 - Participant Handout: *Milestones in male and female sexual and social development*
 - Participant Handout: *Normal changes in sexual response with aging*
-

Steps

1. Divide the participants into 5 groups. Provide each group with a piece of flipchart paper with an assigned age range.
2. Instruct the groups to list the physical and emotional changes in sexual development that occur during that age category. Have each group choose a “reporter.”
3. Reconvene the larger group. Have a volunteer from each group post that group’s paper on the wall. Beginning with the first age range (“birth to 3 years”) have the reporter from each group present the group’s lists.
4. Distribute the handouts entitled, *Stages of female and male sexual development*, *Milestones in male and female sexual and social development* and *Normal changes in sexual response with aging*. Review them with the group.
5. Facilitate a discussion based on the questions below.

Key Discussion Points

- ↔ In what ways do men and women experience sexual development similarly and differently?
- ↔ At what age do most of the changes occur?
- ↔ What role do hormones have on sexual development throughout the life cycle for men and for women?
- ↔ How do culture and varying societal norms, including gender roles, affect the age at which

people experience particular stages of sexual development?

→ How can an awareness of psychosexual milestones help us in our work as counselors?

Possible responses include:

- *By knowing psychosexual milestones we can better help clients who have concerns about their own development.*
- *Family planning/reproductive health providers have traditionally only worked with women of reproductive age and/or those who are married. If we are to meet the needs of a broader audience (men, adolescents, post-menopausal women), we must be familiar with psychosocial milestones throughout life.*

Essential Ideas to Convey

- Sexual experience is part of the entire life cycle from birth to death.
- While men and women may experience milestones at different times, due to social and biological factors, overall the milestones themselves are quite similar.
- Knowledge of the major milestones in sexual and social development can help participants to address clients' concerns about their own sexual development.

UNCOVERING CLIENTS' UNDERLYING CONCERNS ABOUT SEXUALITY

Objectives

1. To provide an opportunity for participants to practice discussing issues related to sexuality with clients.
2. To provide an opportunity for participants to practice probing skills as a part of sexual and reproductive health counseling.
3. To analyze approaches to addressing personal issues in a sensitive manner.

Time

45 minutes

Materials and Advance Preparation

- Prepare slips of paper with role play scenarios for “clients” and “providers” on them (see below).
 - Facilitator Resource: *Uncovering clients' underlying concerns about sexuality: Sample role play scenarios*
-

Steps

1. Introduce the exercise by presenting the objectives for this session, pointing out that we will be engaging in role plays to help us apply what we have learned in the previous exercises on sexuality.
2. Invite 6 volunteers to perform role plays in front of the group.
3. Distribute scenario descriptions to the volunteers, with 3 receiving “client” roles and 3 receiving “counselor” roles (see Facilitator Resource, *Uncovering clients' underlying concerns about sexuality: Sample role play scenarios*). It is the counselor’s role to uncover the client’s concerns. Make sure that none of the volunteers see any of the others’ role descriptions.
4. Have each pair (“counselor” and “client”) perform a short role play in front of the group, based on their scenarios.
5. After each pair has performed, lead a discussion based on the key discussion points below.

Key Discussion Points

- ↪ Why is it important to explore the client’s sexual life and relationships?
- ↪ Which types of questions seemed to help the clients feel more comfortable voicing their true concerns? Which types of questions did not work as well?
- ↪ What are some other types of questions that were not raised in the role plays that could be helpful?
- ↪ What approaches can we use to ask these questions in a sensitive way?
- ↪ How did those playing the part of the counselor feel about probing and asking sensitive questions? How did those playing the clients feel about revealing their concerns?

- ↔ Did these scenarios seem realistic? What other types of problems could you imagine clients would be too embarrassed to mention unless providers made them feel comfortable?
- ↔ In your own work to date, what types of sexual health concerns have clients raised? Have different groups of people (i.e., young people, farm workers, older married women, etc.) expressed different types of concerns about which you could generalize?

Considerations for the Facilitator/Training Options

Instead of conducting the role plays in a large group, participants could be divided into small groups. Assign the small groups one scenario and have two volunteers from each group enact the “provider” and “client” roles. Other members of the small group then observe the role play, give feedback to the “provider,” and discuss different ways to approach counseling the “client.”

Before the role plays begin, it is important for the facilitator to explain that the observations and feedback from the “audience” should focus on both the positive things the “provider” did while counseling the “client” as well as any suggestions for improvement.

The facilitator should make sure to acknowledge and thank participants who volunteer to enact the role plays. If available, small prizes can be given to those who volunteer to recognize their effort.

Essential Ideas to Convey

- It is critical for providers to develop strategies and skills for making clients feel comfortable discussing their concerns, especially when they are related to sexuality or other sensitive issues.
- In order to provide effective counseling, providers need to explore and understand the client's social context. Developing skills in asking probing questions facilitates exploring the client's circumstances. A client's presenting concern may not necessarily be the same as a client's underlying concern. A skilled counselor can uncover a client's true concerns.
- It is often best to start with more general, open-ended questions to get the conversation rolling and make the client feel more comfortable. Counselors can later "probe" with more pointed questions to obtain more specific information.
- When talking to clients about sexuality, providers must keep in mind the power dynamic inherent in the client-provider relationship. In other words, in a clinic setting, clients have less power than providers because they must conform to the clinic's schedule and rules, rely on the provider for information and resources and provide personal information during a counseling or medical session. This inequality often leaves clients feeling vulnerable and less likely to feel comfortable talking about sexuality, a subject that is already difficult to discuss in most cultures. Additional power dynamics that may affect a counseling session include economic, class, gender and age differences between provider and client.
- In light of the power dynamic, providers must act quickly to build trust with clients by being non-judgmental, assuring clients that their confidentiality will be respected, acknowledging how difficult it can be to talk about sexuality, and even by acknowledging the power dynamic.

FACILITATOR RESOURCE: UNCOVERING CLIENTS' UNDERLYING CONCERNS ABOUT SEXUALITY: SAMPLE ROLE PLAY SCENARIOS

SCENARIO 1

Client: You are a 25-year old woman and your husband wants to have anal sex with you. You are afraid that this request means that he is homosexual. You want to know if this behavior is “normal,” but you are afraid to ask the provider directly. You try to hint to the provider and won't open up unless the provider makes you feel comfortable. You are using the pill and have no problems with the method.

SCENARIO 1

Provider: A 25-year old married client who is currently using the pill comes to see you. Why has she come to see you? Your task is to find out why she has come to the clinic and to address any concerns that she may have.

SCENARIO 2

Client: You are a 16-year old girl with a secret that you feel is shameful, and “all your fault.” For the past year, your uncle has been sneaking into your bed at night and sexually abusing you. You are afraid of getting pregnant, getting diseases and worst of all terrified that someone in your family will find out and think that you want him to do it. You might even be thrown out of the house if your family finds out. You come to the family planning clinic to ask for a contraceptive method. You don't want to tell the provider about your uncle, but you just might if the provider wins your trust and asks the right questions. You feel very nervous and tense. You have come to the clinic to ask for birth control pills to protect yourself against pregnancy.

SCENARIO 2

Provider: A 16-year old girl has come to see you for a family planning method. She seems nervous and tense. Why has she come to see you? Your task is to find out why she has come to the clinic and to address any concerns that she may have.

SCENARIO 3

Client: You are a 35-year old married woman who has been using the IUD as your method of contraception for the past 2 years. You have no problems with the IUD. You have four children and you think that you probably don't want to have another child. You are very religious and active in your church. Your husband travels frequently for work and you suspect that he has other partners. You are very concerned about STIs, including HIV, because you know other married women like you who have gotten infected. You don't really want to discuss your fears with the provider, but you just might if the provider makes you feel comfortable.

SCENARIO 3

Provider: A 35-year old woman has come to see you. She is married, has 4 children and is using the IUD. She appears to be satisfied with the method. Why has she come to see you? Your task is to find out why she has come to the clinic and to address any concerns that she may have.

SCENARIO 4**Client:**

You are a 22-year old woman who has been married for 4 years. You have 2 young children. You know that your husband has other partners and you have recently convinced him to use condoms as a form of birth control because you told him that you want to wait a while to have another child. The real reason you would like to use condoms is to protect yourself from STIs. Since you've been using condoms, however, your husband has been having problems maintaining his erection during sex. He now refuses to use condoms. The whole problem has gotten so bad that he is drinking a lot and even avoiding sex. You are confused and worried that his losing his erection is your fault. You really would like him to use condoms, though. You would like to talk about this with the provider, but you are afraid. If the provider makes you feel comfortable, you will discuss your concerns.

SCENARIO 4

Provider: A 22-year old woman has come to see you. She is married and has 2 young children. She is using condoms as her method of contraception. Why has she come to see you? Your task is to find out why she has come to the clinic and to address any concerns that she may have.

SCENARIO 5

Client: You are a 30-year old married woman who gave birth to your third child one month ago. You have been breastfeeding the newborn, which has caused vaginal dryness. In addition, you are feeling no sexual desire since the baby was born. Your husband, however, has been forcing you to have sexual intercourse against your will. You are very upset about your husband's behavior, but can't talk to him or anyone about it because you think it's your own fault. In addition, since your vagina has not been properly lubricated during sexual intercourse, you are experiencing vaginal irritation and discomfort. You have come to the clinic seeking treatment for the vaginal irritation and will only reveal the full story if you feel comfortable with the provider.

SCENARIO 5

Provider: A 30-year old married woman comes to you complaining of vaginal irritation. She has three children, including a one-month old infant who she is breastfeeding. You have conducted a physical exam and find no signs of disease. She seems very shy and nervous. Your task is to determine what is going on with her and to address any concerns that she may have.

SCENARIO 6

Client: You are 48-year old married man who comes to the clinic to ask for something to protect against HIV, but you don't want to use condoms. You are having sex with women outside your marriage and you are concerned about getting infected and infecting your wife. You have tried condoms but do not want to use them and are reluctant to explain what the problem really is. The reality is that you have performance anxiety – you are afraid you will lose your erection if you stop to put a condom on because you are getting older, and it isn't as easy for you to get erections as it used to be. You are also afraid that even if you do get an erection with a condom, the reduced sensation with the condom will prevent you from having an orgasm.

SCENARIO 6

Provider: A 48-year old married man comes to you for protection against HIV. He does not want to use condoms, but is reluctant to say why. Your task is to find out why.

VOLUME 1

**SECTION TWO: INTRODUCTION TO HIV/STI PREVENTION
AND DUAL PROTECTION**

(EXERCISES AND RESOURCES)

THE IMPACT OF HIV/AIDS ON OUR PERSONAL AND PROFESSIONAL LIVES

Objectives

1. To allow participants an opportunity to explore their feelings and attitudes about how HIV/AIDS has affected them personally and professionally.
2. To encourage participants to consider different types of responses to the HIV/AIDS epidemic within their community, country and internationally.
3. To foster empathy among participants for those infected by HIV, by enabling participants to imagine how they would feel if they were infected.

Time

25-45 minutes (depending on the number of questions selected)

Materials and Advance Preparation

- Create a participant handout with prepared questions (for suggested questions, see Facilitator Resource: *Suggested questions about the personal and professional impact of HIV/AIDS*, which presents three options for sets of questions about a particular topic)
 - Paper and pens or pencils for participants
 - Flipchart paper
 - Markers
 - Tape
-

Steps

1. Distribute handout with questions to each participant (or write the questions on flipchart paper that is posted on the wall, show the questions on an overhead, or write them on a blackboard). Make sure participants have pens or pencils and writing paper.
2. Instruct the participants to write short responses to the questions, and to keep their papers to themselves.
3. Ask for volunteers to share their responses to the first set of questions on a topic (i.e., those on *Personal experiences with HIV*). If the group is hesitant to begin, facilitators should share their own experiences to get them started.
4. After several volunteers share their experiences based on the first set of questions, ask for volunteers to discuss the other questions.
5. Keep track of the main points that participants bring up by writing them on flipchart paper and posting them on the wall. This will help guide the large group discussion.
6. Lead a large group discussion based on the questions below.

Key Discussion Points

Note: Tailor these discussion points based on the topics and specific questions addressed by the participants.

- How did you feel answering these questions?
- How can thinking about these topics help us become better reproductive health counselors?
- How can our own attitudes about and personal experiences with HIV/AIDS affect our work as counselors?
- Which questions were the most difficult to answer and why?
- How has the existence of HIV/AIDS changed our priorities in life, both personally and professionally?
- In what ways (if any) has HIV/AIDS brought something meaningful or positive into our lives? (For example, has the existence of AIDS made it easier for you to discuss sexuality with clients? Has the urgency of the epidemic caused you to become more politically active on AIDS issues? Have you cared for someone with AIDS and found a different side of yourself, etc.?)
- How can we confront and overcome our fears and concerns about working with clients who are HIV-positive or at-risk of infection?

Possible responses include:

- *Talk about our fears (with friends, co-workers, religious or spiritual leaders).*
- *Learn more about HIV and AIDS and resources available to people living with HIV/AIDS in our communities.*
- *Get to know or talk to someone living with HIV.*
- *Ensure universal precautions/infection control procedures are in place and observed at the healthcare facilities in which we work.*

Considerations for the Facilitator/Training Options

This activity can be conducted in several different ways. It can be conducted, as described above, as a personal reflection in which participants write their own responses but do not share them with anyone else. Alternatively, the facilitator can read the questions out loud while participants close their eyes and silently imagine their own responses. In another version, participants can share their ideas in pairs or small groups (with or without first writing responses to the questions on their own).

Suggested questions are provided on a variety of topics (see attached). Facilitators are encouraged to select questions they feel are most relevant to the needs of the participants. Remember that some of these questions – especially those in the section, *What if you had HIV or AIDS* – can be very personal and emotional for some participants, particularly those who may be infected with HIV. Be prepared to address emotional issues as they arise.

This activity can be tailored to address other STIs beyond HIV. This can be accomplished by substituting the term “STI” in some of the questions. For example, participants can answer the question, *How did you feel the first time you worked with a client that you knew was infected with an STI?*

Essential Ideas to Convey

- HIV/AIDS is an emotionally charged issue that is frequently associated with fear, stigma and prejudice. Myths, misunderstandings and mistreatment of clients can result from the sense of panic that surrounds HIV/AIDS. In addition, talking to clients about a life-threatening illness can be stressful and disturbing for providers.
- Fears and worries about HIV/AIDS in the workplace can increase providers' stress levels, diminish job satisfaction, and decrease quality of services if they are not addressed adequately.
- As providers, it is important for us to be aware of our feelings, thoughts and attitudes about HIV/AIDS. If we do not address our personal reactions and emotions, we may unintentionally treat HIV-positive or at-risk clients differently than we normally treat clients, thereby diminishing the quality of care that we provide.

FACILITATOR RESOURCE: SUGGESTED QUESTIONS ABOUT THE PERSONAL AND PROFESSIONAL IMPACT OF HIV/AIDS

Personal experiences with HIV/AIDS

- When was the first time you heard about HIV/AIDS?
- What was your reaction and how did you feel about it?
- Have your reactions or feelings changed over time? If yes, in what sense?
- Do you know anyone who has HIV or AIDS or has died from AIDS?
- Have you changed your life because of this? How? If you have not changed, why not?

What if you had HIV or AIDS?

- If you were infected with HIV, would you want to know?
- What would motivate you to want to know your HIV status?
- If you were told that you had HIV, in what ways would it change your life?
- What do you think would be the most difficult part about being infected with HIV?
- If you were infected with HIV, how would you want to be treated by others?
- If you had HIV, how would it affect your relationship with your sexual partner(s)?

Professional experiences with HIV/AIDS

- How did you feel the first time you worked with a client that you knew was infected with HIV?
- Do you think HIV-infected clients should be treated differently from clients who are not infected? Why or why not?
- What are your fears or concerns about working with clients who are or might be infected with HIV?

WHEN SOMEONE SAYS AIDS, I THINK...I FEEL...*

Objectives

1. To increase participants' awareness of their personal reactions, feelings, values and attitudes related to HIV/AIDS.
2. To reflect upon how participants' own views and feelings about HIV/AIDS might influence their approach to counseling clients on related issues.

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
 - Writing paper (letter size sheets cut in half) or small cards
 - Pens or pencils
-

Steps

1. Distribute two small pieces of paper or cards and pens or pencils to participants.
2. Ask them to independently complete the following sentences, writing the first phrase and their completion of it on one card or piece of paper, and then writing the second phrase and their completion of it on the other piece or paper or card. The two phrases are:
 - When someone says the word AIDS to me, I think....
 - When someone says the word AIDS to me, I feel...
3. Instruct the participants to place their completed cards or pieces of paper face down in a pile. Make sure participants do not write their names on their responses.
4. Mix up the cards or pieces of paper and ask the participants to randomly select two of them from the pile. Ask them to take turns, one after another, reading aloud what is written on their cards or pieces of paper. At the same time, the facilitators post two pieces of flipchart paper, one entitled "thoughts" and the other "feelings," and write down the participants' responses in the appropriate category.
5. Lead a large group discussion based on the questions below.

* This exercise is adapted from: *Unmasking AIDS*, G. Bone, et. al., IPPF, London, 1991.

Key Discussion Points

- What are the main differences and similarities between our *thoughts* and *feelings* about AIDS?
- Overall, how would you describe our feelings (e.g., feeling overwhelmed, fear, depressed, hopeless, energized, militant, etc.)?
- Overall, how would you describe our thoughts?
- How can becoming aware of our thoughts and feelings about AIDS affect how we work with clients?
- In what way have your thoughts and feelings about AIDS changed over time?

Considerations for the Facilitator/Training Options

Facilitators can expand this activity by adding more sentences for participants to complete, using the same sentence structure but substituting different main words. For example, “When someone says the word *sexuality* to me, I think...” or “When someone says the words *safer sex* to me, I feel...” etc.

Essential Ideas to Convey

- HIV/AIDS is an emotionally charged issue that is frequently associated with fear, stigma and prejudice. Myths, misunderstandings and mistreatment of clients can result from the sense of panic that surrounds HIV/AIDS. In addition, talking to clients about a life-threatening illness can be stressful and disturbing for providers.
- Fears and worries about HIV/AIDS in the workplace can increase providers’ stress levels, diminish job satisfaction, and decrease quality of services if they are not addressed adequately.
- As providers, it is important for us to be aware of our feelings, thoughts and attitudes about HIV/AIDS. If we do not address our personal reactions and emotions, we may unintentionally treat HIV-positive or at-risk clients differently than we normally treat clients, thereby diminishing the quality of care that we provide.

VALUES CLARIFICATION: WHERE DO YOU STAND ON THE ISSUES?

Objectives

1. To explore participants' attitudes and values about a range of potentially sensitive issues in reproductive health, including sexuality, HIV/AIDS, STIs, gender roles, and violence.
2. To develop understanding of and respect for the diversity of opinions within the group, and between provider and client.
3. To recognize and become aware of our own values and attitudes regarding sensitive issues, in order remain neutral while working with clients.

Time

30–60 minutes (depending on how many value statements are addressed)

Materials and Advance Preparation

- Prepare two pieces of flipchart paper by writing “Agree” on one of them and “Disagree” on the other. Post the “Agree” and “Disagree” signs on opposite sides of the room, or on one large wall, a few body lengths apart.
 - Select a list of value statements (see Facilitator Resource: *Sample values statements by topic*) or create new statements, depending on the needs and particular interests of your training group.
 - Arrange the training room so that there is adequate open space for participants to assemble on different sides of the room and in the middle.
-

Steps

1. Explain that this exercise will help us understand viewpoints that are different from our own, and to consider how this affects our effectiveness in counseling. State that there are no “right” or “wrong” answers and that we are all entitled to our own opinions.
2. Ask participants to gather in the center of the open area. Direct their attention to the “Agree” and “Disagree” signs.
3. Explain that you will be reading a series of value statements. After you read a statement aloud, the participants will decide whether they agree or disagree with the statement, or if they are unsure of their response. Those who agree will move and stand by the “Agree” sign. Those who disagree will move and stand by the “Disagree” sign. Those who are unsure will remain in the middle of the room. Let participants know that if they hear something that causes them to change their opinion during the course of the activity, they may move from one area of the room to another.

4. Read a statement out loud. Ask participants to move to the appropriate area of the room, according to their opinion. Invite comments from one or two participants from each location (“Agree,” “Disagree,” “Unsure”), to explain why they have chosen to stand where they are. The facilitator remains neutral, but can share factual information to clarify matters, as needed. After hearing a representative from each position, give participants the option of switching positions if they wish. When participants move, ask them what prompted their decision to change position.
5. Repeat this process until you have posed all the statements that you wish the group to consider.
6. Ask the participants to return to their seats for a group discussion. Facilitate a discussion based on the questions below.

Key Discussion Points

- How did you feel during this exercise? What was it like for you?
- Which statements were the most controversial and why?
- How did you feel when other people expressed values and beliefs that were different from yours?
- How did it feel to hold a minority opinion?
- How did it feel to hold a majority opinion?
- How can you explain the differences of opinion among the group?
- What differences would you expect to find between the values of providers and clients in your work place?
- How do such differences affect our work in counseling clients?
- How can providers help clients to make difficult decisions when they disagree about fundamental values?
- How can we keep our own values from influencing our counseling work in a negative way?

Considerations for the Facilitator/Training Options

This exercise can be used repeatedly in a workshop at different times by selecting different topics to address with participants. A short version (i.e., only a few statements) can be used as warm-up exercise or a longer version (i.e., many statements) can be used to explore participants’ attitudes and values in greater depth. The attached list of sample value statements is divided into different topics to help facilitators select statements that explore a particular subject area (i.e., HIV, gender, sexuality, etc.).

During this exercise, it is important to emphasize that there are no “right” or “wrong” answers. We all respond to the statements based on our own beliefs and values, and the purpose of this activity is to help explore these differences where they exist.

It is important for the facilitator to remain neutral throughout the exercise and to maintain a balance among the different viewpoints expressed.

In order to explore a range of issues, you may need to limit discussion of each statement to comments from one or two participants representing each position.

If the dynamics or conditions of the group are not right for individuals to state their own opinions publicly (e.g. if staff are not comfortable stating their opinions in front of supervisors), provide pre-written statements on pieces of paper, making sure that each participant has a copy of all the statements. Instruct participants to anonymously write their opinion about each statement by writing or checking off whether they “agree,” “disagree” or are “unsure.” Before each statement is read aloud by the facilitator, the participants can place their responses to that particular statement facedown in a pile. After the responses are mixed up, participants can select a piece of paper and argue whatever position is indicated on it for that particular statement, even if it does not reflect their own opinion.

Do not clarify the meaning of the statements, as this may influence the results. Simply read the statement again if participants ask for clarification.

If everyone moves to one side of the room (e.g. everyone “agrees” with the statement), you can ask the group how a person with the opposite opinion might defend their position. Alternatively, facilitators can step into that spot and speak out on that position, clarifying to the group that they are just stating the rationale for that position in a direct and straightforward manner.

Essential Ideas to Convey

- Beliefs and attitudes about sexuality, pregnancy, health and disease may be difficult for clients to express, particularly with strangers. Health providers have a professional obligation to remain objective and non-judgmental with clients and to avoid letting their personal beliefs and attitudes become barriers to communication with clients.
- By exploring and becoming aware of our beliefs about sensitive topics before we broach them with clients, we can learn how to stay neutral during counseling sessions.
- Health providers cannot make decisions for their clients. Clients’ right to make decisions must be respected, even if you do not personally support their choices or do not personally condone their behavior.

FACILITATOR'S RESOURCE: SAMPLE VALUES STATEMENTS BY TOPIC

Gender

- It is more acceptable for men to have multiple sexual partners than for women to have multiple sexual partners.
- Parents should not allow their daughters as much sexual freedom as their sons.
- It is more acceptable for a man to have an extramarital sexual partner than for a woman.
- It is acceptable for parents to encourage their sons to have sex before marriage.
- It is the man's responsibility to bring the condom.
- Most women who get STIs are promiscuous.
- The average woman wants sex less often than the average man.
- Women should be virgins when they marry.
- Men enjoy sex without love more than women do.
- If a woman never experiences childbirth, she is less of a "woman".
- A man is more of a "man" once he has fathered a child.
- There is no such thing as rape in marriage.
- Men have a right to extramarital sex if their wives are not sexually available.
- Polygamy protects women from being harassed by their husbands for more sex.
- Women are incapable of sexual pleasure without a man.
- A woman who suspects that her husband has an STI or HIV has the right to refuse to have sex with him.
- Pregnant women should not have sex.

HIV/AIDS

- People who don't use condoms can only blame themselves for getting HIV.
- Health care providers have the right to know the HIV status of their patients.
- A woman who knows that she is infected with HIV should not have a baby.
- People with HIV should not have sex.
- It is a crime for people who are infected with HIV to have sexual relations without informing their partner.
- People who get HIV through sex deserve it because of the behaviors that they practice.
- The government is doing an adequate job of responding to the needs of people with HIV.
- Life is hopeless and not worth living if you have AIDS.
- People with AIDS should be isolated from the rest of the community.
- AIDS is mostly a problem of prostitutes and truck drivers.
- Health care providers who are HIV-positive have a moral obligation to resign from their jobs.
- If a health care provider is HIV-positive, those who work with him or her should have the option to change their schedule if they are no longer comfortable working under those circumstances.

- Pregnant women thought to be at risk for HIV should be tested for HIV whether or not they agree to it.
- Women with HIV who get pregnant should be encouraged to terminate their pregnancy.

Sexuality

- It is acceptable for people of the same sex to have sex with each other.
- Homosexuals can change if they really want to.
- Anal sex is normal behavior.
- Sex without intercourse is not real sex.
- To be “good,” sex must end in orgasm.
- It is acceptable for someone to have more than one sexual partner at the same time.
- Oral sex is wrong.
- Men who use prostitutes are socially and sexually inadequate.
- If people go too long without sex, it is bad for them.
- The purpose of having sex is to show love for someone.
- Any sexual behavior between two consenting adults is acceptable.
- A person can lead a perfectly satisfying life while being celibate.
- Celibacy goes against human nature.
- Homosexuality – sex between women and sex between men – does not exist in our culture.
- Bisexuality – people who have sexual partners of both sexes – does not exist in our culture.

Condoms

- Condoms should be distributed to secondary school students who request them.
- Condom use is a sign of caring and not of distrust.
- Condoms ruin the enjoyment of sex.
- Couples can have an enjoyable sex life while using condoms every time they have sex.
- Educating teenagers about condoms will only encourage them to have sex.
- If my teenage son asked me for condoms, I would give them to him.
- If my teenage daughter asked me for condoms, I would give them to her.
- Educating parents about condoms will help protect teenagers from HIV.
- Condoms should not be given to teenagers without their parents’ consent.
- Condoms should be promoted not only as a means for disease prevention but also as a FP method in order to take the stigma away.

Judgments about Clients

- Most uneducated women are incapable of making their own decisions about their sexual and reproductive life.
- If providers are uncomfortable with homosexuality, it is acceptable for them to refer homosexual clients to other providers.

- It is hard for me to understand why people who know how HIV is transmitted would continue to expose themselves.
- Clients who have good, up-to-date information about HIV transmission will make good choices about keeping themselves safe.
- Prostitutes have too much pressure in their lives to change their behavior to protect themselves.

MTCT (Mother To Child Transmission)

- HIV-positive women (who know their status) should not get pregnant.
- In settings where antiretroviral treatment (AZT/Nevirapine) for the prevention of MTCT is not available, pregnant women should not be tested for HIV.
- In places where antiretroviral treatment for the prevention of MTCT is available, like in the U.S., all pregnant women should be required to get tested for HIV.
- Antiretroviral treatment for the prevention of MTCT of HIV should not be provided in settings where there is no treatment for the mother.
- Donors and PVOs/NGOs should support the provision of baby formula for HIV-positive women in developing countries.
- HIV-positive pregnant women should be enabled to assess the best options for choosing breast-feeding or baby formula methods depending on their circumstances.
- HIV-positive women who decide to become pregnant anyway should be denied access to treatment for prevention of MTCT of HIV.
- All VCT services should ensure that all clients, including men and young people, receive information about MTCT.

MYTHS ABOUT HIV/STIS*

Objectives

1. To identify common rumors and myths about HIV and other STIs, their origin and how they spread.
2. To gain an understanding of how common misconceptions about HIV and other STIs may hamper clients' abilities to protect themselves from infection.
3. To explore ways to correct HIV/STI misconceptions, rumors and myths clients may have.

Time

45–60 minutes (depending on how many skits are performed)

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
 - Prepare two pieces of flipchart paper by writing “Myths about HIV/AIDS” on one, and “Myths about other STIs” on the other, and post them to the wall. (Add additional sheets during the group brainstorming session, if necessary).
 - Props for skits, if available, including old clothes, such as lab coats, wigs, sunglasses, etc.
 - Facilitator Resource: *Sample myths or rumors about HIV/AIDS and other STIs*
-

Steps

1. Tell the participants that they will spend some time thinking about common myths or rumors about HIV and other STIs. Facilitate a brainstorming session by asking the participants to identify rumors or myths that they have heard about HIV or other STIs. These myths can relate to transmission, treatment, prevention or cures. If participants have difficulty listing myths, prompt them with some of the statements contained in the Facilitator Resource: *Sample myths or rumors about HIV/AIDS and other STIs*.
2. As participants identify myths, record them on the flipchart paper under the appropriate category – “Myths about HIV/AIDS” or “Myths about other STIs.”
3. After the participants have identified a variety of myths or rumors, divide them into small groups of 3-4 people.
4. Instruct the small groups to develop short skits, which could entail acting, singing, dancing, etc., that highlights one or more of the myths identified by the group. Each

* This exercise is adapted from: *AIDS/STD Education and Counseling in Africa*, Family Health International – AIDSTECH, 1993.

skit should address the origins of the myth and explain how to correct the myth or misconception.

5. Reconvene the larger group and invite each small group to perform its skit in turn, one following the other.
6. Once all the groups have performed, lead a discussion based on the questions below.

Key Discussion Points

- ↔ How and why are myths invented and why do they spread?

Possible responses:

- *Myths often stem from lack of knowledge and fear and are spread like gossip.*
- *As myths are passed from person to person they often become distorted resulting in rumors and misconceptions.*

- ↔ In what ways do myths play on people's fears and prejudices?

Possible responses:

- *When people are fearful or unsure about a phenomenon (such as the transmission of HIV/STIs), they might look for a culprit for the problem and unfairly accuse a person or group of people as the source of the problem.*

- ↔ How do these myths contribute to discrimination against certain people? Which people are most affected?
- ↔ Which myths are uniquely about AIDS? Which ones are unique to other STIs? Which myths could apply to both HIV and other STIs?
- ↔ Were these skits realistic? In your experience, what are the main misconceptions that clients have about HIV/AIDS and STIs?
- ↔ How can these myths affect clients' ability to protect themselves and their partners from infection?
- ↔ Do health care providers sometimes believe these myths as well? Which ones? How would this affect their ability to work with clients?
- ↔ As part of a reproductive health counseling session, how could you address clients' misconceptions about HIV/AIDS or other STIs, while respecting their knowledge and beliefs at the same time?
- ↔ How do you make sure clients fully understand the corrected information once you've dispelled a myth?

Considerations for the Facilitator/Training Options

Depending on the background and knowledge of the group, there may be some confusion between facts and myths. The facilitator must help clarify any misconception among training participants while respecting their beliefs. One useful way of doing this is by asking the group to provide clarification or explanations of misconceptions and myths.

Essential Ideas to Convey

- Information about HIV and other STIs can be distorted as it is passed from person to person, resulting in prevalent rumors or misconceptions. Fear, denial and other strong emotions can play a role in the emergence and perpetuation of myths.
- Clients often have personal beliefs about HIV/STIs that providers have no way of knowing about or understanding, unless they ask. Providers must strike the right balance between providing accurate information, respecting clients' beliefs and not making them feel inferior.
- Providing accurate information about HIV and STIs is an essential component of high quality family planning counseling and helps ensure informed choice. Therefore it is important that providers ask clients about their knowledge and understanding about HIV/STI transmission and prevention and correct any misconceptions they may have.
- Often HIV myths and misconceptions are focused on specific groups who are marginalized in a community (commercial sex workers, for example). It is important for health care providers to recognize how these myths contribute to discrimination against these groups so we can help fight this stigma and ensure that our services are welcoming and accessible to all groups.

FACILITATOR RESOURCE: SAMPLE MYTHS OR RUMORS ABOUT HIV/AIDS AND OTHER STIS

Myths about HIV/AIDS

- You can catch AIDS from a toilet.
- You can get AIDS from using an infected person's utensils or living in the same house.
- AIDS is a disease that only affects homosexuals and sex workers.
- If someone looks healthy, then they can't be infected with HIV.
- AIDS can be caused by the evil eye.
- There is a cure for AIDS.
- You can get infected with HIV from mosquito bites.
- If a man withdraws or "pulls out" before ejaculation, this will prevent HIV transmission.
- A man can be cured of HIV if he has sex with a virgin.
- People with HIV/AIDS deserve it because of their immoral behavior.
- There is nothing you can do if you are meant to have AIDS – it is your fate.
- Condoms are useless because they break easily and don't work to prevent HIV transmission.
- If you know and trust your partner you cannot get infected with HIV.
- You can get AIDS from hugging or kissing an infected person.
- You can get infected with HIV by donating blood.

Myths about other STIs

- You can get STIs from sharing clothes.
- You can get STIs from swimming in a pond or public pool.
- You can always tell when someone has an STI by the way they look.
- If you wash your genitals (with soap or alcohol) right after sex you can prevent STIs.
- You can catch STIs from a toilet.
- You can get STIs from sharing soap.
- Masturbation can cause STIs.
- If you have an STI then you must be promiscuous.
- Bicycle riding can cause STIs in women.
- STIs can be caused by the evil eye.
- You always know when you have an STI.
- If you know and trust your partner you cannot get STIs.
- Only prostitutes get STIs.
- Condoms are useless because they break easily and don't work to prevent STI transmission.
- Only unmarried people get STIs.
- If you have an STI once, you become immune and cannot get it again.
- A man cannot transmit an STI if he withdraws before ejaculation.

ESSENTIAL KNOWLEDGE ABOUT HIV/AIDS AND STIs

Objectives

1. To provide factual information about HIV/STI infection and transmission to participants.
2. To provide an opportunity for participants to educate each other about HIV/STI infection and transmission.

Time

60 - 90 minutes (depending on the number of topics presented)

Materials and Advance Preparation

- **Important:** Facilitators will need to gauge the level of knowledge regarding HIV/STIs of the training group prior to structuring this exercise. Facilitators will also need to supply their own factual information about HIV/STIs to participants to help them prepare for this exercise. Some good sources of basic information about HIV/STIs are EngenderHealth's on-line mini-courses on HIV/AIDS and STIs (<http://www.engenderhealth.org/res/onc/trh-index.html>), which are also available on CD rom. Facilitators are encouraged to use local sources of information on HIV/STIs, or other websites such as UNAIDS (www.unaids.org), or thebody.com (www.thebody.com).
 - Participants will need to receive the background information identified by the facilitators prior to the training workshop. If possible, it is recommended that participants receive the background information at least one week before the workshop in order to familiarize themselves with the content matter. If this is not feasible, participants should be given the background information at the beginning of the workshop and instructed to read the material before this activity takes place.
 - Extra copies of factual information about HIV/STIs from the resources identified by the facilitators.
 - Prepare slips of paper with the topics written on them (see Facilitator Resource: *Suggested topics: HIV/STI information*).
 - A basket or envelope out of which participants can pick slips of paper with topics written on them.
 - Flipchart paper
 - Markers
 - Tape
 - Optional: props, including balloons, pelvic models, flipcharts or diagrams of the human body, construction paper, string, clay, etc.(for the teams to use as models during their presentations)
-

Steps

1. Divide participants into small groups of three or four. Explain that each group will receive two or three topics (depending on time and needs of the group) related to HIV or other STIs. The groups will study the topics and then do a short and clear

presentation on each topic to educate the rest of the group. The groups will educate the other participants as if they are doing an in-service training on their particular topic.

2. Instruct a volunteer from each group to pick two or three pieces of paper out of the basket or envelope. The topics that are written on the pieces of paper will be the subject of each team's presentations.
3. Provide each team with extra copies of the factual information about HIV/STIs identified by the facilitators and ample pieces of flipchart paper and markers. **(Optional:** Invite them to also use the props provided for their presentations, including balloons, pelvic models, diagrams of the human body, etc.)
4. Instruct the teams to use the extra copies of the information provided as reference materials, as well as drawing on their previous knowledge, to plan a 10-15 minute presentation on each of their topics. Encourage them to develop short, engaging presentations on the most pertinent information relating to their topics. Encourage them to draw pictures or to write key phrases on the flipchart paper as a part of their presentations. If props are provided, encourage the participants to incorporate them into their presentations.
5. Once the teams have finished preparing their presentations, invite each group to present them. Stop after each presentation and facilitate a brief large group discussion about the accuracy, thoroughness and clarity of the information presented. Encourage other participants to ask any questions they may have. The facilitator must also make sure to correct any factual inaccuracies and add important pieces of information omitted immediately after each presentation.
6. After all the teams have presented on all their topics, facilitate a large group discussion based on the questions below.

Key Discussion Points

- How did it feel to summarize detailed information into concise messages?
- After viewing all the different types of presentations, which techniques did you find helpful for conveying the information?
- How can we feel more prepared to respond to clients' inevitable concerns and questions about HIV and other STIs?

Possible responses include:

- *Keep HIV/STI resource materials on hand at the clinic for reference.*
- *Develop or purchase job aids on HIV and STIs for quick reference during counseling sessions.*
- *Ask co-workers who may have more experience on these issues to share their knowledge.*
- *Invite a local AIDS NGO to conduct and in-service training on HIV/STI with facility staff.*

- *Establish HIV self-help groups, support groups or a peer educator program for clients and community members either at the clinic or in the community.*
- ↔ How would you respond to clients if they raise issues that you are unsure of or feel that you do not know enough about?

Considerations for the Facilitator/Training Options

This activity needs to be tailored to the needs of the particular group that is being trained. For groups with less of a knowledge base, you might need to take more time to answer questions and clarify information.

If feasible and appropriate, invite an outside expert on HIV/STIs to give a talk to participants on HIV/STI information as a part of this exercise, or prior to it.

Essential Ideas to Convey

- Information about STIs, particularly HIV, is subject to change as scientists discover new details about the infection and treatment process. As counselors, it is important to keep up with information in order to respond to clients' questions as accurately as possible.
- Practicing talking about factual information related to infection can help providers feel more comfortable when they work with clients on these issues.

