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Comprehensive Counseling for Reproductive Health: An Integrated Curriculum

Trainers' Manual

EngenderHealth

Improving Women's Health Worldwide

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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

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Preface

Since the International Conference on Population and Development, held in Cairo in 1994, and the Fourth World Conference on Women, held in Beijing in 1995, the international development and public health communities have embraced a more comprehensive reproductive health agenda and have sought to provide an expanded range of services in a more integrated fashion. This shift to integrated reproductive health has included heightened attention to the rights of clients, the quality of care, informed choice, and gender sensitivity.

Equally important, the shift has brought increased recognition of clients' broad, interrelated sexual and reproductive health needs and of the changes required throughout the health care system to meet them. If service programs are to seize all opportunities to identify and meet clients' reproductive health needs more holistically, they must take a client-centered approach, link services so as to offer comprehensive care that covers clients' interrelated needs, and ensure that their providers are sensitive to medical, behavioral, and social issues that may underlie the expressed reasons for the client's visit.

Providers require training and institutional support to develop the skills, knowledge, and comfort they need to communicate effectively with their clients about health care that relates to the function of reproduction, the anatomy that supports that function, and the behaviors related to sexuality and reproduction. This includes, for example, family planning, maternal health, sexually transmitted infections, and related sexual practices. All of these services and subjects share certain characteristics that make them particularly sensitive: They are intensely personal and command a high degree of privacy; they are associated with strongly held beliefs; and they are the subject of social, religious, political, and legal strictures. All also are significantly affected by sexual partners and behaviors, which bear directly on an individual's choices, health status, and treatment outcomes.

In 2001, a literature survey conducted by EngenderHealth noted a dearth of training resources to help providers counsel clients about their reproductive health in a comprehensive manner. Existing training materials on counseling largely ignored a discussion of sexual practices and their relationship to health. Similarly, providers generally addressed the different areas of reproductive health care separately, without regard for what these areas have in common, for what linkages there are among them, or for how interrelated clients' reproductive health needs often are. Discomfort and lack of information related to sexuality as a health issue remain widespread among both clients and providers, posing a substantial barrier to effective client-oriented counseling and good client-provider interaction. Opportunities for addressing the whole client and all of his or her reproductive health needs too often are missed, producing a negative impact on the public health of communities.

This curriculum responds to the identified gap in existing training materials and fills a field-expressed need for help in developing knowledge about, skills in, attitudes toward, and comfort with effective communication and counseling in all areas of reproductive health, including

sexuality. It thus adopts the term *sexual and reproductive health* to describe the scope of health issues sought by those who would receive integrated counseling.

This curriculum's intended audiences are health care providers, their supervisors, and the managers of the programs in which they work. The counseling skills addressed here are expected to be relevant to the provision of both preventive and curative health services through the participants' national health systems. Finally, the curriculum's participatory approach to defining terms and to generating profiles of potential clients is designed to assist trainees in addressing the realities of and exploring the reproductive health priorities of their communities in a culturally appropriate manner.

Acknowledgments

Comprehensive Counseling for Reproductive Health: An Integrated Curriculum represents the work of many teams and country programs at EngenderHealth. It is the culmination of a process that began in 1998, when sexual and reproductive health (SRH) counseling training tools and skills-development exercises were introduced to EngenderHealth[1] staff from five global teams and 12 country programs. This curriculum's development also involved follow-up surveys and interviews on field needs, a literature search and review of training materials, planning and coordination among several global teams, writing, and field testing. Thus, many individuals and EngenderHealth teams must be recognized and thanked for their input into this training package. (All individuals recognized below were with EngenderHealth when this curriculum was developed or written, unless otherwise noted; in addition, some EngenderHealth teams acknowledged here either no longer exist or operate under a different name.)

A staff-development workshop on informed choice and counseling training, held in Bangkok in 1998, was conducted by members of EngenderHealth's Advances in Informed Choice, Clinical Services Support, Postabortion Care, Reproductive Health Linkages, and Training teams, with major support from the staff of EngenderHealth's Bangkok regional office and with participation by staff from 12 country programs.

Follow-up surveys on counseling training needs pertaining to SRH were conducted in 2000 with Dr. Mavzhuda Babamarodova (Central Asian Republics), Akua Ed-Nignpense (Ghana), Luz Helena Martinez (Guatemala), Dr. Jyoti Vajpayee (India), Dr. Nisreen Bitar (Jordan), Feddis Mumba (Malawi), Damien Wohlfahrt (Mongolia), Rahda Rai (Nepal), Dr. Annabel Sumayo (Philippines), Dr. Jean Ahlborg (Southeast Asia), Dr. Levent Cagatay (Turkey), and Karen Levin (United States).

The curriculum was conceptualized, drafted, and reviewed over the period 2000 to 2002 by Julie Becker, Dr. Fabio Castaño, Dr. Carmela Cordero, Kristina Graff, James Griffin, Connie Kamara, Jan Kumar, Andrew Levack, Manisha Mehta, Amy Shire, Jill Tabbutt-Henry (coordinator), and Peter Twyman. A literature search and review of training materials was performed in 2001 by Kathryn L. Schnippel Bistline (intern).

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[1] Prior to March 2001, EngenderHealth was known as AVSC International.

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Suzanne M. Plopper (consultant) and EngenderHealth's Evaluation Team assisted with conceptualizing the evaluation plan, and Suzanne Plopper also drafted the evaluation tools. Karen Landovitz oversaw publication of the curriculum for the Publishing Team; Michael Klitsch edited the curriculum; Margaret Scanlon proofread the curriculum; Virginia Taddoni designed the cover and adapted several of the illustrations; and Anna Kurica developed the interior design, typeset the pages, and managed production.

Although the Advances in Informed Choice Team coordinated the development of this curriculum, much of the curriculum and the participants' materials were adapted from materials developed by other teams at EngenderHealth, including the HIV/STI Team, the Maternity and Postabortion Care Team, the Men As Partners Team, and the Quality Improvement Team. The following EngenderHealth training materials, in particular, are used widely throughout this curriculum:

- AVSC International. 1995. *Family planning counseling: A curriculum prototype.* Trainer's Manual. New York.
- EngenderHealth. 2000. *Introduction to men's reproductive health services.* Trainer's Manual and Participant's Handbook. New York.
- EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual.* Working draft. Volume 1—Manual; Volume 2—Handouts. New York.
- EngenderHealth. 2002. *Youth-friendly services: A manual for service providers.* New York.
- EngenderHealth. 2003. *EngenderHealth online courses: Sexuality and sexual health online minicourse, sexually transmitted infections online minicourse,* and *HIV and AIDS online minicourse.* [Online.] Available: http://www.engenderhealth.org/res/onc/index.html.
- EngenderHealth. 2003. *Counseling and communicating with men.* New York.
- EngenderHealth. 2003. *Counseling the postabortion client: A training curriculum.* New York.
- EngenderHealth. 2003. *Choices in family planning: Informed and voluntary decision making.* New York.

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For more information, contact:

Advances in Informed Choice Team
EngenderHealth
440 Ninth Avenue
New York, NY 10001 U.S.A.
Telephone: 212-561-8000
Fax: 212-561-8067
e-mail: info@engenderhealth.org

Introduction for the Trainers

Overview

Need for This Course

The international family planning community has broadened its focus in recent years to take a more comprehensive view of reproductive health in which family planning service delivery is integrated with other sexual and reproductive health (SRH) services. As a result of this change, a need has emerged for counseling and communications training that will prepare service providers to:

- Perceive the client as a whole person with a range of interrelated SRH needs, including information, decision-making assistance, and emotional support
- Address sensitive issues of sexuality with greater comfort
- Support and protect the client's sexual and reproductive rights
- More easily access resources covering a variety of SRH services

This curriculum attempts to meet that training need in several unique ways:

- By introducing the concept of "integrated SRH counseling"
- By using *client profiles* developed by participants to reinforce an orientation to the individual client, while tailoring the training to local needs
- By adapting counseling frameworks from family planning to help providers effectively assess and address clients' comprehensive SRH needs

Goal and Objectives

The goal of this training is to enable providers to address clients' comprehensive sexual and reproductive health needs by offering integrated SRH counseling services within their own particular service-delivery setting.

For the purposes of this curriculum, *integrated sexual and reproductive health counseling* is defined as:

> A two-way interaction between a client and a provider intended to assess and address the client's overall SRH needs, knowledge, and concerns, regardless of what health service the provider is working within or what service the client has requested.

The general objectives of this curriculum are to ensure that, by the end of the training, the participants will have the knowledge, attitudes, and skills necessary to carry out the following key counseling tasks:

- Help clients assess their own needs for a range of SRH services, information, and emotional support
- Provide information appropriate to clients' identified problems and needs

- Assist clients in making their own voluntary and informed decisions
- Help clients develop the skills they will need to carry out those decisions

Rationale: Why Integrated SRH Counseling?

Clients typically seek SRH services for *one* particular need or problem—e.g., family planning, a sexually transmitted infection (STI), postabortion care, or some aspect of maternal health care—and service providers typically respond to that *one* particular need or problem. However, people may have other needs or concerns that contribute to their primary problem but that are never identified or addressed by a service provider. By not addressing those needs, providers may miss key opportunities to improve clients' overall health status. This problem of missed opportunities is particularly serious in SRH services, given the social stigma associated with many SRH problems, the embarrassment that many clients and providers feel about discussing these issues, and the potentially life-threatening consequences of high-risk pregnancies, STIs, and HIV and AIDS.

By helping providers take a broader perspective and *integrate* clients' immediate needs or problems into their overall SRH status, this training can help providers resolve issues contributing to clients' primary problems or prevent future SRH problems, as well as provide more comprehensive care. By focusing on the client as a whole person—rather than as a particular type of client—and by considering factors both inside and outside the clinic setting that influence a client's decision making about SRH, providers will be better able to assess and meet a client's information, decision-making, and emotional needs. This will help the client make decisions that he or she is more likely to carry out and follow through more effectively with plans to seek treatment or change behavior.

Course Approach

This training's core curriculum presents counseling as a general service-delivery skill that relates to *all* areas of SRH, not as a specialized service or skill for one or two areas. This integrated approach teaches staff to use communication skills and counseling to assess and address clients' SRH needs holistically, rather than restricting the needs assessment and counseling to one service area. It emphasizes the clients' comprehensive needs, the clients' rights, and how the decision-making process is influenced by a combination of social, personal, and service-delivery factors.

In designing this curriculum, EngenderHealth faced the challenge of addressing the wide scope of counseling needs of individual clients, both in the different SRH areas and in varying cultures around the world. A unique approach that proved successful in field tests was having the participants develop *client profiles* to reflect the realities of the communities and clients that they serve. These profiles become the basis of case studies and role plays throughout the training. This approach supports client-centered services by focusing on the client as an individual, while tailoring training to local needs and realities (see "Before the Training Course: Using 'Client Profiles' to Tailor the Training to Participants' Needs," page xxi).