FACILITATOR’S RESOURCE: HIV/STI INFORMATION – SUGGESTED TOPICS

- What is the difference between HIV and AIDS?
- What are the major modes of HIV transmission?
- What are some of the symptoms of AIDS?
- What are some ways that HIV can be prevented?
- How can HIV be detected?
- What is meant by the “window period”?
- What information can HIV antibody testing provide?
- What do “positive” and “negative” HIV antibody test results mean?
- What is VCT?
- What are the stages of HIV infection?
- What are STIs and how do people get them?
- What are some of the most common STIs? Describe a few of them.
- What is the difference between a Reproductive Tract Infection (RTI) and an STI?
- What does it mean to have an asymptomatic infection with an STI?
- Which STIs can be treated and cured? Which ones can be treated but not cured?
- What are some common signs and symptoms of STIs in women and in men?
- What are some complications of STIs if left untreated?
- What is MTCT of HIV? What are the main modes of transmission from mother to child? What are some options for treatment or prevention?
- Why should RH services focus on STIs/RTIs and HIV/AIDS?

HIV/STI INFORMATION GAME

Objectives

1. To provide an opportunity for participants to learn about and share their knowledge of HIV and other STIs in a game format.
2. To reinforce information that will be critical to participants' abilities to provide technically accurate, as well as non-judgmental, counseling to clients.

Time

20 – 60 minutes (depending if it is used as a quick “warm-up” activity or more in-depth)

Materials and Advance Preparation

- Write multiple choice questions on HIV and other STIs or use sample questions provided (see Facilitator Resource: *Sample questions for HIV/STI information game*). If this activity is a warm-up, select only 3 questions at most. For a more in-depth activity, select more questions.
 - Flipchart paper and markers or black board and chalk (for keeping score for teams)
 - Small prizes for the winning team (i.e., candy, key chains, etc.)
-

Steps

1. Divide the participants into 3 teams of equal numbers (Teams A, B and C)
2. Explain to the participants that they are going to play a game in which 3 teams have a friendly competition to win a small prize. The teams will be competing to show their knowledge of HIV and other STIs.
3. Instruct each team to choose one person to be the first “player” and another to be the first “helper,” while the rest of the group is the audience. Explain that each team will switch roles after the “player” has responded to a question, so that everyone in the team gets to be a player or a “helper” at least once. (Note: if this activity is done as a warm-up, not all participants will be able to serve as “player” or “helper.”)
4. Explain that the player will respond to a question about HIV or STIs that has 5 multiple-choice options, selecting the option that he or she thinks is correct. If the player is unsure of an answer, he or she can ask for assistance from the designated “helper” from their team. The helper teammate then tells the player which choice he or she thinks is correct. The player then considers the helper’s answer when deciding on his or her final choice of answers to the question. A team scores a point each time that it answers a question correctly. A team scores a negative point for every wrong answer. Each team will respond to 5 questions (or fewer, if this is a warm-up, or more, if a longer activity is desired).

5. Begin the game by reading a question to the first player on Team A. Make sure to read all of the multiple-choice answers. Remind the participants that they can call on the helper if they are unsure of an answer.
6. After Team A responds, tell them if their answer is correct or not. Mark their score on the flipchart paper or blackboard. Move on to Team B, asking their first player another question, indicating whether their answer is correct or not, and marking their score. Repeat the process with Team C. Once all three teams have responded to one question, start on the second question for Team A. Remind them to rotate players and helpers so that new people get a chance to play. Continue this process until all the questions have been answered.
7. When questions are answered wrong, or there appears to be confusion about the correct answer, the facilitator should pause the game and ask the audience for the correct answer or clarification. If the audience cannot answer, the facilitator should explain the correct answer.
8. Count the final score and reward the winning team with a small prize.

**FACILITATOR'S RESOURCE:
SAMPLE QUESTIONS FOR HIV/STI INFORMATION GAME**

1. Untreated STIs can lead to the following conditions except:
- a. infertility
 - b. high blood pressure
 - c. transmission from an infected woman to her baby
 - d. pelvic inflammatory disease
 - e. inflammation of the testes

Correct answer: (a) high blood pressure

2. Which of the following is a viral infection?:
- a. Chlamydia
 - b. Genital warts
 - c. Nongonococcal urethritis
 - d. Syphilis
 - e. Gonorrhea

Correct answer: (b) Genital warts, also known as HPV, is a viral infection

3. Which of the following is caused by a protozoan infection?:
- a. Trichomoniasis
 - b. Hepatitis B
 - c. Chlamydia
 - d. Chancroid
 - e. Herpes

Correct answer: (a) Trichomoniasis

4. HIV cannot be transmitted through which of the following bodily fluids?:
- a. Blood
 - b. Saliva
 - c. Semen
 - d. Breast milk
 - e. Vaginal fluid

Correct answer: (b) Saliva. While it contains HIV, it does not contain enough to cause infection.

5. Which of the following can cause complications for a baby born to an infected mother?:
- a. Hepatitis B
 - b. Herpes
 - c. Gonorrhea
 - d. Syphilis
 - e. All of the above

Correct answer: (e) All of the above

6. Which of the following is not a symptom of HIV/AIDS?:
- a. Diarrhea lasting several weeks
 - b. A white coating on the tongue
 - c. Unexplained weight loss
 - d. Migraine headaches
 - e. Night sweats

Correct answer: (d) Migraine headaches

7. A person can become infected with HIV through all of the following except:
- a. exposure to urine
 - b. unprotected anal sex
 - c. having sex with their spouse
 - d. sharing injecting drug needles
 - e. breastfeeding

Correct answer: (a) exposure to urine

8. All of the following can reduce the risk of HIV infection except:
- a. never sharing scarification tools
 - b. practicing manual sexual stimulation
 - c. taking an HIV test periodically
 - d. using a condom for every act of intercourse
 - e. abstaining from sex

Correct answer: (c) taking an HIV test; it can tell your HIV status but it won't prevent infection

9. You can tell a person has HIV:
- by the symptoms that he or she has
 - if he or she is a prostitute, homosexual or drug user
 - by whether or not a woman breastfeeds her child
 - by a blood test that determines a person's HIV status
 - if a man's penis is uncircumcised

Correct answer: (d) by a blood test that determines a person's HIV status

10. The most common blood tests used for determining HIV look for:
- the presence of antibodies to HIV
 - opportunistic infections
 - t-cell count
 - the presence of HIV
 - white blood cells

Correct answer: (a) the presence of antibodies to HIV

11. HIV antibody tests cannot detect HIV infection until approximately how long after exposure to HIV?:
- 3 hours
 - 3 days
 - 3 months
 - 3 years
 - up to 3 decades

Correct answer: (c) 3 months

12. The following STIs have no known cure except:
- HIV
 - herpes
 - HPV
 - chlamydia
 - hepatitis B

Correct answer: (d) chlamydia

13. It is possible for a man to infect another man with HIV through all of the following except:
- anal sex without a condom
 - oral sex without a condom
 - sharing drug injecting needles
 - manually stimulating each other's penises with unbroken skin
 - an infected blood transfusion

Correct answer: (d) manually stimulating each other's penises with unbroken skin

14. For prevention of mother to child transmission of HIV, Nevirapine is given to HIV-infected pregnant women:
- at the onset of labor
 - early in pregnancy
 - neither a. nor b.
 - both a. and b.

Correct answer: (a) at the onset of labor

15. With regard to HIV infection, what is the highest-risk sexual behavior?:
- Receptive vaginal sex without a male or female condom
 - Insertive vaginal sex without a male or female condom
 - Receptive rectal sex without a condom
 - Insertive rectal sex without a condom

Correct answer: (c) Receptive rectal sex without a condom

16. The definition of "dual protection" includes:
- abstinence
 - use of condoms
 - mutual monogamy between uninfected partners combined with a contraceptive method
 - all of the above

Correct answer: (d) all of the above

17. Why are women biologically more vulnerable to HIV infection than men?
- The concentration of the virus is higher in semen than in vaginal secretions
 - Younger women are more at risk because their immature cervix and scant vaginal secretions offer less resistance to HIV.
 - Women have a larger genital mucosal surface area, which increases exposure to the virus.
 - All of the above

Correct answer: (d) All of the above

18. Which of the following elements are included in human sexuality?

- a. Sex
- b. Gender roles
- c. Sexual orientation
- d. Sexual identity
- e. All of the above

Correct answer: (e) All of the above

HIV/STI RISK CONTINUUM

Objectives

1. To understand the risk of transmission of HIV/STIs for various practices and the factors that influence risk.
2. To dispel myths about HIV/STI transmission.

Time

60 minutes

Materials and Advance Preparation

- Prepare four cards using letter-sized colored cards or paper, with the following titles: “High Risk,” “Low Risk,” “Medium Risk,” “No Risk.”



- Post the title cards (“High Risk,” “Medium Risk,” “Low Risk,” “No Risk”) high on a wall, with plenty of space between each for participants to post behavior cards. Place the cards in the order suggested above in order to create a continuum from “High risk” to “No risk.”
 - Prepare behavior and myth cards (see Facilitator Resource: *Sample behavior or myth cards* or make your own) using letter-sized paper or cards, with one behavior or myth per card or piece of paper.
 - Make sure that the space in front of the wall is cleared so that the participants have enough room to mingle as they post their cards.
 - Tape (prepare many pieces in advance for participants to stick cards or pieces of paper to the wall rapidly).
 - Prepare a flipchart with the three main modes of HIV transmission (see below)
 - Flipchart paper
 - Markers
 - Participant Handout: *HIV/STI Levels of Risk Continuum – Summary Table*
 - Participant Handout: *Risk Continuum – Additional Considerations*
-

Steps

1. Distribute all of the cards with behaviors and myths to the participants, trying to ensure that each participant has the same number of cards. Provide the participants with an adequate number of pieces of tape to post their behavior or myth cards on the wall.
2. Instruct the participants to read their cards and to determine on their own what level of HIV and STI risk that their card poses. Then ask the participants to go to the wall all at once and place each of their cards along the continuum according to their

assessment of the risk of what's written on their card ("High Risk," "Medium Risk," "Low Risk," "No Risk).

3. Once all the cards are placed, facilitate a discussion based on the key discussion points below. Be sure to allow participants to answer their peers' questions and to share their knowledge of the relative risk of various behaviors. Affirm accurate responses and correct any misconceptions that do not get resolved in discussion among participants.

Key Discussion Points

- ↪ Do you disagree with the placement of any cards? Where should they go instead and why?
 - ↪ Are you confused by the placement of any cards? Why is a particular card placed where it is along the continuum?
 - ↪ Which cards did you find most difficult to place along the continuum?
 - ↪ Which cards can be categorized as myths? Are there other myths about HIV transmission you've heard about in your community? Where do these myths come from and how can we dispel them?
 - ↪ How can we translate the information we learned in this session into simple, clear messages for clients to take home with them?
 - ↪ How can you help clients explore the possibility of engaging in activities that are less risky but still sexually pleasurable?
 - ↪ How will the information learned in this exercise apply to your work as counselors in sexual and reproductive health?
4. Following the discussion, distribute the hand out *Levels of Risk Continuum* and review with the group.
 5. Using a prepared flipchart, conclude the session by presenting an overview of HIV transmission as indicated below.

Overview of HIV Transmission

HIV is spread through three main modes. These modes of transmission are as a result of exposure to body fluids (blood, semen, vaginal fluids, and breast milk) of infected individuals. Specifically, HIV can be transmitted through:

Sexual contact:

- Vaginal sex
- Anal sex
- Oral sex

Blood contact:

- Injections/needles (sharing needles, IV drugs, drug paraphernalia, or injury from contaminated needles or other sharp objects)
- Cutting tools (using contaminated skin-piercing instruments, such as scalpels, needles, razor blades, tattoo needles, circumcision instruments)
- Transfusions (receiving infected blood or blood products) or transplant of an infected organ
- Contact with broken skin (exposure to blood through cuts or lesions)

Mother-to-child transmission (MTCT):

- Pregnancy
- Delivery
- Breastfeeding

Considerations for the Facilitator/Training Options

Instead of providing pre-written behavior or myth cards, as a first step in the activity, the group can brainstorm a list of sexual behaviors that are practiced in their culture and of all the ways someone can get HIV/STI. Once the list is determined, the different behaviors and factors are written on separate cards, and the exercise is conducted as described below.

This exercise can be long and involved, or conducted quickly, depending on how long the group takes to analyze the risk continuum and to dispel the myths. For example, when discussing the placement of the cards, the facilitator can either provide an overall summary of the risk continuum when working with a more advanced training group, or discuss the placement of each card, one by one, for a less knowledgeable group. Also, the facilitator can provide fewer cards, by, for example, concentrating on actual HIV/STI risks exclusively rather than incorporating myths as well.

It is recommended that the facilitator add cards with local myths to tailor this exercise to the needs of each group.

When appropriate, this exercise can be conducted using behaviors that are related to the work place such as “cleaning up a spill with latex gloves” (see sample list attached).

The risk continuum can also include the category “unknown” or “unsure of risk.” Participants can place cards in this category either because they are unsure of the level of risk, or because the card itself does not provide sufficient information to make a judgment.

Note: Sometimes participants begin the activity by placing behaviors that they find offensive in the “high risk” category, even if they present little risk of infection. If this happens in your group, recall how attitudes and judgments can influence a counselor’s assessment of risk.

Essential Ideas to Convey

- Variations in sexual behaviors, relationships and social factors can influence HIV and STI risk. Risk of transmission depends on the context in which a particular behavior occurs, as well as other factors such as age (younger women may be more susceptible due to less mature vaginal tissue), gender, whether or not a partner is infected, whether or not a person is a “giver” or “receiver” of a sexual behavior, and the difficulty of knowing a partner’s sexual history and infection status.
- HIV is not as easily transmitted as other STIs through unprotected vaginal or anal intercourse. In addition, some sexual behaviors may present little risk of HIV transmission, but pose significant risk for transmission of other STIs; for example, while orally transmitted gonorrhea and herpes are fairly common, HIV is rarely transmitted through oral sex.
- While there are some activities for which we can definitively determine their level of risk, others are less clear cut (i.e. oral sex), and this can be confusing to providers and clients.
- As counselors we must understand and respect that people have different understandings about what risk means in their life. Some people are willing to take risks, while others may not think they are at risk. We must work with clients to better understand their perception of HIV/STI risk and help them find ways to reduce the risk in their life.
- Once people perceive their risk, most make changes in their behavior in incremental steps, over a period of time. Therefore, emphasizing harm reduction (how clients can reduce rather than entirely eliminate their risk) is often a good strategy. For example, a woman may find it difficult to use condoms for every act of intercourse, but if she can increase the frequency of condom use, she may reduce her risk somewhat by decreasing her exposure.
- It is important for clients to know that there are sexual activities that are pleasurable, erotic and creative and pose little or no risk of infection. Safe sex can be pleasurable as well as healthy.

FACILITATOR'S RESOURCE: SAMPLE BEHAVIOR OR MYTH CARDS

Abstinence
Masturbation
Manual sexual stimulation
Sex with a monogamous, uninfected partner
Oral sex on a man (fellatio) with a condom
Oral sex on a man (fellatio) without a condom
Oral sex on a man (fellatio) without ejaculation in the mouth
Oral sex on a woman (cunnilingus) with a barrier
Oral sex on a woman (cunnilingus) without a barrier
Vaginal sex with a condom
Vaginal sex without a condom
Vaginal sex using oral contraceptives
Vaginal sex using spermicides
Vaginal sex with multiple partners always using a condom
Anal sex with a condom
Anal sex without a condom
Massage
Having unprotected sex with your partner or spouse
Having safer sex with someone of the same sex
Having unprotected sex with someone of the same sex
Hugging a person with HIV
Deep (tongue) kissing
Vaginal sex with withdrawal prior to ejaculation
Using sharp instruments to cut the skin
Sharing injection needles
Sitting on a public toilet seat
Getting bitten by a mosquito
Breastfeeding from an HIV-infected mother
Receiving a blood transfusion
Vaginal sex using a diaphragm
Helping someone with a nosebleed
Sharing eating utensils with an HIV-infected person
Rubbing genitals together fully clothed
Rubbing genitals together without penetration, unclothed
Donating blood
Anal sex with multiple partners without condoms
Anal sex with multiple partners with condoms
Getting pierced
Sex with a man who has had a vasectomy
Vaginal sex using an IUD
Rubbing sweaty bodies together
Shaking hands with an HIV-positive person

Labor and delivery (risk to child)
Breastfeeding
Sharing needles cleaned with bleach
Biting as part of sexual play
Going to the dentist
Swimming in a public pool
Performing a pelvic exam without gloves
Sticking yourself with a used needle in the lab
Cleaning up a blood spill with latex gloves
Telling each other sexual fantasies
Using the same condom twice
Intercourse using an oil-based lubricant and a condom
Having “dry” vaginal intercourse
Sex with a commercial sex worker
Sex during menstruation, without a condom
Sex with an uncircumcised man without a condom
Sex with a circumcised man without a condom

CONTRACEPTIVE METHODS: LINK TO HIV/STI PREVENTION AND SEXUALITY*

Objectives

1. To clarify the relationship of each family planning method to pregnancy prevention, HIV/STI transmission and sexual relations.
2. To develop skills addressing contraceptive effectiveness and the effectiveness of contraceptive methods in preventing HIV/STIs, as well as their impact on sexuality, with clients as an integral part of dual protection counseling.

Time

90 minutes

Materials and Advance Preparation

- Flipchart paper
 - Two sets of pieces of paper with the names of contraceptive methods written on them, as well as the header signs – “Most Protective”, “Somewhat Protective”, “No Protection” (see below)
 - Facilitator Resource: *Pregnancy and HIV/STI prevention effectiveness – Answer Key*
 - Participant Handout: *Contraceptive Methods: Effectiveness, Impact on Sexuality, and Prevention of HIV/STI Transmission*
 - Prepare case studies on contraception, sexuality and HIV/STI prevention, or use handouts provided (*Case studies on contraception, sexuality and HIV/STIs* and Facilitator Resource: *Case studies on contraception, sexuality and HIV/STIs – Answer Key*)
 - Markers
 - Tape
-

Steps

1. Before the session, prepare two sets of cards with all locally available contraceptive methods written on them. The two sets of cards should be on different colored paper (for example one set on blue paper, the other on green). If you don't have more than one color paper, write “pregnancy” in the bottom corner of each card in the first set, and “HIV/STIs” on each card in the second set). The cards should include all of the following that are available in your setting:
 - male condom
 - female condom
 - birth control pill
 - injectables (Depo Provera)
 - implants (Norplant)

* Adapted from: *Positive Images: Teaching Abstinence, Contraception, and Sexual Health A New Approach to Contraceptive Education*, P Brick and B Taverner, Planned Parenthood of Greater Northern New Jersey, Morristown, NJ, 2001.

- spermicidal foam, cream, film or jelly
 - continuous abstinence
 - periodic abstinence
 - tubal ligation (tubal occlusion)
 - vasectomy
 - IUD
 - withdrawal (coitus interruptus)
 - no method
 - diaphragm
 - emergency contraception
 - natural family planning (i.e., fertility awareness method)
 - lactational amenorrhea method (LAM)
2. Next prepare three pieces of paper, each with one of the written on it in large lettering: “High Effectiveness,” “Moderate Effectiveness,” and “Low Effectiveness.” Tape these signs to the wall at the front of the room, leaving a good amount of space in between each.
 3. It is also a good idea to have individual pieces of tape torn off before the session in preparation for this activity. These can be placed at the edge of a table or wall. Tear off enough pieces for both sets of contraceptive methods.
 4. Distribute the first set of contraceptive method cards to the participants, one card per person (hold on to the second set), and ask them to think about how much protection the method on their card provides against pregnancy. Ask them to take a piece of tape and tape their sheet under the appropriate category: “High Effectiveness,” “Moderate Effectiveness,” or “Low Effectiveness.” If there are not enough cards to distribute one per participant, split the large group into pairs or groups of three and give each one a card that they will then discuss and tape on the wall.
 5. Once all the sheets are up, ask the group whether they agree with everything that is up on the board. Invite anyone who sees anything they feel is inaccurate to come up and move the piece of paper to another category.
 6. Take the second set of contraceptive methods, and distribute them to the group again. This time, ask them to think about how much protection the methods provide against HIV/STIs, and to post their sheets accordingly.
 7. Once all the sheets are up, ask the group whether they agree with everything that is up on the board. Invite anyone who sees anything they feel is inaccurate to come up and move the piece of paper to another category.
 8. Then, using the Facilitator Resource, *Pregnancy and HIV/STI prevention effectiveness – Answer Key*,” move any remaining sheets from category to category to

ensure that they have a correct understanding of each method's level of protection against pregnancy and HIV/STIs.

9. Lead a group discussion, asking the question:

- What do you notice when you look at the wall? Which methods are most effective at preventing pregnancy only? HIV/STIs only? Pregnancy and HIV/STIs?

Note: The activity will reveal the fact that while the hormonal methods are highly effective at preventing pregnancy, they offer no protection against STIs. The final picture will show that the male condom, the female condom, and continuous abstinence are the most effective methods for preventing both pregnancy and STIs.

When discussing transmission in general, and methods that offer little or no protection against HIV/STIs, especially methods like withdrawal, it will be important to share information about pre-ejaculatory fluid. HIV and other STIs can be transmitted through pre-ejaculate. There is also some debate about whether pre-ejaculate contains sperm and can therefore cause a pregnancy. Generally the consensus has been that pre-ejaculate itself does not contain sperm but that if a male has not urinated since his last ejaculation, live sperm can remain inside the urethra and therefore be pushed out by the pre-ejaculate. However, one study has found that pre-ejaculate does contain what appear to be inactive sperm¹. Therefore, although withdrawal can be fairly effective for pregnancy prevention when used consistently and correctly, it is not likely to be highly effective against HIV/STI transmission.

This is also a time when you can highlight dual protection (using male or female condoms to prevent both pregnancy and HIV/STIs), or dual method use (using two methods, for example, both a hormonal and barrier method to prevent pregnancy as well as HIV/STIs.) After introducing this concept, you can discuss the likelihood of clients doing this.

10. Divide the participants into smaller groups of 4 people. Assign each group several of the contraceptive methods, and ask them to discuss the following:

- How could each of these methods positively affect sexuality?
- How could each of these methods negatively affect sexuality?

11. After a few minutes, ask each smaller group to present their methods to the larger group. Discuss responses and reactions from the rest of the group, asking the following questions:

- What positive and negative aspects of contraception came up repeatedly in the different groups?

Possible responses include:

- *Lack of information*
- *Lack of access to the method*

¹ *Contraceptive Update: Withdrawal Popular in Some Cultures*, Network: Fall 1996, Vol. 17, No.1

- *Discomfort touching one's own body*
 - *Discomfort talking with partner about the method*
 - *Partner's refusal to use method*
 - *Interferes with spontaneity of sex, etc.*
- ↪ Why is it important to talk with clients about the impact of contraceptive methods on sexuality?
- Possible responses include:
- *Information about the impact of methods on sexuality helps clients to make an informed choice about the method that is best for them.*
 - *If a method has an unexpected negative impact on a client's sexual life, he or she may stop using the method.*

12. Distribute and discuss the handout, *Contraceptive Methods: Effectiveness, Impact on Sexuality, and Prevention of HIV/STI Transmission*. Identify positive and negative effects that did not come up during the discussion.
13. To conclude the exercise, distribute the handout, *Case studies on contraception, sexuality and HIV/STIs*. Ask for a volunteer to read the first case study aloud. Facilitate a discussion about how to counsel the client in the case study. Repeat with the second case study. Use the Facilitator Resource: *Case studies on contraception, sexuality and HIV/STIs – Answer Key* to help guide the discussion.

Considerations for the Facilitator/Training Options

If you have additional time, you might consider adding small group work using case studies on contraception, sexuality and HIV/STIs (see attached handout: *Case studies on contraception, sexuality and HIV/STIs* and Facilitator Resource: *Case studies on contraception, sexuality and HIV/STIs – Answer Key*). This can be done by distributing case studies to small groups and asking them to determine how to counsel the client in question. You can use the two sample case studies provided or make-up your own. The cases can then be presented in the larger group, and then discussed. Sample answers to the case studies included are provided in the Facilitator Resource: *Case studies on contraception, sexuality and HIV/STIs - Answer Key*.

Essential Ideas to Convey

- Not all family planning methods are the same. Each has its own effectiveness rates for preventing pregnancy and for preventing HIV/STIs. Often, the most effective methods against pregnancy offer little protection against HIV/STIs (with the exception of the condom).
- Each method also has negative and positive consequences for the sexual experience of the people using them. What may be a negative impact on sexuality for one person may be a positive consequence for another (for example, some people may like male condoms because they can prevent premature ejaculation; others may dislike them because they have difficulty maintaining an erection while using them).
- To ensure that clients have the necessary information to make an informed choice about contraception, providers must discuss the degree to which methods protect against HIV/STI as well as pregnancy, and should explain the potential positive and negative effects methods have on sexuality.
- If clients are not informed about the potential negative impact some methods may have on their sexuality, or that of their partner, they may discontinue using the method.

FACILITATOR RESOURCE: PREGNANCY AND HIV/STI PREVENTION EFFECTIVENESS – ANSWER KEY

FOR PREGNANCY ONLY

High Effectiveness

- Norplant (implants)
- The Pill
- Emergency Contraception
- IUD
- Depo-Provera (injectables)
- Female Condom
- Continuous Abstinence
- Male Condom
- Tubal Occlusion (tubal ligation)
- Vasectomy
- LAM (has failure rate of only 0.5-1.5%)

Moderate Effectiveness

- Diaphragm
- Fertility Awareness
- Coitus Interruptus (withdrawal)
- Spermicides

Low Effectiveness

- No Method
- Periodic Abstinence

FOR HIV/STIS ONLY

High Effectiveness

- Male Condom
- Female Condom
- Continuous Abstinence

Moderate Effectiveness

- Diaphragm (against gonorrhea and chlamydia only)

Low Effectiveness

- Norplant
- The Pill
- Depo Provera
- Fertility Awareness
- Emergency Contraception
- No Method
- Periodic Abstinence
- Withdrawal
- Tubal ligation
- Vasectomy
- IUD
- LAM
- Spermicide

FACILITATOR RESOURCE: CASE STUDIES ON CONTRACEPTION, SEXUALITY AND HIV/STIS – ANSWER KEY

Case study 1 (on erection problems with condom use)

Ana is a 22-year old woman who has been married for 4 years. She has 2 young children. She knows that her husband has other partners and has recently convinced him to use condoms as a form of birth control because she told him that she would like to wait a while to have another child. She reveals to you that the real reason she would like to use condoms is to protect herself from STIs. Since they've been using condoms, however, her husband has been having problems maintaining his erection during sex. He now refuses to use condoms. The whole problem has gotten so bad that he is drinking a lot and even avoiding sex. Ana is confused and worried that his losing his erection is her fault. She really would like him to use condoms, though.

How do you counsel her?

Sample Answer:

- *Congratulate her and praise her for her concern about her health and taking action to protect herself.*
- *Explain that many men may experience a loss of sensation from condom use, but that there are ways to address this. Tell her that it is normal for men to experience problems with erections from time to time, particularly if they are using condoms. Assure her that it is not her fault.*
- *Support her to attempt condom use again with her husband.*
- *Give her specific suggestions to enhance sensation for her husband, such as: putting a drop of water-based lubricant inside the tip of the condom; applying the condom on him while stimulating him; manually stimulating him for a while before putting on the condom for intercourse, etc.*
- *If female condoms are available in your area, discuss with Ana the possibility of her using them. The looser fit may be more comfortable for her husband.*
- *Suggest that she invite him to come see you together if she thinks that would be helpful.*

Case study 2 (on client thinking STI symptoms are side effects of contraception)

Valerie, an 18-year old student, comes to your clinic because she has recently become sexually active for the first time and wants a family planning method. She chooses oral contraceptives, but returns a few weeks later complaining that her partner says she is “too wet.” She thinks that the pills are causing the wetness and asks about switching methods.

What could be causing the “wetness” and what issues would you have to explore with Valerie to provide her with good counseling?

Sample Answer:

The wetness could be related to several factors. Since Valerie is recently sexually active, she may not be familiar with her sexual response. The wetness could be normal vaginal lubrication as a result of sexual excitement. Her boyfriend may not understand this either. Alternatively, if

the discharge is profuse, itchy, smelly, or persistent, it could be related to an RTI or STI. Oral contraceptives would not cause vaginal “wetness.”

In order to provide good counseling to Valerie, it would be helpful to explore the following issues:

- *What is the nature of the relationship with her partner? (How is it going? How long have they been together?, etc.)*
- *Does either Valerie or her boyfriend have other partners?*
- *How is their communication? Have they ever discussed issues related to sexuality, contraception, condom use?*
- *Is she experiencing any other symptoms besides “wetness”?*
- *Does she have any side effects with the pill?*
- *Is she familiar with male and female sexual response?*
- *What does she know about STIs, including HIV?*

Given that Valerie has recently become sexually active and that as young people she and her boyfriend may be more likely to have multiple sex partners, it would be important to address the following issues:

- *Does she think that she could be at risk of HIV/STIs?*
- *Does she know how to use a condom (male or female)?*
- *Would she consider condom use for dual protection if she perceives herself to be at risk?*
- *Would it be helpful to invite her partner to the clinic for a joint or individual counseling session?*

HIV VOLUNTARY COUNSELING AND TESTING (VCT) OVERVIEW

Objectives

1. To provide participants with information about voluntary HIV counseling and testing (VCT).
2. To help participants work with clients to think through the question about whether or not they would choose to take an HIV test (if testing is available).

Time

45-60 minutes

Materials

- Flipchart paper
 - Markers
 - Participant Handout: *HIV Voluntary Counseling and Testing*
 - Participant Handout: *Advantages and Disadvantages of VCT*
-

Steps

1. Inform the participants that you will be discussing voluntary counseling and testing for HIV.
2. Ask the participants each of the key discussion questions below. Ask for their ideas and input for each question, and then provide additional information from the handouts, *HIV Voluntary Counseling and Testing*, and *Advantages and Disadvantages of VCT*," if specific points were not mentioned during the discussion.
3. Distribute the handouts, *HIV Voluntary Counseling and Testing* and *Advantages and Disadvantages of VCT* for participants' reference.

Key Discussion Points

→ What is an HIV test?

Possible responses:

- *An HIV test is used to determine whether or not a person is infected with human immunodeficiency virus (HIV), which causes AIDS. An HIV test usually involves taking a sample of blood, oral fluid (fluid from the mouth), or urine from a person and then analyzing the sample in a laboratory. These tests look for antibodies to HIV. Antibodies are proteins produced by the immune system to fight a specific germ.*
- *However, when a person is infected with HIV, it generally takes three months, and sometimes up to six months, for his or her body to produce detectable levels of antibodies (96% of infected individuals develop antibodies within 12 weeks). This length of time is called the window period. During this period, a person will not test positive even if he or she is infected with HIV. The most common HIV tests are more than 99.5% accurate.*
- *Anyone who has an HIV test should only do so voluntarily. It is strongly recommended that clients be counseled both before and after taking the test.*

➤ What is pre-test counseling?

Possible responses

- *Pre-test counseling provides an opportunity for counselors and clients to talk about the HIV test process, the meaning of positive and negative test results, the client's potential HIV risks, ways to reduce HIV risk, and the client's intended plan of action once he or she gets the test result.*
- *In addition, before the actual test, the counselor should ensure that the client is getting tested voluntarily and has the information he or she needs to make an informed decision about proceeding with the test.*

➤ What happens if the test results are positive?

Possible responses:

- *A positive HIV test indicates the presence of HIV antibodies and means the person is infected with HIV. Testing positive does not mean that the person has AIDS. Many people who test positive stay healthy for several years, even without treatment.*
- *If a client tests positive, the counselor should explain what a positive result means, address the client's emotional response, answer any questions, discuss treatment options (if they exist) and self care, discuss how the client can avoid transmitting the virus to others, and set up referrals for health care and social support services. A counselor should also address family planning options, if desired.*
- *Women who test positive and are pregnant should be counseled on options available to prevent mother-to-child transmission (MTCT) of HIV, including termination of pregnancy if desired and legal. They should be referred to programs specializing in the prevention of MTCT.*

➤ What happens if the test results are negative?

Possible responses:

- *A negative HIV test result means that no HIV antibodies were present in the person's body at the time of the test. If a person tests negative and has not been exposed to HIV in the past six months, most likely the individual is not infected with HIV.*
- *When disclosing a negative test result, the counselor should explain what the test result means, discuss the window period, indicate whether or not the client should return for another test, answer any questions the client might have, address the client's emotional response, suggest strategies for remaining HIV-negative, and talk to the client about his or her personal risk reduction plan.*

➤ Once a person becomes infected with HIV, how long does it take for antibodies to the virus to show up in a test?

Possible responses:

- *When someone becomes infected with the virus, HIV antibodies usually show up in his or her blood within three months of the date of infection. Therefore, it can take up to three months after infection before a test shows someone to be HIV-infected (the window period). The person might have contracted the virus one or two months before the test – or previous night. So although a person's test result is negative, he or she might still be infected.*
- *If an individual thinks that he or she might have HIV and would like to take a test to find out, it is recommended that he or she be tested. If the result is negative, encourage the person to have another test three months later. If this test is also negative and the person*

has not been exposed to the virus in the meantime and continues to practice safer sex, it is unlikely that he or she is HIV-infected.

→ Can a person be tested for HIV without permission?

Possible responses:

- *Unfortunately, this has been a common occurrence in some countries. Clients have the right to know which tests providers intend to conduct and the right to refuse tests they do not want.*
- *Some countries have laws that protect people from being given treatments and tests without their permission. These laws state that a person must understand the nature of the test and give his or her oral or written consent. With an HIV test, before agreeing to having the blood drawn an individual must know what the test is, why it is being done, and what the result will mean for him or her. The explanations, which are given before a test is done, are part of pre-test counseling. A person should also be helped to determine whether or not having the test is the right decision for him or her.*
- *It is inappropriate for health care facilities to require pre-surgical HIV testing. Rather, health care facilities should ensure that all health care providers follow universal precautions to prevent exposure to HIV.*

→ What are some implications of VCT for pregnant women?

Possible responses:

- *HIV has consequences for the person who is tested, beyond that of the diagnosis. The result of VCT will also have implications for the baby, partner and family of an HIV-positive pregnant woman. A positive test result can lead to isolation and stigma because of misinformation, fear and prejudice surrounding HIV. In addition to regular pre-test and post-test counseling, HIV-positive pregnant woman should be given appropriate information to make informed decisions about continuation of their pregnancy and future fertility, treatments to prevent mother to child transmission (MTCT) during labor and delivery, and breastfeeding options.*

→ What are some advantages of VCT?

Possible responses:

- *If an individual takes an HIV test and the result is negative, the person can be reassured that he or she did not have HIV three months before the test.*
- *Some people think they would feel better if they knew their HIV status, even if they are infected.*
- *If a person is infected with HIV, he or she can prevent infecting other sexual partners in the future.*
- *If a couple has been practicing safer sex, they may want to be sure that neither of them has HIV before they stop using condoms.*
- *Children born to women who have HIV stand a considerable risk of becoming infected during pregnancy, labor and delivery, and breastfeeding. Therefore, when a woman finds out that she is pregnant, she may want to have an HIV test so that she can decide on treatment and breastfeeding options to prevent MTCT.*
- *Some people want to know their HIV status so that if they are infected with HIV, they can make lifestyle changes that will help preserve their health and ensure that they live longer or better lives.*

↔ What are some disadvantages of VCT?

Possible responses:

- *When an HIV test comes back positive, a client may not be able to handle knowing that he or she is infected with HIV. Before a person takes the test, he or she should think about how he or she will react to receiving such a result and about delaying the test.*
- *Before providing an HIV test, providers should discuss the possibility of a positive result with the client. He or she should be aware of the fact that being HIV-positive carries with it a lot of stigma. Some HIV-infected people have been thrown out of their homes, fired from their jobs, victimized in their community, and physically assaulted. In addition, sometimes the children of HIV-infected parents are prevented from going to school.*

Considerations for the Facilitator/Training Options

If feasible and appropriate, you might consider inviting an outside expert on VCT to talk with the training group prior to, or as a part of, this exercise.

Essential Ideas to Convey

- HIV testing should always be done voluntarily and never mandated or coerced. If people have a desire to know whether or not they are infected, they have a right to know.
- VCT is an important entry point to other HIV/AIDS services, which can benefit clients with either positive or negative test results. When they are well implemented, VCT services offer the possibility of benefiting the community by “normalizing” the existence of HIV/AIDS, reducing stigma and promoting awareness. At the same time, education about VCT at the community level is important to reduce stigma and to foster community concern.
- Systems to ensure confidentiality and follow-up support are critical components of VCT services.
- Before providing an HIV test, providers should discuss the possibility of a positive result with the client, addressing the potential social stigma that it carries. In some settings, people with HIV have been thrown out of their homes, fired from jobs, victimized in their community and physically assaulted.

MOTHER-TO-CHILD-TRANSMISSION OF HIV (MTCT) OVERVIEW*

Objectives

1. To familiarize participants with basic facts about the MTCT of HIV.
2. To encourage participants to think about how they will address the MTCT of HIV with clients.

Time

60 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Participant Handout: *MTCT of HIV*
 - Participant Handout: *Benefits and disadvantages of VCT in the maternity setting*
-

Steps

1. Tell participants that you will be providing them with some basic information about mother-to-child transmission (MTCT) of HIV. Then they will work in small groups on some questions about MTCT.
2. Give the participants a short presentation on MTCT of HIV, making sure to cover the following information:
 - MTCT of HIV or “vertical transmission” occurs when babies acquire HIV infection from their mothers, before, during or after delivery (through breastfeeding).
 - Since the start of the HIV epidemic, it is estimated that over 4 million children have died of AIDS before their 15th birthday. Another 2.7 million children are currently living with HIV (2001). According to UNAIDS, the vast majority of these children were born to mothers who were infected with HIV.
 - Without any medical intervention, up to 40 percent of HIV-positive women transmit the virus to their newborns.
 - Where women do not breastfeed, most of the transmission occurs during labor and delivery. Transmission during early pregnancy is less common.
 - Where most women breastfeed, there is an additional risk of HIV transmission through breastfeeding. It is thought that up to one-third of MTCT is through breast milk where breastfeeding is the norm.
 - Although the medical community has learned a lot about preventing MTCT in recent years, most preventive interventions take place in high-income countries and not in lesser developed countries, where they are most needed.
 - Several antiretroviral treatments have proven effective in reducing perinatal transmissions of HIV, including short-course treatments given right around the time of delivery.

* The handouts for this exercise were taken from: *Preventing MTCT of HIV, a training manual for healthcare providers*, N. T. Ndong, *Reproductive Health Alliance and Perinatal HIV Research Unit, 2001*.

3. Divide participants into four groups and assign each group one of the following topics:
 - What are some of the factors that increase the risk of MTCT during breastfeeding?
 - What are some of the ways of preventing the MTCT of HIV?
 - What are some of the factors that increase the risk of MTCT of HIV during labor and delivery?
 - What are some of the advantages and disadvantages of VCT for pregnant women?
4. Give each group flipchart paper and markers and ask them to brainstorm responses to their assigned question.
5. After about 15 minutes, invite the groups back into the larger group and have each group present their responses.
6. Lead a group discussion on the questions, correcting any misinformation and encouraging questions.
7. Summarize the key points from the discussion and add any additional information that is needed. Provide the participants with the handouts listed above.

Key Discussion Points

- ↪ Why would it be appropriate to offer VCT services in maternal health settings? In what circumstances would it not be appropriate?
Possible responses:
 - *It would be appropriate to identify HIV-positive pregnant women, the first step in preventing MTCT.*
 - *It would be appropriate to provide ARV therapy (if available).*
 - *It would be appropriate to help women to make informed decisions about infant feeding, etc.*
 - *It might not be appropriate if no treatment for the prevention of MTCT or for the treatment of the woman herself exists (i.e., this may present an ethical dilemma).*
 - *It would not be appropriate if an adequate system of confidentiality did not exist in the clinic setting.*
- ↪ What would be some of the essential information to communicate to an HIV-positive pregnant client?
Possible responses:
 - *Present facts about MTCT*
 - *Present information about preventive treatment for MTCT (if available)*
 - *Discuss breastfeeding options*
 - *Address condom use and future transmission prevention*
 - *Provide nutritional counseling*
 - *Provide referrals for social services for AIDS care and support (if available) and preventive treatment for MTCT (if available)*
 - *Address client family situation and resources. Are there family members who would care for orphaned children, etc.?*

- *What it would mean to take care of a child with HIV, including the course of the child's infection and the likelihood of early death*
- *Teach correct condom use and skills for negotiating condom use with her partner*

Considerations for the Facilitator/Training Options

You may need to tailor the small group questions to the needs and knowledge base of the group. For example, if the group is less knowledgeable about MTCT issues, then you may need to lengthen the introductory mini-lecture and supplement it from facts contained in the handouts.

If feasible and appropriate, you might consider inviting an outside expert on MTCT to talk with the training group prior to this exercise.

Note: *Preventing MTCT of HIV, a training manual for healthcare providers (Reproductive Health Alliance and Perinatal HIV Research Unit, 2001)* from which this exercise is adapted, is an excellent resource. Direct participants to this manual if they are interested in additional information on MTCT.

Essential Ideas to Convey

- Decreasing the vulnerability of women to HIV infection is the best way to prevent MTCT. This includes dual protection and HIV prevention education, awareness-raising and skills-building (condom use, partner negotiation, etc.).
- MTCT prevention education at the community level is important to reduce stigma and to foster community concern.
- VCT in antenatal care is an important component of the prevention of MTCT because if a woman is HIV-negative she can be counseled on appropriate prevention strategies. If she is HIV-positive, she can receive early counseling and treatment (if available) to reduce the risk of MTCT during pregnancy, labor, delivery and breastfeeding. Systems to ensure confidentiality and follow-up support are critical components of VCT services.
- VCT is an essential component of MTCT programs because such programs cannot be implemented if women do not know their HIV status. Programs, however, should not only focus on identifying HIV-positive women for the prevention of MTCT interventions, they should also focus on risk reduction and helping women who test negative to remain that way.
- VCT programs for pregnant women can benefit from the involvement of men. Some studies have shown that when women test positive for HIV and their male partners are not tested, the women are often blamed for introducing the infection into the couple. Such unfounded blame can lead to conflict, abandonment and violence.

SOCIAL VULNERABILITY TO HIV/STIS

Objectives

1. To explore the concept of social vulnerabilities to HIV and other STIs, including power dynamics in sexual relationships.
2. To increase understanding of how various social forces can affect the ability of clients to negotiate sexual relationships with partners and to protect themselves from infection.

Time

45 minutes

Materials and Advance Preparation

- Develop case studies on situations of vulnerability to distribute to small groups (see Facilitator Resource: *Sample case studies on unequal power in sexual relationships*, attached)
 - Flipchart paper
 - Markers
 - Tape
 - Participant Handout: *Social Vulnerabilities and HIV/STI Risk*
-

Steps

1. Introduce the topic by saying to participants:
Often in sexual relationships, partners do not have equal control or power due to differing social statuses. In situations of unequal power, behavior change to reduce HIV/STI risk is particularly difficult for the partner with less power. For example, even if the people with less power decide they are at risk for HIV and wants to start using condoms, they may not be able to control whether or not they or their partners use them.
2. Divide the participants into small groups of 3 or 4. Distribute a written case study to each group (see Facilitator Resource: *Sample case studies on unequal power in sexual relationships* attached). **Note:** if you use the sample case studies provided make sure to photocopy the case studies and to cut the sample answers off before distributing them to the groups.
3. Instruct the groups to read their case study together and to analyze it by answering the following questions:
 - What are the factors that contribute to the client's vulnerability to infection (i.e., increase risk of infection)?
 - If you were counseling this client, what strategies would you recommend to enable the client to protect him or herself against infection?
4. Ask each group to prepare a short presentation on their case study to present to the large group. The presentations should describe the scenario, the factors that contribute to the client's risk and possible strategies for protecting the client against infection.

5. After all the groups have presented their case studies, facilitate a large group discussion based on the questions below.
6. Distribute the handout, *Social Vulnerabilities and HIV/STI Risk*, for participants' reference.

Key Discussion Points

- ↪ These case studies described different types of relationships in which one partner did not have equal control in decisions related to sex. What other types of examples of relationships such as these can you think of?

Possible responses include:

- *A "sugar daddy" with younger woman*
 - *A young man pressured into visiting a sex worker by friends or relatives*
 - *A sex worker who is offered more money not to use condoms*
 - *When one partner has other partners*
 - *A much older partner with a young adolescent*
 - *A woman in a refugee situation and a border guard (or someone else in a position of power over her)*
 - *A young woman who is sexually abused by an older relative or neighbor*
- ↪ What are the main factors that contribute to a person's risk? Which ones are beyond a person's control? Which ones can a person control?
 - ↪ How do gender role expectations and traditional cultural values affect a person's risk of infection with HIV or other STIs?

Possible responses include:

- *Women/young women are not expected to know about or talk about sex, therefore it is difficult for them to negotiate the terms of sexual relations.*
 - *Women often have less education and thus less access to written information about HIV/STI.*
 - *Women who are economically dependent on men are less able to define the terms of sex and condom use for fear of abandonment or even violence.*
 - *In many cultures, men are expected and encouraged to have multiple sexual partners.*
 - *In some cultures, men are encouraged to consume alcohol or other substances, which may lead to increased risky sexual behaviors.*
- ↪ How does age affect peoples' ability to protect themselves against infection and to negotiate with partners about the nature of the sexual relationship, including condom use?

Possible responses include:

- *Younger people, especially children and adolescents, tend to have less power to stand up to the demands of an older person.*
- *Older people tend to have more sexual experience, money, access to resources, etc., than younger people.*
- *Younger people may be coerced into sexual behaviors with older people through manipulation or threats (i.e., "I'll tell your family that you wanted it," etc.);*
- *Because older people (particularly men) tend to be more sexually experienced they are more likely to have been exposed to HIV/STIs and therefore more likely to pass it on to the younger*

person (e.g., in many countries older men seek younger women as sex partners and therefore women are becoming infected with HIV at much younger ages than men).

- ↪ How does access to money and other resources affect peoples' ability to protect themselves against infection and to negotiate with partners about the nature of the sexual relationship, including condom use?

Possible responses include:

- *People with fewer resources are often less likely to protect themselves because they may be dependent on the relationship for resources that they need (i.e., having unprotected sex in exchange for money or shelter, etc.).*
- *People with more resources can use those resources to manipulate someone with fewer resources, or to entice them into doing something risky (i.e., a "sugar daddy" can provide a poor student who needs school fees the money she needs in exchange for unprotected sex).*

- ↪ How do government policies affect a person's vulnerability to infection with HIV or other STIs?

Possible responses include:

- *If government's penalize or make illegal certain practices or behaviors such as commercial sex work or sex between people of the same sex, it may drive them underground and place people at greater risk because they do not have access to information on how to protect themselves.*
- *Government policies that limit women's access to education, property, money, and other resources may make women more vulnerable to HIV/STI infection because they must depend on men, giving them less power to negotiate safer sex.*
- *Government policies may restrict sex education (including information on HIV/STI prevention) in public schools, which keeps younger people unaware of their risks and ignorant about how to protect themselves from HIV/STI infection and unintended pregnancy.*

Considerations for the Facilitator/Training Options

This activity can be conducted as a brainstorm and corresponding presentation on social vulnerabilities. The facilitator could ask the participants to brainstorm responses to the questions "what kind of relationships or partnerships can we describe where people have unequal power regarding sex?" (for example, a young girl with a "sugar daddy" older man); and "what social forces contribute to such power imbalances?" (for example, gender, age, poverty). The facilitator can then give a short presentation on social vulnerabilities and risk (see participant handout, "Social Vulnerabilities and HIV/STI Risk," attached).

Rather than in the "case study" format, this exercise can be conducted through role play. After brainstorming types of relationships with power imbalances, participants can be divided into small groups to develop role plays based on these relationships. After presenting the role plays, the group can discuss the issues that were raised.

Essential Ideas to Convey

- As health care providers, we must realize that individuals' risk for infection with HIV/STIs is sometimes beyond their control; people with less power or resources may not be able to control the terms of sex and condom use with their partners. Individual risk reduction counseling must take these limitations into account.
- In many cultures, gender relations and lack of power in sexual decision-making prevent women from protecting themselves, even if they are aware that their partner's behavior may be putting them at risk. It is often difficult, if not impossible, for many women to negotiate safer sex with their partners or to control the circumstances under which they have sex. Because of their social and economic dependency on men, women frequently have little power to refuse sex or to insist that barrier methods, such as condoms, be used during intercourse.
- Lack of economic power can also lead to vulnerability as some women are forced to enter into prostitution or multiple or temporary partnerships in the hopes of bartering sex for economic gain or survival, including food, shelter and safety. In some cases, women are at risk simply because they are economically dependent on their husbands for survival and support.
- Stigmatization of certain groups in society can also put them at higher risk for HIV. For example, in places where homosexuality is taboo and illegal, people who identify as homosexual or who engage in homosexual behaviors are less likely to get messages about HIV risk and prevention because they need to be secretive about their behaviors.
- Young people of both sexes are at high risk of infection with HIV/STIs in many countries. Young women may be particularly vulnerable both for biological reasons (less mature tissue may be more readily permeated by the virus or more easily damaged) and for social reasons, including lack of negotiating or economic power. In contrast, young men often face tremendous peer pressure to be sexually experienced and are therefore less likely to seek information about how to protect themselves and their partners for fear of appearing ignorant or inexperienced. Young people in sexual relationships with adults usually have limited power to negotiate the terms of sex and condom use.

FACILITATOR RESOURCE: SAMPLE CASE STUDIES ON UNEQUAL POWER IN SEXUAL RELATIONSHIPS

Case Study 1

Patricia is a 15-year old secondary school student. Her family is very poor and often does not have enough money to pay for school fees, books and uniforms. Lately Thomas, a 35-year old small business owner, has been paying special attention to Patricia. He has been offering her rides in his car and taking her out for meals. Thomas is married to Claudia and they have two young children. Thomas tells Patricia that if she is his “special friend” then he will give her money to pay for school expenses. Thomas is the first person that Patricia has had sex with. She has never discussed sexuality or contraception with her family nor has she been offered sex education in school. The little information that she has about sex comes from rumors that she hears from her peers. Thomas tells her not to worry about getting pregnant because he will make sure it doesn’t happen. He also makes fun of condoms saying that real men would never use them. Patricia never knows in advance when she will see Thomas. He has forbidden her from contacting him because he does not want his wife to find out about their relationship. When Thomas does find Patricia, he picks her up in his car and takes her to a remote area for sex. He tells her exactly what to do and how to behave sexually. When the sex is over, Thomas tells Patricia he will give her some money for school only if she promises not to tell anyone about what they have just done. He also threatens to hurt her if anyone finds out.

Sample Answer

Patricia is at risk for a variety of reasons. Her poverty makes her vulnerable to exchanging sex for money and supplies for school. The age disparity between Patricia and Thomas makes her vulnerable because he has power and control over her. Her young age places her at risk biologically because her vaginal tissue is less mature and more likely to tear or abrade, making it easier for infection to occur. Her lack of knowledge related to sexuality, contraception and infection places her at risk because she is unable to perceive her own risk and unequipped to protect herself. Cultural taboos against discussing issues related to sexuality at home or in school perpetuate myths about STIs that increase her risk. The gender-related factors include Thomas’ refusal to use condoms because “real men” don’t wear them, which stems from societal attitudes about masculinity. Socialization for women to be compliant and submissive about sex and men to be aggressive and in control about sex affects the dynamic between Patricia and Thomas. His threat of violence and control of economic resources are also related to gender roles.

Case Study 2

Virginia is 25 and married to Carlos, with whom she has 4 children. She got married at 16 and never completed her education. In the past year, there have been strains on their marriage. Carlos maintains strict control over the money in the household. Yet he has not been able to find steady employment as a laborer. When there is work, Carlos seems happy to provide for the family, but when he is out of work, he takes what little money there is to spend on alcohol and, as Virginia suspects, other women. When Carlos is out of work, he often comes home drunk and demands sex from Virginia. Virginia complies with his demands even if she doesn't feel like having sex because she believes it is her obligation as a wife. She has been to a health clinic to get a method of contraception. Carlos agreed that it would be a good idea for her to use the pill. About six months ago when she went for a follow-up visit, the clinic doctor noticed an unusual vaginal discharge and subsequently diagnosed Virginia with an STI. She took medicine to treat it but did not tell Carlos for fear of his reaction. She knows that Carlos must have gotten it from one of the women he was with. Virginia has heard that condoms can prevent STIs, but she knows that Carlos would never use one. In fact, if she asked him to, he would be suspicious and defensive, perhaps accusing her of infidelity. He might even leave her, as he has threatened to do before. While they have their problems, Virginia loves Carlos. He is a good father, especially when he is working. If he left, she doesn't know how she and the children would survive.

Sample Answer

Many factors place Virginia at risk of infection. Her poverty, lack of education and lack of access to resources make her vulnerable because they make it difficult for her to learn about ways to protect herself and to obtain the necessary resources to do so. Gender-related factors are also at work here. Carlos and Virginia are in an unequal relationship, with Carlos controlling the resources, determining the nature and timing of their sexual activity, and threatening to leave if Virginia defies him. Prevailing attitudes about masculinity and femininity perpetuate a situation in which Carlos demands sex from Virginia and she feels that she must comply even when she does not want to. Other attitudes about male and female have influenced this situation, such as expectations that men be "good providers," expectations that men have multiple sex partners, the notion that drinking makes men "manly," and idea that it is a wife's obligation to provide sex whenever her husband wants it.

Given that Virginia has already experienced one STI, she is at risk of re-infection or infection with another STI, especially because Carlos was not treated. The fact that there are positive elements in their relationship further complicates the situation because Virginia is even more willing to place herself in risky situations for the "good of the relationship." Virginia, despite all the factors against her, has had the wherewithal and fortitude to visit a family planning clinic, and is aware that condoms could protect her. She could greatly benefit from counseling to help her develop a risk reduction plan, and to build skills to follow it through.

Case Study 3

Patience is 30-years old, a mother of 3 children and a widow from a very poor country. Her husband recently died in a mining accident. She sells vegetables in the market, but barely makes enough to feed the children and maintain the household. To supplement her income, she has begun to go out on the road at night to have sex for money with the truck drivers who come through her village. She has some condoms that she got from a clinic once and sometimes she asks the men to use them. Some men do use them, but others will offer her more money for not using a condom. Given her financial situation, she accepts additional money and forgoes condom use. As far as she is concerned, feeding her children right now is her immediate concern, and this priority is much more important than insisting on condom use to prevent the possibility that she could get pregnant or contract HIV/STIs.

Sample Answer

Patience is at risk for a variety of reasons. The primary factor is her poverty and status as a single mother struggling to provide for her children. Because she is from a poor country, the government has not prioritized pensions or financial subsidies for widows. Poverty fuels her need to supplement her income through informal sex work, and poverty places her at risk when she is offered extra money to forgo condom use. When she has sex with truck drivers, they have the financial resources to influence the nature of their sexual activity (i.e., whether or not to use condoms). Despite these factors against her, Patience has obtained condoms and has asked clients to use them. She could benefit from counseling and support to insist on condom use at all times.

Case Study 4

Fatu is an 18-year old first year nursing student living in a women's dormitory in the capital city. She is living away from home, a smaller city 200 kilometers away, for the first time and receives financial support from her family. Her living expenses in the capital turned out to be much greater than she or her family anticipated and for the first six months she was constantly struggling to make ends meet. Fatu's friend Sheri was in the same situation until she started dating a businessman who takes her out and buys her gifts. Sheri offered to introduce Fatu to a friend of her boyfriend's, Omar, a 35-year old unmarried businessman. Fatu has now been dating Omar for several months. Omar is very generous with Fatu, buying her gifts and paying for books and other school supplies she needs. Fatu is somewhat hesitant about getting too serious with Omar because she is committed to her studies, however, she likes the attention and is relieved to no longer worry about her expenses. About a month ago, the relationship became sexual. Fatu resisted his sexual advances at first, fearing disease and pregnancy, and wanting to remain a virgin for marriage. Ultimately, she did not know how to resist pressure from Omar, who refuses to use condoms because he claims not to enjoy sex while using them. Fatu hopes that Omar is not infected with HIV or other STIs, and has come to believe that since Omar is a respected businessman he must be "clean." In order to avoid pregnancy, she takes the pill.

Sample Answer

Despite attending nursing school and having access to information and education about HIV and STIs, Fatu finds herself in a vulnerable position because of her precarious economic situation. Fatu is also on her own for the first time, in an environment where she does not have a network of family and friends for advice or support. At the same time, she is juggling the pressure of remaining in school and needing financial resources to do so. This situation is placing Fatu at increased risk because it undermines her ability to negotiate the terms of her sexual relationship with Omar, including condom use. Omar is much older than Fatu and in a position of relative power over her, as the financial support he provides enables her to continue her studies. While she is able to avoid unintended pregnancy by taking the pill, she may be vulnerable to HIV/STIs because she cannot negotiate condom use with Omar.

Case Study 5

Maritim is a 25-year old man living in a large urban area in Eastern Africa where he works as a driver. Maritim was born in a rural area about 250 Km from the city and moved away when he was 12. His parents were struggling with the aftermath of a very long drought and could no longer support him. Maritim went to live with his oldest brother and his family in the city, until he got married to Damaris three years ago. Damaris is 21 and works as a cleaner in a hotel in the city. Maritim is under a lot of pressure from his family to have children, and this has caused a lot of tension in his marriage, as he blames Damaris for not having become pregnant yet. Recently, Maritim started having sexual relationships with other women, as he is determined to father a child before his next birthday. He knows about HIV and STIs, but he feels that fathering a child is more important than taking precautions because he is afraid that people may start thinking that he is not “man enough.” Maritim continues to have sex with Damaris and he is not using condoms, because he is afraid that Damaris would think that he is having an affair. Although she is not sure about it, Damaris suspects that Maritim is seeing someone else, but she feels very guilty about what she perceives as her failure to produce a son for Maritim and does not feel that she can confront him.

Sample Answer

This situation is creating a complex pattern of vulnerability that results in increased risk for all those involved. Maritim's risk is increased by many socio-cultural factors, including: the social pressure to have children, the perception of manhood associated with fatherhood, and the fear of being judged as an inadequate man and shaming his family if he does not father a child. The sexual history of Maritim's extramarital sexual partners is unknown, but it can be assumed that Maritim is not using condoms since he is trying to achieve pregnancy with them. Thus, Maritim and his partners are all potentially at risk of infection. In turn, this cycle of risk may dramatically increase Damaris' vulnerability, as she continues to have unprotected sex with Maritim. She feels trapped in a situation of suspicion, fear, and guilt that is made even worse by the lack of skills to communicate and negotiate with Maritim.

Case Study 6

Christopher is a 28-year old man living in a big city. He is married to Rose, who is 24, and they have three young children. Christopher loves his family and is a good father and a good provider, and works hard to give his children a better chance for a good education and a better future. As long as he can remember, Christopher has always felt a sexual attraction for other men, but he has had to hide it all his life because he knows that this is not accepted in his culture. Christopher knows that there are lots of other men like him, and most of them get married and live a second life like he does. Christopher doesn't have a regular male sexual partner because he is too afraid that people might find out, so he goes to several places where men meet other men to have casual sex. None of the men use condoms. Christopher, like most people in his community, has heard about HIV and STIs. He knows that the local health center has information about HIV and STIs, but the people there seem to be concerned with women and he feels that it would look strange if he were to go there. In addition, he fears that the health practitioners would find out about his having sex with other men and would shame him and tell other people in the community. Meanwhile, Christopher continues to have unprotected sex with Rose and she does not suspect anything.

Sample Answer

The fear of becoming an outcast and shaming his family is a very powerful force that places Christopher in a vulnerable situation. He and the other men who are leading "double lives" are at risk because the denial and secrecy surrounding their sexual relationships makes it difficult for them to perceive and acknowledge their risk and to take steps to protect themselves. Christopher perceives the local health center as a place that is not equipped to respond to the needs of men like him. His fear of disclosing his sexuality may be based on the assumption that the staff at the center probably shares the same views as the rest of the community on men who have sex with other men. He feels that seeking help there would only worsen his situation, and this increases his isolation and further undermines his ability to seek help and to discover ways to protect himself and others. Christopher does not know how to manage the situation with Rose, and as he continues to have unprotected sex with her she too may be at increased risk of infection. Christopher's children are also affected by the situation because their future may be in jeopardy if one or both of their parents fell ill.

WOMEN'S VULNERABILITY TO HIV/STIS

Objectives

1. To increase participants' understanding of the root causes and consequences of women becoming infected with HIV.
2. To increase participants' awareness of the social, cultural, economic, gender and other forces that may increase women's vulnerability to HIV/STIs.

Time

45–60 minutes

Materials and Advance Preparation

- Flipchart paper or blackboard (if no black board is available tape a few pieces of flipchart paper together to make a space big enough to draw the “why” tree)
 - Markers or chalk
 - Tape
 - Facilitator Resource: *Sample problem tree*
-

Steps

1. Divide participants into four small groups. Introduce the exercise by telling participants that they will explore the problem of **women's HIV infection** by examining its root causes and consequences. Each small group will take 25 minutes to draw a tree to depict the problem.
2. Quickly demonstrate the exercise to participants by drawing a sample tree on a flipchart in the front of the room. First draw a trunk of a tree in the center of the blackboard or flipchart paper. Write in the trunk the problem “**Women infected with HIV**” in the trunk.
3. Draw roots leading out of the trunk and tell participants that their small groups will brainstorm possible causes for women being infected with HIV (the root causes of the problem). These could range from the personal to the community to the societal level (as well as biological). (For example, “sex work,” “lack of control over sexual life,” “inability to use condoms,” “biological vulnerability,” “they don't know they are at risk,” etc.) Ask participants to name as many possible causes as they can think of, showing each one as a “root” on their tree.
4. Tell small groups that for each “root” cause they should “dig deeper” to explore additional roots, going as far down into the “soil” as they can go. For example, the roots of “sex work” might be “poverty,” “lack of resources to support one's family,” or “men's objectification of women.” Going deeper, the roots of “poverty” might be “poor government policies,” “colonialism,” “legal restrictions of women's right to own property,” or “unequal resources worldwide.”
5. Next, tell participants that after the “roots” have been addressed, they should draw some branches going upward from the trunk and brainstorm the consequences of the problem

“Women infected with HIV.” Encourage participants to think of consequences or results at different levels (the family, health care system, individual, society, nations, economy, etc.). For example, some of the branches may be “Women are getting ill,” “Women are dying,” “Babies are getting infected through MTCT,” “Women are seeking treatment,” “Women are getting kicked out of their homes,” “Women are being blamed by the community,” or “Women are getting beaten by their husbands.”

6. As in the “roots,” small groups should examine each consequence and determine if there are other consequences that stem from that particular problem. Draw more branches leading out of the consequences and write in additional ones. For example, some consequences of “Women are dying” might be “Children are becoming orphaned,” “Communities are losing valuable members,” and “Families are losing sources of support.” Instruct the groups to follow through with as many branches they can think of.
7. Have each small group present their “tree” to the large group.
8. Lead a group discussion based on the questions below.

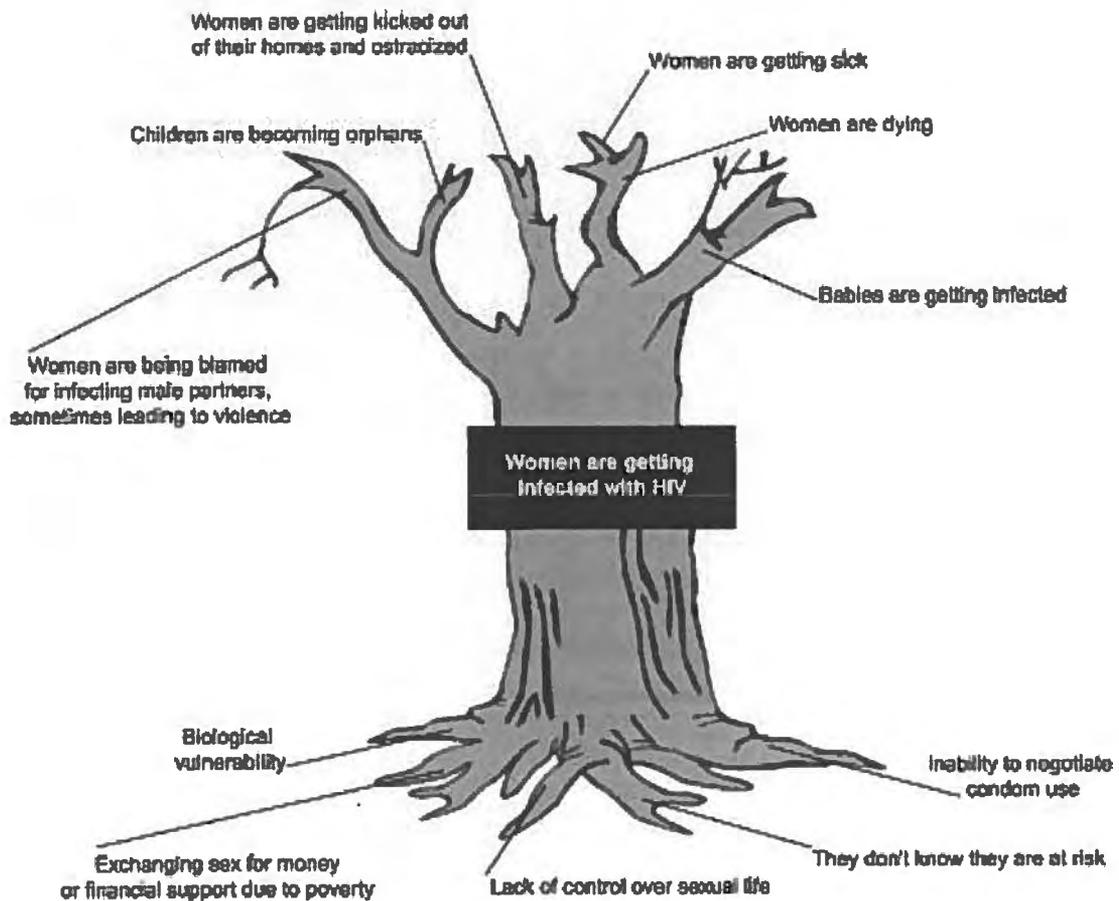
Key Discussion Points

- ↪ How do you view the problem of women being infected with HIV now that we have done this exercise?
 - ↪ Which of the roots do you think it is possible for us to address in our work?
 - ↪ How, if at all, do you think addressing the “roots” will affect the “branches”?
- Possible responses:
- *If we address a root like “poverty” or “gender relations” then fewer women will become infected and the “branches” (consequences) will be fewer.*
 - *These roots are so deep that it will take a long time before any change is seen in the consequences.*
- ↪ How can we address the consequences, or “branches,” through our work? Does it make sense to address consequences without addressing the roots?

Essential Ideas to Convey

- In many cultures, gender relations and lack of power in sexual decision-making prevent women from protecting themselves from HIV, even if they are aware that their partner's behavior may be putting them at risk. It is often difficult, if not impossible, for many women to negotiate safer sex with their partners or to control the circumstances under which they have sex. Because of their social and economic dependency on men, women frequently have little power to refuse sex or to insist that barrier methods, such as condoms, be used during intercourse.
- Women who are infected with HIV are often faced with stigma and discrimination from their communities, families and partners. In addition to being emotionally painful, this social isolation can lead to poverty due to abandonment and loss of employment.
- The children of HIV-positive women, some of whom may be infected themselves through mother to child transmission during pregnancy, labor, delivery or breastfeeding, also suffer from the consequences of stigma and discrimination: poverty, isolation and ill health. In addition, if a woman is rejected by her family and community, when she dies, her children may be left without caretakers.
- Health care providers are rarely in a position to address the root causes of health problems, particularly those forces which make women vulnerable to HIV. However, if we are aware of them, it will help us to better understand the context of our clients' lives so we can help them explore ways to reduce their risk for HIV and STIs within that context.

FACILITATOR RESOURCE: SAMPLE PROBLEM TREE



SEXUAL NEGOTIATION AND GENDER-BASED VIOLENCE

Objectives

1. To review the different forms of gender-based violence and how they can affect the ability of women to negotiate safer sex.
2. To identify ways to help clients negotiate safer sex with partners in relationships when there is gender-based violence or a power imbalance between partners.

Time

90 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
 - Five prepared sheets of flipchart paper, each of which has one of the following headings: “Physical”, “Emotional”, “Psychological”, “Financial”, and “Sexual”
 - Participant Handout: *Power and Control Wheel*
 - Prepare role plays or use sample ones provided (see Facilitator Resource: *Sexual negotiation and gender-based violence role play assignments*)
-

Steps

1. Introduce the session by explaining to participants that negotiating condom use in a relationship is never easy. It is even more challenging, however, in a relationship where there is a power imbalance between partners, or if one partner is abusive of the other partner.
2. On the flipchart paper, write the five different categories of behavior that people use to control their partners – “Physical”, “Emotional”, “Psychological”, “Financial”, and “Sexual”. Explain the difference between “emotional” and “psychological” by saying that emotionally controlling behavior is designed to take away a person’s self-esteem or sense of worth. Psychologically controlling behavior is designed to frighten a person or make them doubt their sense of reality.
3. Divide the participants into five groups. Give each group a marker and one of the prepared sheets of flipchart paper, and ask the group to brainstorm as many behaviors they can think of that people use to control their partners that fit under that particular category. (For example, under the category “sexual,” a partner force the other partner to engage in a sexual behavior that he or she didn’t want to do, etc.)
4. After about 5–10 minutes, call time. Ask each group to come up and present the list they developed. Ask the rest of the groups whether they have any behaviors they might like to add. Supplement from the handout, *Power and Control Wheel*, as necessary. After all the groups have presented their lists, distribute the handout, *Power and Control Wheel* to participants.

Note: You will see that many of the types of controlling behaviors will overlap categories, especially in the categories of emotional and psychological abuse. In addition, most sexual abuse is also physical abuse. It is acceptable for this overlap to happen, and just reinforces the way controlling behavior can affect so many aspects of a person's life. The following represents some possible responses to the above activity:

- **Physical**
 - *hitting*
 - *kicking*
 - *biting*
 - *punching*
 - *choking*
 - *restraining*
 - *pushing*
 - *pulling hair*
 - *burning*
 - *cornering a person and not letting her enter or leave a room*
 - *throwing objects at a person*
 - *cutting*
 - *not allowing her to go to the doctor*
 - *preventing her from taking medication, etc.*
- **Emotional**
 - *criticizing a person constantly, especially in front of other people*
 - *putting the person down*
 - *calling her names*
 - *questioning her intelligence*
 - *telling her that she is a bad mother, cook, or lover*
 - *criticizing her appearance, etc.*
- **Psychological**
 - *threatening to hurt her or the children*
 - *following her around town*
 - *accusing her of infidelities*
 - *threatening to destroy her property*
 - *not allowing her to sleep at night*
 - *threatening her with weapons without using them*
 - *threatening to leave the relationship*
 - *sending her out to run an errand and timing her departure and return*
- **Financial**
 - *not letting her own anything in her own name*
 - *not allowing her to handle money or make decisions about spending*
 - *stealing money that she had from her family or from working*
 - *preventing her from working*
 - *not allowing her to go to or finish school*
 - *forcing her to work several jobs, etc.*
- **Sexual**
 - *rape*
 - *forcing her to do anything sexual she does not want to do*

- *forcing her to have sex with another person in front of the partner*
- *forcing her to have sex for money*
- *selling her to another person*
- *forcing her to view pornographic material*
- *criticizing her sexual performance*

5. Remind participants of the challenges that women have discussing safer sex with their partners under the best of circumstances. Engage the group in a brief discussion about how this is further complicated when there is a power imbalance, violence or abuse in the relationship.

Possible responses:

- *There are fewer options available to the woman who is controlled or abused by her partner.*
- *There is greater pressure on her to “fix” what is wrong with the relationship.*
- *The woman may be suffering from depression or a sense of hopelessness, and therefore care less about safer sex or family planning herself.*

6. Brainstorm with the group possible suggestions that they, as providers, can make to their clients for discussing safer sex and condom use in a relationship where there is violence, abuse or extreme power differential. Record suggestions and ideas on the flipchart paper, supplementing as necessary. Acknowledge that some suggestions may be about reducing harm for the client. In other words, these would be realistic options or “survival strategies” for clients who are in violent situations.

Possible responses may include:

- *Be non-judgmental – of the partner as well as of the client.*
- *Try to eroticize safer sex. Rather than focusing on it as an obligation or inconvenience to the male partner, the female partner can make it a playful part of their relationship.*
- *Encourage the client to compliment the partner or use another tactic to get him to realize that he is still exercising his power by using condoms. (Note: This could be considered a “survival strategy”)*
- *Be specific in planning. If the client says she is going to get condoms herself and have them with her, ask her where she is going to get the condoms from, where she plans to keep them, how she will bring this up with her partner, etc. Role play this with the client in your office.*
- *Respect the client’s willingness and ability to negotiate with her partner. If she says that she cannot discuss this with her partner, explore other options. If there are truly no other options, schedule a follow-up visit and address the topic again.*

7. Explain to the group that, using the ideas they just came up with, you will be doing some role plays to practice talking with a client whose partner has a greater amount of control in the relationship, or is violent or abusive.

8. Ask for two volunteers to come to the front of the room, asking one to volunteer as the “counselor” and the other as the “client.” Provide the client and the counselor with their roles from the Facilitator Resource: *Sexual negotiation and gender-based violence role play assignments*. Allow the role play to continue for 5–10 minutes.

9. When the role play is completed, ask the large group to share their observations of what the counselor did well and what he or she could have done differently. Ask for two other volunteers, and do as many role plays from the handout as time allows, asking for and providing comments after each.

Key Discussion Points

- ↪ How did it feel to play the part of the counselor with clients who are at risk for HIV/STIs but are reluctant or unable, for whatever reason, to discuss condom use and safer sex with their partners?
- ↪ What counseling approaches do you think would work best with women who are in relationships with power imbalances or who live with violence? What approaches do you think would definitely not work? Why?
- ↪ What are your options when a client absolutely refuses to discuss condom use or safer sex with her partner?
- ↪ Do programs to address gender-based violence exist in your community? What types of referrals could you make for a woman who might be facing some of these issues?

Considerations for the Facilitator/Training Options

This exercise is appropriate for participants with advanced counseling skills. It can be incorporated in a longer, more advanced training on counseling skills. It is not recommended for a more basic-level training workshop.

There may be participants who have experienced some of these abusive behaviors themselves. The facilitator should acknowledge this at the beginning of the session by saying that this activity might bring up strong emotions for some participants, and that if they feel uncomfortable at any point, they can stop.

An alternative to this exercise is described below. (**Note:** This is the same methodology used in the exercise *Women's vulnerability to HIV*) The steps are as follows:

1. Divide participants into four small groups.
2. Tell participants that they will be drawing a "tree" that illustrates the cause and impact of sexual violence towards women and girls. Explain the following:
 - The "trunk" of the tree is gender based violence (the problem)
 - The "roots" of the tree are the root causes of the problem (encourage groups to dig deeper and deeper by asking "why?" – e.g. if a someone mentions a root cause being women's lack of power, ask why do women lack power to depict the root causes of that problem as well)
 - The "branches" and "leaves" are the impact of the problem
3. Instruct the groups to also discuss ways SRH programs can address both root causes and impact of gender based violence.
4. Have each small groups present their "tree" to the large group.

Essential Ideas to Convey

- Physical abuse is not the only type of abuse that women experience in their relationships. Non-physical abuse comes in many forms, and can be just as or even more damaging than physical abuse. Many women who are not physically abused do not even realize that they are being abused. They may feel as if they don't have any options for negotiating safer sex when they live with violence, or the threat of violence. For this reason, a provider should not simply suggest to a woman that she leave her partner. Abusive or controlling relationships are rarely resolved by simply suggesting that the woman leave – nor is that always the best or most realistic option available to her.
- Do not criticize the partner or spouse. If you criticize her partner, this may alienate her and disrupt the counseling process.
- Even when there is a power imbalance or violence in a relationship, a woman has options for negotiating safer sex and contraception. This often requires some creativity, and a willingness to adapt to the partner's needs. Many of these options can be considered "survival strategies," as they are options of last resort and serve to reduce harm. While providers may find this frustrating or even challenging, we must work within the client's situation without being judgmental.
- If a client does not feel that she is able to discuss condoms, don't force her. Try to encourage her to come back for further discussion. But in the end, she knows her relationship best. Urging her to press this issue when there is a power imbalance, especially when there is violence or abuse, could end up putting the woman's health and life in danger.
- Providers should be aware of any services available in their community for women who are in abusive relationships or who live with gender-based violence, and mechanisms for referrals should be put in place.