This integrated SRH counseling curriculum could be used either to develop basic communication and counseling skills or to enable participants already trained in counseling to integrate other areas of SRH counseling into their work. The goal and objectives of this course are

heavily oriented toward helping the participants develop attitudes and skills that are appropriate for integrated SRH counseling. Knowledge is usually covered in the participants' job preparation—i.e., in preservice training—or it can be addressed in focused prerequisite or follow-on trainings.

This core curriculum is intended to be supplemented by one-day modules that focus on specific concerns and counseling needs of clients seeking particular services. These can be conducted immediately following the core curriculum or at some later time. As this book was being finalized, the training modules were still under development: it is anticipated that they will address such areas as family planning, STIs and HIV and AIDS, and SRH counseling for men and for adolescents, with the selection of modules determined by the needs of the trainees.

Further in-depth training—whether on its own or in conjunction with this basic skills course—can be offered in these areas through the use of other curricula developed by EngenderHealth.[2] These include:

AVSC International. 1995. *Family planning counseling: A curriculum prototype.* Trainer's Manual. New York.

EngenderHealth. 2000. *Introduction to men's reproductive health services.* New York.

EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual.* Working draft. Volume 1—Manual; Volume 2—Handouts. New York.

EngenderHealth. 2002. *Youth-friendly services: A manual for service providers.* New York.

EngenderHealth. 2003. *Counseling and communicating with men.* New York.

EngenderHealth. 2003. *Counseling the postabortion client: A training curriculum.* New York.

Course Participants and Trainers

Everyone working at a health care facility where SRH services are provided has a role to play in making integrated SRH counseling successful, regardless of whether the person provides clinical, counseling, or support services. Therefore, this curriculum can be adapted to train several levels of staff.

The term *providers* is used here to refer to the staff who provide clinical or counseling services. Providers can include doctors, medical officers, nurses, medical or surgical assistants, counselors, health educators, and outreach workers. The term *frontline staff* refers to all staff other than providers who interact with clients. These include receptionists, switchboard operators, records staff, appointment clerks, accounts clerks, lab technicians, doormen, guards, janitors, interpreters, drivers, and maintenance workers. Finally, while *administrative or supervisory staff* do not actually work with clients, they usually supervise or make decisions affecting those who do.

A team of at least two trainers is necessary for this intensive workshop. As one trainer facilitates a session, the others can record information on flipcharts, monitor time, help keep the

[2] AVSC International became EngenderHealth in March 2001.

discussion on track with the session objectives, monitor small-group work, and act in demonstration role plays.

It is imperative for the trainers to have extensive experience either in counseling or in counseling training. Since this training is about "integrating" different service areas into counseling, the trainers' backgrounds should complement each other and (as much as possible) represent the range of services being covered in the training.

This manual is designed for use by skilled, experienced trainers. While the manual contains information to guide the trainers during a workshop and to assist them in making decisions that will enhance the learning experience, it is assumed that the trainers understand adult learning concepts, employ a variety of participatory training methods and techniques, and know how to adapt materials to meet the participants' needs

Course Structure

This course has been designed to be flexible, to accommodate different types of participants—e.g., providers, frontline staff, and administrators or supervisors—from sites offering family planning, HIV and STI services, maternal health care, or postabortion care and from different countries and cultures. The training package includes the essential materials for facilitating this course, including three sample agendas (Appendix A). These address the different needs of various levels of participants.

For *providers,* the curriculum is structured as a six-day workshop on core counseling skills and attitudes necessary for providing integrated SRH counseling. The follow-on modules (when developed) will allow for a concentration on specific SRH areas, to broaden the scope of in-depth counseling. Providers usually have already received basic training (whether pre-service or in-service) in their assigned service-delivery area and have acquired the technical knowledge necessary to provide services, whether in family planning, STIs, HIV and AIDS, postabortion care, or maternal health care. If the participants have not had *basic training* in their assigned area of service delivery, program planners may want to combine the core curriculum with one or more EngenderHealth curricula described earlier (see page xiii).

Frontline staff have a vital role in welcoming clients, making them feel comfortable, and gathering information from and providing it to clients. However, they are not generally involved in communication concerning the client's decision making. Therefore, a two-day workshop should be sufficient to address their role in setting the stage for and reinforcing integrated SRH counseling (see Appendix A).

The support of *administrators and supervisors* is absolutely essential to the establishment of any kind of counseling services, particularly integrated SRH services. Administrators and supervisors have three options for participation in this training program.

- The best option is for administrators and supervisors to attend the entire six-day training, along with providers from their facility. This would allow them to hear the providers' perspectives on both clients' and providers' needs. Since supervisors could be expected to provide feedback and technical assistance to providers following the training, they would benefit greatly from attending the six-day course in its entirety.

- A three-day workshop has been developed to specifically address the needs of administrators and supervisors (see Appendix A). The three-day agenda allows them to identify SRH needs in the community and to explore their own role in meeting those needs by supporting integrated SRH counseling services.
- Since the three-day agenda consists of a selection of sessions from the core curriculum, administrators and supervisors could attend those sessions *with the providers*, within the sequence of the six-day training, rather than attend a separate workshop only for them. Again, this would allow them to hear the providers' perspectives on both clients' and providers' needs and to participate with their staff in action planning.

The Training Package

Trainers' Manual

Format

This Trainers' Manual consists of this Introduction for the Trainers, a detailed curriculum with session guides, and a series of appendixes containing additional materials.

The session guides in the curriculum have nine basic components:

- Objectives
- Materials
- Advance Preparation
- Time
- Training Activities (overview)
- Detailed Steps
- Training Tips
- Trainers' Tools
- Trainers' Options

The Objectives are the concrete, measurable behaviors that the participants should have adopted by the end of the session. These provide the basis for pretests and posttests and for outcome assessment in follow-up evaluations of the training. They also give the participant and trainer a sense of why each session is necessary.

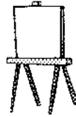
The Materials section notes all of the educational and training materials that will be needed for that session. Some of these materials need to be adapted, developed, or gathered in advance. Advance Preparation lists the steps that the trainers need to complete ahead of time and provides suggestions for developing flipcharts and other training aids.

A time is suggested for the entire session. The Training Activities section gives an overview of the training methodology and time estimates for each activity. The Detailed Steps provide detailed instructions for conducting each activity.

Training Tips provide additional background information for the trainers on content or training approach. Trainers' Tools are background materials that the trainers will need for the session but that are *not* meant to be distributed to the participants (for example, sample statements for

the "Providers' Beliefs and Attitudes" exercise, a sample script for the guided visualization in "Learning about Sexuality," and sample lists of behaviors for the "Variations in Sexual Behavior" and "Risk Continuum" exercises). Trainers' Options outline alternative approaches to covering material presented in a session.

In addition, several symbols appear in this Trainers' Manual to indicate to the trainers when particular training methodologies are used or to highlight significant issues. For example, each time a flipchart is used to impart important information or to begin an activity, the following symbol appears in the left margin:



Likewise, when the client profiles are used as the basis of role plays, the following symbol appears:

Finally, key questions are denoted by the symbol ✱, which appears instead of a bullet to emphasize the question's importance.

Appendixes

The appendixes contain explanatory materials and tools that will help the trainers conduct the training activities as effectively as possible. Curriculum appendixes are as follows:

- *Appendix A: Sample Training Agendas.* This section contains course agendas for the full six-day training (geared toward providers), for the two-day training (for frontline staff), and for the three-day training (for administrators and supervisors).
- *Appendix B: Daily Warm-Ups and Daily Wrap-Ups.* Guidelines are provided in this section for activities to begin and to end each workshop day. (See "During the Training Course: Participant Feedback," page xxiv, for a more detailed description.)
- *Appendix C: Promoting Informed and Voluntary Decision Making to Support Clients' Rights and Address Clients' Needs.* This is a presentation that can be photocopied onto transparencies if an overhead projector and transparencies are available (see Session 5, page 19). Depending on the training methodologies chosen for this session by the trainers, only some of the transparencies may be needed.
- *Appendix D: Participants' Self-Assessment of Knowledge and Attitudes: Pretest/Posttest.* This self-assessment is designed to be administered at both the beginning and the end of the workshop. When it is given at the beginning of the workshop, the trainers can use the results to customize the training to best suit the participants' level of knowledge and experience. When it is given at both the beginning and the end of the workshop, the trainers can use the survey to gauge how participants' knowledge and attitudes changed over the course of the workshop. The trainers must make and distribute copies of the survey to the participants. (See "Evaluation," page xxvi, for more details about using this tool.)

- *Appendix E: Participant Evaluation Form.* This and the following appendix offer tools for evaluating the strengths and weaknesses of the curriculum. The Participant Evaluation Form is to be used to gauge the feelings of the training participants about the curriculum immediately after they have completed it.
- *Appendix F: Trainer Evaluation Form.* The Trainer Evaluation Form offers a means for the trainers to provide their perspective to the developers of the curriculum on, among other things, the participants' ability to master the information and the usefulness and relevance of the different materials used. (See "Evaluation," page xxvi.)
- *Appendix G: Outcome Evaluation Using Observation of Client-Provider Interactions.* This and the following two appendixes offer tools for evaluating the outcome of this training (i.e., for obtaining feedback on the curriculum's success at improving providers' skills and on-the-job application of these skills). The Observation Guides included in this appendix are guidelines for observing the counseling interaction between providers who have been through this training and actual clients, and are meant to answer the questions "Is the provider applying integrated SRH counseling skills in service delivery?" and "If so, how well?" (See "Evaluation," page xxvi.)
- *Appendix H: Outcome Evaluation Using Provider Interviews.* The form provided here serves as a template for interviewing providers on how well they have been able to apply what they learned in the training and what challenges they may have encountered. This is meant to complement the information provided in the Observation Guides, and to answer the question "Why not?" if it is found that the provider is not implementing integrated SRH counseling with clients. (See "Evaluation," page xxvi.)
- *Appendix I: Outcome Evaluation Using Client Interviews.* The tool included here is to be used in the months following the training to gather feedback from clients about their perception of the quality of the counseling services they have received. Again, it is best used in conjunction with the Observation Guides and Provider Interview Form. (See "Evaluation," page xxvi.)
- *Appendix J: Using Visual Aids to Explain Reproductive Anatomy and Physiology—Transparency Guides.* This appendix provides the trainers with a set of simple drawings showing different aspects of the male and female reproductive systems. These drawings should be made into transparencies. By using the transparencies in sequence (laying one on top of the others below), the trainer can demonstrate in a simple, step-by-step manner the complexity of the internal organs and how they interconnect. (For a more complete explanation of how these are used, see Session 17, page 94.)