FACILITATOR RESOURCE: SEXUAL NEGOTIATION AND GENDER-BASED VIOLENCE ROLE PLAY ASSIGNMENTS

SCENARIO 1

Client: You are very quiet and shy with the provider. You've come to the clinic for family planning, but the provider has begun discussing HIV/STIs and your risk of infection. You have heard about HIV and suspect that your husband has had other partners. The counselor suggests that you talk with your husband about using condoms, but you rarely talk with him at all so you can't possibly imagine talking with him about this. Your husband came with you to the clinic, and seemed quite perturbed when the provider asked him to wait outside during the checkup. He has knocked on the door several times during your visit.

SCENARIO 1

Counselor: Your client is very quiet and shy and her husband is very brusque and aggressive. You've asked him to wait outside for the client, but he is knocking on the door and acting impatiently. Your client came in to discuss family planning, but you are also exploring her risk for infection with HIV/STIs, as well as unintended pregnancy. She has just admitted that she believes that her husband has other partners. Your goal is to help her consider her options for best protecting herself. This includes encouraging her to talk to her husband about safer sex and suggesting ways to bring up the topic in a non-threatening way.

SCENARIO 2

Client: You have come in for a visit because you've been experiencing some severe abdominal cramping. After finding out that everything is okay, you've been cornered by this provider who keeps talking to you about condoms. You are terrified of your husband – the last time you asked him a question about why he was out so late, he punched you in the face. This provider does not seem to understand that you can't possibly question him about his other relationships, let alone what you do together sexually.

SCENARIO 2

Counselor: Your client has come in because of severe abdominal cramping. You are concerned that she may have pelvic inflammatory disease (PID) but upon examination she appears to be well. You take the time to explore other aspects of her sexual and reproductive health situation, including her risk of HIV/STI infection. Whenever you mention her husband, she tenses up and seems nervous. Your goal is to find out more about how she feels about her relationship with her husband and how she perceives her own risk of infection, as well as unintended pregnancy. If she feels she is at risk, discuss strategies for bringing up safer sex with her husband.

SCENARIO 3

Client: You came in to the clinic because you thought you were pregnant and were relieved to find out that you are not. You have four children (all girls) and cannot afford another one right now. Your husband was furious because he had hoped you were finally pregnant with “his son.” The provider is talking with you about HIV and safer sex, and you do not think this is an issue for you – both you and your husband are clean people. You think that if you are polite and agree with everything the provider says you will be able to leave the clinic and get back to your housework. Some of things that she is saying make you think, though. Especially the part about behaviors that could place you at risk of infection with HIV, such as having sex without condoms. You know that your husband sometimes goes with his friends to visit sex workers in town, and you are almost certain that he would never use condoms. He has a terrible temper, especially when he is drinking, which has been frequent lately. He criticizes you constantly and makes fun of you in front of your in-laws. You would be terrified to talk to him about condoms.

SCENARIO 3

Counselor: Your client came in for a pregnancy test, which was negative, and she seems quite relieved. You begin to explore her sexual and reproductive health needs and risks, including her needs for dual protection. She is being very quiet, but polite, answering questions with “yes,” “no” or “I don’t know,” and seems anxious to leave. You have the feeling that she is just nodding and agreeing with you so that she can leave. Your goal is to break through her reserve and find out what her real needs and concerns are, including how she perceives her own risk of HIV/STI infection, and how she feels about her relationship.

SCENARIO 4

Client : You think that you might be at risk for HIV because your husband travels often and you know that he has sexual relations with other women when he is on the road. You are shocked that this provider has asked you to discuss this with your husband, because no proper woman would bring this up. If the provider were to talk with you about eroticizing what you do with your husband, you would be extremely offended.

SCENARIO 4

Counselor: Your client has revealed that she is concerned about becoming infected with HIV/STIs because she is aware that her husband has other partners when he travels. When you talk about how she can protect herself, including by talking with her husband about safer sex, she becomes very uncomfortable. Apparently, she feels that it would be “unladylike” to discuss this with her husband. Your goal is to help the client to learn how she can protect herself and to encourage her to talk to her husband about safer sex. You should also discuss condom use with her and give suggestions for eroticizing condoms.

DEFINING SAFER SEX

Objectives

1. To explore participants' understanding of the concept of "safer sex."
2. To arrive at a common, technically sound understanding of this concept that participants can apply to their work.

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
 - Participant Handout: *Safer Sex Activities*
 - Participant Handout: *What is Safer Sex?*
-

Steps

1. Divide participants into small groups of 3-5 people. Give each group several pieces of flipchart paper and markers.
2. Ask the participants to brainstorm a list of safer sex behaviors. Encourage them to think broadly about various activities that are sexual and that present no risk.
3. Invite the participants back into the larger group and ask each group to present their list to the other groups. Facilitate a discussion about the various lists, focusing on similarities and differences.
4. Distribute the participant handout, *Safer Sex Activities*, emphasizing that this is just an example to help summarize the main points of the activity. Acknowledge that some participants may be uncomfortable with some of the specific safer sex activities on the handout, depending on their personal, moral, or religious beliefs (e.g. looking at erotic pictures together). The menu should be used as a flexible tool to help people identify safer sex alternatives that they feel comfortable with and can discuss with clients. Review it with the large group, noting any information on the handout that was not covered by the small groups.
5. Distribute the handout, *What is safer sex?* for participants' reference.
6. Facilitate a larger group discussion based on the questions below.

Key Discussion Points

- ↪ Why do we say "safer sex" and not "safe sex"?
- Possible responses:

- *There is no sex that is 100 percent “safe,” so the term “safer” shows that there are ways to increase safety.*

➤ What are some barriers to safer sex?

Possible responses:

- *People may not know about safer sex or think that it makes sex less desirable.*
- *One partner may want to have safer sex but the other may not.*
- *People may not have access to condoms.*
- *People may not want to use condoms because they want to get pregnant.*

➤ How might our definitions of safer sex differ from those of our clients?

➤ How can safer sex have a positive impact on both sexual pleasure and safety?

Possible responses:

- *Condom use (or non-penetrative sex) can provide dual protection – protection against infection with HIV/STIs and unintended pregnancy.*
- *Safer sex can make partners feel less worried about negative consequences (HIV/STI infection and/or pregnancy) so that they enjoy themselves more.*
- *Condom use may prolong erections for some men and therefore enhance pleasure;*
- *Some partners can make safer sex part of their erotic experience and make sex more pleasurable;*
- *Non-penetrative sex or intimate activities such as massage, can bring partners closer together through sharing new experiences together.*

➤ How can safer sex have a negative impact on sexual pleasure?

Possible responses:

- *Some may feel that it takes the spontaneity out of sex because you have to stop and put on condoms or use dental dams.*
- *Some may feel that condom use is unappealing or that it decreases sexual sensation*
- *If one partner wants to practice safer sex and the other doesn't this may end their sexual contact or result in a situation in which one partner agrees to unprotected sex but feels upset or concerned about it.*
- *Some people may not be used to exploring their sexuality in other ways besides penetrative sex and may feel uncomfortable trying new things (such as massage, mutual masturbation, condoms, dental dams, intimacy while clothed, etc.).*

➤ What role does communication between partners play in safer sex? Beyond verbal communication, are there other ways couples can communicate about safer sex?

Essential Ideas to Convey

- We cannot assume clients know what we mean when we recommend practicing “safer sex.” When talking to clients, it is very important to be explicit about the meaning and the various ways that people can have “safer sex.”
- Safer sex not only offers protection against HIV/STIs (and pregnancy), it may also increase sexual pleasure by reducing the worry associated with unprotected sex. It can also push partners to be more creative in their sexual relationship, possibly leading to increased pleasure.
- Using condoms and dental dams can reduce sexual pleasure for some, particularly when they are not used to using them. Providers must help clients move beyond this barrier by helping them think of ways to eroticize safer sex.
- Communication between partners is an important element of safer sex. Providers can help clients improve their communication about safer sex with partners through role plays that practice communication skills.
- Due to unequal power in some relationships, safer sex may be difficult to negotiate for the person with less power. This is particularly true for many women. As such, it is important for providers to help clients explore all the options available to them to reduce their risk, so they can make decisions about HIV risk reduction that make sense in the context of their lives.

COMFORT WITH CONDOMS: PERSONAL AND PROFESSIONAL CONSIDERATIONS

Objectives

1. To analyze personal and professional biases against condoms, clarify condom effectiveness.
2. To improve participants attitudes about condoms and increase comfort in handling and discussing condoms.
3. To develop strategies for promoting condom use, and make condom use more fun!

Time

45 minutes

Materials and Advance Preparation

- Condoms (ideally enough for at least one per participant)
 - Flipchart paper
 - Markers
 - Tape
 - Write the following three questions on flipchart paper (one question per piece of paper):
 - a. What are some of the professional biases that family planning providers may have against condoms?
 - b. What are some of the personal biases that people, including providers, may have against condoms?
 - c. How can providers help clients feel more comfortable using condoms?
 - Write the following questions 3 times (on 3 separate pieces of flipchart paper):
 - d. How effective (what percent) do you think condoms for pregnancy prevention? How effective do you think condoms are for HIV prevention?
-

Steps

1. Explain to participants that we are going to spend some time thinking about condoms. Condoms are the only method that provides significant protection against HIV and other STIs, yet they often have not been highly regarded as a method of pregnancy prevention. We are going to discuss why family planning providers might have biases against promoting the condom, how effective condoms are, and how we can help clients feel more comfortable using them.
2. Divide participants into three groups. Give each group markers and flipchart paper. Assign each group one of the three topics listed above. Then give each group question number four (about condom effectiveness).
3. Ask each group to brainstorm responses to their two questions and to write their ideas on flipchart paper (give them about 20 minutes to do so). Note: Effectiveness refers to the percent effectiveness per 100 couples over one year of use. If 100 couples used condoms over the course of one year, how many of them would not get pregnant? If participants ask

whether to consider typical or perfect use, tell them to list what they think is the best number. It is best not to explain, but to encourage them to put down all of the figures that people in their group think.

4. Once the groups have finished answering the questions, ask them to post their questions and responses on the wall with tape.
5. Invite a representative from each group to present the group's question and responses to the larger group. Facilitate a large group discussion based on each group's presentation. When discussing question four, about condom effectiveness, compare the group's responses and provide the correct answer and explanation below.

Below are some possible responses to each question. The facilitator should work these into the discussion if they are not raised by participants.

- a. What are some of the professional biases that family planning providers may have against condoms?
 - *Condoms are considered less effective in terms of fertility control than long-term methods, which may hinder demographic goals.*
 - *Some family planning programs are under pressure to report high CYPs (couple-years of protection) to donors or government agencies, and condoms have lower CYP values.*
 - *Providers are misinformed about the effectiveness of condoms.*
 - *Providers do not trust clients to be responsible enough to use condoms consistently and correctly.*
 - *Providers do not consider condoms a serious option as a family planning method, rather as an STI prevention method or as a back-up method if, for example, a woman forgets to take a pill.*
 - *Providers assume that clients do not want condoms or they will be offended if they bring them up.*
 - *Providers associate condoms with certain types of people like commercial sex workers and their clients.*
- b. What are some of the personal biases that people, including providers, may have against condoms?
 - *People including providers, may find them distasteful and unappealing on a personal level.*
 - *People may assume that condoms are not for married couples but rather for certain groups of people such as commercial sex workers and their clients, people with STIs, men in the military, adolescents, etc.*
 - *Some people think that condoms ruin the spontaneity of sex.*
 - *Some think that the loss of sensation with condom use is unappealing.*
 - *Some think that if a partner suggests condom use it implies that the partner is unfaithful.*
- c. How can providers help clients feel more comfortable using condoms?
 - *Help people to believe in the idea that condoms can be highly effective.*
 - *Get clients used to touching and handling condoms.*
 - *Show clients how to use condoms correctly with a demonstration on a penis model.*
 - *Discuss ways to make condoms more erotic and appealing.*

- *Break taboos and fears by making condoms fun.*
- d. How effective do you think condoms are in terms of percent effectiveness per 100 couples over one year of use?

Answer:

- *With “typical” use, the effectiveness of condoms is 86 percent, and with “perfect” use, the effectiveness is 97 percent. (Typical use would imply that the couple had no instruction in proper usage). What this means is that only 3 of 100 couples who use condoms perfectly for 1 year will experience an unintended pregnancy.*
 - *If each couple had intercourse at the average coital frequency for US women of 83 acts per year, then the 100 couples would have had intercourse a combined total of 8,300 times over the course of a year. Three pregnancies resulting from 8,300 acts of condom use (or about one pregnancy per 2,800 acts of intercourse) is a remarkably low pregnancy rate (0.04%) when calculated on a per-condom basis.**
 - *The success of condoms in preventing pregnancy and infection depends on the people using it. Most condom failure is due to incorrect usage, not due to flaws in the condom itself. Therefore, it is essential to teach clients how to use condoms correctly in order have typical use rates approach that of perfect use rates.*
 - *In terms of male condom effectiveness in preventing HIV, studies have found perfect use effectiveness of 96%, and typical use effectiveness of 87%.*
 - *In addition, studies of HIV discordant couples have found less than 1 percent transmission with consistent and correct use of condoms.*
6. After the questions have been discussed, distribute unopened condoms to the participants (at least one per participant). Explain to them that many people feel uncomfortable buying condoms, talking about them and handling them. Helping clients get used to seeing them, touching them and playing with them can contribute to making their use more acceptable.
7. Instruct the participants to open their condoms and do something creative and fun with them. If they appear uncomfortable, give them some suggestions such as: put it over your hand, arm, foot, or even head; blow it up like a balloon; fill it up with water, etc.
8. After participants are done playing with the condoms, ask volunteers to show the rest of the group what they did with the condoms. Facilitate a wrap-up discussion based on the following questions below:

* D.L. Warner, et. al., *Male Condoms*, in R.A. Hatcher et. al., *Contraceptive Technology: Seventeenth Revised Edition*, Ardent Media, New York, 1998.

Key Discussion Points

- ↪ How are you feeling about condoms right now? How (if at all) have your thoughts or personal feelings about condoms changed?
- ↪ How do our personal and professional biases affect our ability to actively promote condom use to clients?
- ↪ How can people make condoms more fun?

Possible responses:

- *Use different colored condoms.*
- *Incorporate putting the condom on as part of the sex act in an erotic way.*
- *Have the partner put on the condom.*
- *Put on condoms creatively (e.g., with the mouth).*
- *Try different brands and styles.*

Considerations for the Facilitator/Training Options

At the beginning of this exercise, you might want to consider filling a box with opened condoms. Participants are not told what is in the box but rather instructed to close their eyes, put their hands in the box and use adjectives to describe the sensation that they feel. This exercise can result in positive descriptions such as “soft,” “silky,” etc. as well as negative, leading to a discussion of condom attributes.

Essential Ideas to Convey

- As we help meet our clients’ needs for dual protection (i.e., protection against both unintended pregnancy and infection with HIV/STIs), we, as family planning professionals, need to change our attitudes and ideas about the condom as a family planning method. Even though the condom is the only method that provides significant protection against HIV/STIs, it is often among the least recommended by family planning professionals.
- Professional and personal biases against condoms may interfere with our ability to promote condoms to clients. From a professional perspective, we may not see condoms as highly effective or may be skeptical about clients’ willingness or ability to use them. From a personal point of view, we may have our own negative feelings about condom use based on experience, or because we are members of a society that looks upon condoms unfavorably.
- It is important for us as reproductive health counselors to identify and address our personal and professional biases related to condoms, so that we can be objective when discussing dual protection and condom use with clients. Assuring that clients’ use condoms consistently and correctly is essential to their effectiveness.

CONDOMS AND SEXUALITY

Objectives

1. To improve understanding of the impact of condoms on sexuality, and pleasure both positive and negative.
2. To increase participants' comfort with discussing condom use and sexuality with clients.

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
-

Steps

1. Divide participants into small groups of 2-4 people. Give each group several pieces of flipchart paper and markers.
2. Assign half of the small groups to address the topic of "how condoms may enhance sexual pleasure." Assign the other half of small groups the topic of "how condoms may diminish sexual pleasure."
3. Ask the participants to work together as a group to respond to the corresponding question, and to write their ideas on the flipchart paper.
4. Invite the participants back into the larger group and post each group's ideas on the wall, separated by topic.
5. Invite representatives from the "enhance sexual pleasure" groups to present their ideas.
Possible responses:
 - *By reducing penile sensation, condoms can delay ejaculation thereby preventing premature ejaculation and prolonging intercourse.*
 - *Partners can relax and enjoy sex more, knowing that they are protected against pregnancy and infection.*
 - *Partner can put on condom as part of sex play and massage the penis while putting it on.*
 - *Discussing condoms use can enhance intimacy between partners.*
 - *Less "mess" to clean up afterwards when ejaculate is contained in the condom.*
 - *Pressure at the rim of the condom can prolong erections and make them "harder".*
 - *Using a condom means that you care about your partner and vice versa.*
 - *Partners can extend foreplay while waiting for both partners to be aroused (i.e., for sufficient erection and/or lubrication of female partner).*
 - *Using a condom involves handling the penis, which may be erotic for some couples.*

6. Then invite representatives from the “diminish sexual pleasure” groups to present their ideas.
Possible responses:

- *Reduction in penile sensation may cause some men to lose their erections.*
- *Can cause latex allergy with resulting discomfort.*
- *Most people prefer skin to skin contact rather than a latex barrier.*
- *Can interrupt the spontaneity of sex when partners must stop to put on the condom.*
- *Stigma around condom use may make partners feel uncomfortable or “dirty”.*
- *If vagina or anus is not sufficiently lubricated can cause friction and discomfort.*
- *If partners want “dry sex” condom failure may result.*
- *Using a condom involves handling the penis, which may make some couples uncomfortable.*
- *Condom use can cause “performance anxiety” which can lead to loss of erection.*

7. Facilitate a large group discussion based on the following questions below.

Key Discussion Points

- ↔ How would you discuss condom use objectively with clients and talk about how condoms affect sexuality (positively and negatively)?
- ↔ Is it truly possible for a couple to have a fulfilling and meaningful sexual relationship while using condoms during every sex act? If so, how can this be communicated to clients? If not, what are the trade offs? How could people keep using condoms even if they felt unfulfilled?
- ↔ Some people may find that a particular aspect of condom use enhances sexual pleasure, while for others this same aspect may interfere with sexual pleasure. How can we as providers encourage clients to appreciate the positive aspects of condom use while acknowledging and addressing the potentially negative aspects?
- ↔ How can people make condoms more attractive and fun?

Possible responses:

- *Use different colored condoms.*
- *Incorporate putting the condom on as part of the sex act in an erotic way.*
- *Have the partner put on the condom.*
- *Put on condoms creatively (e.g., with the mouth).*
- *Try different brands and styles.*

Essential Ideas to Convey

- It is important to acknowledge that condom use, like any family planning method, has an impact on a couple's experience of sexuality. Clients may find that certain aspects of condom use enhance sexual pleasure while other aspects may diminish it.
- As counselors, it is critical that we provide objective information about the potential benefits and disadvantages of condom use in relation to sexual experience. It is also important to allow clients to express their concerns and personal experiences with condoms
- Discussing the impact of condoms on sexuality is part of helping a client to make an informed choice about pregnancy and HIV/STI prevention. And if clients who choose to use condoms know what to expect, they are more likely to use them correctly and consistently.
- Many people, providers included, tend to recognize the negative input of condoms on sexual pleasure, but it is important to recognize and discuss the potential positive effects as well, in order to encourage condom use.

CONDOM DEMONSTRATION*

Objectives

1. To identify the correct steps for using a condom effectively.
2. To practice communicating with clients about how to use a condom correctly.
3. To identify common errors in condoms use and how to correct them.
4. To practice conducting a condom demonstration on a penis model.

Time

60 minutes

Materials and Advance Preparation

- Flipchart paper with 13 steps to correct condom use plus hints written on it (see Facilitator Resource: *Steps to correct condom use*)
 - Writing paper
 - Pens or pencils
 - Condoms
 - Penis models (or substitutes such as cucumbers, bananas, wooden sticks with a rounded end, etc.)
 - Basket or envelope or other item from which participants can pull out written instructions
 - Participant Handout: *Reducing Condom User Error*
-

Steps

1. Divide participants into small groups of 3 or 4.
2. Give each group writing paper and pens or pencils.
3. Explain to the groups that they are going to participate in an activity in which they will discuss the correct steps of using a condom effectively. Then they will practice doing demonstrations of proper condom use on penis models. The goal of this exercise is to help them feel comfortable discussing condom use with clients and instructing them on how to use condoms correctly.
4. Ask each group to make a list, in the proper order, of all the steps that they think are necessary in correct condom use. Tell them that there are at least 13 steps. Give them a clue by informing them that the first step is “Check the manufacture date on the condom to make sure it is not expired.”
5. Ask them to write their instructions, with the numbered steps, as clearly and legibly as possible on the paper.

* Adapted from: *Integrating STDs and AIDS Services into Family Planning Programs: Training Community Workers*, L Stacey, CEDPA.

6. Once the groups have finished writing, collect the written instructions and put them in a basket or envelope and mix them up. Go around to each group and have one representative select a set of instructions out of the basket or envelope. If the instructions chosen are those created by that particular group, instruct the representative to return them and to select another set.
7. Ask one group at a time to take turns following the set of written instructions that they have selected. Instruct each group to select a volunteer who will physically follow the instructions by placing the condom on the penis model, based on cues from the other members of the group who will read the instructions out loud. Each group will select one member to read the instructions to the participant who is conducting the demonstration. The other members of the group will help tell the volunteer what to do. Make sure to inform the participants that they should follow the instructions as written and do not alter them, even if they disagree with the order of steps or specific instructions.
8. After all the groups conduct the demonstration, review what the group did correctly and make suggestions for improving the quality of demonstrations.
9. Display the flipchart with the correct 13 steps plus helpful hints. Either ask a volunteer to conduct the demonstration based on these instructions or conduct the demonstration yourself.
10. Ask participants to divide in pairs. Give each pair a penis model and condoms. Instruct them to take turns playing the role of the “counselor,” demonstrating and explaining to the “client” how to put a condom on a penis model correctly, using the instructions on the flipchart. Tell the “clients” to ask questions if the instructions are vague or unclear. Walk around the room and monitor the participants as they practice to make sure they are using the condoms correctly. Ask them to switch roles and repeat the process.
11. Invite the participants back into the larger group and facilitate a large group discussion based on the key discussion points below.

Key Discussion Points

- ↪ How did it feel trying to follow instructions for using the condom? How could this experience give us insight into how clients may feel when using condoms for the first time?
- ↪ What fears or concerns do you have about demonstrating proper condom use to clients? How can we address these?
- ↪ What are some of the most common mistakes people make when using condoms?
Possible responses include:
 - *Failure to use condoms throughout intercourse. For example starting intercourse without a condom and then putting one on just before ejaculation.*
 - *Placing the condom on the penis inside out and flipping it over rather than throwing it out and getting an new one (the inside out condom may have pre-ejaculate fluid which can contain HIV).*
 - *Withdrawing the penis when it has become soft instead of when it is still hard, immediately after ejaculation (this can lead to slippage and leakage).*

- *Not holding the rim of the condom against the base of the erect penis when withdrawing, leading to slippage.*
 - *Not waiting until the female partner is sufficiently aroused and lubricated or not using sufficient additional lubrication (non-oil based such as saliva or KY jelly) to prevent breakage.*
 - *Not leaving sufficient space at the tip of the condom for the ejaculate.*
 - *Using oil-based lubricant such as petroleum jelly (Vaseline), baby oil or hand lotion which can degrade the latex and lead to breakage (instead of water-based lubricants such as K-Y Jelly) Note: Some vaginal medication (e.g. those used to treat yeast infection) may contain oil-based ingredients which can damage latex condoms.*
 - *Not storing the condom properly in a cool, dry place (e.g., leaving it in a wallet).*
 - *Washing it out and using it again. Condoms are made to be used once and only once!*
 - *Using condoms that are beyond their expiration date.*
 - *Unrolling it and pulling it on like a sock, rather than rolling it down the penis*
 - *Using condoms while under the influence of alcohol or drugs and using them improperly because of impaired judgment.*
 - *Dry sex or putting herbal preparations or powders in the vagina can cause condoms to break.*
- How can we help clients feel more comfortable handling condoms and practicing putting them on a penis model?
- Possible responses:
- *We can reassure them that most people feel awkward handling and using condoms at first.*
 - *We can blow them up, stretch them over our hands, etc., to show them that they are strong and flexible (this touch of humor may make them feel more comfortable, too).*
 - *Have them practice in the dark, or with their eyes closed, to feel more comfortable using a condom with partners at night.*
 - *We can give them positive feedback and encouragement as they go through each step of condom use.*
 - *We can encourage them to talk about how they are feeling handling the condoms and practicing using them.*

Considerations for the Facilitator/Training Options

This exercise can be done in the form of a “race” where the participants are divided into 2 or 3 teams that compete to finish a task the fastest. The task is to take a set of 16 cards (3 “hint” cards and 13 “condom step” cards) that have been mixed up and to place them in the proper order. The teams compete to line up their set of cards in the correct order, with the team that finishes first without any mistakes winning the competition. After determining the winning team, the facilitator clarifies condom instructions and conducts a demonstration of correct condom use on a penis model. Participants can then practice condom demonstration in pairs. **Note:** It is necessary to prepare several sets of cards ahead of time.

Some participants may be uncomfortable talking about or working with condoms. If you think that it would be useful to conduct an exercise to desensitize the issue, ask the participants to blow up non-lubricated condoms like balloons, or ask volunteers to put condoms over their heads or hands. This is a good way to reduce anxiety and to show the participants how strong condoms

are. This exercise also shows the participants that condoms can accommodate a large-sized penis.

Essential Ideas to Convey

- It is important for reproductive health providers to have skills in promoting and demonstrating correct condom use, especially given that most condom failure is due to improper use rather than flaws in the method itself.
- In order to explain condom use properly it is important for providers to have experience with putting on a condom correctly. It is also important to talk to clients about the most common reasons for condom failure and how to prevent it.
- In the event of condom failure, if a woman is concerned about pregnancy, instruct her to obtain emergency contraception (if available). If a man or woman is concerned about possible exposure to HIV or STI as a result of condom failure, counsel them about their options, such as having an HIV antibody test.
- Emphasize to clients that practice improves the correct use of condoms. Make sure that clients practice putting on condoms on penis models while you are watching so that you can encourage them and correct their mistakes.

FACILITATOR RESOURCE: STEPS TO CORRECT CONDOM USE

Hint: Make sure condoms are stored properly and obtained from a good source.

1. Check manufacture or expiration date on package.

2. Remove condom from package.

Hint: Do not use teeth or sharp objects to open condom package.

3. Unroll condom slightly to make sure it unrolls properly.

4. Place condom on the tip of the erect penis.

Hint: If condom is initially placed on the penis backwards, do not turn it around, throw it away and start with a new one (because some pre-ejaculate may be on the condom).

5. Squeeze air out of tip of condom.

6. Unroll condom down penis.

7. Smooth out air bubbles.

8. With condom on, insert penis for intercourse.

9. After ejaculation, hold on to condom at base of penis while withdrawing penis.

10. Withdraw penis while still erect.

11. Remove condom from penis.

12. Tie condom to prevent spills or leaks.

13. Dispose of condom safely.

THE FEMALE CONDOM: AN INTRODUCTION

Objectives

1. To introduce participants to the female condom, describing what it is and how effective it is.
2. To demonstrate how the female condom is inserted and removed.
3. To reflect on common questions and concerns about the female condom and to develop effective responses to these questions and concerns.

Time

60 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
 - Participant Handout: *Female condom overview*
 - Handouts/charts demonstrating how the condom is inserted (if available)
 - Participant Handout: *Instructions for using a female condom*
 - A plastic pelvic model, if available
 - Enough female condoms for all participants (or to share)
 - Tissues or towels for wiping off lubricant from hands
 - Facilitator Resource: *Responding to questions and concerns about the female condom*
-

Steps

1. Begin the session by asking the participants to brainstorm everything they have heard about the female condom. Write these comments on the flipchart paper. Once they are done, provide a brief lecture on the female condom, using the handout, *Female Condom Overview*. Be sure to correct any misinformation that may have been mentioned.
2. Distribute the female condoms to everyone (or to pairs, if there are not enough female condoms for each person to have one). Using the charts and handout, *Instructions for using a female condom*, (and the female pelvic model, if available), demonstrate how the female condom is inserted.
3. Invite participants, if they feel comfortable, to open their female condoms and practice squeezing the flexible ring. Distribute tissues or towels so that they can wipe the lubricant from their hands. Answer any questions they may have.
4. Ask the participants to brainstorm a list of questions they think their clients might have about the female condom when they first hear about or see it. Record these questions on the flipchart paper, supplementing the list with those on the facilitator's resource, *Responding to questions and concerns*.
5. Break the larger group into smaller groups of four and assign each group as many of the client questions as is necessary to guarantee that an equal (or close to equal) number of

questions is being discussed by each small group. Give the small groups approximately 10 minutes in which to come up with answers to each question.

6. In the larger group, ask each small group to present their questions and answers. Ask for comments from the other small groups on the answers they hear. Supplement or correct information, as necessary.

Key Discussion Points

- ↔ How likely do you think it is that your clients will be able to use a female condom? Why or why not?
- ↔ What are some of the ways in which you might be able to address clients' concerns and discomfort about the female condom?
- ↔ How easy do you think it will be for your clients to use the female condom with their partners? What are the barriers that they might face? What would be some of the advantages to their using them?
- ↔ How would you communicate with clients about the female condom as a good method of dual protection (i.e., protection against unintended pregnancy and HIV/STIs)?

Possible answers:

- *Explain that the female condom (like the male condom) is an effective method of family planning when used consistently and correctly and that it also provides protection against HIV/STIs.*
- *First assess and explore their sexual and reproductive health needs and if they require dual protection, promote the female condom as a good option.*

Essential Ideas to Convey

- The female condom is a good option for dual protection in relationships where partners want to avoid both pregnancy and sexually transmitted infections, particularly if a male partner is less willing to use a male condom because of reduced pleasure.
- The female condom is a brand new concept to many clients. As with anything new, it is important to encourage them to try the female condom more than once, especially if they found insertion difficult or if they do not like how it looks at first.
- For some women, the female condom offers a barrier method option which they can control (i.e. they can insert it themselves as opposed to relying on the man to put on a condom). However, some studies have shown that the challenges women face in negotiating male condom use with their partners are also true for the female condom. In counseling about the female condom, providers should help their female clients improve their communication and negotiation skills with male partners.

FACILITATOR RESOURCE: ADDRESSING COMMON QUESTIONS AND CONCERNS ABOUT FEMALE CONDOMS*

How effective is the female condom?

The typical use effectiveness rate is 79%.

When should it be inserted?

Right before sex or up to eight hours ahead of time.

Is the female condom difficult to use?

It is not difficult to use, but it does take some practice to get used to it. It is important to not abandon the female condom just because it feels a bit awkward the first few times a woman tries to use it. One thing you can try is practice putting it inside when you are not about to have sex so that there is not the additional pressure of having someone wait for you while you are trying to figure it out.

What happens if the penis does not go in correctly?

If the penis goes inside the vagina on the outside of the female condom, the man should pull his penis out, and place it back inside the ring of the female condom. Sometimes, this is caused by insufficient lubricant. Adding lubricant at this time may help.

Will the ring on the outside hurt?

No, the outer ring is soft and flexible. Some women have reported that the outer ring can tug against the clitoris during intercourse and this may enhance pleasure for the woman.

What kind of lubricant should be used with the female condom?

The female condom comes pre-lubricated with a silicone-based, non-spermicidal lubricant. Some brands also supply small tubes of additional lubricant. If not, the female condom can be used with both water-based and oil-based lubricants. This is different from the male condom, which can be used with only water-based lubricants.

Can the female condom be used more than once?

The female condom is currently approved for only single use. Initial studies exploring whether it can be used more than once are currently being conducted. While the initial results are promising, it appears that what is used to clean the female condom and exactly how it is cleaned are two significant factors.

Can the female condom be used in different sexual positions?

The female condom can be used in any sexual position, although additional lubrication may be needed in some. If the woman is standing up or on top of her partner, she may wish to return to a lying down position before her partner withdraws his penis to avoid spilling semen.

* From: *The Female Condom: A guide for planning and programming*, WHO and UNAIDS, 2000.

Can I use a female and male condom at the same time?

No, you should not use a male and female condom together. This can cause friction that can lead to slipping and tearing to either or both condoms. In addition, if oil-based lubricant has been used with the female condom, it will break down the latex in the male condom.

Does the female condom's inner ring need to fit snugly around the cervix?

No, because usually the ejaculate is captured inside the sheath, which adheres to the vaginal wall thanks to the lubrication, lining it as if it were a second skin.

Can the man feel the inner ring?

Usually most men don't, although there have reported cases of men who have felt it.

Why is the inner ring not attached to the sheath?

To allow the ring to slip into place and lodge under the cervix. Once in place, the inner ring does not get in touch with the penis during sex.

Can a woman urinate while wearing a female condom?

Yes, because it can be moved aside for urination. Gently move the ring that forms the outer edge to the side or back. After urinating, check with your finger to be sure that the inner ring is in place past the pubic bone. If you cannot feel the ring, it's in place.

Can the female condom be used when a woman has her period?

Yes, but then it is best not to insert it very far in advance of intercourse.

Can the female condom be used by women who have a retroverted uterus?

Yes, as it lines the vaginal walls covering the cervix along the way.

Can it be used if the woman has had a hysterectomy?

Yes. The lubrication makes the sheath cling to the inner vagina, conforming to its natural contours and lining the inner vagina like a second skin.

Can it be used soon after childbirth?

There is evidence that the female condom can reduce pain for women who find sex uncomfortable and is useful for women who have recently given birth or had an episiotomy.

Can it be used by a pregnant woman?

Yes, there are no contra-indications.

Can it be used if the woman has an RTI?

In the presence of any infection, a woman should discuss the use of any method with a health care provider.

Does it protect the man's scrotum from genital warts?

If inserted correctly, during intercourse the scrotum should not come in contact with the labia, so protection is provided.

Can spermicides be used with a female condom?

It depends whether or not the woman is sensitive to spermicides. If there is no sensitivity, spermicides can be put into the vagina before inserting the female condom, or cover the outside of the condom with the spermicide, whichever is preferable.

My partner has a very large penis, will the female condom fit?

If he fits in your vagina, he will fit in the female condom.

I know that male condoms expire. For how long do female condoms last? Where do they have to be stored?

The US FDA has approved the female condom to have a shelf life of five years from the date on which it is manufactured. This date usually appears on the package. Polyurethane is different from latex, so no special storage is required.

CONDOM NEGOTIATION: WHY IS IT DIFFICULT FOR WOMEN?

Objectives

1. To identify some of the common reasons why it can be difficult for women to negotiate condom use with their partners.
2. To develop strategies to help clients confront barriers to condom negotiation.

Time

45 minutes

Materials and Advance Preparation

- Blank flipchart paper
 - Markers
 - Tape
 - Participant Handout: *"I can't ask my partner to use a condom because..."*
 - Facilitator Resource: *"I can't ask my partner to use a condom because..."* (filled in for your reference)
-

Steps

1. Ask participants whether they feel that their clients always practice safer sex in their relationships. (There will be a range of answers, but many will say "no.")
2. Distribute blank copies of the handout, *"I can't ask my partner to use a condom because..."* Note that in the middle of the handout is a rectangle that reads, "I can't ask my partner to use a condom because..." Surrounding this rectangle is a number of other shapes.
3. Ask the participants to brainstorm together some of the common reasons why women cannot ask their partners to use condoms. Record these on flipchart paper and ask participants to write reasons down on their handout in each of the shapes extending out from the center circle. (Note: These are not "excuse" lines as in the *Condom excuses game* on page 158. These reasons should focus on more social, cultural, gender or situational issues. For example, "Lack of transportation to the clinic where condoms are available." or "Because he will beat me up.")
4. Divide the group into pairs. Ask the pairs to discuss what kinds of suggestions they would make or strategies they would use if a client mentioned any of the reasons written in the shapes on their handouts. Instruct them to draw a line extending from each shape (reason) for as many responses or suggestions as they have, and to write how they would address the concerns of a client who expressed each of the responses.
5. Discuss the activity in the larger group, asking different pairs to share their suggestions and strategies for each factor that prevents women from asking their partners to use condoms. Lead a group discussion based on the discussion points below.

Key Discussion Points

- ➔ What are the main themes you see expressed here for why women find it challenging to negotiate condom use with their partners?

Possible responses:

- *Fear (of violence, that partner will think she is cheating, abandonment)*
 - *Desired pregnancy*
 - *Partner's wishes (i.e., he hates them, finds them unpleasant, diminishes sexual experience, etc.)*
 - *Lack of confidence*
 - *Stigma (the belief that only prostitutes, truck drivers and homosexuals use condoms, etc.)*
- ➔ How did you feel when discussing the reasons clients cannot ask their partners to use condoms? Did any feel like they were excuses to you? Why might it be important to recognize how particular reasons and responses might affect you as a provider?