Participant's Handbook

Each provider participating in the training will receive a copy of the Participant's Handbook, which includes essential ideas to remember from the course, summary materials, discussion points, and review exercises to accompany the training sessions. (Frontline staff and administrators and supervisors should receive photocopied handouts based on this material.) Having the handbook minimizes the participants' need to take notes during sessions and enables them to give their full attention to activities and discussions. In addition, the handbook provides basic background information on family planning, HIV and STI prevention, maternal health care, postabortion care, SRH counseling for men, SRH counseling for youth, and sexuality. Ideally, the participants should receive their copy of the handbook in advance of the course so

they can become familiar with the information before the course begins. The participants can also use it as a reference after the training course is over.

Trainers should be completely familiar with the Participant's Handbook, since it details the essential ideas, discussion points, and other content meant to be covered in each session. In particular, for each session, the handbook contains a detailed overview of the "Essential Ideas" conveyed in that session. Trainers should study these essential ideas before the start of the training, should keep both the objectives and the essential ideas in mind from the beginning of the session, and should guide the participants toward these points throughout the activities and discussions. (It is possible to use the essential ideas to summarize a session, but do *not* read to the participants or reprint in their entirety the full sets of Essential Ideas from the Participant's Handbook. By the end of the session, the participants should be able to explain these points in their own words.)

Not all of the information in the Participant's Handbook will necessarily be addressed in every training. For example, discussion points give a list of possible responses that the participants may give during discussions, but not all of these points will be relevant to every group of participants. The trainers need to read these points ahead of time and determine which ones to highlight during the discussion.

The participants will find the interactive and highly participatory nature of this training to be intensive; after the training, the materials in the handbook will help them remember the scope and depth of the subjects covered. In addition, the participants should feel free to read ahead in their free time during the workshop. Although the trainers may worry that the participants will get "ideas" and that this will spoil the spontaneity of some activities, the concepts and attitude change involved in this curriculum will take time for the participants to grasp. Helping them to start thinking about the concepts ahead of time will only enhance the discussions.

However, to help keep their focus, the participants should *not* read from their handbooks *during* the sessions. They will need to refer to their handbooks at specific times for particular exercises, and the trainers should give them instructions to do so. (This manual specifically instructs trainers when during the sessions to use the Participant's Handbook.)

Training Materials, Supplies, and Equipment

Along with the materials provided as part of this training package (the Trainers' Manual and the Participant's Handbook), the trainer should obtain for use during the course such training aids as flipchart paper, masking tape or blue tack, and colored markers. In addition, many training activities will require index cards or large and small pieces of paper; some sessions specifically ask for different colors of paper, if available.

This training relies heavily on the use of flipcharts to guide or summarize discussions. Most of the flipcharts can be prepared in advance. However, there are dangers in overusing flipcharts: Paper is expensive and sometimes scarce; participants can become bored with "training by flipchart," even though it is meant to be more interactive; and some information needs to be saved by the participants and is already provided in their handbooks. Flipcharts are most often

overused in brainstorming, so it is important to be aware that not everything participants say in such sessions needs to be written down. Specific instructions are given in this trainer's guide for when to write on flipcharts and when not to; try not to do more than is suggested.

If an overhead projector, transparencies, and electricity are available, then transparencies can be used instead of flipcharts in some instances. If the resources to develop and use transparencies are not available, the trainer should create flipcharts for posting key information during training sessions.

Handouts are not used very much in this training because much of the key information is already provided to participants in the Participant's Handbook. However, handouts can be developed to address local issues, as needed.

Here are a few guidelines for when to use flipcharts, transparencies, or handouts:

- Use flipcharts if you are recording suggestions or ideas from the participants (e.g., during brainstorming) and you want to post the information on the wall or refer to it later in the training or if you want the participants to think through a question or concept together.
- Use an overhead projector and transparencies if you want to present a piece of text for everyone to read and then discuss, but not save (e.g., quotations from a key document).
- Use handouts if you want the participants to save the information to refer back to after the training.

Before the Training Course

Confirming Institutional Commitment

The trainers should read the Trainers' Manual and the Participant's Handbook one time quickly to get an overall sense of the purpose, content, and approach of the training. They should then meet with the program administrators at the institution requesting or sponsoring the training. Administrators at the service sites that requested this training should be aware of the goals, objectives, and intended audience for this training. Nevertheless, the trainers should meet with them to clarify the purpose of the training and to confirm the time committed for the workshop.

During this visit, the trainers should:

- Confirm that appropriate participants have been selected
- Identify the specific areas of SRH and the community groups or client populations to be emphasized in the training (see "Before the Training Course: Using 'Client Profiles' to Tailor the Training to Participants' Needs," page xxi)
- Decide whether to use REDI or GATHER as the counseling framework (see "Before the Training Course: Choosing REDI or GATHER," page xx)
- Identify and schedule follow-on modules or more in-depth content trainings that would best meet the training and service-delivery needs of the participants (*Note:* Consider whether any knowledge-oriented trainings are needed as "prerequisites." See "Overview: Course Approach," page xii, and "Overview: Course Structure," page xiv.)

- Agree on steps for training follow-up, with timing and responsibility assigned (i.e., to the trainers or to program supervisors) (see "After the Training Course," page xxv).
- Identify which supervisors or administrators will attend the trainings, or plan for a three-day workshop to specifically address their needs
- Identify which frontline staff will attend the two-day training and schedule this
- Discuss the possibility of conducting baseline observations and client interviews before the training, in preparation for outcome evaluations (see "Evaluation: Evaluation After the Training," page xxvii.)

Obtaining Background Information

Try to visit the service site before the workshop is to take place. Before the training, you should have a thorough understanding of the participants' background (including previous receipt of counseling training, if any), work assignments, and training needs. EngenderHealth recommends that trainers observe the participants at work and note the current status of SRH counseling in their facilities. In addition, trainers should talk with the participants to find out their experience with SRH counseling, asking specific questions related to their level of knowledge and attitudes.

Choosing REDI or GATHER

This course introduces a new framework for integrated SRH counseling, REDI, which stands for Rapport-Building, Exploration, Decision Making, and Implementing the Decision.[3] REDI was developed specifically for integrated SRH counseling in the following ways:

- It emphasizes clients' responsibility for making a decision and for carrying it out.
- It provides guidelines for considering clients' sexual relationships and social context.
- It addresses the challenges that clients may face in carrying out their decisions and offers skills-development to help clients meet these challenges.

GATHER is a counseling framework that has been in use for family planning for many years and that can be adapted for integrated SRH counseling. Both frameworks can be effective as a guide for carrying out the four counseling tasks that are the general objectives for this training.

Since the REDI framework was developed for integrated SRH counseling, this is the preferred framework for this training. It is intended for participants who are learning counseling for the first time, as well as those who already use the GATHER model for family planning counseling but are willing to consider a different approach. However, if participants have already been trained in GATHER, their administrators or the trainers themselves may decide that they would prefer to keep using GATHER. Therefore, this curriculum gives trainers the option to use either REDI or GATHER. Session 8 actually has two different session plans, depending on which framework is chosen. From Session 8 onward, the training sessions are generally oriented to REDI, but include training tips and other notes to help trainers adapt the activities

[3] REDI is adapted from: EngenderHealth, 2002; Pyakuryal, Bhatta, & Frey, no date; and Gordon & Gordon, 1992.

for GATHER. The decision on whether to use REDI or GATHER should be made during the planning phases of the workshop, based on participants' previous training and the trainers' and administrators' preferences.

Finalizing the Agenda

After meeting with administrators of the host organization and the service sites, and resolving all the issues identified under "Before the Training Course: Confirming Institutional Commitment" (page xix), the trainers should read the curriculum again, this time slowly, and think about each session in terms of the needs of clients and providers at the local service sites. They also should carefully review each session in the Participant's Handbook.

After field-testing and extensive deliberation, EngenderHealth has determined that six days is the ideal length of time for the core curriculum on counseling skills, with one-day follow-on modules added as needed. This allows time for the participants to develop basic counseling skills, plus learn to integrate different SRH services into one counseling session. If the participants are already well-trained in counseling skills but need to explore how to integrate new content areas into their work, the time needed for the core curriculum itself can be adapted, but with the client profile approach maintained.

Although specific times are given for each session, the actual length of time needed will depend on several factors, including the participants' level of knowledge and experience and even the logistics of the workshop space. Therefore, the trainers should review the lesson plan after the first training day to see if the time allowed for each session still seems sufficient, and should modify it if necessary.

Regardless of any changes in the timing of sessions, the trainers should be sure to follow the recommended sequence of sessions, since later sessions build on knowledge, attitudes, and skills addressed in earlier ones. Also, the exercises in this course have been carefully designed to achieve specific objectives, many focused on changing attitudes. While it will be necessary to adapt certain portions of the curriculum based on the participants, their culture, and the service setting, the trainers should follow the instructions as closely as possible.

Using "Client Profiles" to Tailor the Training to Participants' Needs

Planning Phase

One of the complexities of designing training for integrated SRH counseling is the wide variety of providers and service settings that may be involved. However, it is assumed that most participants in any training will come from one particular type of service setting. If so, that training can be customized to meet the needs for integrating SRH counseling into that particular setting. For example, in some trainings, the participants will work only in family planning settings and will make referrals for other services. In other trainings, participants (e.g., those providing postabortion care) may work in medical settings, with no connection to other services and no previous orientation to counseling. Even HIV and AIDS services may be segregated from other STI services. By addressing "generic" counseling and communication skills and being structured for flexibility in terms of content area, this curriculum can meet the varying needs of different providers in different settings.

Introduction for the Trainers

To adapt this course to fit the needs of differing audiences, the key is in how the trainers conduct Session 4 (on problem trees), which then leads to Session 6 (on developing client profiles). The client profiles, which function like case studies, are referred to repeatedly throughout the training and are used for practicing counseling skills in role plays. These profiles, which are based on needs identified by program planners and participants, give the training a local focus and offer the participants a sense of "ownership"—that these are the challenges faced by *their* clients, in *their* service sites, and in *their* communities. The profiles also give each problem a face, a name, and often a family scenario within which the problem must be addressed.

Although the participants are the ones who develop the profiles, at the beginning of the training they may not be aware of the range of SRH needs and concerns of people in the communities they serve. Thus, during the planning phase, the trainers should involve local program planners and administrators, to identify the needs and concerns to be addressed within the course. Although the "problem trees" session begins with brainstorming to generate a list of real SRH problems that people face, the trainers should be prepared to guide the brainstorming to ensure that the participants cover the needs that were discussed during planning. After the brainstorming, the trainers select which problems will be developed into problem trees, reflecting the needs identified during the planning phase. By guiding the brainstorming, the trainers are assured that the appropriate problems needed for the training will be selected.

During the Training

Although SRH needs identified in the brainstorming (Session 4) will vary depending on the community and on the participants, in general the problem trees (and, thus, the client profiles) should cover the following categories:

- Men
- Women
- Unmarried youth
- Family planning needs
- HIV and STI needs
- Maternal health care needs
- Postabortion care needs

During the brainstorming in Session 4, the trainer should probe to make sure that all key SRH areas are included. For example, if a program focuses on family planning and the participants brainstorm only about the family planning problems of the typical married female clients, trainers should ask: "What about family planning problems faced by men? By unmarried women? By adolescents? By postabortion clients? By people who are HIV-positive? By postpartum women? What about other problems faced by married women who come to your clinics?"

In Session 6, the participants will develop client profiles based on each of the problem trees. These profiles will include the demographic and social characteristics of each client, plus descriptions of the client's SRH needs, the decisions that the client is making, the information he or she needs to make those decisions, his or her access (or not) to services, and the client's feelings about his or her situation. The problem trees and client profiles determine the focus of the discussion throughout the rest of the training.

However, not all issues have to be covered in these initial profiles. In later sessions, the trainers can add "new developments" to each client profile, introducing some change in the client's physical, social, or emotional condition. The new developments can be used to help the participants focus on issues that they may have been reluctant to bring out in the initial profiles, as well as to raise the problem of missed opportunities by making sure that the client has more than one SRH problem that needs to be addressed. For example, one profile might be of a male STI client who is reluctant to tell his wife about his infection, and the new development might be that he learns his wife is pregnant. Now, over and above the standard STI issues, the profile must cover antenatal care, plus the client's need to communicate with his wife about STI treatment issues for her and the fetus. Trainers can use this technique to introduce such issues as power imbalances within relationships, women's lack of control over when to have sex, denial of services or information to unmarried and adolescent women, men's lack of access to services, the risk during unprotected sex of HIV and STIs (as well as unintended pregnancy), stigmatization of people who are HIV-positive, involuntary HIV testing, and pressure for sterilization in postabortion services.

Participants are instructed to develop five client profiles, based on five problem trees. This number was chosen because it allows for some variation in clients and needs; more than five profiles would create time problems, particularly during the plenary discussions after small-group work, when time is needed for each group to share their findings.

However, the trainers should develop a *sixth* client profile. Several counseling practice sessions during later sessions require demonstration role plays by the trainers. For these role plays, the trainers will introduce their own profile—the "sixth client." The trainers can also use this profile to address SRH needs that are not covered in the other five.

During the Training Course

Creating a Positive Learning Environment

Many factors contribute to the success of a training course. One key factor is the learning environment. Trainers can create a positive learning environment by:

- *Respecting each participant.* Trainers should recognize the knowledge and skills that the participants bring to the course, and can show respect for them by remembering and using the participants' names, encouraging them to contribute to discussions, and requesting their feedback on the course agenda.
- *Giving frequent positive feedback.* Positive feedback increases people's motivation and learning ability. Whenever possible, trainers should recognize the participants' correct responses and actions by acknowledging them publicly and making such comments as "Excellent answer!" "Great question!" or "Good work!" Trainers can also validate the participants' responses by making such comments as "I can understand why you would feel that way...."
- *Making sure that the participants are comfortable.* The training room(s) should be well-lit, well-ventilated, and quiet, and should be kept at a comfortable temperature. Breaks for rest and refreshment should be scheduled.

Presenting Sensitive Content

This training course addresses many topics that participants may find difficult to discuss. While this manual provides suggestions for ways to discuss many topics in a group setting, trainers may face situations in which individual participants (or groups of them) hesitate to join in discussions, are judgmental, or inhibit other participants from expressing their feelings freely. To encourage risk-taking and create an environment in which the participants feel comfortable discussing and absorbing new content and ideas, trainers may use the following techniques:

- Acknowledge that it is normal to feel nervous, anxious, or uncomfortable in new and unfamiliar situations.
- Begin with less-sensitive content and build up to content that is more sensitive.
- Use icebreaker activities at the beginning of the training workshop and after breaks to encourage team-building and comfort.
- Use small-group work to allow the participants to express their feelings in front of a smaller audience. Similarly, split the groups by sex, if appropriate.
- Use paraphrasing and clarification techniques to demonstrate attention to what the speaker has said, to encourage the speaker to continue speaking, and to ensure understanding.
- Share your own experiences, including situations in which you were and were not successful.
- Give constructive feedback to reassure the participant that his or her remarks are acceptable and appropriate and to encourage additional participation.

Participant Feedback

Trainers should set aside a segment of time at the beginning of each training day to permit the participants to raise issues that might interfere with learning, such as those related to personal situations, accommodations, or content. Depending on the size of the group, a period of 10 to 15 minutes should be sufficient (see the Daily Warm-Up, Appendix B).

Similarly, the trainers should set aside a segment of time at the end of each training day to allow the participants to share their learning insights and their assessment of what did or did not go well for them that day (see the guidelines for Daily Wrap-Up sessions, Appendix B). This assessment will enable the trainers to adjust the agenda as needed and will give the participants a chance to comment on how the training course is progressing.

At the end of the day before the last training day (e.g., day 5 of the six-day training or day 2 of the three-day training), the trainers might ask the participants if they would like anything discussed in the training to be clarified or if they would like anything else to be included on the last day.

Clients' Rights

The participants may or may not have direct contact with clients during the integrated SRH counseling training. However, they may observe some client-care activities during the training, either at their own facility (if the training is conducted on-site) or during a facility visit (if the training is conducted off-site). As is the case with any medical service, the rights of the client are paramount and should be considered at all times throughout the training course.

Each client's permission must be obtained before those who are participating in the training observe or assist with any aspect of client care. A client who refuses to grant permission to have the participants present when services are provided should not be denied services, nor should any procedure be postponed.

Certification

Because this training focuses on applying knowledge, attitudes, and skills in interactions with clients, it is impractical to certify the competence of the participants at the conclusion of the training. EngenderHealth believes that the participants' competence should be evaluated after they return to their facilities and apply what they have learned. It is only in the real work setting that the participants' abilities can be determined and the impact of the training assessed. Therefore, EngenderHealth does not recommend that the participants receive certificates of competence immediately following the training.

The institution providing the training should determine whether it wants to give the participants some other type of certification. For example, institutions can choose to provide those who complete the course with a certificate of attendance.

After the Training Course

Learning about integrated SRH counseling does not end when this course is completed. Participants' sensitivity to clients' needs and appreciation of potential barriers to counseling will increase as they implement this approach in their work settings.

At the end of the course, most participants will have gained new knowledge, greater comfort, and enhanced skills for discussing SRH issues with clients. They will also have created an "action plan" listing at least three specific ways in which they would like to implement what they have learned in their work setting. After the course, the trainers or program staff should follow up with participants and administrators at the participants' facilities to determine whether those plans have been put into action.

The trainers should determine the strategy for follow-up with supervisors before the workshop (see "Before the Training Course," page xix). During the workshop, the participants should be informed who will be conducting follow-up and when and how it will be conducted (Session 32, page 171).

Follow-up can be provided in several different ways, depending on the participants' needs, the trainers' availability, and financial considerations. Follow-up mechanisms include:

- *Visiting the participants at their facilities.* Follow-up visits can be conducted by the trainers initially (but preferably with the supervisor), with the intention that the supervisor would address counseling as part of his or her routine monitoring. The overall purpose of these visits is to provide feedback and support for the participants in implementing integrated SRH counseling at their service sites. Tasks include interviewing the participants to assess their progress in carrying out the action plans, observing counseling, talking with clients, providing feedback to the participants on counseling content and skills, and meeting with the participant and supervisor to discuss problems they have identified.

- *Arranging site visits for the participants.* Being able to visit facilities that already provide integrated SRH counseling will enable the participants to observe and obtain helpful advice from health care workers who have successfully implemented these services.
- *Publishing a newsletter.* The trainers can request a quarterly update from the participants (by letter, e-mail, or telephone) in which they describe the steps they have taken to initiate or expand integrated SRH counseling. Based on the responses, the trainers can develop a simple quarterly newsletter to send to the participants, summarizing their successes and difficulties in implementing such services and responding to frequently asked questions.
- *Establishing a peer-support network.* Peer support has been found to be an important element in sustaining skills and commitment after a counseling training (Kim et al., 2000). The trainers can prepare for the participants a list of contact information (if the participants are from more than one facility) and distribute it to each (and, if possible, prepare a list of others in the participants' geographic area who have received the integrated SRH counseling training). The trainers also can encourage the participants to stay in contact with one another after the workshop, to help each other with questions and with concerns about providing integrated SRH counseling services. Supervisors can support this strategy by assigning small groups and authorizing them to meet or otherwise contact each other on a regular basis.

Evaluation

An important part of the training, evaluation allows the participants, trainers, and program planners to determine whether the training has met its objectives. Tools are included with this curriculum to cover evaluation during the training and on-the-job evaluation after the training.

Evaluation during the Training

This curriculum contains a number of tools that give the trainers and the participants an indication of what the participants have learned and that help the trainers determine whether the training strategies used were effective.

- *Participants' preworkshop and postworkshop self-assessment of knowledge and attitudes.* This written tool is meant to be completed in 30 minutes by participants in the provider and administrator trainings. In field tests, many participants could not complete the tool when it was given at the beginning of the course, but all were able to do so at the end. This self-assessment addresses many key objectives of the course, focusing on basic knowledge about counseling and on common misperceptions and attitudes that can significantly affect a participant's ability to provide integrated SRH counseling. The trainers can use the preworkshop results to identify key areas that will need special attention during the training. After correcting the postworkshop assessment together with the participants at the end of the course and returning the corrected pretests, trainers have an opportunity to summarize course content and to give the participants a sense of how much they learned.
- *Daily wrap-up sessions.* As noted earlier, these 15-minute closing sessions for each day are key indicators of what the participants learned and what they intend to apply from the day's sessions, what worked well for them and what did not, and whether the objectives for the day's sessions were met (see the Daily Wrap-Ups, Appendix B). If the participants indicate that objectives were *not* met for some of the sessions covered that day, a trainer might ask the participants to review some of the material in their handbooks that evening, might schedule time to return to that issue the next day, or might note the topics for follow-up visits (see "After the Training Course," page xxv).

- *Workshop evaluation by participants.* This written tool, which is meant to be completed in 15 to 20 minutes, allows participants to give feedback on the overall process and immediate results of the training course. It provides feedback to the trainers on the participants' sense of whether objectives were achieved, the relevance of the course, the effectiveness of the training activities and the trainers themselves, and the participants' suggestions for improvement.

Evaluation after the Training

The true test of the success of integrated SRH counseling training is whether the participants are conducting such counseling at their service sites after the training. This emphasizes the importance of good follow-up of all training workshops. As noted in "Before the Training Course" (page xix), trainers should determine the plan for follow-up, including evaluation, with program planners and site administrators prior to conducting the course.

- *Follow-up visits.* These were discussed as part of training follow-up to reinforce learning and provide technical assistance to providers and supervisors in solving problems. However, they also provide important feedback to the trainers on the effectiveness of the training itself and ways to improve it.
- *Outcome evaluation guidelines.* This training is expected to improve the participants' skills in providing integrated SRH counseling *and* in effectively applying these skills to service delivery. The indicators reflect the objectives of the training and the knowledge, attitudes, and skills necessary for achieving these objectives. Gauging this training's effectiveness in terms of outcomes will require evaluation of participants' on-the-job performance, using the Observation Guides (see Appendix G), on at least two occasions: prior to training (for a "baseline" to compare to the posttraining results) and at some interval following training (for example, at three and/or six months following training).