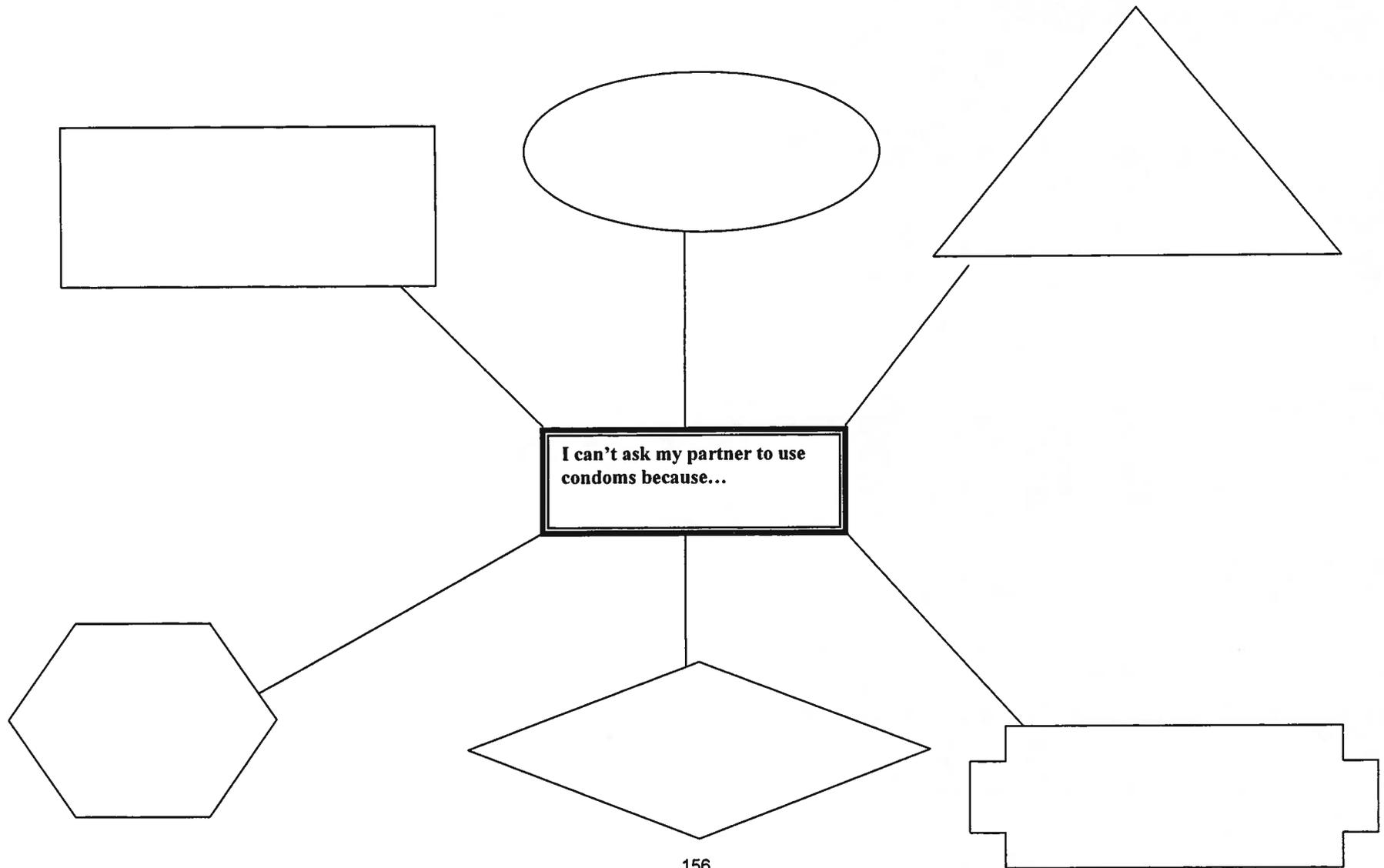
Possible responses:

- *If you find certain reasons to be excuses rather than real barriers you might feel frustrated with clients and you might convey this impatience to them.*
- *Some barriers such as lack of transportation to the clinic or lack of money to purchase condoms may also leave you feeling powerless to help and frustrated.*

Essential Ideas to Convey

- The activity just conducted is one that can be used with clients in a clinic setting. You could use this type of chart to explore individual client's barriers to negotiating condom use or discussing other sensitive issues with partners.
- Some reasons for not using condoms can sound like excuses to the provider. It is important to remember the context in which many clients live, and to understand that many clients have limited options when it comes to negotiation or communicating within their relationships.

FACILITATOR RESOURCE: “I CAN’T ASK MY PARTNER TO USE CONDOMS BECAUSE...”



FACILITATOR RESOURCE: SOME REASONS WOMEN CAN'T ASK THEIR PARTNER TO USE CONDOMS

[Note: these reasons will be written into the shapes on the previous page]

“I can't ask my partner to use condoms because...”

- He would leave me...
- He would hit me or beat me...
- He says that he doesn't like how they feel...
- He will think that I am cheating on him (or that I have a disease)...
- He wants me to get pregnant...
- I want to get pregnant...
- Only prostitutes, homosexuals, truck drivers, etc., use condoms...
- He will think that I am accusing him of cheating...
- I don't feel capable of asking...I wouldn't know how to ask...
- We have no money to buy them...
- We have no place to buy them in our village and I can't get into the city...
- He tried them once and lost his erection...
- They break anyway so it's useless...
- I don't like how they feel...I'd rather have skin to skin contact...

CONDOM NEGOTIATION: EXCUSES GAME

Objectives

1. To examine the various excuses people might use to avoid condom use, and to develop effective responses to persuade them to do so.
2. To find ways to help clients respond to common excuses partners might give for not wanting to use condoms.

Time

30 minutes

Materials and Advance Preparation

- Blank flipchart paper
 - Markers
 - Tape
 - Handout: “Responding to excuses for not using condoms”
 - Two bells or other signals, one for each team to use
 - Prizes (optional)
-

Steps

1. Divide the participants into at least two but no more than three teams. Ask them to choose a name for their team; if they cannot think of anything or do not wish to, simply label them teams 1, 2, and 3.
2. On a piece of flipchart paper, write out the team names for keeping score.
3. Let the group know that you will be reading a common phrase that people might say when they do not want to use condoms. Their job, as a group, is to come up with a fast, effective response to the phrase. The first group to come up with a response should ring the bell provided, or shout out an agreed-upon word or phrase (such as “Got it” or “Done”). Then that small group is to share its response with the large group.

Scoring is as follows: the first group that responds gets one point for being the first to respond. Then ask the other group(s) for their responses. The one with the best response of the three receives two additional points (the “best” response can be determined by audience cheering, through facilitator choice, or through other means).

4. Using the “excuses” listed in the handout, *Responding to excuses for not using condoms*, play the game for at least 15 minutes. Then tabulate the scores and provide prizes to the first and second (and, if applicable, third) place teams (optional).
5. Bring the teams back into one larger group. Distribute the handout, *Responding to excuses for not using condoms* and review it with the group. Highlight any responses that may not have been shared during the activity. Ask if the participants can think of any additional

excuses that people may have for not wanting to use condoms. Suggest that participants write down the additional excuses and ideas for responses that they came up with during the game on their sheets for future reference.

Key Discussion Points

- ↪ What did you learn from doing this activity?
- ↪ Do you think your clients could use these responses? Why or why not?
- ↪ In what ways do you think you might be able to use this exercise with your own clients?

Possible responses:

- *You could role play negotiating condom use with clients and their partners, with clients playing themselves and you playing the role of the partner. In this way the clients could practice responding to partners' excuses.*
- *You could ask them to list some of the reasons why they think their partners won't want to use condoms and come up with some responses together.*
- *You could show them the handout on excuses and responses to keep as a reference.*
- *You could convene a peer support group or lead a discussion with clients in the clinic waiting room so people can share their experiences or suggestions with each other.*

Considerations for the Facilitator/Training Options

There are two alternative ways of conducting this activity:

1. On individual sheets of paper, have one of the various condom excuses written. Break the group into smaller groups. As a small group, they are to write a response to the condom excuse that appears on their sheet of paper. Give them about 3 minutes in which to do this. Call time, and ask each group to pass their sheet of paper to the next group to the right. The groups are now representing the "refuser" – the person who does not want to use condoms. Each group is to write a response to what the previous group wrote. Call time, and ask the groups to pass the sheets around again, where they are to write a response to the next line, and so on. Do until each group has the sheet they started with. Ask two representatives from each group to come to the front of the room. Ask them to decide who is the person refusing to use condoms, and who is the person trying to make that person use them. Ask them then to read what is on the sheet of paper as a dialogue. When done, ask the next group to come up and do the same. Continue until all the groups have presented their "dialogues."
2. Break the larger group into 2 (or 3) teams as instructed above. As a first step, ask each of the groups to come up with a list of at least 5 statements that might be used by a person (male or female) who does not wish to use condoms. Collect these, and use them in the game, supplementing them with what appears on the handout, "Responding to excuses for not using condoms," as necessary.

Essential Ideas to Convey

- Emphasize to the group that this is just a game with quick retorts that people can try to use with their partners. In reality, however, negotiating condom use is never so easy or straightforward. In most cases, using condoms consistently (or negotiating with a partner to do so) is a long-term process, and not something a person can do immediately.
- There are many excuses people come up with for not wanting to use condoms. These can include personal preferences about what is pleasurable or not, ignorance about HIV/STI transmission and prevention, negative associations attached to condoms, a wish to assert power, or desires to get pregnant.
- The desire to remain in a relationship or to adhere to certain societal norms may outweigh one's intentions to use condoms. Therefore, it is important not to minimize any of these excuses for the client. Expect that clients may have difficulty using the response lines developed during the game when they actually negotiate safer sex with partners.
- Good communication in relationships is important for negotiating condom use. However, some people, particularly women, may not have the power in a relationship to insist on condom use with a partner. In fact, insisting on condom use can result in violence or other negative responses towards some people, especially women.
- Making a commitment to use condoms (and negotiating with your partner to do so) can be a long-term process. Don't expect clients to begin using condoms consistently immediately. There may be many reasons, including erectile dysfunction (or fear of it), that make condom use difficult for many people.

WHAT IS DUAL PROTECTION AND WHY TALK ABOUT IT?

Objectives

1. To define dual protection.
2. To explore the challenges of working with clients on meeting their needs for dual protection, and to develop strategies for addressing these challenges.

Time

45 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Participant Handout: *Introduction to dual protection*
 - Tape
 - Facilitator Resource: *Presentation on dual protection*
 - Prepared flipchart paper with definition of dual protection (see Facilitator Resource: *Presentation on dual protection*)
 - Prepared flipchart paper with 4 questions, one for each small group:
 - 1) How does a focus on dual protection better meet clients' needs than a single focus on family planning?
 - 2) Why is it important to address dual protection with the following different populations – young people, sex workers, “typical” family planning clients and men?
 - 3) How could the idea of using condoms for dual protection help women negotiate condom use with their partners?
 - 4) How would promoting condoms as an effective family planning method help to de-stigmatize their use?
-

Steps

1. Introduce the activity by telling participants that they will be exploring the concept of “dual protection” and thinking about ways to work with clients on meeting their needs for dual protection.

Present the group with the flipchart paper with the definition of dual protection written on it. Briefly present the elements of dual protection:

Dual protection can be defined as a strategy to prevent both HIV/STI transmission and unintended pregnancy through the use of condoms alone, the use of condoms combined with other methods (dual method use), or the avoidance of risky sex. More specifically, dual protection can include: 1) the use of condoms alone, 2) dual method use, or 3) the avoidance of risky sex (see Facilitator Resource: *Presentation to Dual Protection*). Answer any questions that the group may have at this point.

2. Facilitate a large group brainstorming session on the four questions that you have written on the flipchart paper, writing down the group's responses to each question.

Possible responses to the four questions:

- 1) How does a focus on dual protection better meet clients' needs than a single focus on family planning?
 - *Clients are multidimensional people with many needs, concerns, fears and hopes, etc.*
 - *Clients may come to the clinic specifically for family planning purposes, but by exploring a client's individual circumstances, sexual relationships, HIV/STI risks, etc., other risks and needs may emerge. In this way, providers are better able to provide services that address multiple aspects of the client's life.*
 - *If providers just met clients' needs for family planning they might leave them at risk of HIV/STIs, or with unanswered questions or concerns about sexuality*
- 2) Why is it important to address dual protection with the following different populations – young people, sex workers, “typical” family planning clients and men?
 - *Young people tend to have more partners than older people and are often not prepared for pregnancy. Dual protection meets their needs for HIV/STI prevention and the prevention of unintended pregnancy. Talking with young people about non-penetrative sex and masturbation may help to delay them from beginning riskier sexual activities (i.e., greater risk of HIV/STI transmission and pregnancy), such as those involving penetration.*
 - *Sex workers have multiple partners and are therefore at risk of both unintended pregnancy and HIV/STIs. Pregnancy prevention may be a prime motivator for sex workers using condoms. Unfortunately, sex workers may have difficulty negotiating condom use with clients because paying clients may threatened to go elsewhere if they insist on condom use.*
 - *A “typical” family planning client may have needs for dual protection but a counselor first needs to explore her circumstances to find out what those needs might be. Since she is visiting a family planning clinic it is most likely that she perceives the need to prevent pregnancy. Many women acknowledge that their partners have other partner. Often women are put at risk for HIV/STIs through the behavior of their partners, who may have other partners and not use condoms.*
 - *Men have their own sexual and reproductive health needs and concerns, including the need for dual protection. They may be unaware of how their sexual behaviors may place themselves and their partners at risk of HIV/STIs and unintended pregnancy. Since dual protection relies on male cooperation to use condoms it is important to involve men in dual protection education and counseling. This might include making clinics more accessible and inviting to men; creating male-oriented education materials on dual protection; developing media campaigns for men on dual protection; offering counseling on dual protection alone or as part of a couple, etc.*
- 3) How could the idea of using condoms for dual protection help women negotiate condom use with their partners?

- *Women could emphasize the use of condoms for family planning purposes rather than for the prevention of HIV/STIs, which may make condom use less threatening for partners.*
 - *Many women and their partners are actively seeking reliable methods of family planning and are comfortable with the use of family planning, but are not as comfortable with the concept of disease prevention. Therefore, when the condom is recognized and promoted as an effective method, a couple can focus on the family planning aspects of condom use rather than on disease prevention, which may be perceived as questioning the fidelity of the relationship.*
 - *Women could promote condom use to their partners as a great method of family planning with the added benefit of disease prevention capabilities.*
- 4) How would promoting condoms as an effective family planning method help to destigmatize their use?
- *Condoms are often stigmatized as a method of “disease” prevention, with the misconception that only certain groups of people such sex workers, truck drivers, etc., use them. If family planning providers promoted them for family planning as well as for the prevention of HIV/STIs, clients might perceive them less negatively, and as “just another” family planning method.*
 - *If clients were to introduce condoms into their relationships for family planning purposes their partners might find this less threatening than if the stated reason for using them was for the prevention of HIV/STIs.*
3. After discussing the four questions above, facilitate a discussion on the challenges of working with clients on dual protection, using the key discussion points below.
4. Distribute the handout *Introduction to dual protection* as a resource for participants. Go over the handout together as a group.

Key Discussion Points

- ↪ One of the challenges of meeting women’s needs for dual protection is that condom use relies on the cooperation of their partners. What are some strategies for addressing this challenge?
Possible responses include:
 - *Involve men in dual protection education and outreach so that they are aware of risks and knowledgeable about how to protect themselves and their partners.*
 - *Encourage women to bring their partners to counseling sessions for couples’ counseling on dual protection.*
 - *Help women clients’ to develop strong communication and negotiation skills through role plays and other one-on-one work.*
 - *Run group counseling sessions for women on dual protection – hearing how other women discuss dual protection and negotiate condom use with their partners can be motivating and supportive.*
- ↪ Why do you think some clients would find it challenging or unappealing to use dual methods (i.e., condoms along with another family planning method)?
Possible responses include:

- *Using two methods can cost twice as much.*
 - *It is that much more disruptive to remember to use or transport both methods.*
 - *There is less of an incentive to use both because one may be sufficient.*
 - *It may be hard enough to convince a partner to use one method, let alone two.*
 - *Two methods (depending on what they are) may be disruptive to the spontaneity of sex.*
- How might promoting dual method use (i.e., condoms along with another family planning method) affect how clients view condoms?

Possible answers:

- *If you are promoting another method because it is a more effective family planning method, clients may view condoms as ineffective family planning methods, and therefore not want to use them.*
- *Clients may not want to “bother with” condoms if they perceive them to be ineffective.*
- *Clients may be concerned about unintended pregnancy if they use condoms alone.*
- *Clients may associate condoms only with the prevention of HIV/STIs rather than pregnancy.*

Considerations for the Facilitator/Training Options

It is important to be familiar with and comfortable discussing dual protection before doing this activity. It may be a good idea to practice giving the presentation on dual protection before trying it out with participants in a real training session.

Alternatives:

- This exercise can be conducted as a small group activity rather than a large group brainstorm. The group can be divided into 4 small groups that are each assigned one of the questions to discuss together. After 10-15 minutes, the groups are invited back into the larger group to present their reactions to their question to the larger group. Given that these questions can be challenging, it is not recommended to conduct this activity in small groups unless 4 facilitators are available to participate (one per group) as the participants brainstorm.
- This activity can also be conducted as a presentation, without brainstorming, instead. In this case, the facilitator would develop a presentation based on the Facilitator Resource, and then facilitate a group discussion based on the key discussion questions.

Essential Ideas to Convey

- Dual protection counseling is designed to meet clients' needs for protection against unintended pregnancy as well as infection with HIV/STIs. Sexuality is a link between family planning and HIV/STI prevention because pregnancy and HIV/STI infection are two possible outcomes of sexual behaviors.
- In some cases it may be appropriate or desirable for clients to use dual methods (i.e., condoms plus another family planning method), but be careful not to stigmatize condoms as a less effective family planning method or as a method solely for the prevention of infection.
- Condoms when used consistently and correctly can be a highly effective family planning method as well as the only method that is highly effective against the transmission of HIV/STIs. Clients need to have hands on training in how to use condoms correctly in order to learn how to protect themselves effectively.
- Dual protection counseling better meets clients' needs than traditional family planning counseling because clients have multiple needs. Clients may come to the clinic specifically for family planning, but by exploring a client's individual circumstances, sexual relationships and HIV/STI risks other needs may emerge.
- Dual protection counseling upholds the concept of informed choice by making sure that clients' are knowledgeable and aware of their risks for HIV/STI prevention and unintended pregnancy while making family planning decisions.
- Clients are not making truly informed choices about family planning unless they are aware of their risks for HIV/STIs and knowledgeable about how effective the various family planning methods are in preventing HIV/STIs. Dual protection counseling ensures that clients are aware, knowledgeable and informed.

FACILITATOR RESOURCE: PRESENTATION ON DEFINING DUAL PROTECTION*

What is dual protection?

Dual protection can be defined as a strategy to prevent both HIV/STI transmission and unintended pregnancy through the use of condoms alone, the use of condoms combined with other methods (dual method use), or the avoidance of risky sex. More specifically, dual protection can include:

1) The use of condoms alone:

- The use of a condom (male or female) alone for both purposes.

2) Dual method use:

- The use of a condom plus another contraceptive method for extra protection against pregnancy;
- The use of a condom plus emergency contraception, should the condom fail;
- Selective condom use plus another family planning method (for example, using the pill with a primary partner but the pill plus condoms with secondary partners).

3) The avoidance of risky sex:

- Abstinence
- Avoidance of all types of penetrative sex
- Mutual monogamy between uninfected partners combined with a contraceptive method for those wishing to avoid pregnancy
- Delaying sexual debut (for young people)

Why is condom promotion so important for dual protection?

- The male latex condom, when used correctly and consistently, is the only technology that has been proven to be highly effective in preventing the sexual transmission of HIV and pregnancy at the same time.
- The female condom may be as effective but there is not enough data to support this claim at this time.

Why is it important to legitimize condoms as an effective method of family planning?

- In some cases, pregnancy prevention can be a greater motivator for condom use than HIV/STI prevention.
- If family planning programs promoted condoms as an effective method for pregnancy prevention, this would have the added benefit of reducing the stigma of the condom as a method to prevent only HIV/STIs.
- In general, many family planning providers believe that condoms are not effective for pregnancy prevention, but they are effective for HIV/STI prevention. In part, this bias is based on the fact that some other family planning methods such as sterilization, IUDs, injectables and implants are more effective than condoms in “perfect” and “typical” use. But

* Adapted from *Condom Promotion and Dual Protection*, Jeff Spieler, Mihira Karra and Kirsten Vogelsong, USAID/G/PHN/POP/R; and PRIME II slide show

if condoms are used correctly and consistently, they are highly effective against pregnancy. This fact needs to be communicated to providers and clients alike.

- Data show that from a single act of unprotected penile-vaginal intercourse, the probability of acquiring various STIs is much greater than becoming pregnant. Therefore if condoms are used consistently and correctly to prevent STIs, then they must be even more effective against pregnancy.
- Condoms and those who use them are stigmatized because they are currently associated with HIV/STI prevention and their use implies that partners may have other sexual partners. This stigma from associating condom use and sex work or sexual promiscuity can be addressed by promoting condoms as effective methods for both pregnancy and disease prevention.

Why is dual protection counseling so important in family planning services?

- Many family planning clients may be at risk of infection with HIV/STIs as well as unintended pregnancy. Many women are at risk of HIV/STIs mostly as a result of their partners' risky behaviors. Dual protection counseling can help clients to perceive their own risk of infection and unintended pregnancy and to develop strategies to protect themselves.
- Meeting clients' needs for dual protection improves the quality of sexual and reproductive health services by addressing clients' multiple concerns.
- Pregnancy and HIV/STI prevention needs are inseparable and should be addressed together.

How does dual protection counseling relate to the concept of "informed choice"?

- Dual protection counseling upholds the concept of informed choice by making sure that clients' are knowledgeable and aware of their risks for HIV/STI prevention and unintended pregnancy while making family planning decisions.
- Clients are not making truly informed choices about family planning unless they are aware of their risks for HIV/STIs and knowledgeable about how effective the various family planning methods are in preventing HIV/STIs. Dual protection counseling ensures that clients are aware, knowledgeable and informed.

What are some key strategies for dual protection in a family planning setting?

- Working with clients on partner communication and condom negotiation skills.
- Involving men in counseling and education and addressing their concerns about condoms.
- Eroticizing condom use and making it palatable to both partners.
- Helping women to consider the ramifications of their decisions – both positive and negative, and recognizing the limitations that many women may have in negotiating condom use (i.e., insisting on condom use may lead to violence, abandonment, etc.).
- Promoting the female condom as a viable method (where it is available).

DUAL PROTECTION MESSAGES

Objectives

1. To identify key issues and challenges related to dual protection promotion.
2. To develop messages for promotion of dual protection with different populations.

Time

60 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
-

Steps

1. Divide participants into four groups.
2. Explain that each group will be responsible for developing one or more messages on dual protection and a means of delivering the message. Each group will be assigned one of the following contexts or media for their message:
 - Mass media (e.g., TV, radio, newspaper, internet)
 - Small media (e.g., posters, billboards, brochures)
 - Counseling/communication in health care facilities
 - Community education (e.g., in schools, community events)
3. Assign each group one of the following audiences for its message:
 - Married women
 - Young people
 - Men
 - Sex workers
4. Give each group 20 minutes to develop their message and means of delivery and explain that they will be expected to present the result to the larger group. The presentation can be on flipchart paper or dramatized.
5. Invite each group present their messages to the larger group.
6. After all the groups have presented, lead a group discussion based on the following key discussion points.

Key Discussion Points

- ↔ What was the most challenging thing about developing the messages?
- ↔ How were the messages different for men and women? How were they similar?
- ↔ How were the messages tailored to (designed for) young people?
- ↔ How were the messages tailored to (designed for) sex workers?

- ↪ How are these messages different or similar to the current messages you hear about condoms in your country?

Considerations for the Facilitator/Training Options

Some messages will be the same for all of the groups. For example, the focus on communication with partners, pregnancy prevention as a motivator for condom use, or the positive aspects of condoms, may be the same for sex workers as it would be for young people.

Essential Ideas to Convey

- Dual protection messages are essential to convey to a variety of audiences through a variety of media. The more information and awareness people have about dual protection, the more likely they will be able to protect themselves. Information alone, however, is never sufficient for behavior change. People also need skills, support and motivation to change.
- Condoms when used consistently and correctly can be a highly effective family planning method as well as the only method that is highly effective against the transmission of HIV/STIs. People need to have hands on training in how to use condoms correctly in order to learn how to protect themselves effectively.
- Men's involvement in dual protection is essential. Tailoring dual protection messages and counseling to men as well as women will help couples prevent unintended pregnancy and STIs.
- Pregnancy prevention may be a greater motivator for condom use than HIV/STI infection. Therefore, the twin benefits of condom use (i.e., pregnancy prevention and HIV/STI prevention) should be communicated to a variety of audiences.

DUAL PROTECTION COUNSELING: CASE STUDIES

Objectives

1. To introduce participants to the principles of dual protection counseling.
2. To explore with participants how they might tailor dual protection counseling to meet different clients' needs.

Time

60 minutes

Materials and Advance Preparation

- Copies of the two "Counseling case studies" (see handout: *Counseling case studies*)
 - Flipchart paper
 - Markers
 - Tape
-

Steps

1. Introduce the activity by telling participants that we are going to be discussing dual protection counseling and how they might approach working with different clients on meeting their needs for dual protection.
2. Tell the participants that you will begin by reading two different scenarios out loud (see the handout, "Counseling case studies," case numbers 1 and 2). Distribute copies of the handout, *Counseling case studies* so that the participants can follow along as you read the first two cases out loud.
3. After reading the first two cases out loud, facilitate a group discussion and brainstorm based on the following questions:
 - a) **What was different about the two cases?**

Possible responses:

 - *The first case is about family planning – it doesn't address HIV/STI prevention.*
 - *The second case is about HIV/STI prevention – it doesn't address pregnancy prevention.*
 - *The first case presented a range of methods; the second case focused on just the condom.*
 - b) **What was similar about the two cases?**

Possible responses:

 - *The counselors are warm and seem interested in helping the clients.*
 - *The counselors spent time with the client, provided information and encouraged questions.*

c) How did the cases approach condom promotion differently?

Possible responses:

- *In the first case, condoms were mentioned as one of many methods, and the counselor presented it as a less effective family planning method. That the condom is effective against HIV/STI transmission was not mentioned.*
- *In the second case, the condom was the only method mentioned, and it was promoted as an effective method against HIV/STIs. The condom's role as a family planning method was not mentioned.*
- *In the first case, the counselor did not do a condom demonstration; in the second case the counselor did a condom demonstration and encouraged the client to practice putting a condom on a model.*
- *In the first case, the counselor implied that the condom was not suitable for married couples.*
- *In the second case, the counselor encouraged a married client to use condoms and discussed how to eroticize condoms, or to make them more appealing to partners.*
- *In the second case, the counselor helped the client to practice discussing condom use with her partner through role playing.*

d) How could have each case addressed dual protection more fully? What was missing from each case in terms of dual protection?

Possible responses:

- *In the first case, while the counselor addressed the client's needs for family planning, she did not explore the client's needs for dual protection. She did not explore the client's risk for HIV/STIs or assess how the client perceived her own risk of infection with HIV/STIs. The counselor made assumptions about the client's situation, assuming that because she was married, condoms wouldn't be a suitable method for her. In order to counsel the client effectively on dual protection, the counselor needed to ask questions about the context of the client's relationship with her partner, about their sex life, about their risks for HIV/STIs, and how the client perceived her own risk, etc. If the client were at risk for HIV/STIs, the counselor would need to discuss condoms, demonstrate condom use, encourage the client to practice putting a condom on a model, assess how the client would feel discussing condom use with her partner, and discuss strategies for addressing condoms with her partner, etc.*
- *In the second case, the counselor did not explore the client's needs for dual protection. She did not explore the client's risk for unintended pregnancy or address her family planning needs. She promoted the condom without exploring the client's (and her partner's) priorities for pregnancy or pregnancy prevention. In order to explore effectively the client's needs for dual protection, the counselor should have asked the client about her pregnancy objectives and needs for family planning, etc.*

4. Divide the participants into 4 small groups. Provide them with flipchart paper and markers.

5. Ask two of the groups to discuss and brainstorm responses to the following question:

- **How would you talk to a client who is at low risk for HIV but at high risk for pregnancy about dual protection?**

Possible responses:

You would first need to assess how the client perceived her own risk of HIV by asking questions about her relationships, if she thought her partner(s) may have other partners, how she felt about her sex life, and any other concerns that she might have. If she did not perceive herself to be at risk, you would talk to her about all the family planning methods available, making sure to discuss the dual benefits of condom use for pregnancy prevention and HIV/STI prevention. Following her lead and interests, you would help her select a family planning method that best suited her needs and lifestyle; that method might be the condom, among a range of other options. Even if she did not discuss the condom, you might encourage her to practice putting a condom on a model, for her own education and possible future needs.

6. Ask the other two groups to discuss and brainstorm responses to the following question:

- **How would you talk to a client who is at high risk for HIV AND at high risk for pregnancy about dual protection?**

Possible responses:

After assessing that the client perceived herself to be at high risk for unintended pregnancy and HIV infection, you might begin the discussion by talking about the dual benefits of condom use. You would demonstrate condom use and encourage the client to practice putting a condom on a penis model. You would assess how she would feel discussing condom use with her partner and develop and practice strategies for doing so (perhaps through role plays). You would also discuss the other family planning methods, but emphasizing that the condom is the only method that prevents against both pregnancy and HIV/STIs. If she is interested in another method, you could discuss the feasibility of dual method use (i.e., condoms plus another method of family planning). If she finds it extremely difficult to address condom use with her partner (for fear of violence, abandonment, etc.) you might discuss risk reduction strategies, such as encouraging her partner to use condoms with other partners by, for example, packing them in his bag before he travels. You could encourage her to bring home literature from the clinic and leave it where he might read it, or other similar ways of communicating less directly. You might suggest that she present the condom to her partner as solely a family planning method, downplaying its HIV/STI prevention role.

7. After 10-15 minutes, invite the groups back into the larger group and have them present their responses to the larger group. Ask the groups that answered the first question (question a) to go one after another, highlighting differences in responses between the two groups. Then ask the groups that answered the second question (question b) to present one after another, highlighting differences in responses between the two groups.

8. Facilitate a group discussion based on the key discussion points below.

Key Discussion Points

- ↪ What are the key differences between the way you would talk about dual protection with a client who is high risk for unintended pregnancy, but not HIV and one who is at high risk for both unintended pregnancy and HIV?

Possible responses:

- *(see possible responses under steps 5 and 6 above)*

- ↪ What other information would you need to know about each client in order to help her address her needs for dual protection?

Possible responses:

- *You would need to find out why the clients are “at low risk” and “at high risk” for HIV infection. You would need to probe to find out how they feel about their relationships. Do they have other partners? Are they concerned that their partners may have other partners? Have they or their partners ever had an STI in the past? Have they ever used condoms? Do they perceive themselves to be at risk of violence, including sexual violence? Does their financial situation necessitate that they exchange sex for money, food or gifts? Are they vulnerable for any other reason, e.g., refugee status? Young woman with older partner? Partner has another family with another woman? Etc...*
- *You could also further explore their family planning needs. How would they feel about an unintended pregnancy at this time? How do they think their partners would feel? Are they and their partners in agreement about not seeking a pregnancy at this time? Etc...*

- ↪ Is it ever appropriate to encourage clients who are at high risk for HIV/STI transmission and who are unable to communicate directly with their partners (i.e., they are in violent or potentially abusive relationships), to bend the truth in order to get their partners to use condoms? For example, would it be appropriate to suggest that a client tell her partner that the health care provider recommended condom use for the following reasons, among others, even if they weren't true? Reasons: “The doctor said I'm allergic to semen and I need to use condoms,” “Condoms will help prevent yeast infections,” “The clinic was out of other methods,” “I couldn't use other methods because I had high blood pressure,” etc.

Essential Ideas to Convey

- Whether you are operating from a family planning perspective or an HIV prevention perspective as your starting point, in order to address dual protection with your clients, you need to explore and assess their risks of unintended pregnancy AND HIV/STI infection, in all cases.
- Pregnancy prevention can sometimes be a greater motivator for condom use than HIV/STI infection. Therefore, the twin benefits of condom use (i.e., pregnancy prevention and HIV/STI prevention) should be communicated to a variety of audiences.
- It is important not to push ideas on clients, even if you are very concerned about their risks for HIV and unintended pregnancy. The counselor's role is to help the client to assess and explore her own risks and to help her formulate a plan for addressing these risks. A critical step in counseling is helping clients to consider the ramifications of their decisions. A counselor cannot and should not make a decision for a client, but should provide accurate information, help her build decision-making and negotiating skills, and help her to examine her risks and options.

VOLUME 1

**SECTION THREE: INTEGRATED COUNSELING SKILLS
BUILDING**

(EXERCISES AND RESOURCES)

INTEGRATED DUAL PROTECTION COUNSELING: INTRODUCTION TO A FRAMEWORK

Objective

To introduce participants to a framework for integrating family planning, sexuality, HIV/STI prevention and dual protection counseling.

Time

60 minutes

Materials and Advance Preparation

- Blank flipchart paper
 - Prepared flipchart with the basic elements of the Integrated Dual Protection Counseling Framework written out (see content below)
 - Markers
 - Participant Handouts: *Integrated Dual Protection Counseling Framework* (two versions, long and short)
-

Steps

1. Introduce the exercise by telling participants that we will now examine a framework for integrating family planning, sexuality, HIV/STI prevention and dual protection counseling.
2. Using the prepared flipchart paper (see content below), explain the four basic steps of integrated dual protection counseling.

Note to the facilitator: Prepare the flipchart paper with the following content:

STEP ONE: Introductions

1. Welcoming the client
2. Introductions
3. Assuring confidentiality
4. Help the client to relax and feel comfortable

STEP TWO: Exploration

1. Exploring clients' needs, risks, sexual lives, social context and circumstances
2. Providing information about dual protection, HIV/STI transmission and prevention and/or pregnancy prevention
3. Assisting clients to perceive or determine their own risk for HIV/STI transmission and/or unintended pregnancy

STEP THREE: Decision-making

1. Discuss dual protection, HIV/STI prevention and/or pregnancy prevention options
2. Assist clients to make decisions that are realistic to carry out, based on their social context
3. Help clients to anticipate the ramifications (positive or negative) of their decisions
4. Discuss risk reduction options

STEP FOUR: Skills-building for action:

1. Develop partner communication and negotiation skills
2. Develop condom use skills
3. Develop other family planning method use skills
4. Develop skills for carrying out decisions

3. Divide participants into four small groups.
4. Assign each group one of the four basic steps of integrated dual protection counseling. Instruct each group to brainstorm all the elements of counseling and information-giving that could be addressed within their assigned step of the framework for integrated dual protection counseling. For example, for step one, participants could include, “*Make the client feel comfortable by assuring confidentiality and explaining that you ask all clients about their sex lives in order to best help them meet their reproductive health needs,*” etc. (See the handout, *Integrated Dual Protection Counseling Framework (long version)*, for a list of elements within each step).
5. Instruct the groups to write their responses on flipchart paper and designate one or two people to report back to the larger group.
6. Invite each group to present the results of their brainstorm discussion to the large group, starting with the group that addressed Step One. After all the groups have finished presenting, lead a large group discussion based on the key discussion points below.
7. Distribute the handouts, *Integrated Dual Protection Counseling Framework* (two versions, long and short), and go over it with the group, addressing any questions that participants may have.

Key Discussion Points

- ↪ How does this framework ensure that the counseling is client-centered?
Possible responses:
 - *The framework starts with the client’s situation and takes into account the client’s individual circumstances. Each counseling session is then tailored to the specific needs of the individual client.*
- ↪ How much time do counselors in your facility generally spend with each client? Do you think this framework helps counselors to work within this timeframe? Do you think counselors can save time with this framework? If yes, how? If no, why not?
Possible responses:

- *Counselors can ultimately save time by learning first about the client's situation and then limiting the information-giving portion of the session to addressing what the client truly needs, rather than providing detailed information on every family planning method.*
- *It might initially take longer for counselors to follow the framework because they will need to adjust to the new way of interacting with clients, etc.*

↔ How does this framework ensure a client's informed choice?

Possible responses:

- *The framework focuses on supporting clients to make their own informed decisions and to develop skills to carry out these decisions, rather than steering the client to a particular decision.*
- *The framework helps clients to understand and to perceive their own risks for unintended pregnancy and HIV/STI transmission and provides them with knowledge about the various options to protect themselves, allowing clients to make informed decisions.*

↔ Why does the framework address the social context of decisions?

Possible responses:

- *It is important to address the social context of decisions in order to help clients to identify and address potential barriers or obstacles to carrying out decisions they may make. This might include, for example:*
 - *Who has the decision-making power in the relationship and who influences decisions (i.e., partners, friends, family members, etc?)?*
 - *Economic pressures that may affect decisions (e.g. Will decisions to use condoms impact financial gain from sexual relationships? Can the client afford a continuous supply of condoms?, etc.)*
 - *The importance to the client of preventing pregnancy relative to preventing disease.*
- *Addressing the social context can also help the counselor to identify sources of support and resources in the client's life that can help them implement decision they've made to prevent pregnancy or reduce HIV/STI risk.*
- *Clients need to make realistic decisions that they can carry out successfully and safely. Examining the social context helps them to understand the potential consequences of their decisions (e.g., a partner may have a violent reaction if a client insists on condom use, etc.).*

Essential Ideas to Convey

- It is important for counselors to personalize counseling sessions by exploring each client's individual situation, as opposed to talking generally about family planning methods or HIV/STI transmission and prevention. The counselor should talk to a client about these issues in the course of a conversation about that person's life situation. By personalizing the information about HIV/STI risks and applying it to the client's specific situation, it can help clients to perceive their own risks of HIV transmission rather than thinking of HIV as an abstract "thing that other people get."
- Integrated counseling moves away from the traditional family planning counseling model that relies on giving detailed information about every method. Instead, by exploring a client's sexual life and individual circumstances, the provider can better tailor the information to the client's needs. This not only saves time – it better meets clients' needs.
- With integrated counseling, informed choice doesn't rely on giving detailed information about each family planning method, how to take it, and possible side effects. Informed choice is based on understanding and perceiving one's own pregnancy and disease risks, and having enough knowledge about the options for prevention as needed to make decisions.
- Understanding and exploring the social context of decisions is critical to helping clients determine their risk and make decisions about pregnancy and HIV/STI prevention that are feasible. This context includes a client's power to make decisions about reproduction and sexuality and the people and factors that influence a person's decisions such as partners, family members, or friends. This also includes anticipating the ramifications of decisions, such as whether or not a decision (like a suggesting condom use with a husband) could lead to violence.

USING THE GATHER MODEL TO ADDRESSING SEXUALITY, HIV/STI PREVENTION AND DUAL PROTECTION

Note: This exercise is designed for those participants who already use the GATHER model for family planning, if they choose to continue using this model. If not, they can choose to adopt the integrated dual counseling framework model (see exercise entitled, “Integrated dual protection counseling: introduction to a framework”).

Objectives

1. To identify how sexuality, HIV/STI prevention and dual protection can be addressed in the steps of the GATHER family planning counseling model.
2. To explore how the framework for integrated counseling can fit into the steps of GATHER.

Time

60 minutes

Materials and Advance Preparation

- Flipchart paper
- Prepared flipchart paper with GATHER model written out (see Step 1 below)
- Prepared flipchart paper with the three steps of integrated counseling (from the exercise entitled, *Integrated dual protection counseling: Introduction to a framework*) (see Step 1 below)
- Participant Handout: *Dual Protection GATHER approach*
- Extra copies of the handouts: *Integrated Dual Protection Counseling Framework* (long and short versions, from the exercise entitled, *Integrated dual protection counseling: introduction to a framework*)

Steps

1. Before the session, write the following on a piece of flipchart paper:
 - G** – GREET the client politely and warmly
 - A** – ASK client about her/himself
 - T** – TELL client about clinic, family planning methods
 - H** – HELP client make a decision that is best for her/him
 - E** – EXPLAIN (method, etc.)
 - R** – Schedule a RETURN visit

Also write a shortened version of the four basic steps of integrated counseling on a piece of flipchart paper (this is from the exercise entitled, *Integrated dual protection counseling: introduction to a framework*, on page 175 of this manual):

STEP ONE: Introductions

STEP TWO: Exploration

STEP THREE: Decision-making

STEP FOUR: Skills-building for action

2. Re-introduce the steps of GATHER for family planning and go over them with participants, referring to the steps on the flipchart. Review the four basic steps of integrated counseling, referring to flipchart. Explain that in this exercise we will be thinking about how to incorporate a broader definition of sexual and reproductive health into GATHER. Specifically, we will be thinking about how to incorporate sexuality, HIV/STI prevention and dual protection (i.e., awareness of HIV/STI risk and risk reduction and/or pregnancy prevention) into the steps of GATHER. This will involve thinking about how the integrated dual protection counseling framework can be adapted to fit into the steps of GATHER.
3. Divide participants into small groups. Explain that each group will take one or two steps of GATHER (depending on the number of participants), and will have 30 minutes to brainstorm all the ways that they can think of about how to incorporate sexuality concerns, HIV/STI prevention and dual protection into those steps. Remind the groups to think about the four basic steps of integrated counseling and where they would apply to GATHER as they brainstorm.
4. Invite each group to present to the larger group its suggestions for expanding a particular step of GATHER to address sexuality, HIV/STI prevention and dual protection. Ask them to explain how they used the four basic steps of integrated counseling as they came up with their suggestions.
1. Distribute the handout, “The dual protection GATHER approach,” and go over it with the participants. Ask participants to refer to their handout called, “Integrated Dual Protection Counseling Framework” (long version), from the exercise entitled, “Integrated dual protection counseling: introduction to a framework.” Distribute extra copies of this handout if participants do not have them. Facilitate a group discussion based on the key discussion points below.

Key Discussion Points

- ↪ What do you think of the Dual Protection GATHER model? How effective do you think it could be in your own work? Is there anything about this model that you think might NOT work? What and why not?
Possible responses:
 - *It seems like it would take too much time to go through all the steps, especially the ASK.*
 - *Clients have a hard time getting to the clinic so it is unrealistic to schedule return visits.*
 - *We're used to using GATHER for family planning only, it feels awkward to focus on sexuality, HIV/STIs and dual protection, too.*
- ↪ What is the most challenging step of Dual Protection GATHER for you and why? What do you think you could do to make it easier?

→ In general, when you have used GATHER in the past for family planning counseling, have you always followed GATHER in strict order of steps? Is it necessary to follow GATHER in strict order?

Possible responses:

- *GATHER is merely a guide and is not meant to be followed in strict order. A conversation between client and provider should flow naturally, and therefore certain steps of GATHER may be out of order or repeated at various times during the session, etc.*

Considerations for the Facilitator /Training Options

Make sure that participants understand and feel comfortable with the basic elements of the Integrated Dual Protection Counseling Framework,” and that they have already participated in the exercise entitled, *Integrated dual protection counseling: introduction to a framework*, before attempting this exercise.

This exercise is intended specifically for participants who currently use the GATHER method for their work in family planning. If the participants do not use GATHER, this exercise is not appropriate.

Essential Ideas to Convey

- The GATHER approach can be an important tool to ensure that providers are client-focused since it emphasizes learning about the client and having a dialogue together rather than talking at the client. Ensuring informed choice is a critical element of GATHER.
- Revising GATHER to address HIV/STI prevention, dual protection concerns (i.e., risk of pregnancy and/or HIV/STIs) and sexuality involves thinking about the whole client. Specifically, this involves exploring the following: what are clients’ circumstances; who is important to them; what is the nature of their sexual relationships; how do they perceive their risks (of pregnancy, HIV/STIs, sexual violence, etc.); and how can you help them to protect themselves and to lead a healthy, satisfying sexual and reproductive life?
- With client-centered dual protection counseling, counselors should avoid giving out unnecessary information to clients because the counselor first examines the client’s situation and then tailors the session to meet his or her needs.
- GATHER is a useful counseling model, but this does not mean that it must be followed exactly, or in sequential order during a counseling session with a client. GATHER is merely a suggested guide of areas and topics to cover while the provider and client engage in an interactive two-way discussion of the client’s needs and risks.

INTEGRATED DUAL PROTECTION COUNSELING CASE STUDIES

Objectives

1. To enable participants to apply the concepts featured in integrated dual protection counseling models (such as the integrated dual protection counseling framework and integrated dual protection GATHER) through case study activities.
2. To heighten participants' awareness of the key differences between traditional family planning counseling and integrated dual protection counseling.

Time

60 minutes

Materials and Advance Preparation

- Flipchart paper
 - Extra copies of the handouts, *Integrated dual protection counseling framework* (long and short versions)
 - Extra copies of the handout, *Dual protection GATHER approach* (if participants already use GATHER for family planning and choose to continue its use for dual protection counseling)
 - Participant Handouts: *Alicia visits a family planning clinic (Case Study version 2: Integrated dual protection counseling framework version and dual protection GATHER version)*. (Note: there are two versions of *Case Study Version 2*, one that shows how the integrated dual protection counseling framework was used, and another that shows how dual protection GATHER was used. Make sure to distribute the appropriate version to participants, according to the model they will be following.)
 - Extra paper and pens if participants need it for the case study
 - Markers
 - Tape
-

Steps

1. Distribute the handout, *Alicia visits a family planning clinic (case study version 1)*
2. Distribute extra copies of handout, *Integrated Dual Protection Counseling Framework* (long and short versions), if participants need them. Distribute extra copies of the handout, *Dual Protection GATHER approach*, if participants will be using GATHER for dual protection counseling, and they need additional copies of the handout.
3. Ask two participants to take turns reading the case study aloud, one playing the part of the client, and one playing the part of the provider. Tell the group to follow along, making notes on their handouts of what the provider did that was either more or less effective in counseling the client.
4. Lead a large group discussion about the case, using the key discussion points below.

5. Break the participants into small groups of 3-4 and ask them, in their small groups, to make a list of recommendations on ways to change the scenario so that the provider would be more focused on the client's needs. Let them know that they have approximately 10 minutes in which to do this, and provide a 2-minute warning.
6. Invite the small groups back into the larger group, and ask for volunteers to come and present their recommendations for a revised scenario. After each, ask for feedback from the group, and discuss with the presenting group why they chose to make the changes they did.
7. Ask for a few other small groups to present their recommendations if the groups say they have something different from what the previous group presented. Discuss in the same way.
8. Distribute the handout, *Alicia visits a family planning clinic (case study version 2)* which provides a revised version of the original scenario, along with notes relating to how integrated dual protection counseling models were used. (Note: There are two versions of the second case study, one that shows how dual protection GATHER was used and the other that shows how the integrated dual protection counseling framework was used. Make sure to distribute the appropriate copy of, *Case Study Version 2*, to participants, depending on which model they are following – integrated dual protection counseling or dual protection GATHER.)
9. Read aloud *Case Study Version 2*, inviting volunteers to play the provider and the client. Facilitate a larger group discussion on the main points that the group has learned from this exercise.

Key Discussion Points

When discussing *Case Study Version 1*

- ↔ What was this experience like for the client? Why?
- ↔ Did you find this scenario realistic? Could it happen in your clinic?
- ↔ What was missing from the role play? What could the provider have done better? Why might the provider have thought that what she was doing was appropriate?

When discussing *Case Study Version 2*

- ↔ What was this experience like for the client? Why?
- ↔ What are the main differences between versions 1 and 2 of the case study?

Considerations for the Facilitator/Training Options

When providing feedback, particularly in front of the larger group, always ask the two people who performed the role play to speak first. Ask them to say at least one or two things that went well, and then one or two things they would have done differently. Then open the discussion up to comments from the rest of the group, asking that participants provide only new comments, not just state their agreement with a previous comment made.

It may be necessary to change the scenario to make it more relevant to the culture in which you are working. You may wish, for example, to change the characters' names, or to change the family planning method selected by the client, etc.

Essential Ideas to Convey

- Never make assumptions about the nature of a client's visit based on appearances, including age, socio-economic status, number of children that she has, etc. Be open to and explore the concerns and interests of the client and let the counseling session flow out of those concerns.
- The starting point for integrated counseling is exploring the client's needs, risks, sexual life and social context. The provider then tailors the information to reflect the client's needs. In traditional family planning counseling, in contrast, providers often follow a standardized format, giving detailed information about every family planning method available in the clinic.

EXPLORING CLIENTS' SEXUAL AND REPRODUCTIVE HEALTH NEEDS, RISKS AND SOCIAL CONTEXT

Objectives

1. To recognize the challenges related to exploring clients' personal sexual and reproductive health needs, risks and social context.
2. To understand the importance of exploring a client's sexual and reproductive health situation, and to learn ways of asking such questions sensitively.

Time

30 minutes

Materials and Advance Preparation

- Become familiar with the list of questions below before asking them of participants
 - Flipchart (optional for recording important points of group discussion)
 - Markers (optional for recording important points of group discussion)
 - Participant Handout: "Suggested questions for exploring a client's sexual and reproductive health needs, risks and social context"
-

Steps

1. Tell the participants that you are going to read aloud a list of questions to which they should respond silently to themselves. Ask the participants to close their eyes and tell them that they will not be asked to share any of their responses with anyone else.
2. Tell the participants that the questions you are about to read out loud are examples of those a provider might ask a client to assess their HIV/STI risk. Ask the participants to put themselves in the place of a client hearing these questions for the first time and to think about how they feel being asked these questions.
3. Read out loud the following list of questions slowly, allowing time for participants to formulate answers to themselves:
 - How many sexual partners have you had in the past 3 years?
 - When you have sex, what kind of sex do you have?
 - Do you have vaginal sex with your partner? Anal sex? Oral sex?
 - Do you ever use condoms?
 - If yes, what has been your experience with them?
 - How do you feel about your current or most recent relationship?
 - How do you feel about the sex you have with this person? Are you satisfied?
 - Who decides when and how you will have sex?
 - Aside from your primary partner, do you have other sexual partners?
 - Do you think your partner may have other sexual partners?
 - Have you ever talked to your partner about family planning?

- Have you ever talked to your partner about sexually transmitted infections or HIV/AIDS?
 - Have you ever talked to your partner about your sexual life in general?
 - As far as you know, have you ever had a sexually transmitted infection?
 - Have you ever had sores in the genital area or discharge from your (penis/vagina)?
4. Once all of the questions have been asked, have participants open their eyes and ask the key discussion questions below to facilitate a discussion.
 5. Distribute the handout entitled, *Suggested questions for exploring a client's sexual and reproductive health needs, risks and social context.*

Key Discussion Points

- ↪ Which, if any, of the questions made you feel uncomfortable and caused you to react as if you didn't want to respond?
- ↪ How do you think a client would react to this type of question during a visit?
Possible responses:
 - *A client might become angry, annoyed, embarrassed, or relieved to find someone to talk to about these issues, among other reactions.*
- ↪ Why do you think it would be difficult for a client to respond honestly to such questions?
Possible responses:
 - *Clients might feel like you are judging their responses or that they are "abnormal" if they respond truthfully, etc.*
- ↪ Would you ask these questions differently?
- ↪ Why do you think it is important to ask these types of questions?
Possible responses:
 - *The more you know about the specifics of a client's situation, the better you can help them to determine and perceive their own risk of unintended pregnancy and infection with HIV/STIs, to reduce these risks, and to address other sexual and or reproductive health concerns.*

Essential Ideas to Convey

- Asking questions in a counseling session about a client's sexual life can be challenging because it involves discussing very intimate activities that may be embarrassing for the counselor as well as the client. This exercise is designed to assist us in recognizing and dealing with the difficulties related to asking and answering questions that enable us to explore a person's sexual and reproductive health situation. Many of the activities that could expose a person to HIV and other STIs, as well as unintended pregnancy are very intimate.
- Asking these types of questions can facilitate a conversation about how one can reduce risk of infection and pregnancy. The list of questions above is just an example of the types of questions that are important to ask. When talking with clients, do not necessarily formulate your questions in the order that they are presented here, or use the same words or phrases. The questions have to flow in a two-way conversation with the client and must be appropriate to his or her level of understanding.
- Clients will experience a range of feelings when asked personal questions about their sexual lives, including fear, resentment, anger, embarrassment, relief (to be finally able to share a concern with someone), annoyance, etc.
- Preface your discussion by letting the client know in advance that you will be asking some very intimate questions and that you ask them of all clients to better meet their health needs. This will prepare the client, and will help make your questions seem less shocking.

TALKING WITH CLIENTS ABOUT SENSITIVE SUBJECTS: OVERCOMING FEARS

Objectives

1. To help participants identify the sexual and reproductive health issues that their clients may be uncomfortable addressing.
2. To increase participants' awareness of their own discomfort broaching topics related to sexual and reproductive health with their clients, and to help them overcome their fears.

Time

45 minutes

Materials and Advance Preparation

- Flipchart paper
 - Individual sheets of flipchart paper, prepared as described below
 - Markers
 - Tape
-

Steps

1. Before the session begins, prepare several sheets of flipchart paper, one sheet for each group (plan on creating small groups of 3-4 participants). Draw a vertical line down the middle of each sheet, and then a horizontal across the top, creating a "t." In the upper left-hand quadrant write, "CLIENT," and in the upper right-hand quadrant write, "COUNSELOR."
2. Break the group into smaller groups of no more than 4 in each group. Provide each group with a prepared sheet of flipchart paper and a marker. Instruct each group to ask one person to serve as recorder for the group.
3. Ask the small groups to come up with a list of sexuality-related topics that participants think their clients seem to or will find particularly challenging to discuss. These topics should be listed on the flipchart paper under "client."
4. After about 2 minutes, ask the group to list the topics related to sexuality that they, as counselors, find challenging to discuss. This list should be made on the same sheet of flipchart paper under the word "counselor."
5. After another 2 minutes, invite a member of one group to come up with the group's list, tape it up, and read what is written on it. Ask the other participants to follow along on their own lists as the first group reads theirs, and to cross off any topics or issues that are on their sheets as well.
6. Then ask the next group to send up a representative with their list, and ask that representative to read only the items that were not listed by the previous group. Remind the other groups that they should continue to follow along and cross off any ideas that have already been

listed. If the last group does not have any new ideas, let them know that it is not a problem, and that there is no need to post the last list.

7. Once all the flipchart lists have been read, go through each item individually with the group. As the group to the following question: "What about each topic or issue makes it hard for either a counselor or a client to discuss?" Record these responses on a blank sheet of flipchart paper.

Note: The topics that come up will vary from group to group. In some cases, participants might hesitate to acknowledge that anything makes them feel uncomfortable. If this were to happen, take the focus off participants and ask them to speculate on what a "typical provider" might find it challenging to discuss and why. Some topics that make people uncomfortable (and reasons for this discomfort) might include, but are not limited to:

Past (or current) sexual relationships:

- **Client:** *This would require clients to disclose that they have had a certain number of sexual partners, or that they were not virgins when they married, or that they have had a same-sex relationship, etc. Some clients simply may not be comfortable discussing sexual behaviors with anyone.*
- **Counselor:** *It might be a challenge for counselors because of their own feelings about discussing intimate issues. In addition, a counselor's cultural and religious beliefs may make her or him feel that it is inappropriate to raise these types of questions, even if they are necessary to risk assessment and treatment.*

Same-sex relationships:

- **Client:** *Clients may feel uncomfortable because of personal, religious, or cultural values and stigma relating to homosexuality, or they may feel judged by providers or hostility on the part of the counselor.*
- **Counselor:** *Counselors may feel uncomfortable because of personal, religious or cultural values and stigma relating to homosexuality. Counselors may wrongly equate HIV/AIDS with homosexuality and discriminate against those clients who disclose a same-sex relationship.*

Sexual behaviors:

- **Client:** *Clients may feel uncomfortable discussing sexual behaviors, including those that might place someone at risk of infection, because they may feel that it is too private, or they may feel embarrassed or worried that they are not "normal."*
- **Counselor:** *Counselors may pick up on a client's discomfort and feel awkward for making the client embarrassed, or counselors may have their own biases and judgments about what sexual behaviors are acceptable or unacceptable, and react negatively to clients who mention behaviors which they personally find "unacceptable."*

Rape or sexual abuse:

- **Client:** *This might be uncomfortable for a client who is a rape or sexual abuse survivor because it could cause the client to remember the trauma, or because a client is currently in an abusive relationship.*
- **Counselor:** *It could be uncomfortable for counselors who have experienced sexual violence as well, or they find the topic particularly sensitive or emotional for other reasons. The counselor may feel uncomfortable when listening to a client's story of abuse and feel at a loss to help.*

Key Discussion Points

- ↔ What did you notice about the two lists you made? Were there more similarities or differences in what you assumed clients would find difficult to discuss vs. what counselors would find difficult to discuss?
- ↔ What did it feel like to acknowledge your own discomfort when discussing sexuality?
- ↔ What steps can you take to ensure that your clients do not become aware of your discomfort?
Possible responses:
 - *You can make sure that your body language and facial expressions are neutral and that you are not conveying a judgmental attitude.*
 - *You can acknowledge that it is often difficult to discuss sexuality and that many people feel uncomfortable.*
 - *You can practice asking questions by role playing with colleagues to get over any discomfort you might have.*
- ↔ What are some of the ways in which we convey our discomfort without expressing it verbally? How can we guard against doing so with our clients?
Possible responses:
 - *Our facial expressions and body language may show that we are uncomfortable. We may blush, look away from the client, cross our arms, roll our eyes, etc.*
 - *We must make an effort to keep our body language and facial expressions neutral and be open to whatever the client is saying by nodding, affirming, asking clarifying questions and conveying a warm presence.*

Essential Ideas to Convey

- It can be hard to talk with someone we know about personal issues, let alone a complete stranger. Providers must be sensitive and attentive to the fact that we must often ask our clients very personal questions about their pasts, their behaviors, and their relationships. We can neither rush forward and do so without thought, nor shy away from them due to discomfort – our clients’ or our own.
- It is important for providers to be aware of the topics that they are less comfortable discussing themselves. While there still may be topics or situations that may make counselors feel uncomfortable, they need to work to avoid conveying this discomfort to their clients through their facial expressions, body language or comments.
- Know your limitations. If there is a topic you truly do not feel you can address, refer the client to another provider in your setting – if that is an option. **However, it is a provider’s professional responsibility to provide equal attention and care to all clients.** If there is no one else in your setting who can discuss a particularly challenging topic (for example, abortion or homosexuality), the counselor needs to stay with that client and provide whatever information, services, and support that is needed.

BROACHING THE SUBJECT OF SEXUALITY AND HIV/STIs WITH CLIENTS: APPROACHES TO PUTTING THE CLIENT AT EASE

Objectives

1. To develop strategies for asking clients sensitive questions about their sexual lives as part of assessing risk for HIV/STIs, unintended pregnancy and other sexual and reproductive health concerns.
2. To practice asking sensitive questions related to sexuality.

Time

45-60 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Facilitator Resource: *Role play assignments*
 - Participant Handout: *Sexuality and HIV/STI risk: Broaching the subject with clients*
-

Steps

1. Introduce the exercise by acknowledging that many providers find it challenging to initiate a discussion about sexual behaviors or HIV/STI risk with clients.
2. Next conduct a large group brainstorm using to address the following questions:
 - How can providers put clients at ease when asking sensitive questions?
 - How can providers broach the subjects of sexuality and HIV/STIs with clients?
 - What types of questions can providers ask to explore clients' sexual lives?
3. On a blank sheet of flipchart paper, record the participants' ideas for each question. Discuss the responses, making sure that the following points are included:

Putting the client at ease:

- *Make sure that you talk to clients about sensitive issues only in a private space where the conversation cannot be overheard.*
- *Explain to the client up front that there are some standard questions that are asked of all clients. Let her or him know that you do this to best serve your clients – to help them to prevent HIV/STI infection and/or unintended pregnancy, and address other concerns.*
- *Explain also that the specific reasons for their coming in for counseling and services may require a frank discussion of sexual behaviors and relationships.*
- *Talk to clients about the importance of being honest, and reassure them that you are not there to judge them. Explain to a client that she should not worry about what you would think, for example, if she had had a number of sexual partners before she got married. Let her know that this information is very important, because it helps you determine what*

other questions to ask to best figure out whether she is at risk for HIV/STIs and unintended pregnancy.

- *Assure all clients that everything they talk about will be kept confidential and explain your facility's confidentiality policy (if applicable). (Note: In some countries, clinics have policies that protect the confidentiality of their clients, particularly related to sexual and reproductive health issues due to potential consequences of revealing this information. Be sure to tell the participants to check with their agency or hospital about their confidentiality policy. If they do not have one, encourage them to raise the topic within their workplace).*
4. Distribute the handout, *Sexuality and HIV/STI risk: Broaching the subject with clients*. Review it with the participants, asking if there are any questions. Ask if there is anything they would like to add to the points raised on the handout.
 5. Introduce the role plays. Break the large group into small groups of three. Ask each group to decide who will play the client, who will play the counselor, and who will serve as the observer.
 6. Once the group has decided, distribute the role play assignments to each client and to each counselor. Make sure that no one shows his or her assigned role to anyone else in the small group, including the observer.
 7. Give the groups 5 minutes in which to play out their scenarios, asking the observer to take notes on what happens between the “counselor” and “client.” Once the five minutes have elapsed, ask the small groups to discuss the following, allowing 2-3 minutes for each question:
 - What was going on between the counselor and client?
 - What did the counselor do that was effective in this situation?
 - What might the counselor consider doing differently if this situation were to come up again in the future?
 8. After the last question has been discussed, continue the discussion in the larger group (see key discussion points below).

Considerations for the Facilitator/Training Options

When conducting the role plays, you have a few options. While all counselors will receive the same role assignment, you can choose to photocopy and use as many or as few of the client roles as you wish. Some facilitators choose to assign the same role to all participants. Others prefer to distribute different roles. The choice depends on the type of discussion you wish to have – more focused on one or two examples, or more general, including a greater number of potential scenarios.

Key Discussion Points

- How did it feel to play the role of provider? Which types of questions were more or less challenging to ask?
- How did it feel to play the role of client? What did you observe about the provider's body language and mannerisms as she or he asked you questions about your sexual life?
- In your role plays, what did the counselor do effectively? What suggestions do you have for counselors to do in similar situations in the future?
- Are there any topics that you think clients might refuse to talk about? If so, why? And how could you obtain the information relating to risk of HIV/STI infection or unintended pregnancy if you cannot address the topic directly?

Possible responses:

- *If a client is unwilling for any reason to discuss whether her partner might have other partners, for example, you could speak about the issue of risk hypothetically or use other clients as examples. For example, you could say "Many clients know or suspect that their husbands may have other partners, when this is the case, I counsel them on how to protect themselves from the risk of HIV/STI infection, etc..."*
- How might gender, age, ethnicity and other factors influence how a client and counselor interact, particularly when addressing sensitive topics like sexuality?

Possible responses:

- *In some places, it would be inappropriate to have a counseling session between a female counselor and a male client (or vice versa).*
- *In some places, it would be inappropriate for a younger counselor to discuss these issues with an older client.*
- *In some places, clients may prefer to discuss these issues with a counselor of the same ethnic or religious group.*

Essential Ideas to Convey

- Gender, upbringing, family, culture, and religious values can all play a role in what a client is comfortable discussing. It is therefore important to explain the reasons for asking sensitive questions in order to help clients understand the importance of discussing the information with you.
- Interaction between a provider and a client can be influenced by personal factors such as age, gender, ethnicity or socioeconomic status. Providers must work to make all clients feel comfortable and to bridge any gaps. In some cases, however, providers and clients must be more evenly matched in terms of age, gender or other factors, in order to address successfully sensitive issues. Providers must work within these limitations.
- When working with clients, **how** a counselor or provider asks questions is just as important **what** she or he asks. If a counselor appears nervous or uncomfortable, the client will be more likely to feel the same. Counselors need to be aware that their body language, facial expressions, and tone of voice can convey messages as easily as language can.
-

FACILITATOR RESOURCE: ROLE PLAY SCENARIOS

Counselor: You are meeting your client for the first time and need to assess what his or her sexual and reproductive health needs are, i.e., whether he or she is at risk for HIV or any other sexually transmitted infection, unintended pregnancy, sexual violence, sexual problems or dysfunctions, etc.

Client 1: You are a 22-year old woman whose health has always been fairly good, and you have never been to see a healthcare provider before. You have always been told that healthcare providers are not to be trusted – that they ask a lot of questions, and then spread information about you within the community. However, your partner just told you that he once had an STI. You have never been with anyone else but this person. You thought it would be best to go see a healthcare provider just to see if you can learn anything about what STIs are.

Client 2: You are a 20-year old man who has had many sex partners in the past, but only occasionally used condoms. You were curious about having a sexual relationship with another man, so you tried it once. You did not use condoms, because you figured you were young enough to not be at risk. You are now with a woman whom you hope to marry next year. You and she have not yet had vaginal intercourse, but you have had anal and oral sex. Recently, you have noticed some bumps around your genitals.

Client 3: You are a 30-year old woman who has been married for 8 years. You were a virgin until you got married, and your husband maintains the same. You have a very close female friend, someone you have known since childhood. You have always spent a lot of time together, been very comfortable embracing and sleeping in the same bed, and shared cups and eating utensils. Several days ago, your friend told you that she has HIV. You do not know much about HIV, except that sex isn't the only way a person can get it. You want to know if you've contracted it from touching your friend and sharing utensils, and whether it's possible that you've given it to your husband.

Client 4: You are a 24-year-old man who is to be married in several months. While your culture believes strongly that a girl should be a virgin when she is married, it also maintains that a boy or man should be sexually experienced. The men in your family have taken you to see several sex workers, with whom you have had intercourse without using condoms. You and your fiancée have had anal intercourse, because you both believe that as long as her hymen is intact, she is still a virgin. You do not use condoms because there is no risk for pregnancy.

Client 5: You are a 42-year old woman who is married and has 5 children. You recently had a tubal ligation (surgical sterilization) because you and your husband agreed that you didn't want to have any more children. You feel healed from the surgery and physically well. You have a problem, however, about which you are afraid to tell the provider. The problem is that ever since you had the sterilization you feel like you have lost your interest in sex with your husband. He keeps insisting on having sex, and you keep making excuses. He has hit you in the past and you are worried that he will hurt you again if you refuse sex.

Client 6: You are a 25-year old woman who has been trying unsuccessfully to get pregnant for the past five years. Your husband is very upset that you can't get pregnant and his whole family blames you. You feel very isolated and desperate. Lately the problem has been affecting your sex life with your husband. He feels under pressure to perform and has trouble maintaining his erection during vaginal intercourse, so he keeps insisting on anal sex. You are worried that you will never get pregnant.

PROVIDING INFORMATION ON HIV/STIS

Objectives

1. To practice giving information related to HIV and other STIs.
2. To identify which communication skills are most effective when discussing information related to HIV/STIs with clients.
3. To identify any gaps in knowledge among participants and to reinforce their existing knowledge about HIV and other STIs.

Time

60 minutes

Materials and Advance Preparation

- Make cards with questions related to HIV and other STIs that clients might ask (30-40 questions may be needed; see Facilitator Resource: *Sample carousel questions* and select those most appropriate to the training group, or make up your own, based on participants' needs.
 - Move chairs into two circles, one inside the other with the chairs facing each other (in a "carousel" formation)
-

Steps

1. Divide the participants into two groups, and ask one group to sit in the inner circle and the other group to sit in the outer circle. Explain that those sitting in the inner circle will be playing the part of "clients" and those in the outer circle will be the "health care providers."
2. Give each "client" a card with a question related to HIV or other STIs. Instruct the "clients" to ask their question to the "provider" seated directly in front of them. Tell the "clients" that after asking their question, they should observe the "providers" technique in responding, and to remember which communication styles they find to be helpful or confusing.
3. Instruct those playing the part of the "provider" to answer the question as clearly and briefly as possible. Tell participants that this exercise is more about communications skills and responding effectively to clients' concerns and questions, than it is about correct information. Tell them that if they are unsure of an answer, they can still respond effectively by reassuring a client and indicating that they will find out the correct information, etc.
4. After allowing the "providers" 2-3 minutes to respond, call time and ask all of the service "providers" to shift one chair to the left.
5. Instruct the "clients" to repeat the same question to the next service provider.
6. Repeat this process several times in order to allow the "clients" to observe the way different service "providers" give them the same information, and to allow "providers" the chance to respond to a variety of questions.

7. If time permits, instruct the participants to change places by moving to the opposite circle and to switch roles so that they have the opportunity to play both “client” and “provider.”
8. Instruct the group to return to their seats and lead a large group discussion based on the key discussion points.

Key Discussion Points

- When you played the role of “provider,” how did you feel responding to clients’ questions? What did you find difficult about this exercise? What did you find helpful to your work on counseling clients about HIV and other STIs?
- When you played the role of “client,” what did you observe about the differences in the ways that the various “providers” responded to your question? What types of responses and communication styles did you find helpful? What types of responses did you find less helpful?
- Do these questions seem realistic in terms of the questions that clients might ask providers? What other types of concerns do you imagine that clients might have?
- What are some strategies providers could use to respond effectively to clients’ questions and concerns related to HIV and other STIs?
- What gaps in your knowledge has this exercise identified? What additional training might you need?
- How could you answer clients’ questions if you are unsure of the correct response and wish to maintain the confidence of the client and your professional credibility?

Possible responses:

- *Acknowledge that the client has asked an important question.*
- *Indicate that you want to confirm that your answer is correct with another source and will find out the correct information for the client.*
- *Address the client’s feelings and concerns behind the question, in order to address the client’s emotional needs as well as needs for factual information.*

Considerations for the Facilitator/Training Options

This exercise is primarily about communication skills rather than information. During this exercise, participants should be focused on determining which communication styles and responses are most helpful (i.e., conveying information effectively) rather than on delivering factual information.

Instead of in a short response carousel format, some of these questions can be addressed as part of a longer role play between “client” and “provider.” For example, using a question such as “How can I possibly tell my sex partner about this infection when I hardly know her?” as a starting off point, have two volunteers conduct a role play between client and provider where the provider explores more about the client’s situation and needs.

Essential Ideas to Convey

- As providers we must find ways to clearly and concisely communicate information about HIV and STIs to our clients. Non-verbal communication is just as important as we attempt to make clients feel welcome and free to ask us questions about any of their concerns.
- Clients will have different learning styles so providers need to be prepared to present information in multiple ways.
- When feasible, using pictures, models or samples can be an effective way to help convey information about HIV and STIs.
- Providers can ensure that clients understand the information given by encouraging questions and asking clients to repeat back information.

FACILITATOR RESOURCE: SAMPLE CAROUSEL QUESTIONS

Note: If you need additional information to answer these questions, please refer to the EngenderHealth minicourses on HIV/AIDS, STIs and sexuality at www.engenderhealth.org).

- What is the female condom and how do I use it?
- I heard I can get AIDS from getting an injection at the clinic. Is this true?
- Does having syphilis mean that I could have AIDS, too?
- Once my STI is cured, how can I make sure this doesn't happen again?
- I hate using condoms and but I have more than one partner. What should I do?
- My husband hates using condoms but I know he has other partners. What should I do?
- How can I find out how I got infected with an STI?
- If I had an STI, what types of symptoms would I have?
- If I were infected with HIV, what types of symptoms would I have?
- Isn't it true that once you've had an STI you can't get the same one again?
- Why are so many people getting AIDS?
- What should I do if I think I have an STI?
- Can someone without any symptoms of an STI still be contagious?
- How could I have an STI? I only have sex with my husband!
- Is it OK to have sex without a condom if my partner looks "clean"?
- I had sex without a condom last week and now I'm scared that I have HIV. Can I find out for sure this week if I have been infected?
- Wouldn't I know if I had HIV?
- I'm thinking about taking an HIV test. What do I need to know?
- My friend said condoms are useless because they break anyway. Is that true?

- I just found out that I have HIV and I'm pregnant. Should I breastfeed my baby?
- I'm afraid to tell my husband about my infection. He can get violent. What should I do?
- How can I protect myself from pregnancy and HIV?
- I've been married for a long time and faithful to my husband. How can I be at risk for HIV?
- How can I bring up the subject of AIDS with my husband without him getting angry at me?
- Is it true that you can cure an STI by having sex with a virgin?
- Can I become infected with HIV from oral sex?
- If my partner and I both test negative for HIV, should we practice safer sex?
- Can I get HIV from a mosquito bite?
- Why can't my partner and I just practice withdrawal and not use condoms?
- Can I get AIDS from kissing?
- Is it true that everyone who is currently infected with HIV will eventually die of AIDS?
- If people are sterilized, does that mean that they cannot transmit HIV?
- I've heard that men who are circumcised do not get AIDS. Since, I'm circumcised, does that mean I don't need to use condoms?
- I'm pregnant and I just found out I have HIV. Does this mean that my baby will get it, too?

ASSESSING RISK AND IMPROVING CLIENTS' RISK PERCEPTION

Objectives

1. To explore the reasons why it is difficult for people to perceive their own risks.
2. To identify how participants can help clients to perceive and understand their own risks for HIV/STI transmission and unintended pregnancy.

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Participant Handout: *Client perception and risk assessment*
 - Prepare a flipchart with the following title: "Reasons people underestimate or don't perceive their own risk of HIV/STIs"
-

Steps

1. Introduce the activity by explaining that in general most people underestimate their own risks in life, and this includes risks for HIV/STI transmission and/or unintended pregnancy.
2. Ask the group to brainstorm the following question and write their responses on a flipchart:
 - *Why do people have difficulty perceiving their risk for HIV, STIs or unintended pregnancy?*
3. Distribute the handout, *Client perception and risk assessment* and review it with participants.
4. Conclude by leading a group discussion of the key discussion points below.

Key Discussion Points

- ← Why is a client's **perception** of his or her own risk so important?

Possible responses:

- *Most people will not be able to make a behavior change unless they perceive that they are at risk. If a client doesn't perceive sufficient risk than he or she will not be motivated to make health-related changes.*
- *In most cases people need to feel "ownership" of a plan to change behavior in order to carry it out. If the provider simply tells the client what to do without working together to develop a plan that is both practical and realistic for the client it is unlikely that the client will follow it.*

- Of the factors relating to client perception (see the handout on *Client perception and risk assessment*), which do you think will be the most challenging to work through? Why?
Possible responses:

- *“Bigger or more urgent problems,” where people have other concerns (like hunger, poverty or war) that need immediate attention and put the threat of HIV/STIs and/or unintended pregnancy into the background, is challenging because the current threats are visible while HIV/STIs or pregnancy may seem more distant. This could be related to fatalism if people say, “Life is so terrible and I am probably going to die soon anyway so it doesn’t really matter what I do about my health right now.”*
- *Fatalism may be difficult to address because if clients believe that circumstances are beyond their control, they may be unable to feel confident enough to take actions to protect themselves.*
- *Given that the illusion of invulnerability is a normal part of adolescent emotional development, this can be a challenging obstacle to helping young people perceive their risks.*

- What are some of the ways that providers can help clients to perceive and understand their own risks?

Possible responses:

- *Relate clients’ risks to the specifics of their circumstances. For example, if a client acknowledges that her husband has other partners and doesn’t use condoms, highlight that particular risk to her. To make it less threatening you might say that, “Many women find themselves in similar situations.”*
- *Try to personalize clients’ risk by providing information that is specific to the client. For example, if an adolescent girl does not wish to get pregnant but is not using contraception, you could provide her with brochures or comic-style booklets specifically designed for adolescents that discuss the risks and realities of adolescent pregnancy.*
- *Try to look for ways that clients have protected their health in the past and draw their attention to these successes. For example, if a client has used the pill to prevent unintended pregnancy, acknowledge that she perceived a risk of getting pregnant and took positive action to prevent the risk. Gently suggest that there may be other health risks that she might address as well. For example, if her partner recently was treated for an STI, point out that any sex partner of a person with an STI is at risk, etc.*

Essential Ideas to Convey

- For a variety of reasons, people have a tendency to underestimate their risk and perceive themselves to be at less risk than they actually are. Given this reality, providers need to develop skills in helping clients to perceive and understand their risks.
- Self-perception of risk is an essential step in behavior change. People who do not perceive themselves to be at risk will not be motivated to make changes to protect themselves from unintended pregnancy and/or HIV/STI transmission.
- Providers can work with clients to better perceive and acknowledge their own risks by personalizing a client's risk based on information about a client's individual circumstances shared in the discussion with the provider.

PERSONAL REFLECTIONS ON BEHAVIOR CHANGE

Objectives

1. To reflect on personal experiences with changing health-related behavior.
2. To better understand and increase empathy to the challenges encountered by clients as they make health-related behavior changes.

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper
 - Prepared flipchart paper with discussion questions (see below)
 - Markers
 - Tape
-

Steps

1. Before the session, write the following on a sheet of flipchart paper:
 - What behavior did you change? Did you stop doing something unhealthy or did you adopt a new healthy behavior?
 - Why did you change your behavior, and how long did it take?
 - Did you ever relapse and try the behavior again (or stop doing the new healthy behavior)?
 - Who or what in your life helped you change? Who or what made it difficult?
2. Ask participants to think about a time in their own lives when they tried to change a particular health-related behavior. Let them know that for the purposes of this discussion, the behavior should not be related to sexuality, family planning or HIV – it could be anything, from a person who has stopped smoking, to someone who has decided to get more exercise, etc. (**Note:** Provide examples of health-related behavior changes that are relevant to the local context.)
3. After allowing a minute of reflection, divide the group into pairs. Instruct them to discuss in their pairs the questions listed on the flipchart paper. Let them know that they only have about 5 minutes in which to do this, and that both people need to have a chance to speak. Give them a two-minute warning before time elapses to ensure equal discussion time.
4. Bring the participants back into the larger group. Ask whether any participant would be willing to share some of the details of his or her behavior change with the larger group. Go through each question in order, recording important points on the flipchart paper. As you record the information, invite other participants to comment on similarities and differences in their own experiences. Summarize the discussion by emphasizing the essential ideas (see below).

Key Discussion Points

➤ Generally speaking, is it easy or challenging to change a behavior? What does this depend upon?

Possible responses:

- *Making a change is more difficult if it involves other people and not just your own behavior.*
- *Generally, the longer you've been engaging in the behavior, the more difficult it is to change.*
- *It can be more difficult to change if "everyone else" (i.e., family, friends) continues the behavior or does not adopt the new healthy behavior.*
- *It can be more difficult to change if family, friends and the community do not support the change.*
- *It can be difficult to change if logistical or practical reasons get in the way of change (e.g., lack of resources).*
- *Change can be particularly difficult for those who lack power (financial, social) in their lives.*

➤ After quitting or changing a behavior, did you ever relapse (i.e., return to the unhealthy behavior or give up the new healthy behavior), how did you feel? How did others around you respond? In what way did this affect your motivation to continue or discontinue the change?