Competence in counseling is evaluated through observation of counseling and through interviews with participants and clients, and so is necessarily somewhat subjective. To make the observation process as reliable as possible from one evaluation to another, the same individuals should conduct the evaluations each time, and these evaluators should be competent in the skills being evaluated. The trainers should *not* do the evaluations, although they can help orient local evaluators to the desired outcomes of the training.

The results of outcome evaluation can be used in many ways. Program planners and administrators will want to know if the training had the desired effect on service delivery (i.e., establishing integrated SRH counseling services). If it did not, these tools provide clues for what the barriers are and whether they are training-related or can be traced to other aspects of service delivery. The participants will want to know how clients respond to this approach to counseling and how they can improve their skills. Trainers will want to know if their training approaches were effective in imparting appropriate knowledge, attitudes, and skills for integrated SRH counseling and how these approaches can be strengthened. Finally, EngenderHealth would like to know the outcomes of these trainings in different countries, so lessons learned can be shared both across the agency and throughout the health and development community.

Part I

Principles and Approaches for Client-Centered Communication in Sexual and Reproductive Health

In this section, the workshop participants consider the context of sexual and reproductive health (SRH), identify typical SRH problems faced by people in their communities, and develop "client profiles" that will be used for case studies and role plays throughout the rest of the training. Since counseling focuses on facilitating decision making, the training sessions here explore the client's decision-making process from the perspective of sexual and reproductive rights, informed and voluntary decision making, and clients' rights in the service setting. Principles of client-provider interaction and counseling provide the foundation for developing key counseling skills, attitudes, and knowledge in the rest of the training.

Session 1
Welcome and Introduction

Objectives

- To officially welcome all participants and guests and to introduce the participants, guests, and trainers
- To describe the purpose, goal, objectives, and agenda for this training
- To administer the pretest

Materials

- Paper and pens
- Workshop agenda (Appendix A, page 177)
- Pretest (Appendix D, page 233)

Advance Preparation

1. Review Session 1 in the Participant's Handbook (page 3). Consider if or how you want to use the Participant Worksheet for this session (see Note to Trainers, page 5).
2. Identify a representative of the "host" organization to formally open the workshop (Activity A). Brief him or her on the purpose, goal, and objectives of the training.
3. Identify and brief any guest speakers thoroughly in advance, to explain the purpose of the training and to be clear about how long their opening remarks should be and what subjects they should cover (Activity B).
4. Arrange for refreshments, if appropriate. (Refreshments could be served *prior* to the start of this session.)
5. Prepare copies of the workshop agenda for all guests and participants.
6. Prepare one copy of the pretest for each participant.
7. Arrange for all other materials necessary for the training to be in place before the start of this session.

Time

1 hour, 15 minutes

	Training Activities	**Time**
A.	Welcome/introduction	5 min.
B.	Opening remarks	10 min.
C.	Introduction of trainers and participants	15 min.
D.	Presentation/discussion	15 min.
E.	Pretest	30 min.

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Session 1 Detailed Steps

Activity A: Welcome/introduction *(5 minutes)*

Have a representative of the local "host" organization (the "moderator") formally open the workshop, by welcoming the participants, explaining the purpose of the training, and introducing the guest speaker.

Activity B: Opening remarks *(10 minutes)*

The guest speaker makes his or her opening remarks.

Activity C: Introduction of trainers and participants *(15 minutes)*

Have the moderator introduce the trainers and ask the participants to introduce themselves.

> **Training Tip**
>
> Depending on the number of participants, they may introduce themselves very briefly (by name, where they are from, where they work, and what their job is) or they may make a somewhat longer statement (e.g., all of the above, plus why they believe they were selected for the training or what strengths they bring to this work). Even with a large group, a brief icebreaker exercise would be to ask them to add one thing interesting about the town or village where they work.

Activity D: Presentation/discussion *(15 minutes)*

1. Refer the participants to Session 1 in their handbooks (page 3) and briefly discuss the section stating the goal and overall objectives for the workshop. (See the Introduction for the Trainers [page xi] for background on why this integrated SRH counseling curriculum was developed. Your comments here can be drawn from that, depending on the background and interests of the participants.)
2. Hand out the agenda for this workshop and review it with the participants.
3. Have a representative from the host organization or the training team address logistical questions from participants.

Activity E: Pretest *(30 minutes)*

1. Explain to the participants that, to get a sense of the effectiveness of the workshop, you would like to have them complete a self-assessment of their knowledge and attitudes, both at the beginning of the workshop and at the end. Explain that this is not a test, and that the trainers will use the results to judge how well they and the workshop were able to meet their objectives, not how well the participants learned. Assure them that all answers and scores will be confidential.

➻ Training Tip

Confidentiality is important for these self-assessments—the scores for individual participants are specifically not to be shared with program managers or administrators. The test forms currently have a place for participants' names. This is to make it easier to compare pretest and posttest scores, and to return the pretests to participants at the end of the training. However, if you think that having the participants' names on the forms would make it too difficult to maintain confidentiality, you can write a number on the line for the name. In this case, participants must be responsible for remembering their numbers until the end of the workshop, and for being sure to write the same number on the posttest as they wrote on their pretest.

2. Distribute the pretest (which appears in Appendix D, page 233), briefly point out the different sections, and ask if the participants have any questions. Give the participants 30 minutes to complete the test, with time checks at 20 minutes and 25 minutes. (In field tests of this curriculum, some participants were not be able to complete the pretest in 30 minutes, but all were able to finish the posttest in that time.)
3. After collecting the pretests, explain that group scores will be announced the next day. You will not be reviewing the test questions themselves, but all of the necessary information to answer these questions should be covered during this training workshop. The pretests themselves will be returned at the end of the training, after the participants have taken the posttest, so they can compare their own scores before and after the workshop.

Note to Trainers

Participant Worksheets

For this and a few other sessions, a Participant Worksheet is provided in the Participant's Handbook (page 4) as an *optional* training tool. This may be useful in any of the following ways:

- As a "homework" assignment, to reinforce important concepts from the session (Participants can work on it during the evening and share their thoughts the next day.)
- As an alternative group exercise, to add to the session or to replace an activity currently planned
- As a way of orienting participants who have missed the session (This is particularly important for the first day, when the key concepts of the training are being established, but when participants traveling from some distance may arrive late.)
- As a more engaging way of refreshing participants' memories of the sessions at some later time (e.g., as part of the training follow-up)

Session 2
Defining Sexual and Reproductive Health and Integrated SRH Counseling

Objectives

- To define the terms *sex, sexuality, reproductive health, sexual health,* and *sexual and reproductive health*
- To explain the difference between integrated SRH *counseling* and integrated SRH *services*
- To name at least four health and social services that are necessary to meet people's SRH needs and to know where these services are provided in the participants' communities

Materials

- Flipchart paper, markers, and tape
- Pens or pencils
- Extra writing paper

Advance Preparation

1. Review Session 2 in the Participant's Handbook (page 5). Prepare a 15-minute presentation on the definitions (Activity C).
2. Prepare a flipchart divided into four sections, with each of the terms "Sex," "Sexuality," "Reproductive health," and "Sexual health" heading one section (see below) (Activity A).

Sex	Sexuality
Reproductive health	**Sexual health**

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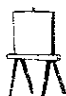
Session 2 Detailed Steps

Activity A: Small-group work *(10 minutes)*

1. Introduce the session by noting that some participants may be thinking, "I know about reproductive health, but why are they always saying 'sexual and reproductive health'? And what is *integrated SRH* counseling? How is that different from what I am already doing?" Explain that if they are confused, many other people probably share their confusion.
2. Divide the participants into four groups.
3. Give each group several pieces of writing paper and a marker.



4. Post the prepared flipchart and assign one of the headings ("sex," "sexuality," "sexual health," or "reproductive health") to each group.
5. Ask the participants to spend 5 minutes defining their term and to write their definition on their paper with the marker. They should write large enough so people can read it on the flipchart. They can use as many sheets of paper as they need. Encourage the participants to avoid using the words *sex*, *sexual*, or *reproduction* in their definitions.

Activity B: Discussion/brainstorm *(15 minutes)*

1. One group at a time, post each group's definition papers on the flipchart. Ask a member of each group to read their definition, and ask the rest of the participants if they have different ideas about this term.
2. Ask the participants about the similarities and differences between "sex" and "sexuality" and between "sexual health" and "reproductive health."
3. Note that SRH is a relatively new term that is finding common usage in international health care organizations. Ask the group to describe what they think SRH might be, based on the other definitions.

4. On a separate flipchart, write "Sexual and Reproductive Health Care Services." Brainstorm what health care services would be included in SRH; list the participants' responses on the flipchart.

Activity C: Presentation/discussion *(20 minutes)*

1. Give a short presentation on the definitions of *sex*, *sexuality*, *reproductive health*, *sexual health*, and *SRH*, based on the information in the Participant's Handbook (pages 6 to 9). Compare these "official" definitions with those of the small groups. Note any parts of the definitions that were missed and clarify any remaining questions. *(15 minutes)*
2. Ask participants to turn to Session 2 in their handbooks, to "Components of SRH Care" (page 8). Review this list, then return to their own list of SRH services on the flipchart and see if any should be added.
3. Review the final list, asking the participants which services are available in their communities. Place a check mark next to each one that is available. Ask the participants to say where the service is provided, but do not write down the location.

Session 3
Why Address Sexuality?

Objectives

- To explain how the quality of integrated SRH counseling and services can be improved by including a focus on sexuality issues and concerns
- To describe barriers or challenges for providers in addressing sexuality in integrated SRH counseling
- To identify strategies for helping providers feel more comfortable about and be better equipped to address issues related to sexuality and sexual health

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Read Session 3 in the Participant's Handbook (page 11) to review the key discussion points to be covered.
2. Review Trainers' Options (page 13) to consider alternative ways to conduct this session's activity.
3. Prepare three flipcharts with a heading for each of the discussion topics—"Why is it important to address sexuality as a part of integrated SRH counseling?" (Activity A); "What barriers or challenges might providers experience in discussing sexuality issues with clients?" (Activity B); and "What can providers do to feel more comfortable and better equipped to address issues related to sexuality?" (Activity C).

Time

45 minutes

Training Activities	Time
A. Brainstorm/discussion	15 min.
B. Brainstorm/discussion	15 min.
C. Brainstorm/discussion	10 min.
D. Summary	5 min.

Note: This session is adapted from: EngenderHealth. 2002.

Session 2
Defining Sexual and Reproductive Health and Integrated SRH Counseling

Objectives

- To define the terms *sex, sexuality, reproductive health, sexual health,* and *sexual and reproductive health*
- To explain the difference between integrated SRH *counseling* and integrated SRH *services*
- To name at least four health and social services that are necessary to meet people's SRH needs and to know where these services are provided in the participants' communities

Materials

- Flipchart paper, markers, and tape
- Pens or pencils
- Extra writing paper

Advance Preparation

1. Review Session 2 in the Participant's Handbook (page 5). Prepare a 15-minute presentation on the definitions (Activity C).
2. Prepare a flipchart divided into four sections, with each of the terms "Sex," "Sexuality," "Reproductive health," and "Sexual health" heading one section (see below) (Activity A).

Sex	Sexuality
Reproductive health	**Sexual health**

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Session 2

3. Prepare a flipchart with the definition of integrated SRH counseling (Activity D).

Time

1 hour

Training Activities	Time
A. Small-group work	10 min.
B. Discussion/brainstorm	15 min.
C. Presentation/discussion	20 min.
D. Discussion	15 min.

Note: This session is adapted from: EngenderHealth, 2002.

Session 2 Detailed Steps

Activity A: Small-group work *(10 minutes)*

1. Introduce the session by noting that some participants may be thinking, "I know about reproductive health, but why are they always saying 'sexual and reproductive health'? And what is *integrated SRH* counseling? How is that different from what I am already doing?" Explain that if they are confused, many other people probably share their confusion.
2. Divide the participants into four groups.
3. Give each group several pieces of writing paper and a marker.

4. Post the prepared flipchart and assign one of the headings ("sex," "sexuality," "sexual health," or "reproductive health") to each group.
5. Ask the participants to spend 5 minutes defining their term and to write their definition on their paper with the marker. They should write large enough so people can read it on the flipchart. They can use as many sheets of paper as they need. Encourage the participants to avoid using the words *sex, sexual,* or *reproduction* in their definitions.

Activity B: Discussion/brainstorm *(15 minutes)*

1. One group at a time, post each group's definition papers on the flipchart. Ask a member of each group to read their definition, and ask the rest of the participants if they have different ideas about this term.
2. Ask the participants about the similarities and differences between "sex" and "sexuality" and between "sexual health" and "reproductive health."
3. Note that SRH is a relatively new term that is finding common usage in international health care organizations. Ask the group to describe what they think SRH might be, based on the other definitions.

4. On a separate flipchart, write "Sexual and Reproductive Health Care Services." Brainstorm what health care services would be included in SRH; list the participants' responses on the flipchart.

Activity C: Presentation/discussion *(20 minutes)*

1. Give a short presentation on the definitions of *sex, sexuality, reproductive health, sexual health,* and *SRH,* based on the information in the Participant's Handbook (pages 6 to 9). Compare these "official" definitions with those of the small groups. Note any parts of the definitions that were missed and clarify any remaining questions. *(15 minutes)*
2. Ask participants to turn to Session 2 in their handbooks, to "Components of SRH Care" (page 8). Review this list, then return to their own list of SRH services on the flipchart and see if any should be added.
3. Review the final list, asking the participants which services are available in their communities. Place a check mark next to each one that is available. Ask the participants to say where the service is provided, but do not write down the location.

Activity D: Discussion *(15 minutes)*

1. Ask the participants to close their handbooks. Post the flipchart, and review the definition of integrated SRH counseling.
2. Ask the following key questions:
   * What are integrated SRH services?
   * How does integrated SRH *counseling* differ from integrated SRH *services*?
   * Where can integrated SRH counseling be provided?
3. After a brief discussion, ask the participants to open their handbooks to page 9 and ask for volunteers to read aloud the bulleted points under "How Does Integrated SRH Counseling Relate to Integrated SRH Services?"
4. Summarize the session by asking participants:
   * Why is it important to understand the differences between these terms?
   * How can integrated SRH counseling help them avoid missing opportunities to help clients in their service-delivery setting?

➻ Training Tip

- "Integrated" SRH counseling reflects the fact that one's sexual and reproductive life is *not* separated into unrelated units of contraception, disease prevention and treatment, reproduction, and experience with intimacy and pleasure. For individuals and couples, all of these elements are woven together into sexual and social relationships, interactions, and consequences—personal, medical, and social. Since these issues are integrated in the client's life, it makes sense to provide information about them in an integrated manner when clients seek SRH services.
- In an *integrated* approach, we attempt to identify these issues in a comprehensive assessment of the individual's SRH status and concerns, regardless of the reason for the visit. In many cases, subsequent visits will have to be scheduled or referrals will have to be made to other service sites. The most important thing, though, is that the client's needs have been identified and addressed in some concrete and comprehensive way.

Session 3
Why Address Sexuality?

Objectives

- To explain how the quality of integrated SRH counseling and services can be improved by including a focus on sexuality issues and concerns
- To describe barriers or challenges for providers in addressing sexuality in integrated SRH counseling
- To identify strategies for helping providers feel more comfortable about and be better equipped to address issues related to sexuality and sexual health

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Read Session 3 in the Participant's Handbook (page 11) to review the key discussion points to be covered.
2. Review Trainers' Options (page 13) to consider alternative ways to conduct this session's activity.
3. Prepare three flipcharts with a heading for each of the discussion topics—"Why is it important to address sexuality as a part of integrated SRH counseling?" (Activity A); "What barriers or challenges might providers experience in discussing sexuality issues with clients?" (Activity B); and "What can providers do to feel more comfortable and better equipped to address issues related to sexuality?" (Activity C).

Time

45 minutes

Training Activities	Time
A. Brainstorm/discussion	15 min.
B. Brainstorm/discussion	15 min.
C. Brainstorm/discussion	10 min.
D. Summary	5 min.

Note: This session is adapted from: EngenderHealth. 2002.

Session 3 Detailed Steps

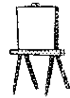
Activity A: Brainstorm/discussion *(15 minutes)*

1. Lead a large-group brainstorm on the following question: "Why is it important to address sexuality as a part of integrated SRH counseling?"

2. List the participants' ideas on the prepared flipchart. Ask leading questions, as necessary, to make sure that the main ideas from the Participant's Handbook are identified and discussed by the group.

Activity B: Brainstorm/discussion *(15 minutes)*

1. Despite all of the benefits of addressing sexuality within integrated SRH counseling, it can often be difficult for providers to introduce the subject with clients. Brainstorm and discuss the following question: "What barriers or challenges might providers experience in discussing sexuality issues with clients?"



2. List the participants' ideas on the prepared flipchart. Ask leading questions, as necessary, to make sure that the main ideas from the handbook are identified and discussed by the group.

Activity C: Brainstorm/discussion *(10 minutes)*

1. Lead a large-group brainstorm on the following question: "What can providers do to feel more comfortable and better equipped to address issues related to sexuality?"

2. List the participants' ideas on the prepared flipchart. Ask leading questions, as necessary, to make sure that the main ideas from the handbook are identified and discussed by the group.

Activity D: Summary *(5 minutes)*

1. Ask the participants to summarize what they have learned about each of the three discussion areas.
2. Add your own comments to be sure that the Essential Ideas given in the Participant's Handbook (page 11) have been covered.

Trainers' Options

There are several additional ways to conduct this activity.

Option 1

Set up a "message" or "graffiti" wall, in which the participants write their responses on large pieces of paper that are posted throughout the room. The steps are as follows:

Preparation

1. Create three large banners by taping together three or four flipcharts horizontally.
2. At the top of each banner, write one of the following questions:
   - Why is it important to address sexuality as a part of integrated SRH counseling?
   - What barriers or challenges might providers experience in discussing sexuality issues with clients?
   - How can providers feel more comfortable and better equipped to address issues related to sexuality?
3. Post each banner on the wall.

Large-group exercise

1. Distribute markers to the participants and encourage them to walk around and stop at each banner to contribute either a written phrase, a slogan, or a picture in response to each of the questions posed on the "message wall."
2. Encourage the 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.

Viewing

1. 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.
2. Facilitate a discussion based on the key discussion points given in the Participant's Handbook.

Option 2

Split the participants into three groups and assign one of the questions to each group. (If the number of participants is large—i.e., more than 15—split them into six groups and assign each question to two groups.) Allot 15 minutes for members to brainstorm their answers and list them on a flipchart, then spend 20 minutes in plenary discussions, with each group reporting. Save 5 minutes for a summary.

Session 4
The Problem Tree—
Roots and Consequences of SRH Problems

Objectives

- To identify the causes and consequences of at least three SRH problems
- To describe the provider's role in addressing the causes and consequences of SRH problems

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Review Session 4 in the Participant's Handbook (page 15).
2. Review pages xxi to xxiii in the Introduction for the Trainers about using the problem trees and client profiles to adapt this course to the specific needs of the participants.
3. Identify the kinds of SRH problems and client population groups to be addressed in this training, based on earlier discussions with local program planners and with the administrators who requested or approved the training. The client profiles (Session 6) should reflect these predetermined needs. Since the client profiles are based on the problem trees developed in this session, be prepared to guide the brainstorming of problems in Activity A, to ensure that the list includes the SRH needs and client groups that have been identified for this training.
4. Prepare a sample "problem tree" flipchart. Taping two flipchart sheets together may be helpful, to create enough space for the drawing and to ensure that the writing can be seen by all participants. Draw a large tree trunk in the middle, with numerous roots filling the bottom of the page and with branches filling the top. Use a different colored marker for each section. Refer to the sample "tree" provided on page 17 to fill in the problem, root causes, and consequences.
5. Post the flipchart sheet with the list of SRH services (from Session 2, Activity C) where all participants can see it.

Time

1 hour		Training Activities	Time
	A.	Brainstorm	10 min.
	B.	Presentation	5 min.
	C.	Small-group work	20 min.
	D.	Plenary	15 min.
	E.	Discussion	10 min.

Note: The content of this session is adapted from: IIED, 2000.