Possible responses:

- *It feels very frustrating to relapse.*
- *Often, if those around you are supportive, you can be more motivated to continue.*
- *If people criticize you, you may lose motivation.*

➤ Who are some of the key individuals in any person's life? What role can and should they play in another person's attempt to change an unhealthy behavior or adopt a new healthy behavior?

Possible responses:

- *Some key individuals are family members, friends, spouses, teachers, neighbors, co-workers, elders, religious leaders, etc.*
- *They can be supportive by giving encouraging words, helping the person to avoid situations that facilitate the behavior, etc.*

➤ How do you think reflecting on your own challenges and successes in behavior change will affect your work with your clients?

Possible responses:

- *Reflecting on your own attempts to change can make you more sympathetic to the challenges that clients face and to the need for praise and affirmation of successes.*

➤ What is similar and different about making a behavior change related to sexuality, family planning or HIV/STI risk, compared to the examples of change that we just discussed?

Possible responses:

- *Making a change related to sexuality, HIV/STI risk or family planning is generally more private than other changes and you might have less support since fewer people will know.*
- *Changes of any sort (related to sexuality or not) can be challenging and a person goes through similar steps in making any type of change.*

- *Changes related to sexuality, family planning and HIV/STI risk usually involve the cooperation of partners, so it may be necessary to communicate about changes that may affect another person. For other types of changes, it may be enough to change your own behavior without involving someone else.*
- *Some people, women in particular, lack control over their sexual lives and may find making changes beyond their power, especially within the realm of sexual and reproductive health.*
- *It might be easier for someone to start using condoms to prevent HIV/STIs if it has become the norm in the community.*

Essential Ideas to Convey

- Changing behavior is often challenging, and can take some time in order for the change to be long-lasting. Therefore, providers should not expect immediate results from clients attempting to change a particular behavior.
- Successfully changing any behavior depends on the nature of the behavior, the types and number of social supports and other resources available to the client, and the level of motivation the client has to change.
- We are all individuals. Therefore, changing behavior may be easier for some to do, and more difficult for others to do and maintain. As health professionals, we must be able to tolerate variations in individual experiences and treat each client's attempt to change an unhealthy behavior within the context of that person's life experience.
- Making changes related to sexuality, family planning or HIV/STI risk can be particularly challenging, as they are private (less support) and they often involve the cooperation of another person (i.e., a partner).

INTRODUCTION TO THE STAGES OF BEHAVIOR CHANGE MODEL

Objectives

1. To introduce participants to a model of behavior change (the stages of change theory) to help them understand how people change their behavior.
2. To learn the stages in the model and explore ways of working with clients at each stage in the model.
3. To help participants to assess a client's particular stage and to develop interventions to help clients progress to the next stages in their behavior change.

Time

60 minutes

Materials and Advance Preparation

- Flipchart paper
 - Participant Handout: *Stages of Behavior Change Model*
 - Flipchart paper with the five stages of the behavior change model written out in advance
 - Participant Handout: *Stages and Suggested Interventions*
 - Markers
 - Tape
-

Steps

1. Distribute the handouts, *Stages of Behavior Change Model* and *Stages and Suggested Interventions*. Present and discuss the information on the handouts together with the group, making sure to address the key discussion points listed below. Respond to any questions that may arise.

Key Discussion Points

- ↔ What do you think it would be like to use this model when working with clients on reducing their risk for HIV/STIs and/or unintended pregnancy?

Possible responses:

- *It might be helpful to place clients' individual efforts along a continuum in a framework.*
- *It may be difficult to help clients to move into the "action" and "maintenance" stages when working on using condoms, for example.*

- ↔ What do you think some challenges would be to using the Model with clients?

Possible responses:

- *It might take a while to get used to thinking in this way.*
- *It could be difficult working with women clients who may have limited power and control over their sexual lives.*
- *Some behaviors, such as negotiating condom use, involve the client and the client's partner. If you are working with the client only, and not the partner, it can be challenging to help the client to develop the skills necessary to negotiate with the partner.*

- *Behavior change is a long-term process. If you only see clients one or two times, you may not be able to support them over time.*
- ↪ In some cultures, it is inappropriate to discuss sexual behaviors, even with one's partner or spouse. How do you think these restrictions could affect using this Model for HIV risk reduction?

Possible responses:

- *For many people, especially women, their vulnerability to HIV and other STIs may be heightened by social norms that make it very difficult for them to initiate behavior change related to sexuality by, for example, negotiating condom use with a partner.*
- *If they can't talk about sex, clients may reach a plateau in the Model, or will have to develop creative ways of progressing.*

Considerations for the Facilitator/Training Options

Before the session, it is important that you go over the handouts to make sure that you are familiar with the model and the suggested interventions for each stage.

Essential Ideas to Convey

- The Stages of Behavior Change Model is a model based on a cycle (or stages) that assumes at least one relapse before long-term behavior change is achieved. It can be very effective in the context of HIV counseling and risk reduction.
- A model can be a useful way of organizing information, but not every situation fits neatly into a model. There will be exceptions to any model and counseling should always be client-focused.
- The counselor's intervention must be specific to the stage the client is in. Too aggressive of an intervention might force the client back to a previous stage. Since a client could be between stages, a counselor should yield on the conservative side by trying interventions from an earlier phase.
- In an ideal situation, the counselor would have extended contact with the client through visits over time. In reality, a counselor may work with a client only one or two times, given the difficulties of accessing health services for most people. A counselor must make the most of a limited opportunity to work with a client.

BEHAVIOR CHANGE: WHAT STAGE AM I IN? CLIENT CASE STUDIES*

Objective

1. To provide an opportunity for participants to practice applying the Stages of Behavior Change model to sample client case studies.

Time

75 minutes

Materials and Advance Preparation

- Flipchart paper
 - Extra copies of the handouts: *Stages of Behavior Change Model* and *Stages and Suggested Interventions* (see exercise called *Introduction to the stages of behavior change model*)
 - Participant Handout: *Sample Scenarios: Client Case Studies*
 - Facilitator Resource: *Suggested responses and guide for discussing responses to case studies*
 - Markers
 - Tape
-

Steps

1. If any members of the group have forgotten to bring their copies of the handouts from the session entitled, *Introduction to the stages of behavior change model*, distribute the extra copies as needed.
2. Break the group into small groups of 3 or 4. Distribute the handout called, *Sample Scenarios: Client Case Studies*. Instruct each group to work together to determine which stage “client” is in, as well as the types of interventions that would be appropriate in each situation. They should also discuss what would not be appropriate interventions, considering the person’s circumstances and stage.
3. Once the small groups have completed their discussion, have each group in turn read their client case study aloud and then present their assessments. After each group presents their decision about which stage they think their client is in, ask the large group if they agree with their assessment and discuss. Have the Facilitator Resource, *Suggested responses and guide for discussing responses to case studies* with you as you facilitate the discussion.
4. Facilitate a large group discussion based on the key discussion points.

* Adapted from Building Quality HIV Prevention Counseling Skills, The Basic Training I (9/99/State), Day 3, page T-164, University of California San Francisco, AIDS Health Project, 1999.

Key Discussion Points

- ↔ Behavior change does not occur in a vacuum. A person's environment can affect whether and how a person can make changes. What are some of the environmental and social factors that contribute to a person's ability to make a behavior change?

Possible responses:

- *Some social factors that affect behavior change include the nature of personal relationships and social support; socioeconomic status; social position; age; gender roles; access to information, education and other resources (financial, material and community knowledge), etc.*
- *There are legal, cultural, political, ethical and spiritual factors that influence a person's ability to change behavior.*

- ↔ What kinds of feelings did you have as you read the client scenarios? Was there anything that made you feel impatient or frustrated? If so, what was it – and how did it make you want to respond?

Possible responses:

- *It can be frustrating when clients deny or fail to see their own risk of infection or unintended pregnancy.*
- *Sometimes you can feel like shaking them and saying "Wake up!" you are at risk and there are ways to protect yourself and your partners!"*

- ↔ As a counselor, how can you ensure that your clients' desire to change their behavior is theirs and not imposed by you?

- ↔ What do you think it would be like if you helped a client create a plan for changing his or her behavior, the client changed his or her behavior for a short time and then returned to a previous stage? How do you think you would respond?

Possible responses:

- *Given that behavior change is not an easy process, I would expect some clients to return to previous stages. I would try to remain encouraging.*
- *I would find it frustrating to have worked so closely with a client and then to see him or her relapse, but I would support the client to continue making changes.*

- ↔ Which environmental or social factors (such as poverty or gender roles) seem to have the most powerful effects on your clients? What could you do to help them under the circumstances? How might you need to adjust your interventions based on these, if at all?

Possible responses:

- *Gender roles can affect how a client might follow-through on attempts to change behavior. For example, some women may find it nearly impossible to bring up the subject of condom use with their partners because of fear violence, accusations of infidelity or loss of financial support. In this case, you might suggest other options to clients such as presenting condom use to partners as an effective method of pregnancy prevention, downplaying the HIV/STI prevention aspects of the method.*
- *Some clients may lack sufficient resources to carry out change. For example, some clients may not be able to afford to purchase a regular supply of condoms. In this case, you could try to identify sources of free or low-cost condoms and tell the client how to obtain them.*

Considerations for the Facilitator/Training Options

This session should not be attempted without first doing the exercise entitled, *Introduction to the stages of behavior change model*.

Depending on how well you know the participants and the context in which they work, you may wish to allow time for the participants to provide examples from their own work to use as case studies. Otherwise, use the case studies provided as examples.

Essential Ideas to Convey

- Behavior change is not just about reducing HIV/STI risk; it is also about changing behaviors that place clients at other risks such as unintended pregnancy.
- Sometimes, the stage a client is in is not easy to determine. It is possible for a client to be between stages, or in one stage and close to changing to the next.
- When in doubt, use a more conservative approach. Being too aggressive in your intervention could overwhelm the client and cause her or him to return to a previous stage.
- Always take advantage of the opportunity to provide more information and correct misinformation gently. In doing so, make sure that the information is as relevant to the client as possible.
- In the end, it is the client who must be willing to commit to making a decision. Even if she or he does not reach a certain stage, or returns to a previous stage, the counselor must remain patient. Responding in a disappointed manner will only serve to alienate the client.
- When working with clients on their dual protection needs, it is critical to emphasize the family planning benefits of condom use (in addition to the HIV/STI prevention benefits), particularly for women whose partners may react negatively to introducing condom use for the prevention of HIV/STIs.

FACILITATOR RESOURCE: SUGGESTED RESPONSES AND GUIDE FOR DISCUSSING RESPONSES TO CASE STUDIES

Example 1: Ana, an 18-year old, comes to your clinic with her friend, Maria, who has a visit with a provider. Ana wants to be supportive of Maria, who has come in for a follow-up visit to make sure that an STI has been properly treated. Maria was infected by her boyfriend, Juan, who Ana knows has many sex partners. When Maria goes in to see the provider, a counselor asks Ana if she would like to talk about her own sexual and reproductive health needs. For example, would she like to discuss her own risks for STIs, including HIV, and unintended pregnancy? Ana declines – after all, she has been with her fiancé, Javier, for over a year, he is the only person she’s ever had sex with, and they plan to get married. She uses the pill for contraception. He did tell her that he had chlamydia before, but he was treated and it’s never come back. Since Javier said he got it from a toilet seat, Ana doesn’t feel she is at risk herself.

Stage: *Precontemplation*

Why: *Does not see herself at risk. Does not know how STIs are transmitted, and therefore believes boyfriend’s incorrect explanation that he contracted chlamydia from a toilet seat. Assumes that their engagement means that he will not have sexual relationships with other people.*

Possible Interventions:

- *Provide informational brochure about STIs, including HIV, and how they are and are not transmitted.*
- *Provide a fact sheet about the rate of HIV infection and other STIs among young women her age in her country or region.*
- *Gently correct her misinformation about how chlamydia is transmitted. If screening is available in your clinic, or there are service sites nearby to which you can provide a referral, ask whether she would like to be screened to be safe, since her fiancé did have chlamydia.*
- *Praise her for using contraception to reduce her risk of unintended pregnancy. Gently ask her if she would like to learn more about reducing the risk of HIV/STIs.*

Do not:

- *React strongly, and tell her how mistaken she is to think that she’s not at risk.*
- *Try to convince her to be screened or tested if she does not wish to.*
- *Say anything negative about her fiancé or try to imply that he may be cheating on her.*

Example 2: Patrick, a 27-year-old man, has been married for 4 years and has 2 children. He and his wife use oral contraceptives (OCs) as their method of contraception. His wife does not know that Patrick sometimes has sex with men. He knows that he could become infected with HIV and other STIs if he does not use condoms with his other partners. He is terrified that if he got infected he might infect his wife, not only making her ill, but also perhaps exposing his secret. He has been meeting in secret with his current partner, Justin, a 38-year-old man, for 6 months. While they used condoms together for the first few months of their relationship, Justin said he didn't like how they felt. Patrick has heard that your clinic offers HIV testing. He would like to be tested for HIV and some other STIs. He also would like Justin to be tested, and to start using condoms again, but he's not sure of how to ask. He's afraid of scaring Justin away.

Stage: *Contemplation/Preparation*

Why: *Is aware of his own risks and his partners' (including his wife's) risk for HIV. Would like to start using condoms again, and to encourage his male partner, Justin, to do the same. Is seeking assistance in how to do this. His ambivalence about talking with Justin and the concern that trying to take care of his own health risk could bring an end to his relationship may put him on the border of Contemplation.*

Possible Interventions:

- *Praise Patrick for recognizing his risks and seeking assistance in determining the best course of action.*
- *Provide informational brochures about STIs, including HIV, and the importance of condom use. (If available, provide brochures that are specific to men who have sex with men.) Suggest that he share them with his partner, if he thinks it's appropriate.*
- *Talk with Patrick about the positive benefits and negative outcomes of talking with his partner about their risk for HIV. The benefits include using condoms consistently, protecting their health. The potential negative outcome is that his partner could decide to end the relationship – although this is only a possibility, not a guaranteed outcome.*
- *Explore with Patrick how he feels about his two relationships and his future plans, if any. Explore the possibility of talking with his wife about the fact that he has other partners. Explore the positive aspects and potential negative outcomes of talking with his wife.*
- *Role play discussing condom use with his partner (or his wife), alternating which role the client and counselor play.*
- *Offer testing for HIV and other STIs to Patrick (and his partners). Offer condoms. Offer a follow-up visit for him and his partner (or his wife) to come in to discuss their HIV risk and condom use.*

Do not:

- *Tell Patrick what to do. This includes not telling him whether you think he should or should not remain in his relationship with Justin or his wife.*
- *Say anything negative about Patrick, Patrick's wife, or Justin, or judge any of them in any way.*

Example 3: Marguerite, a 42-year-old married woman, comes to see you because she has had pain urinating. While she is there, she tells you that she has noticed some whitish fluid at the tip of her husband's penis, and that it gives off a strong odor. When she asked her husband about it, he said it was something that happens to all men, and there is nothing to worry about. When you ask whether she or her husband have had sexual relationships with other people, she becomes indignant, and reminds you that they are married.

Stage: *Precontemplation*

Why: *Although she perceives that something is wrong with the discharge she observed coming from her husband's penis, she cannot entertain the notion that her husband might be having sex with other people. Therefore, she will not think that she or her husband could be at risk for any STI, including HIV.*

Possible Interventions:

- *Provide informational brochures about RTIs and STIs, including HIV, and how they are and are not transmitted.*
- *Provide specific information about signs and symptoms of STIs, including that they often do not have any symptoms, particularly in women.*
- *Refer her for RTI diagnosis and treatment, explaining that the discharge she noticed on her husband's penis and the pain that she has had while urinating may indicate infection.*
- *Suggest that her husband come to the clinic to have his symptoms checked out.*

Do not:

- *Press the possibility that her husband may be having sex with other people.*
- *Say anything negative about her husband or try to imply that he may be having sex with other people.*

Example 4: Marcel is a 19-year-old man who comes to the clinic with Marie, his girlfriend of 8 months. Marcel says that in the past he did not know very much about HIV or STI prevention, so he did not see any reason to use condoms. After being cured of gonorrhea, which he contracted from a previous girlfriend, Marcel realized that it was important to use condoms and has ever since. Marie says that she was a virgin before they met. Now that he and Marie have been monogamous for so long (and have used condoms their entire relationship), he does not think he needs to continue using condoms and would like to use another method for pregnancy prevention.

Stage: *Maintenance*

Why: *Has been using condoms consistently for at least 8 months.*

Possible Interventions:

- *Explore the reasons why they might want to continue condoms and the pros and cons of doing so for dual protection (prevention of pregnancy and of HIV/STIs). Explore the potentially positive and negative consequences of not using condoms.*
- *If available and feasible, offer testing for HIV and other STIs to both Marcel and Marie.*
- *Provide condoms and make sure that they have access to a supply of condoms, even if they end up choosing not to use them.*
- *Suggest a follow-up visit in a month to check in.*

Do not:

- *Tell them you think their decision to stop using condoms is a mistake. Simply help them weigh the pros and cons, and let them decide for themselves.*
- *Try to scare them into continuing to use condoms.*

Example 5: Angela is a 24-year old woman who comes to the clinic to talk about family planning because she has 3 young children and cannot afford to have another one right now. During your conversation, Angela reveals that she is currently working in commercial sex to support her children. Her clients do not like to use condoms and she is afraid that she will lose business if she insists that they do. She has tested positive for syphilis and has had other STIs in the past.

Stage: *Contemplation/pre-contemplation*

Why: *She has identified her risk of pregnancy and is seeking to do something about it (contemplation); she has had STIs but is not using condoms or planning to use them (pre-contemplation).*

Possible Interventions:

- *Praise Angela for recognizing her risks of pregnancy and for coming to the clinic.*
- *Discuss and provide informational brochures about STIs, including HIV, and the importance of condom use. (If available, provide brochures that are specific to the needs of women or sex workers.)*
- *Talk with Angela about dual protection – how condoms can help her prevent pregnancy AND HIV/STIs. Talk with Angela about other family planning methods.*
- *Talk with Angela about the positive benefits and negative outcomes of talking with her clients about using condoms. If the clients agree to use them, the benefits include protection against pregnancy and HIV/STIs. If they refuse, she will be at continued risk for pregnancy (unless she uses another family planning method) and HIV/STIs. A potential negative outcome is that clients may leave and find someone else who doesn't insist on condoms or offer to pay less money to use them.*
- *Role play discussing condom use with clients, alternating which role the client and counselor play.*
- *Offer condoms to Angela and make sure she knows how to access more.*
- *Offer a follow-up visit to see how Angela is doing in terms of reducing her risk for pregnancy and HIV/STIs.*

Do not:

- *Make Angela feel bad or judged for doing commercial sex work.*
- *Force condoms on her.*

Example 6: Edna is a 32-year old woman who is married and has 5 children. She and her husband agree that they don't want another child right now so she has come to talk to you about family planning. During your conversation, Edna confides in you that she knows her husband has other partners, including a family with another woman. When you talk to her about condoms she says that her husband would never use them and that he often hits her and the children when he gets upset. Both Edna and her husband have had STIs in the past.

Stage: *Contemplation/pre-contemplation*

Why: *Edna recognizes her risk of pregnancy and is motivated to protect herself (contemplation); Edna recognizes that her husband's behavior may place her at risk of HIV/STIs, but she is not yet ready to confront it (pre-contemplation).*

Possible Interventions:

- *Praise Edna for recognizing her risks of pregnancy and for coming to the clinic for family planning.*
- *Discuss and provide informational brochures about STIs, including HIV, and the importance of condom use. (If available, provide brochures that are specific to the needs of women.)*
- *Talk with Edna about dual protection – how condoms can help her prevent pregnancy AND HIV/STIs. Talk with Edna about other family planning methods.*
- *Talk with Edna about the positive benefits and negative outcomes of talking with her husband about their risk for HIV/STIs and pregnancy. The benefits include using condoms consistently, protecting their health. A potential negative outcome is that her husband could become violent or threaten to end the marriage, etc. Explore with her how she views the benefits and negative outcomes.*
- *Explore with Edna the extent of violence in her relationship. Talk about options for protecting herself and the children.*
- *Role play discussing condom use for dual protection with her husband, alternating which role the client and counselor play.*
- *Offer condoms to Edna and make sure she knows how to access more.*
- *Offer a follow-up visit to see how Edna is doing in terms of reducing her risk for pregnancy and HIV/STIs.*

Do not:

- *Criticize Edna for staying in an abusive relationship.*
- *Tell her what to do.*

Example 7: Rose is a 21-year old woman who has been doing commercial sex work for the past three years to support herself and her 2 children. She uses condoms consistently with all her clients. She does not use condoms with her steady boyfriend, Philip, who she knows has other sexual partners and does not use condoms. In your conversation, she tells you that she feels that not using condoms with Philip sets him apart from her clients and makes sex more “intimate.” She has come to the clinic to find out more about HIV testing, including where she can get a test. Some of her friends who are also commercial sex workers are talking about getting tested and she thinks this might be a good idea given that it is hard to tell which clients are “clean.”

Stage: *Maintenance and pre-contemplation*

Why: *Rose is in maintenance stage in terms of her behavior with clients because she uses condoms consistently. She is also showing awareness and concern about her health by inquiring about HIV testing. On the other hand, she is in pre-contemplation when it comes to her relationship with Philip. Because she sets her relationship with Philip apart, she is in denial that his behavior (having sex with other partners without condoms) may place them both at risk for HIV/STIs.*

Possible Interventions:

- *Praise Rose for using condoms consistently with her clients and for inquiring about HIV testing. Encourage her to continue protecting herself. Provide information about VCT and a referral for services (if available).*
- *Discuss how Rose feels about a pregnancy with Philip. If she wishes to prevent pregnancy, talk with her about dual protection – how condoms can help her prevent pregnancy AND HIV/STIs. Also, talk with her about other family planning methods.*
- *Discuss how a person’s behaviors may place them at risk (not who they are or if they appear “clean.”) Help her perceive the risk that Philip’s behavior presents.*
- *Talk with Rose about how she would feel about using condoms with Philip. Ask her about the positive benefits and negative outcomes of talking with Philip about their risk for HIV/STIs (and pregnancy, if it is a concern). Explore with her how she views the benefits and negative outcomes.*
- *Role play discussing condom use with Philip, alternating which role the client and counselor play.*
- *Offer a follow-up visit to see how Rose is doing in terms of reducing her risk for HIV/STIs (and pregnancy, if so desired).*

Do not:

- *Criticize Rose for having sex with Philip without condoms.*
- *Make Rose feel bad for judged for doing commercial sex work.*
- *Tell her what to do.*

Example 8: Joseph is a 23-year old migrant worker who is married and has 3 children. Joseph is away from home for several months at a time due to his work schedule. When he is away from home, he often has sex with other women. He uses condoms with all his partners, except his wife, Ruth. He has come to the clinic because he is afraid that Ruth will become pregnant again soon and wants to delay having a fourth child until his income is more regular. He would like to talk to a provider about family planning.

Stage: *Maintenance and contemplation*

Why: *In terms of his behavior with his other sex partners, Joseph is in the maintenance stage because he uses condoms consistently. He is in the contemplation stage of considering using family planning with his wife.*

Possible Interventions:

- *Praise Joseph for using condoms consistently with his outside partners. Encourage him to continue protecting himself and his partners. Help him to perceive how he could place his wife at risk if he does not consistently use condoms with external partners.*
- *Discuss whether Joseph has talked about family planning with his wife. Does he have any barriers to doing so? Since he wishes to prevent pregnancy, talk with him about dual protection – how condoms can help her prevent pregnancy AND HIV/STIs. Also, talk with him about other family planning methods, if he is interested.*
- *Talk with Joseph about how he would feel about using condoms with his wife. Ask him about the positive benefits and negative outcomes of talking with his wife about condoms and other family planning methods. Does he feel able to discuss HIV/STI risk with his wife? Explore with him how he views the benefits and negative outcomes.*
- *Role play discussing family planning (or dual protection) with his wife, alternating which role the client and counselor play.*
- *Offer a follow-up visit for Joseph to come back and discuss how things are going.*
- *Encourage Joseph to bring his wife to meet separately or together with a counselor to discuss family planning, dual protection and other health concerns.*

Do not:

- *Criticize Joseph for having sex with outside his marriage.*
- *Tell him what to do.*

HELPING CLIENTS MAKE DECISIONS AND PLAN FOR ACTION

Objective

1. To provide participants with concrete suggestions for helping clients make a plan to reduce their risk for HIV/STIs and/or pregnancy.

Time

60 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Participant Handout: *Steps to creating a plan for reducing risk*
 - Participant Handout: *Sample form for planning for reducing risk* (Note: This form is for use in this exercise; in most settings, it is unlikely that it will be feasible for providers to use written forms for planning with clients.)
 - Participant Handout: *Sample plan for reducing risk* (Note: This is simply for the purposes of this exercise, to show participants what types of information it is important to obtain to help clients' plan for risk reduction.)
 - Participant Handout: *Role play scenarios: Creating a plan for reducing risk with a client*
-

Steps

1. Introduce the activity by telling participants that we are going to learn about ways to work with clients to develop a plan for reducing their risk. Distribute the handout, *Steps to creating a plan for reducing risk* and go over it with participants.
2. Divide participants into pairs, letting them know that they will be practicing working with a client to establish a risk reduction plan through doing role plays.
3. Ask participants to decide who will be the “client” and who will be the “counselor”, letting them know that they will both have a chance to play each role. Once they have decided, distribute the client roles from the handout, *Role play scenarios: Creating a plan for reducing risk with a client.* Give the participants approximately 2 minutes to read through their scenarios.
4. Ask participants to start their role plays, with the goal of developing a plan for reducing risk. Let them have no more than 10–15 minutes in which to do this.
5. Invite the larger group back together. Ask one pair to present their client situation and their plans. Ask for feedback from the other participants, and provide comments as well.
6. Ask participants to stay in their pairs, and switch roles (the participants who played the counselors will now play the clients, and vice versa). Distribute a different role play and

follow the same format for conducting and discussing the activity as with the previous role plays.

7. Distribute the handouts, *Sample form for planning for reducing risk* and *Sample plan for reducing risk*, explaining that they are purely for participants' reference. In most settings, it is not feasible for providers to fill out and store client forms (due to lack of confidentiality and lack of client records, etc.). These forms, however, demonstrate the types of information that providers should obtain in order to help clients to formulate and develop their own plans for reducing risk.
8. Lead a group discussion based on the questions below.

Key Discussion Points

- How did it feel to be the counselor when developing a plan?
- How did it feel to be the client?
- How can counselors make clients feel more comfortable when developing a plan?

Possible responses:

- *Explain that your job is to help people make their own decisions and strategies about how to best protect themselves.*
- *Communicate your concern and respect for the client through body language, tone of voice as well as language.*

Essential Ideas to Convey

- When a provider and a client work on a plan for reducing the client's risk, the plan must come from the client. The provider's role is to help the client to develop the plan – one that fits into the realities of the client's life and one that they feel confident trying.
- It is helpful to follow a format when helping a client develop a plan for reducing risk. With something written down, the client and provider can refer back to successes and challenges, and monitor progress and client needs. In many settings, however, it is unrealistic to have a written plan, especially where there are no formal client files, people are less literate, confidentiality is not well maintained or certain supplies such as paper aren't available. In these situations, an oral approach, where the provider and client formulate the plan and then discuss it repeatedly until the client has internalized it, is needed.
- Any plans for reducing risk must be **specific**. This means that when clients say they will take a particular step toward reducing their risk, providers need to ask questions that will allow a client to say the specific steps out loud. For example, if a client says he will start to use condoms, the provider should ask, "How often? Where will you get the condoms? How will you pay for them? How will you tell your partner that you want to use them? Where will you keep them so that you will remember to bring them with you when you go out?" etc.

CLIENT BARRIERS TO COMMUNICATING WITH PARTNERS: I CAN'T SAY THAT!

Objectives

1. To identify potential reasons that clients may have for not being able to talk with their partners about sexuality and other sensitive issues.
2. To examine the emotions behind clients' difficulties in discussing sensitive issues with partners.

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
-

Steps

1. Tell participants that we are going to discuss the difficulties that many clients have in talking openly with their partners about sexuality and other issues.
2. Ask participants to brainstorm responses to the questions below. For the first question, instruct participants to use language that their clients might use. For example, "I can't talk to my partner about condoms, because he will think I am cheating on him," etc. Record the responses on flipchart paper.

Key Discussion Points

- ← What are some reasons that clients may not be able to talk to their partners about sensitive issues such as sex, family planning methods, using condoms, sexual problems or monogamy in their relationship?

Possible responses:

- *My partner will think I'm cheating if I ask him to use condoms.*
- *We love each other, so why should we use condoms?*
- *We don't talk about things like that.*
- *People like me don't get HIV or STIs.*
- *My partner will think I have HIV/STIs if I ask to use condoms – and he'll kick me out of the house and tell everyone about it. (Cause: fear of retribution; loss of support, etc.)*
- *I don't want my partner to know that I have other sexual partners.*
- *I can't tell him that I'm unhappy with our sex life – he'll find someone else!*
- *I can't tell him that it hurts because it is a woman's obligation to have sex with her husband any way that he wants.*
- *I can't tell her that I have an STI because then she'll know that I cheat on her.*

- *I can't tell him that I want to use family planning because he thinks that it goes against our religion.*
 - *I can't ask him about his smelly discharge because he'll get embarrassed.*
- What are some of the things a client could say or do to initiate discussion about sex, HIV/STIs or using condoms with their partner(s)?

Essential Ideas to Convey

- There are many different reasons why clients may feel that they cannot discuss sexuality with their partners. Identifying these reasons is an important first step in helping clients determine whether they can move past these blocks and find ways of starting these important conversations.
- It is equally important to address the causes or motivation behind clients' reasons for not talking with their partners. By identifying the root causes you can help clients understand their fears and anxieties related to talking with their partners and develop strategies for overcoming them.
- Clients' reasons for not feeling they can discuss sexuality openly can be **real** or **perceived**. A counselor or provider needs to respect the client's reasons, even if the perception does not fit the counselor's view of the actual situation.

HELPING CLIENTS COMMUNICATE WITH THEIR PARTNERS

Objectives

1. To provide participants with general guidelines for helping clients talk with their partners about sexuality and other difficult topics.
2. To identify possible client assumptions and concerns about talking to partners about sexuality and other difficult topics, through role plays.

Time

45-60 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Participant Handout: *Helping clients communicate with their partners*
 - Facilitator Resource: *Pair activity: Working with clients on communicating with their partners*. Make copies of the activity beforehand and cut them into 3 pieces so that the two “client” roles and the “counselor” roles are divided for distribution to pairs. (Note: There are 2 client scenarios, so half of the pairs will get one scenario and the other half will get the other. The counselor role will be the same in both groups).
-

Steps

1. Distribute the handout, *Helping clients communicate with their partner*, having key points outlined on flipchart paper if you wish. Go over this handout, asking for anything participants would like to add, challenge, or discuss.
2. Explain to participants that often clients are concerned about talking with their partners about sexuality and other difficult topics because they have never done so. Based on what they know about their partners, or what they have heard about HIV/STIs, family planning and sexuality, etc., they may have made certain assumptions or developed fears that have no basis in truth. Sometimes helping a client practice what they will say before talking to their partner can help. This can happen in role play during a counseling session where the provider takes on the role of the client’s partner.
3. Next, facilitate a large groups discussion of the following questions about role plays with clients:
 - ↔ Do you think role playing partner communication with clients will be effective with your clients? Why or why not?
 - ↔ How could you introduce the idea of role playing with your clients? What specifically would you say?
 - ↔ What are the challenges to role playing partner communication with your clients?
4. Break the group into pairs. Explain that one person will receive a slip of paper with a “client” role, and the other a slip of paper with a “counselor” role. The “clients” have come

to meet with the counselor because they are interested in talking with their partner about a difficult topic, but they doubt that they will be able to do so. The job of the “counselor” will be to find out why the client has concerns about talking to his or her partner, make a list of these concerns, and try to address them through discussion and role play. More specifically, the counselor will be listening for the client’s assumptions and fears about talking with his or her partner and working with the client to address them.

5. Once the pairs have done the role plays, recorded the fears and assumptions and addressed them, ask volunteers to share the results of their scenario with the larger group. This includes explaining what the client’s situation was, what the counselor identified as the client’s fears and assumptions about talking with his or her partner, and how the counselor helped the client to address these concerns. Since half the group will get one scenario and half will get the other, ask a few pairs to share what they came up with and what they learned from it as well, for each scenario.
6. Record the fears and assumptions and how they were addressed on the flipchart. Once all the comments are written down, lead a group discussion about ways that providers could respond to the clients’ assumptions and fears about talking with their partners.

Considerations for the Facilitator/Training Options

You can use the two sample clients provided or you can develop additional scenarios to provide participants with a wider range of examples.

You can make up additional client scenarios so that within each pair, both partners have a chance to play the “client” and “counselor” roles.

Key Discussion Points

- ↪ For “counselors,” how easy or difficult was it to respond to the “clients”? What made it easy or difficult?
- ↪ How would you work with clients who, regardless of the number or variety of suggestions you give or the number of role plays that you do, maintain that discussing sexuality with their partners is still impossible?

Possible responses:

- *Tell the client that it doesn’t seem as if they are ready to talk to their partner just yet. Tell the client that you will be there to support them when they are ready.*
- *Ask clients to think about other difficult things they have done in the past and to think about how they went about it. Can they apply any of those steps to talking to their partner?*
- *Encourage clients to take small steps by bringing up a related topic, but not the one they are afraid to address, to see how their partners respond. As they develop confidence, they can take on the “scary” topic.*

Essential Ideas to Convey

- Helping clients to overcome their fears about talking with a partner about sexuality is part of a behavior change process. A provider cannot take too aggressive an approach when exploring the client's ability to bring up sensitive topics with a partner. The client may feel pressured or bullied by the provider.
- It is important to help clients to understand that there are many approaches that they can take for bringing up difficult subjects with their partners. They can start with less threatening subjects and work their way up to the more challenging ones related to sexuality and other sensitive issues.
- Sometimes clients are in relationships in which they have little power, control or ability to express their concerns to partners. Some clients, particularly, women may fear for their physical safety if their partners respond violently to their attempts to communicate about sensitive issues. Providers must be sensitive to clients in potentially violent relationships and not push clients to communicate with partners if doing so might place them at risk of violence or abandonment, etc.
- Sometimes clients may have success communicating with partners by starting with more indirect ways of communicating. For example, a wife might leave a brochure about family planning or HIV/STI transmission that she got at the clinic for her husband to read on his own. This might pave the way for a discussion once he has read and absorbed the material.
- Providers should help clients to determine what is the best context in which to broach the subject with partners. For example, it is generally not a good idea for people to discuss issues related to sexuality, such as condom use, while they are having sex. A provider might recommend that a client choose a moment when both partners are relaxed and not distracted by other concerns (for example, after the children go to sleep, walking to the market together – if no one can overhear the conversation, etc.).

FACILITATOR RESOURCE

PAIR ACTIVITY: WORKING WITH CLIENTS ON COMMUNICATING WITH THEIR PARTNERS

Note: Distribute only one role to each participant, with one half being “clients” and the other half “counselors.” There are two client roles, so half of the clients will get the first role and the other half, the second role.

Client 1: You are a 24-year-old woman who has come to the clinic to find out more about family planning methods. You have 2 young children and want to wait before having another child. You are fairly certain that your husband is having sexual relationships outside of your marriage. You know that there is nothing you can do about this – after all, you are a woman, and you must do what your husband says. However, after talking with the counselor, you feel you would like to protect your health and would like to ask your husband to start using condoms with you. You’ve never had a hard conversation with him – however, when you disagreed with him one time at a family gathering, he made a spectacle of you, humiliating you in front of your entire family. You used to feel like you and your husband had a satisfying sex life, but now you are enjoying sex less because you are worried about HIV/STIs and pregnancy.

Client 2: You are a 28-year old married male truck driver who is often away from home for long periods of time. You and your wife have 3 children. Lately you have been feeling lonely and started having sex with sex workers without using condoms. You would like to start using condoms with your wife because you are afraid that you may have gotten infected with HIV or another STI. You also don’t think she should get pregnant right now. You are scared to discuss using condoms with your wife because she might get suspicious about what you do on the road.

Counselor: You and your client have met once before. Today, your client has come back saying that he or she wants to be able to discuss condom use (for pregnancy and HIV/STI prevention) with his or her partner, but is skeptical about whether this will be possible. Your job is to find out *why* the client has concerns about talking with his or her partner, make a list of these concerns, and then address them. We will then discuss these concerns, what is behind them, and ways to address them with the larger group.

INTEGRATED DUAL PROTECTION COUNSELING ROLE PLAYS

Objectives

1. To provide participants with the opportunity to practice conducting an integrated dual protection counseling session with a new client.
2. To help participants improve their counseling skills by receiving feedback from their colleagues, using a counseling observation sheet.

Time

90 minutes – includes 15 minutes for introduction and participant preparation time; 20 minutes per role play, and discussion

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
 - Extra copies of the *Integrated dual protection counseling framework* handouts (long and short versions)
 - Extra copies of the *Integrated dual protection GATHER model* handout (if participants currently use GATHER for family planning)
 - Facilitator Resource: *Client profiles for role plays*
 - Participant Handout: *Observation of role play* (Option 1 or Option 2, or both)
-

Steps

1. Let participants know that they will be practicing the skills they have gained in previous exercises in order to conduct a role play with a client who comes in for service for the first time. Explain that in this role play will have rotating counselors but the same client throughout. One counselor will start, and the facilitator will stop him or her at a particular time and ask for another participant to take his or place as counselor (with the client remaining the same). Tell participants that the counselor can also ask for help if he or she wishes, and another counselor will step in.
2. Remind participants to use the integrated dual protection counseling approach using the integrated dual protection counseling framework, integrated dual protection GATHER, or any other counseling model that they already use, if they wish, and provide extra copies if they do not have their handouts with them.
3. Explain that while the “counselors” are practicing in the front of the room, the other participants need to pay attention to what has been covered and what questions have not yet been asked, etc. Let them know that during the activity, they will also be asked to fill out a form tracking the skills that the counselors they observed used (see the handout, *Observation of role play*, Options 1 and 2).

4. Ask for a volunteer to serve as the first client. Provide this person with information about the client he or she will be playing, and ask him or her not to show it to any counselor. Ask for a volunteer to act as the first counselor, letting the group know that not everyone will have an opportunity to act as a client or counselor.
5. Distribute blank handouts, *Observation of role play* (Option 1 or Option 2, or both), to the rest of the participants so that they can take notes on it while they observe the counselors. Explain that this form is for discussion purposes only, and that it will not be handed in.
6. After a set period of time (around 3 minutes), stop the session momentarily and select a new “counselor” to take over where the first one left off. Continue to stop and start until 3-5 counselors have had a turn, keeping the same “client.”
7. Switch role plays, selecting a new client scenario and a volunteer to serve as the second “client” with a new counselor. Repeat steps 5 and 6 above, and do additional client scenarios if time and interest permit.