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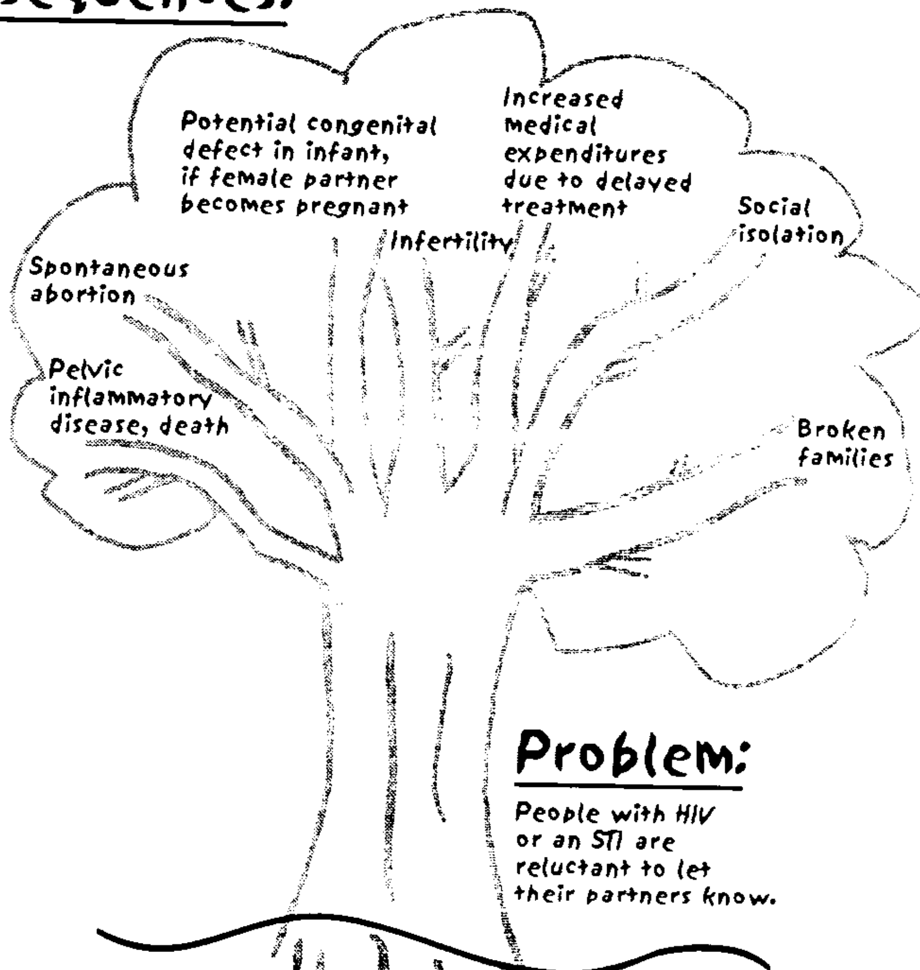
Trainers' Tool

Sample SRH Problem Tree: HIV/STI communications

Consequences:



Root causes:

Social norms that discourage talking about sexual issues

Fear of social isolation

Shame, feelings of guilt

Fear of broken relationship

Ignorance, lack of awareness

Cost of medicine, high medical expenditures

Note: The Participant's Handbook has another example, for maternal health.

Session 5
Supporting Clients' Informed and Voluntary Decision Making

Objectives

- To explain the relationship between human rights and informed and voluntary decision making.
- To name three sexual and reproductive rights recognized by international conventions
- To describe how sexual and reproductive rights apply to specific health needs and services in the particpants' country
- To define *informed and voluntary decision making*, and distinguish it from *informed consent*
- To identify at least one example of an informed and voluntary decision that a client can make in each SRH service area
- To describe three levels of factors that influence informed and voluntary decision making for SRH clients

Materials

- Overhead projector
- Transparencies and notes pages (see Appendix C)

Advance Preparation

1. Review Session 5 in the Participant's Handbook (page 17). Consider if or how you want to use the Participant Worksheet for this session (see Note to Trainers, page 5).
2. Review the transparencies and notes pages on "Promoting Informed and Voluntary Decision Making to Support Clients' Rights and Address Clients' Needs" (Appendix C, page 193), and prepare a presentation. (See Activity A, or the Trainers' Options, page 22.)
3. Identify any official statements from the country in which the training is being conducted about rights that apply to SRH, and incorporate these into the presentation.
4. Identify local program and service-delivery guidelines relating to sexual and reproductive rights and to informed and voluntary decision making, and incorporate these into the presentation.
5. Make transparencies based on the master copies appearing in Appendix C, or prepare flipcharts as visual guides to Activity A (or the Trainers' Options, page 22).
6. Set up the overhead projector for the transparencies.
7. Prepare a flipchart with the small-group questions for Activity B.

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Session 5

Time

Time	Training Activities	Time
1 hour	**A.** Presentation	20 min.
	B. Small-group work	15 min.
	C. Plenary presentation	15 min.
	D. Discussion	10 min.

Session 5 Detailed Steps

Activity A: Presentation *(20 minutes)*

Show overhead transparencies to give an overview of sexual and reproductive rights and of informed and voluntary decision making. (Use slides 1, 4, 5, 6, 7, 8, 12, 14, 15, 16, and 21 from Appendix C, page 191.)

Activity B: Small-group work *(15 minutes)*

1. Divide the participants into five groups; assign each group one area of SRH (e.g., choose from among family planning; maternal health; STIs, HIV, and AIDS; postabortion care; men's SRH services; and adolescents' SRH services).

> **➻ Training Tip**
>
> These can be the same five groups from Session 4 (The Problem Tree), and you can assign them the SRH area that they worked on for their problem trees.
>
> In the next session, the groups will develop client profiles based on the problem trees and on consideration of the decisions that an individual would need to make regarding this problem. Keeping the same small groups for all three sessions (Sessions 4 to 6) would allow participants to build on their discussions from one session to the next in terms of specific SRH problems and specific clients' concerns.

2. Post the flipchart and ask each group to answer these questions about their area of SRH:
   * What are the decisions that individuals make regarding this area of SRH?
   * What are the key sexual and reproductive rights needed to support people in making these decisions?
   * Which of these rights are supported in your program or community? Which are not?

Activity C: Plenary presentation *(15 minutes)*

Have each small group present its findings, with brief discussion for clarification or comments (3 minutes per group).

Activity D: Discussion *(10 minutes)*

Ask the participants:

* What can we do, as service providers and as citizens, to strengthen sexual and reproductive rights so as to support informed and voluntary SRH decision making?

Trainers' Options

An alternative way to conduct this exercise is to offer the entire presentation from Appendix C (page 191), with discussion, as follows:

Presentation (*10 minutes*)
Show the transparencies on sexual and reproductive rights (slides 1 to 6).

Discussion (*10 minutes*)

1. Ask the participants which rights they are aware of in their own country that apply to SRH issues. If you were able to identify an official statement about rights, present that information after a brief discussion by the participants.
2. Ask the participants which rights they believe would be most important to help individuals achieve SRH in their own country or community. List responses on the left-hand side of a flipchart, under the heading "Key S&R Rights."
3. Ask the participants what challenges exist for individuals in exercising those rights. List the barriers that they identify on the right-hand side of the flipchart, under the heading "Barriers."

Presentation (*25 minutes*)
Show the transparencies on informed and voluntary decision making (slides 7 to 21).

Discussion (*15 minutes*)

1. Ask the participants:
   * Can individuals make informed and voluntary decisions in each of the SRH areas covered in this workshop?
2. Explore differences of opinion among the participants. In any given area of SRH, some individuals are better able to make informed choices than others. Ask the participants:
   * Which individuals *can* make informed choices? Which ones cannot, and why?
3. Ask the participants:
   * What can we do, as service providers and as citizens, to strengthen sexual and reproductive rights, and support informed and voluntary SRH decision making?

Session 6
Client Profiles for Sexual and Reproductive Health Decision Making

Objectives

- To develop "client profiles" that reflect each of the SRH-related topics to be addressed in this training and the variety of backgrounds, needs, and concerns that clients present
- To identify the decisions that their "clients" will need to make (based on their defined needs, concerns, and characteristics), the information that those clients will need if they are to make these decisions, and the emotional issues raised by their situations

Materials

- Flipchart paper and markers for five groups

Advance Preparation

1. Review Session 6 in the Participant's Handbook (page 23). Consider if or how you want to use the Participant Worksheet for this session (see Note to Trainers, page 5).
2. Prepare two flipcharts with the guidelines for developing client profiles, as follows:

Client Profile Guidelines: Part I

Demographic and social characteristics:

- Name
- Age
- Marital status
- Parity
- Income
- Educational level
- Social background

Client Profile Guidelines: Part II

Questions to answer about your client:

- What are the client's current SRH needs? What led to them? Who else is affected by this situation?
- What decisions will he or she have to make concerning this SRH problem? Who else will be involved in the decision making?
- Is your client comfortable with seeking services for this situation? Where would he or she go?
- What information will the client need to make those decisions, and where can he or she get that information?
- How does the client feel about this situation? What concerns or worries does he or she have?

3. Review pages xxi to xxiii in the Introduction for the Trainers about using the problem trees and client profiles to adapt this course to the specific needs of the participants.
4. Post the problem tree flipcharts in places around the room (or in break-out rooms) where small groups can gather and work around them.

Time

1 hour

Training Activities	Time
A. Small-group work	35 min.
B. Plenary discussion	25 min.

Session 6 Detailed Steps

Activity A: Small-group work *(35 minutes)*

1. Explain to the participants that, to consider the individual's decision-making process for a range of SRH needs and services, they will first develop "client profiles." These will be in-depth, detailed descriptions of typical clients, in each of the SRH areas that are being addressed by this training. Although it is not possible to represent *every* type of client, this exercise will focus on trying to get a broad representation of the backgrounds, needs, and concerns of clients. The profiles will be used as case studies in some sessions and for role plays in others.

> **➻ Training Tip**
>
> The client profiles provide the foundation for keeping the focus of the training on the client's perspective. They should represent the range of services to be addressed in this training, plus the variety of clients (in terms of background, needs, and concerns) that providers may expect to encounter. It would be quicker for you to prepare client profiles in advance or to provide a group of profiles from which particpants could choose. However, the approach used here is much more effective, because the participants themselves have input and feel "ownership" for the clients with whom they will be "working" for the rest of the training. Basing these profiles on the problem trees also tailors the issues to the unique needs, conditions, and concerns of different communities and cultures.

2. Refer back to the problem trees. Split the participants into the same five groups, and give each group several sheets of flipchart paper and markers.
3. Explain that each group is to imagine a real person who has this particular problem and should describe that person and his or her situation. They are to create a "client profile," which is like a case study. Ask the participants to work in their small groups to develop the details about their client, reminding them that this individual may not have sought SRH services yet and thus technically may not yet be a "client" (see Training Tip below). Case studies should present problems but not solutions. Likewise, these client profiles should present the problem and the situation, but not the outcome.
4. Post the flipcharts entitled "Client Profile Guidelines: Part I and Part II." Ask the partici-

> **➻ Training Tip**
>
> Although we call these *client* profiles, the participants may need to address population groups that for whatever reasons do not access services and thus are never seen as clients. Such groups include unmarried adolescents, men, minority groups, people who do not speak the dominant language, refugees, sex workers, homosexuals, and people who are HIV-positive.

4. Post the flipcharts entitled "Client Profile Guidelines: Part I and Part II." Ask the participants to follow the guidelines to describe their client in each of these areas. Instruct the groups to choose someone from the group to write the information about the client on the flipchart. Explain that they will have 30 minutes, but that, because these are big questions, they could take a lot of time to discuss. Thus, they should strive to provide basic answers to these questions; there will be more time later in the workshop to learn more about each client.

➻ Training Tip

To maintain consistency between profiles and to outline the range of issues to be addressed, guidelines are provided for developing these profiles. However, not all issues have to be covered in these initial profiles. Later in the training (e.g., prior to counseling practice), "new developments" can be announced for each client, introducing some change in his or her physical, economic, social, or emotional condition. These new developments can be used to help the participants focus on issues that they may have been reluctant to bring out in the initial profiles and to raise the problem of missed opportunities by making sure that the client has more than one SRH problem that needs to be addressed.