Key Discussion Points

- For those who played the “counselor,” what were the most challenging aspects of doing a practice session on integrated dual protection counseling? What aspects did you feel most comfortable with, and why?
- Why is it important to integrate a wide range of reproductive health issues in a counseling session, even if the client says she or he came in for one specific reason?
Possible responses:
 - *Clients may come in one for one stated reason, but they may have other concerns that they are too scared to bring up.*
 - *Clients may not be aware that they are at risk for HIV/STIs, unintended pregnancy and other concerns, addressing a wide range of reproductive health issues can help them understand their own risks and do something about them.*
 - *Sexual and reproductive health issues are inter-related, so one stated problem generally relates to something else (e.g., if someone is at risk for pregnancy because they don't use family planning, they may be at risk of HIV/STIs, too).*
- What obstacles to providing dual protection counseling might come up in your clinic setting? How could you try to overcome these obstacles?
Possible responses:
 - *It seems like it takes too long to learn all that extra information about the client! (Response – it may take longer at first, but with practice you can hone in on what is of most concern to the client).*
 - *People may be worried that promoting condoms might result in more accidental pregnancies. (Response – share the information on condom effectiveness with staff members who view them as a less effective FP method).*

Note: This can be a tricky question if more than one provider is attending from the same setting. It is important to not encourage a complaint session here and to keep the discussion general. For example, if a participant were to start complaining that her supervisor pushes them to see as

many clients as possible, you may wish to turn the discussion towards the issue of time and having too little time in which to work with clients.

Considerations for the Facilitator/Training Options

When doing these role plays, it is best to allocate as much time as possible – an entire morning or afternoon, for example. While there are several sample role play scenarios, it is likely that you will only get through one in the time allowed. Don't worry if this is the case.

Two handouts entitled, *Observation of role play* (Option 1 and Option 2), are provided. Both options can be distributed to participants and they can take notes on either or both forms, or the facilitator can choose to use only one of the forms.

Facilitating this activity is challenging. You must remain engaged in everything that is going on, and be comfortable with interrupting the participants. While you cannot stop after every sentence, if there is a glaring omission, it is important to jump in and ask the participants, "What did we forget here?" For example, if a counselor becomes too directive, jump in and simply say, "Try some open-ended questions," and let the counselor continue where he or she left off. Use your best judgment as to when to switch counselors, but try to provide equal time as much as possible. However, if someone is clearly struggling, feel free to "rescue" that person, even if she or he has not been in the role play as long as the previous participants.

Explain to the group why it is important to provide feedback that is respectful as well as corrective – that it must talk specifically about what did not work as well as suggestions for what might work better instead. When going over the feedback, it is important to try to keep the comments as general as possible. If, for example, the group focuses exclusively on one counselor (for either positive or corrective feedback), try to open the discussion up to include the other counselors. Focus less on what a particular counselor did wrong, but instead on what could have been more effective. Let them know that these concepts can be applied to their work with colleagues and supervisors as well.

Essential Ideas to Convey

- Counseling clients on dual protection ensures that providers are treating the whole client. Even if clients come in with a question relating to family planning, the provider must be able to assess the clients' risk for HIV/STIs, and to help clients perceive their own risks and to develop plans for protecting themselves (from unintended pregnancy and/or HIV/STIs).
- Even counselors and providers who have many years of experience need to stop and reflect on their counseling skills when starting to work with clients on dual protection. If counselors feel like they are doing too much of the talking during a session, they are. Keep the focus on clients' needs, fears, concerns and how they might address them.
- Always remember the importance of looking at behaviors that may place clients at risk. Also, the client is the person with whom the counselor is working, and therefore can only be responsible for and attempt to change his or her own behavior, not that of his or her partner. Changes may include efforts to communicate with partners about family planning and HIV/STI risks, or may include other indirect approaches to communication or risk reduction. Focusing the session on a client's partner's behavior may be unproductive, and can actually serve to make the client feel inadequate or hopeless.

FACILITATOR RESOURCE: CLIENT PROFILES FOR ROLE PLAYS

Client 1: You are a married, 28-year-old woman with 3 children who goes to a family planning clinic, but you are having a hard time explaining why you are there. You have deep religious beliefs and are ashamed to admit that you are concerned about HIV/STIs because you suspect that your husband has other partners. You feel very uncomfortable being there, and don't talk much – unless the provider with whom you are meeting makes you feel more comfortable. Otherwise, you keep as quiet as possible.

Client 2: You are an adolescent girl who goes to a family planning clinic to ask for a contraceptive method. Your uncle has been abusing you, but you are terrified to tell anyone because you think if you do, your family will blame you and kick you out of your home. You are also afraid that you might get pregnant. You only want a family planning method, and don't say anything about the abuse unless the provider asks you the right questions.

Client 3: You are a married woman who comes to the family planning clinic regularly for your contraceptive injection. You feel like you have gotten to know some of the people who work there, and feel fairly comfortable. However, this time you have a question but do not know how to bring it up with someone because you are very embarrassed about it. Your husband said that he wants to have anal sex with you, and you are concerned that this means he may be homosexual. You try to make the provider aware of your concern through indirect comments, but you don't feel you can ask directly.

Client 4: You are a recently-married 24-year-old man, and your wife has told you to go to the family planning clinic, but you don't really understand why. All she has told you is that she will not have sex with you again until you go in "to talk about the bumps down there." You care about your wife a great deal, but do not understand what she meant. You remain confused unless the provider can explain to you what your wife may be concerned about. You are then able to provide supplemental information about the sores around your penis.

Client 5: You are a 35-year old man with 5 children who has come to the family planning clinic to talk about vasectomy. A man associated with the clinic gave a talk in your village recently on vasectomy and you think that it is a good idea because you and your wife don't want to have any more children. Your wife doesn't know that you occasionally have sex with other women, sometimes with sex workers that you pay. You have never used any method of family planning, including condoms. One time after having sex with a woman you had a painful discharge from your penis and so you went to see the pharmacist you gave you some medicine to take. It eventually went away.

APPROACHES TO COUNSELING SPECIFIC POPULATIONS

Objectives

1. To identify different groups that may be represented within the client population and some concerns that may be unique to individuals in these groups.
2. To help participants be aware of any of their own biases and discomfort that they may experience when working with clients from different populations.
3. To identify specific counseling techniques that providers could use when working with individuals representing any of these groups.

Time

90 minutes

Materials and Advance Preparation

- Flipchart paper
 - Prepared flipchart paper as described below
 - Markers
 - Tape
-

Steps

1. Before the session, pick 3-5 populations that you feel your group will find most challenging to work with, and write the categories in a list on a piece of flipchart paper. For example, you might choose the following categories of people:
 - Men
 - Men who have sex with men
 - People with HIV
 - Sexual abuse/rape survivors
 - Sex workers
2. Also before the session, take three to five sheets of flipchart paper and write one of the categories of people that you select on each piece of paper. Post these sheets on the walls around the room, with a lot of distance in between them. Hide the category name by either folding the bottom half up and taping it over the title, or by taking blank sheets of flipchart paper and taping them over each pre-printed sheet.
3. Introduce the topic by explaining that while all our work must be client-centered and geared towards the unique needs of each client, certain groups of populations tend to have specific needs. Explain that this is different from stereotyping, although stereotyping is a danger that providers have to guard against (to be discussed at the conclusion of the activity). Show the list on flipchart paper, letting the group know that the list represents only five groups from

the entire larger list. Tell the participants about the other groups, and that they will receive information about working with all these groups. However, for the time being, you are going to focus on the three to five listed here.

4. Break the group into three to five smaller groups and give each a marker. Then ask each group to stand in front of one of the posted flipchart papers without doing anything until they've received your instructions. Let them know that each group has one of these categories written on the sheet of flipchart paper in front of them. Have the groups draw a line down the center of the flipchart paper creating two columns. At the top of the first column, write "special issues" and at the top of the second, "provider biases." Their task is to write down as many special issues they can think of that will come up for clients from their groups and any biases providers may have when working with clients from these groups. Let them know that they only have a couple of minutes in which to do this.
5. After a minute or two, call time and ask each group to move one sheet of flipchart paper to the right, where they should read the previous list and add to it if they can. Continue this until every small group has visited each sheet of flipchart paper. Once done, ask the participants to sit down.
6. Have a volunteer bring each of the sheets of flipchart paper to the front and read the entire list. Discuss briefly the issues listed, and supplement the list as necessary.
7. On a fresh sheet of flipchart paper, ask participants to brainstorm strategies for addressing these issues or concerns. Do this for all of the selected categories of people.

Note: Here are some sample issues (for both clients and providers) that may come up under each category:

Men

- **Clients:**

- *May not think that they need to be involved in family planning decisions*
- *May not feel welcome in a clinic, particularly if most of the clients are female and the majority of materials are geared towards women*
- *May be hesitate to admit they have a problem, question, or concern, or that they do not know something*
- *May feel uncomfortable talking with a female provider*

- **Providers:**

- *May be skeptical about clients' motivation for coming to the clinic*
- *May make assumptions about clients' sexual behaviors, number of partners, etc.*
- *May feel uncomfortable working with a male client*

Adolescents

- **Clients:**
 - *May not have as much information or may have misinformation they have learned from other adolescents, but may be uncomfortable admitting ignorance*
 - *May not be able to grasp the full consequences of their actions or weigh advantages and disadvantages of the choices they make*
 - *May not understand their susceptibility or that they are at risk (i.e., feelings of invulnerability)*
 - *May be embarrassed to admit that they are sexually active*
 - *May be nervous about being in a clinic with adults, and concerned that their parents will find out they were there*
- **Providers:**
 - *May be tempted to tell adolescents what to do and push certain decisions rather than letting the client make decisions for her or himself*
 - *May want to advocate for abstinence over sexual activity, and even refuse to provide the adolescent with a family planning method*
 - *May be tempted to share some information with the adolescent's parent(s) because they feel the parents should intervene in some way*
 - *May be judgmental about adolescents seeking services and let clients know that they disapprove*

Men who have sex with men/women who have sex with women

- **Clients:**
 - *May fear homophobia, condemnation, lack of care, or even violence*
 - *May be reluctant to discuss their sexual orientation, sexual behaviors, partners, etc.*
 - *May be unaware of or in denial about the level of their risk for HIV and other STIs*
 - *Women who have sex with women may not think that they are at risk for HIV and other STIs*
 - *May be in denial about their risk for unintended pregnancy if they have sex with both men and women*
 - *May fear that the providers will tell others about their sexuality*
- **Providers:**
 - *May assume heterosexuality – especially with clients who do not fit their preconceived stereotypes of what a man who has sex with men or a woman who has sex with women “looks” like*
 - *May feel uncomfortable being alone with the client*
 - *May make assumptions about the client's sexual behavior*
 - *May ask questions about homosexuality because they have never met or worked closely with a man who has sex with men or a woman who has sex with women*
 - *May use inappropriate language like “preference,” “choice,” and “lifestyle” to minimize a client's sexual orientation*

Sexual abuse/rape survivors

- **Clients:**
 - *May fear that they will be blamed for the abuse or otherwise condemned*
 - *May feel guilty and that the abuse is somehow their own fault*
 - *May fear that others will find out about the abuse or that the abuser will find out that they have talked about it*
 - *May be reluctant to talk about the abuse*
 - *May have difficulty talking about sexual issues*
- **Providers:**
 - *May judge clients, thinking that they were at least partially responsible for the abuse or rape*
 - *May become uncomfortable with the client or demonstrate pity for them*
 - *May fall into role of mental health counselor and ask the client to talk about the abuse*
 - *May be tempted to disclose their own abuse (if applicable) to normalize the client's experience*

Sex workers/"prostitutes"

- **Clients:**
 - *May fear being judged or condemned for their work*
 - *May ignore or deny their risks of HIV/STIs and/or unintended pregnancy or choose not to take steps to reduce risks in order to earn more income*
 - *May not know how to use condoms correctly*
- **Providers:**
 - *May judge or scorn the client*
 - *May feel uncomfortable working with clients or fear being associated with them by others in or outside the clinic*
 - *Assume that risk reduction is pointless with a sex worker*

HIV-positive clients/clients with STIs

- **Clients:**
 - *May fear judgment or condemnation*
 - *May feel that they no longer need to practice safer sex since they have HIV or another STI already*
 - *May assume that their diagnosis, if it is HIV, is a death sentence and there is nothing they can or should do to take care of themselves (or others)*
 - *May not believe that they are truly infected because they look and feel healthy or have no identifiable symptoms*
 - *May feel a range of emotions, including disgraced, shameful, angry, suicidal, overwhelmed, hopeless, etc.*
 - *May have special needs for home care or care of children (for clients with HIV/AIDS)*
- **Providers:**
 - *May feel uncomfortable working with a client who has HIV*
 - *May discriminate against clients with HIV and be afraid to touch them for examinations or treatments*
 - *May judge clients for anything related to transmitting HIV/STIs; for example, if clients know of their diagnoses and have neither their spouse nor started to use condoms to protect their spouse (or other partners)*
 - *May make assumptions about a client's relationships, sexual behaviors, life circumstances, etc.*
 - *May focus more on HIV/STI risk reduction and less on other family planning issues*

Key Discussion Points

- ↳ How can we be sensitive to various populations' needs while avoiding stereotyping or making assumptions about clients?

Essential Ideas to Convey

- While all our work must be client-centered and geared towards the unique needs of each client, certain groups of populations tend to have specific needs and in order to be most effective, providers should be sensitive to them.
- While addressing the specific needs of specific populations, providers must avoid making assumptions about clients based on who they are or the life experiences they have had.

COUNSELING ABOUT HIV: ISSUES TO CONSIDER

Objectives

1. To identify key HIV counseling approaches and educational messages for various populations.

Time

60 minutes

Materials and Advance Preparation

- Prepare two flipchart papers; one with the 5 client descriptions, another with discussion questions for small groups (see below)
 - Flip chart paper for five small groups
 - Markers
 - Tape
-

Steps

1. Explain that during this session we will apply some of what we learned in previous sessions (MTCT, VCT, sexuality, HIV/STI transmission, gender, condoms, etc) to HIV counseling. We will examine the approaches needed in counseling different populations and the specific types of HIV prevention and care messages needed.
2. Divide participants into five small groups. Have participants count off or use some other method to split into the five groups. Each group will be assigned one of the following client situations below:

Client descriptions:

- A pregnant woman with HIV
 - An adolescent girl seeking HIV testing
 - A female sex worker
 - A man who has sex with men (MSM) who just tested negative for HIV antibodies
 - An injection drug user who just tested positive for HIV antibodies
3. Instruct each group to select a facilitator, a note taker and a presenter. Each group will have 20 minutes to brainstorm responses the following questions:

Discussion questions:

- What are the issues this client might be facing?
- What counseling approach or approaches would you use with this client?
- What are the key points of information this client needs?
- What are their options?
- What referrals would you make, if any?

4. Invite each group to present their responses to the large group (five minutes each).
5. Summarize the findings and stress the importance of client-centered counseling and addressing the specific needs of various groups, being particularly sensitive to gender and adolescent issues and stigmatization of certain groups such as sex workers, MSM and drug users.

Note: Here are some possible responses for each case:

A pregnant woman with HIV

- **Client's issues:**
 - *Concern about health of baby*
 - *Concern about own health and mortality*
 - *Worry about social and family support and reaction*
- **Counseling approaches:**
 - *Non-judgmental*
 - *Reassuring, but present realistic picture of prognosis*
 - *Ask about client's feelings, fears and concerns*
 - *Make sure client understands information*
 - *Address client family situation and resources*
- **Key information and client options:**
 - *Present facts about MTCT*
 - *Present information about preventive treatment for MTCT (if available)*
 - *Address condom use and future transmission prevention*
 - *Provide nutritional counseling*
- **Referrals:**
 - *Antenatal care*
 - *Social services for HIV/AIDS care and support (if available)*
 - *Preventive treatment for MTCT (if available)*

An adolescent girl seeking HIV testing

- **Clients issues:**
 - *Concern about parents finding out about visit to the clinic*
 - *Embarrassed or afraid to talk to clinic staff*
 - *Fear of HIV/STI infection (and possibly unintended pregnancy)*
 - *Possible misinformation and HIV/STIs and pregnancy*
- **Counseling approaches:**
 - *Non-judgmental*
 - *Correct misinformation gently*
 - *Assure confidentiality*
 - *Assess client's situation – why does she want to test? What are the circumstances of her relationship(s)? What does she know about family planning and HIV/STI transmission? Does she have any sexuality concerns? Etc.*
- **Key information and client options:**

- *Present facts about pregnancy, conception, family planning, HIV/STI transmission, condom use, HIV testing*
- *Discuss dual protection*
- **Referrals:**
 - *HIV testing (if available and desired)*
 - *STI treatment (if symptomatic or if partners have STIs)*
 - *Career counseling or other social services (if available)*

A female sex worker

- **Clients issues:**
 - *Concern about prejudice or ill treatment from staff*
 - *Concern about HIV/STI and/or pregnancy prevention*
 - *Possible concern about violence or ill treatment from clients*
 - *Possible difficulty in negotiating condom use with clients*
- **Counseling approaches:**
 - *Non-judgmental*
 - *Discuss, and if possible role play, negotiation skills for condom use*
 - *Don't make assumptions about client's life or reasons for visiting the clinic – ask the client and assess how she perceives her own risk of unintended pregnancy and/or HIV/STIs*
- **Key information and client options:**
 - *Discuss dual protection (i.e., if a client comes in for family planning, be sure explore the client's risks for HIV/STIs as well as unintended pregnancy)*
 - *Make sure clients know how to use condoms correctly and practices condom negotiation skills*
- **Referrals:**
 - *Ask about resources available to the client, including housing, and if possible, make referrals to other social service agencies*

A man who has sex with men (MSM) who just tested negative for HIV antibodies:

- **Clients issues:**
 - *Relief about current test results, but possible concern about the future*
 - *Fear of revealing sexual behaviors to staff*
 - *Fear that staff will tell others about his sexual relationships with men*
- **Counseling approaches:**
 - *Non-judgmental*
 - *Don't make assumptions about sexual behaviors or partners. May have sex with women as well; therefore discuss dual protection.*
 - *Assure confidentiality, as always.*
 - *Help client to assess own risk of HIV/STI infection.*
 - *Make a plan for how client will continue to remain HIV-negative.*
 - *Practice role playing condom negotiation with partners, if desired.*
 - *Praise client for concern about his own health and health-seeking behavior.*
- **Key information and client options:**
 - *Present facts about HIV/STI transmission and prevention.*

- *Present facts about HIV testing and what a positive result mean and what a negative result means.*
- *Make sure client knows how to use condoms correctly.*
- *Discuss dual protection and family planning (if client has female partners).*
- **Referrals:**
 - *Support groups for MSM (if available)*
 - *STI treatment (if symptomatic or partner is)*

An injection drug user who just tested positive for HIV antibodies:

- **Clients issues:**
 - *Possible feelings of hopelessness, despair, anger, denial, etc.*
 - *Concern about prejudice and ill treatment from staff*
 - *Possible concern about infecting others through continued drug use and unprotected sexual behaviors*
 - *Possible difficulty in retaining or understanding information*
- **Counseling approaches:**
 - *Non-judgmental*
 - *Present facts about HIV, sexual and blood transmission in a straightforward manner.*
 - *Don't make assumptions about client's feelings, plans, life circumstances or sexual life.*
 - *Ask about social and family support.*
 - *Encourage client to talk about feelings, fears and concerns.*
 - *Assure confidentiality, as usual.*
- **Key information and client options:**
 - *Discuss dual protection and how client perceives risk of unintended pregnancy (for self or partner) and risk of transmitting HIV to sexual partners and fellow drug users.*
 - *Make sure client knows how to use condoms correctly.*
 - *Make sure client knows not to share drug needles or injection equipment or has access to bleach to disinfect supplies to prevent infecting others.*
- **Referrals:**
 - *HIV care and support (if available)*
 - *Drug treatment (if available)*
 - *Needle exchange program (if available)*

COUNSELING HIV-POSITIVE WOMEN

Objectives

1. To familiarize participants with issues and concerns that may emerge when they are counseling HIV-positive women.
2. To identify and consider ethics and rights issues when working with HIV-positive clients.

Time

60 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Costumes or props for role plays, if available (e.g., white coats, clip boards, etc.)
 - Tape
 - Participant Handout: *Suggested role play topics*
 - Participant Handout: *Counseling HIV-positive women*
-

Steps

1. Introduce the activity by telling participants that they will be discussing issues and concerns that may come up when counseling HIV-positive women.

2. Ask participants to brainstorm responses to the following questions:

↪ What are some of the concerns that an HIV-positive client might have?

Possible responses:

- *Fear of telling partner and family*
- *Fear, anger, sadness and other emotions related to death*
- *Concern about pregnancy and MTCT*
- *Concern about transmitting HIV to others*
- *Fear of stigmatization by the community*
- *Fear of violence or abandonment by partner and family*
- *Concern about maintaining health and questions about expected life span*
- *Questions about possible treatments for self and prevention of MTCT*
- *Confusion or misinformation about how she became infected*
- *Hopelessness or suicidal thoughts*
- *Concern about the future for her partner and children*
- *Lack of economic or social support*

↪ What issues or information would you address with an HIV-positive client?

Possible responses:

- *Check in with how she is feeling emotionally; provide referrals for social or economic support, if available*
- *The kind of family or social support she can expect to receive. Are there family members who would care for any orphaned children, etc.?*

- *Address HIV transmission, review how she can prevent transmission to others, dispel myths and teach correct condom use and skills for negotiating condom use with her partner(s).*
 - *Discuss treatment options, if available; provide referral to treatment, if available.*
 - *Discuss nutrition and maintaining a healthy lifestyle to prolong productivity.*
 - *Address any fears or concerns about violence, abandonment, stigmatization, etc., and, if possible, provide social service referrals.*
 - *If she does not wish to become pregnant, discuss dual protection, including dual method use (condoms and another method of contraception) and the dual benefits of condom use; discuss condoms plus emergency contraception, if available.*
 - *Explain which family planning methods protect against HIV transmission and which don't.*
 - *Provide facts about MTCT, including, if it is available in your setting, some preventive treatment can reduce HIV transmission risks during childbirth.*
 - *Discuss what it would mean to take care of a child with HIV, including the course of the child's infection and the likelihood of early death.*
- ↪ How can we ensure the rights of HIV-positive clients to make truly informed decisions and choices?
- Possible responses:
- *Be welcoming, non-judgmental and treat all clients with respect and dignity.*
 - *Provide accurate, clear and easy to understand information about a range of issues, including – what it means to be HIV-positive, how to prevent HIV transmission, what dual protection is, how to use condoms, family planning options, MTCT and preventive options (if they exist), etc.*
 - *Address and acknowledge any client concerns about sexuality, stigma, violence, orphans, partner communication, economic hardship, etc. Provide referrals to appropriate support services, if available.*
 - *Make sure that confidentiality is maintained in your facility and that staff do not share records with or discuss client information with non-authorized personnel.*
 - *Provide adequate privacy for clients during counseling sessions.*
 - *Do not force your own opinions or beliefs on clients, even if their decisions go against what you would do personally.*
 - *Help clients to understand the ramifications (both positive and negative) of their decisions and support them to make truly informed decisions.*
- ↪ Why might a woman who knows she is HIV-positive want to have a baby?
3. After the brainstorming session, divide participants into small groups of 4 or 5 people.
4. Distribute a copy of the handout, *Suggested role play topics*, to each group. Ask the groups to choose a topic from the handout or to develop their own scenario that deals with HIV-positive clients in the clinic setting. All the members of each group will create the scenario together. If there are not enough roles for each group member to have a part in the scenario, participants can choose whether they want to be “actors” or “directors” (group members who are not acting in the role play, but will provide suggestions and ideas to those who are). If you have props or costumes available, encourage the groups to use them.

5. After 10-15 minutes, call the groups back together into the larger group and invite each group to present its role play, one after another.
6. Lead a group discussion based on the discussion points below. Distribute copies of the handout, *Counseling HIV-positive women*, for the participants' reference.

Key Discussion Points

- What did the role plays have in common? What made them unique?
- Do you think these are realistic scenarios? Have you ever witnessed interactions like these at work?
- What ethical and rights dilemmas did these scenarios explore?
- Are there any questions for any of the groups about why they chose the conduct their role play as they did?

Essential Ideas to Convey

- HIV-positive clients often face stigma and threats of violence and ostracism in the communities in which they live. It is critical to make the clinic a warm, welcoming and non-judgmental environment that is open to and respectful of all clients regardless of their HIV status.
- Make sure that your clinic provides a safe environment for all clients, particularly those with HIV. This means establishing systems that ensure client privacy and confidentiality.
- It is essential not to force your own beliefs or decisions on clients; after providing clear and accurate information, a counselor helps a client consider the ramifications (positive and negative) of a decision and supports her to make the decision herself.

COUNSELOR WELL-BEING AND DEALING WITH STRESS

Objectives

1. To help participants identify and acknowledge the stress in their daily work.
2. To provide participants with concrete suggestions for managing this stress as effectively as possible.

Time

45 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
 - Participant Handout: *Dealing with stress when working in a clinic*
 - Participant Handout: *Blank healthcare provider shields*
-

Steps

1. With the large group, brainstorm the day-to-day stresses people often encounter when working in their settings. Record on flipchart paper at the front of the room. Ask about the sources of these stressors, which might include clients, co-workers, supervisors, and friends and family who may judge their work at the clinic negatively.
2. Distribute the handout *Dealing with provider stress*. Divide the group into five groups, and ask each group to respond to the comments under one of the categories listed on the worksheet.
3. After about 10 minutes, bring the group back together and discuss responses to the stressors listed.
4. Distribute the blank healthcare provider shields. Ask participants what a shield is used for (**to protect oneself; to show one's strength**). Point out that the shield's coat of arms is divided into four quadrants. Ask them to write, individually, the following in each of the four quadrants:
 - In quadrant 1: Three things they think they do well in their work.
 - In quadrant 2: Three things they feel used to be weaknesses or challenges for them in their work, but in which they feel they have significantly improved.
 - In quadrant 3: The names of three people who are sources of support to them in their lives.
 - In quadrant 4: Three things they do or intend to do to combat stress.
5. Once everyone has completed their shields, ask participants to share, if they feel comfortable doing so, what they wrote in the first quadrant only. Remind participants of their right to pass. Record these on flipchart paper.

6. Wrap up this activity by telling participants that they are well-equipped to work with their clients, and have supports they can take advantage of to manage stress. Encourage them to keep their shields with them in their clinics so that they can remind themselves of their strengths during particularly challenging or stressful days.

Key Discussion Points

- In addition to responding verbally to comments that raise stress, what other things can we do as providers to take care of ourselves during stressful times, both on the job and off?
- If the stress is a result of working conditions, how can providers discuss improving the environment with their supervisor or clinic director?

Essential Ideas to Convey

- Working in sexual and reproductive health is stressful work. Providers need to take care of themselves as well as their clients.
- Professionals do not need to passively accept stressful situations. There are steps that providers can take to reduce stress and improve their own physical and psychological health.
- Providers should identify positive forces in their life that can help them to overcome challenges at work and reduce stress.

APPLYING WHAT WAS LEARNED: PROVIDER SELF-ASSESSMENT

Objectives

1. To provide participants with a format for assessing (and continuously improving) their own counseling skills.
2. To help participants recognize their need to seek out support from colleagues and to care for themselves when working in sexual and reproductive health.

Time

30 minutes

Materials and Advance Preparation

- Flipchart paper
 - Markers
 - Tape
 - Participant Handout: *Provider self-assessment tool*
-

Steps

1. Introduce the concept of continuous or ongoing quality improvement of counseling. Explain that it is important to take what we have learned about being an effective counselor and to continue to apply it to get even better over time. Explain that self-assessment is a way for providers to think systematically about how effectively they are conducting their counseling work. In this exercise we will explore a self-assessment job aid that can be useful to counselors.
2. Point out that the training has focused on work relating to the client – that this is a part of being client-centered or client-focused. Another important aspect, however, is making sure that the providers not only have skills (and can improve them over time), but are also taking care of themselves so that they are able to provide the best services possible. This session will discuss both of these aspects.
3. In the large group, ask participants to brainstorm the ways in which they could receive ongoing feedback on their counseling skills. Record their ideas on the flipchart paper, and discuss the ideas and highlight the following methods:
 - **Client survey or interview.** Example: *If working with a literate client, ask her or him to complete a brief, anonymous survey before leaving the clinic. (If the client is illiterate, have someone else in the clinic ask two or three open-ended questions of the client before she or he leaves)*
 - **Self-assessment tool.** Example: *With the clinic staff, develop a standardized self-assessment tool that a counselor can complete once a week after a session with a randomly-selected client. The provider could discuss these self-assessments with a supervisor, to build on*

strengths and to address areas that need improvement. The provider should be sure to conduct the self-assessment with different clients, including those with whom they found it challenging to work.

- **Direct observation.** Example: *Once every few months, a counselor can ask a colleague at the health center to sit in on a counseling session without participating in the session. Then meet with the colleague to hear his or her perceptions of what the counselor did effectively and where the counselor may need to improve his or her skills.*
 - **Provider journal.** Example: *Similar to the idea of having a standardized form for discussion in supervision, counselors can keep a journal on their own. This can either be done individually for their own information and learning, or it can be done with other colleagues who can then meet on a monthly basis to talk about positive experiences and ask for advice on more challenging ones.*
4. Distribute the provider self-assessment tool and go through it with the participants. Ask for their comments on the tool, and encourage them to take it and change it as they feel is appropriate.

Key Discussion Points

- ↪ What needs to happen to make a self-assessment tool useful and successful?
Possible responses:
 - *The provider's willingness to do them,*
 - *Adequate time to do them,*
 - *Support from supervisors and other colleagues, etc.*
- ↪ What steps can providers take to ensure that this type of assessment will actually take place?
Possible responses:
 - *Make sure that they are adopted by all providers and supported by management.*
 - *Make reminders to yourself to use the tools and schedule it into your day.*
 - *Make sure that the tools aren't too long or complicated so that they will be easy to use.*
- ↪ What obstacles could prevent your facility from using self-assessment tools?
Possible responses:
 - *Supervisor's lack of interest,*
 - *Fear that the information would be used against the provider,*
 - *Fear of lack of confidentiality and spreading of rumors about a provider as incompetent, etc.*
 - *Given all the other demands, evaluation is sometimes not a priority*

Essential Ideas to Convey

- The learning process for healthcare providers is ongoing. This includes not only learning new information, which is constantly changing in this field, but also continuously developing one's skills. No counselor should feel that he or she needs to work alone without feedback – or that feedback is provided exclusively in the context of a performance appraisal, given by a supervisor. Constructive criticism can also come from yourself.
- If outside feedback is not available due to time or other constraints, counselors can use a self-assessment tool in order to evaluate themselves on an ongoing basis. These tools include a self-survey, journal writing, and any other format that the counselor thinks will be of help and something that she or he will use consistently.

APPENDIX

APPENDIX

SAMPLE AGENDAS

UNDERSTANDING AND BEING COMFORTABLE WITH SEXUALITY AND GENDER (Sample One-day Curriculum)

Time	Exercise Title	Alternative Exercise
30 minutes	Defining sexuality and sexual health	
30 minutes	Why address sexuality?	Message wall: benefits and challenges of addressing sexuality and HIV/STI risk
45 minutes	How do we learn about sex?	Guided visualization on early learning: a trip down memory lane
45 minutes	Variations in sexual behavior: "That's OK for me!"	
60 minutes	Gender issues and sexual and reproductive health: I'm glad I'm a...but if I were a...	Gender roles: Act like a "lady," act like a "man" Or Sexuality and gender stereotypes
45 minutes	Language and sexuality: finding a comfort zone for you and your clients	
60 minutes	Sexual anatomy, physiology and erogenous zones: body mapping	What is pleasurable to men? What is pleasurable to women? Or Sexual development throughout the life cycle
45 minutes	Introduction to sexual response and sexual problems	
60 minutes	Uncovering clients' underlying concerns about sexuality	

a

WORKING DRAFT

Not for publication, duplication, quotation or citation without prior permission of EngenderHealth.

**INTRODUCTION TO HIV/STI PREVENTION
(Sample One-day Curriculum)**

Time	Exercise Title	Alternative Exercise
15 minutes	The impact of HIV/AIDS on our personal and professional lives	When someone says AIDS, I think...I feel...
30 minutes	Moving survey: where do you stand on the issues?	
45 minutes	Where did you hear that one: Skits on myths about HIV/STIs	
60 minutes	Presenting information on HIV/STI transmission	The "lifeline" game Or Giving information on HIV/STIs: carousel activity
60 minutes	Is that safe? Levels of risk continuum	
45 minutes	Problem tree on women's vulnerability	Case studies on social forces that make people vulnerable to HIV/STI infection
45 minutes	Defining safer sex	
45 minutes	Increasing personal and professional comfort with condoms	Condoms and sexuality Or Condom excuses game
45 minutes	Just following orders: conducting a condom demonstration	ADD: Introduction to the female condom (if time permits)
60 minutes	Why is it difficult for women to negotiate safer sex?	Role plays on safer sex negotiation in relationships with a power imbalance

Note: Add: Introduction to VCT and Preventing MTCT of HIV, if time permits

**INTEGRATED DUAL PROTECTION COUNSELING SKILLS
(Sample One-day Curriculum)**

Time	Exercise Title	Alternative Exercise
45 minutes	Defining dual protection	ADD: Creating dual protection messages (if time permits)
60 minutes	Introduction to a framework for integrated dual protection counseling	
60 minutes	Contraceptive methods: link to HIV/STI prevention and sexuality	
60 minutes	Tailoring the GATHER model to address sexuality, HIV/STI prevention and dual protection	Applying integrated dual protection counseling models through case studies
30 minutes	Exploration of a client's sexual and reproductive health needs, risks and social context	Overcoming fears about talking with clients about sensitive subjects Or Broaching the subject of sexuality and HIV/STIs with clients: Approaches to putting clients at ease and role plays
30 minutes	Improving risk perception and assessing risk	Personal reflection on changing behavior
60 minutes	A model of behavior change	ADD: What stage am I in? Client case studies (if time permits)
60 minutes	Planning for pregnancy prevention and HIV/STI risk reduction	I can't say that! Brainstorm on client barriers to communicating with partners and Role play in pairs: helping clients communicate with their partners
60 minutes	Putting it all together: integrated dual protection counseling role plays	

**INTEGRATING SEXUALITY CONCERNS AND HIV/STI PREVENTION INTO FAMILY PLANNING
COUNSELING
(Sample Three-day Curriculum)**

NOTE: TAKE ONE-DAY AGENDAS AND MAKE 3-DAY AGENDA

d

WORKING DRAFT

Not for publication, duplication, quotation or citation without prior permission of EngenderHealth.

**INTEGRATED DUAL PROTECTION COUNSELING
(Sample Five-day Curriculum)**

DAY 1		
Time	Exercise Title	Alternative Exercise
15 minutes	The impact of HIV/AIDS on our personal and professional lives	When someone says AIDS, I think...I feel
30 minutes	Defining sexuality and sexual and sexual health	
30 minutes	Why address sexuality?	Message wall: benefits and challenges of addressing sexuality and HIV/STI risk
45 minutes	How do we learn about sex?	Guided visualization on early learning: a trip down memory lane
45 minutes	Variations in sexual behavior: "That's OK for me!"	
45 minutes	Language and sexuality	
60 minutes	Gender issues and sexual and reproductive health: I'm glad I'm a...but if I were a...	Gender roles: Act like a "lady," act like a "man" Or Sexuality and gender stereotypes
DAY 2		
Time	Exercise Title	Alternative Exercise
60 minutes	Sexual anatomy, physiology and erogenous zones: body mapping	What is pleasurable to men? What is pleasurable to women?
45 minutes	Sexual development throughout the life cycle	
45 minutes	Introduction to sexual response and sexual problems	
60 minutes	Uncovering clients' underlying concerns about sexuality	
30 minutes	Moving survey: where do you stand on the issues?	
45 minutes	Where did you hear that one: Skits on myths about HIV/STIs	
60 minutes	Presenting information on HIV/STI transmission	The lifeline game (if group is already knowledgeable about HIV/STI transmission)
DAY 3		
Time	Exercise Title	Alternative Exercise
60 minutes	Is that safe? Levels of risk continuum	
45 minutes	Problem tree on women's vulnerability	Case studies on social forces that make people vulnerable to HIV/STI infection
45 minutes	Defining safer sex	
45 minutes	Increasing personal and professional comfort with condoms	Condoms and sexuality
45 minutes	Condom excuses game	
60 minutes	Just following orders: conducting a condom demonstration/Introduction to the female condom	
60 minutes	Why is it difficult for women to negotiate safer sex?	Role plays on safer sex negotiation in relationships with a power imbalance
60 minutes	Contraceptive methods: link to HIV/STI prevention and sexuality	
Note: ADD: Introduction to VCT and Preventing MTCT of HIV, if time permits		

DAY 4		
Time	Exercise Title	Alternative Exercise
45 minutes	Defining dual protection	
45 minutes	Creating dual protection messages	
60 minutes	Introduction to a framework for integrated dual protection counseling	
60 minutes	Tailoring the GATHER model...(if participants use GATHER for family planning)	Applying integrated dual protection counseling models through case studies
30 minutes	Exploration of clients' sexual and reproductive health needs, risks and social context	
30 minutes	Broaching the subject of sexuality and HIV with clients: putting clients at ease and role plays	Overcoming fears about talking with clients about sensitive subjects
60 minutes	Giving information on HIV/STIs: Carrousel activity	
30 minutes	Improving risk perception and assessing risk	Personal reflection on changing behavior
DAY 5		
Time	Exercise Title	Alternative Exercise
60 minutes	A model of behavior change	ADD: What stage am I in? Client case studies (if time permits)
60 minutes	Planning for pregnancy prevention and HIV/STI risk reduction	
15 minutes	I can't say that! Brainstorm on client barriers to communicating with partners	
45 minutes	Role plays in pairs: helping clients communicate with their partners	
75 minutes	Putting it all together: integrated dual protection counseling role plays	
45 minutes	Counseling HIV-positive women (where is this?!)	ADD: other special populations, if desired
60 minutes	Issues to consider in counseling about HIV	
30 minutes	How am I doing? Introducing self-assessment job aids	
45 minutes	Counselor well-being and dealing with stress	