5. Move among the groups to make sure they do not spend too much time on any one point, but that they get some ideas on each one.

Activity B: Plenary discussion *(25 minutes)*

Invite each group's reporter to share the group's client profile with the rest of the participants. After each group has presented, ask if there are any other *key decisions* that this client might need to make. If the client group agrees, these can be added to the flipchart. With five groups, there will be only 4 to 5 minutes per group for reporting and discussion, but allow brief comments and discussion, if time permits.

Session 7
Clients' Rights, Client-Provider Interaction, and Counseling

Objectives

- To list at least four of the seven "rights of clients" and explain how they apply to SRH services
- To explain how different types of health care workers—frontline staff, providers, and administrators and supervisors—can be involved in supporting clients' rights
- To define *client-provider interaction*
- To describe strategies to improve client-provider interaction and to support clients' rights more effectively in the clinic setting
- To define *counseling*
- To explain how counseling supports clients' rights
- To identify specific tasks that need to be carried out in counseling
- To explain how various types of staff in the participants' work setting can carry out different counseling tasks

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Review Session 7 in the Participant's Handbook (page 25) and prepare brief presentations for Activities A, E, and F. The Participant Worksheet will be used in Activity B.
2. Prepare a flipchart showing the seven rights of clients (see Participant's Handbook, pages 26 and 27). List the rights only, *not* the description. Leave enough room on the right for three narrow columns (see Activity B), but do not add the columns yet.

The Rights of Clients
Rights
1. Information
2. Access to services
3. Informed choice
4. Safety of services
5. Privacy and confidentiality
6. Dignity, comfort, and expression of opinion
7. Continuity of care

3. Prepare another flipchart for Activities B and C, as follows:

> **Health Care Workers**
>
> - Frontline staff
> - Providers
> - Administrators/supervisors
>
> Instructions for small-group work:
>
> Identify whether and how health care workers in each category can support each right of clients—or threaten it.

Time

1 hour, 45 minutes

Training Activities	Time
A. Presentation/discussion	15 min.
B. Discussion	10 min.
C. Small-group work	15 min.
D. Plenary/discussion	15 min.
E. Discussion/presentation	20 min.
F. Presentation/discussion	30 min.

Session 7 Detailed Steps

Activity A: Presentation/discussion *(15 minutes)*

1. Explain that, having considered the sexual and reproductive rights of individuals and how these relate to informed and voluntary decision making, the next step will be to look more specifically at the rights of individuals *once they decide to become "clients."* This means that the individual or couple have reached a decision to seek SRH information or services and have succeeded in finding and getting to a service site. Those are major steps in which rights play an important role; this session, however, will focus on the rights that apply once people walk through the gate, or door, of the service site.

2. Explain that the originally, 10 "rights of clients" were established for family planning clients by the International Planned Parenthood Federation. For its quality improvement work, EngenderHealth has since modified these to seven rights. Post the flipchart listing the seven rights.
3. Briefly describe each right shown on the flipchart. Then ask the participants which rights are particularly important for each of the SRH service areas (family planning, HIV and STI services, maternal health care, postabortion care, men's SRH services, and adolescent services).

Activity B: Discussion *(10 minutes)*

1. Ask the participants to turn to the worksheet on page 30 in their Participant's Handbook. Ask for volunteers to read the boxes for the negative interaction, and then for the positive interaction.
2. Ask the group, "Which of the client's rights were involved in these interactions?" and ask them to explain their answers.

➽ Training Tip

Six of the seven rights are involved in these interactions: **information; access to services** (even though she can physically get to the clinic, the negative interaction with staff discourages her from staying; therefore, "access" is effectively denied); **informed choice** (in the negative interaction, she is not given the opportunity to make decisions about services); **privacy and confidentiality; dignity, comfort, and expression of opinion;** and **continuity of care** (if she is not able to begin services, then she is certainly not able to be assured "continuity"). This is an example of how the client's rights can be negatively or positively affected before the client ever sees a provider. This exercise is meant to prepare participants for the small-group work (Activity C) by helping them to think about the impact of nonprovider staff on the client's rights.

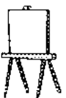
If you have time, a follow-up to this exercise would be to ask: "What role could an administrator or supervisor play in this situation?" Answer: Administrators and supervisors are responsible for the physical layout and timing of services, as well as for monitoring the behavior of frontline staff and giving them feedback on their interactions with clients.

Activity C: Small-group work *(15 minutes)*

1. Post the flipchart entitled "Health Care Workers." (Cover or fold over the "Instructions for small-group work.") Briefly describe each type of health care worker (from the Introduction for the Trainers, page xiii). *(5 minutes)*
2. Divide the participants into three groups. Assign each group to be providers, frontline staff, or administrators or supervisors. Ask each group to choose a "reporter."
3. Ask each group to take 10 minutes to review the seven rights of clients and identify whether and how health care workers in their category can support or impede each right.
4. Have the reporter make a list in his or her notes of the rights that the group's health care workers can influence, either positively or negatively.
5. While the groups are working, draw three columns on the right-hand side of the flipchart entitled "The Rights of Clients" and label them as shown below.

The Rights of Clients			
Rights	**Frontline staff**	**Providers**	**Admin./Super.**
1. Information 2. Access to services 3. Informed choice 4. Safety of services 5. Privacy and confidentiality 6. Dignity, comfort, and expression of opinion 7. Continuity of care			

Activity D: Plenary/discussion *(15 minutes)*



1. Facilitate the group reporting by taking one right at a time and asking each group whether they have any influence on this right. (This way the focus is more on the rights than on the category of health care workers.) Allow for only very brief explanations, since you will have only 30 seconds per group per right. As the reports are being given, put a check mark in the appropriate column, next to each right that a group can influence. *(10 minutes)*

> **➽ Training Tip**
>
> You should find that each type of health care worker can have some effect on most, if not all, of the rights of clients. While the reporting may get repetitive, this is precisely how the learning impact of the session is felt. The participants do not generally expect that frontline staff, in particular, would have such an important role to play in clients' rights. They may even be surprised by the role played by administrators and supervisors, who rarely have direct contact with clients but who have a significant effect in terms of the decisions they make about staffing and space allocation.

2. Ask the participants to suggest ways in which each group can improve their impact on clients' rights. List these on a separate flipchart. *(5 minutes)*

Activity E: Discussion/presentation *(20 minutes)*

1. Explain that one way of helping health care workers to support the rights of clients is to improve the quality of client-provider interaction and its impact on the client's decision-making process. To compile a list of all of the people with whom the client interacts in the clinic setting, ask the participants to close their eyes and imagine themselves as a client, walking up to the clinic or service site where they work. Ask them to think of all of the different types of staff that a client sees or talks to as he or she approaches and moves through the service setting, including guards, drivers, cleaners, and receptionists (anyone who works at that site with whom a client comes into contact).
2. Ask the participants to open their eyes and list the staff that clients come into contact with, trying to get them in sequence as nearly as possible. List the participants' responses on the flipchart.
3. Starting with the first person whom a client is likely to encounter, ask the participants:
   * How can this staff person influence the client's SRH decision-making process, either positively or negatively?
4. Continue with the rest of the staff on the list, in the order in which a client would encounter them (approximately).
5. Refer to the section on "Client-Provider Interaction" in the Participant's Handbook, Session 7, page 27. Review the main points, noting the role of frontline staff in making the client feel comfortable and confident about his or her decision to seek services at that site.
6. Ask the participants what they have learned from these discussions on the rights of clients and on client-provider interaction and how this knowledge can be applied when they return to their work sites.

Activity F: Presentation/discussion *(30 minutes)*

1. Explain that the discussion will now focus on a specific form of client-provider interaction: counseling.
2. Ask the participants:
   * What does "counseling" mean to you? How is it different from client-provider interaction?
   * What role does counseling play in helping clients to make informed and voluntary SRH decisions?
   * Which of the rights of clients are addressed through counseling?
3. Refer to the section on counseling in the Participant's Handbook, Session 7, page 28. Review the main points, including the definition of counseling, the responsibilities or tasks of counseling, and the importance of counseling in helping clients to make informed and voluntary SRH decisions and in supporting clients' rights.

>> **Training Tip**

This session emphasizes the importance of counseling in supporting clients' rights, since this one intervention can be shown to have a significant impact on all of the client's rights. Return to this point whenever the opportunity arises throughout the remainder of the training.

4. Ask the participants:
   * In your work setting, how could different levels of staff be involved in carrying out the specific tasks that comprise counseling?
5. Explain that the rest of the training will focus on helping staff to develop the knowledge, attitudes, and skills necessary to offer integrated SRH counseling, with the goals of helping clients meet their own informational, emotional, and decision-making needs and of supporting clients' rights.

Session 8
Counseling Frameworks
Option A: REDI

Note: Option A is intended for participants who are learning counseling for the first time, as well as for those who already use the GATHER model for family planning counseling but are willing to consider a different approach. The REDI framework is designed for integrated SRH counseling and is thus the preferred training option. However, GATHER can be adapted for integrated SRH counseling; Option B is intended for those trainers or program managers who prefer to continue using GATHER. The decision on whether to use REDI or GATHER should be made during the planning phase of the workshop (see Introduction for the Trainers, page xix).

Objectives

- To describe REDI, a framework for integrated SRH counseling
- To identify which elements of this counseling framework the participants are already doing, which would require more training, and which would encounter barriers at their work sites
- To explain the importance of applying counseling frameworks to each client's unique situation
- To explain the importance of addressing the social context for decision making in integrated SRH counseling
- To describe how integrated SRH counseling supports informed and voluntary decision making by clients
- [If the participants are already familiar with GATHER,] to identify similarities and differences between REDI and GATHER

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Review Session 8, Option A, in the Participant's Handbook (page 31).
2. Prepare a flipchart with the three questions for the REDI tables (Activity B, Step 1).
3. Prepare four flipcharts, one for each phase of REDI, showing the steps for each phase and including columns for checking off the current status of that step (Activity B, Step 2).
4. *Optional:* Prepare a flipchart with two columns. Write the four phases of REDI in one column and the six steps of GATHER in the other (Activity D).

Time

55 to 60 minutes (depending on whether Activity D is used)

Training Activities	Time
A. Introduction	10 min.
B. Small-group work	15 min.
C. Plenary/discussion	25 min.
D. Discussion (GATHER) [optional]	5 min.
E. Summary	5 min.

Session 8, Option A, Detailed Steps

Option A: REDI

Activity A: Introduction *(10 minutes)*

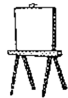
1. Divide the participants into four groups. (If this requires the participants to move, ask them to take their handbooks, notepads, and pencils or pens with them.)
2. Introduce the exercise by telling the participants that they will now examine a framework for integrating family planning, sexuality, HIV and STI prevention, maternal health care, and postabortion care counseling.
3. Emphasize that in all counseling, the client is more important than the framework. During the following exercises and discussions, they should keep in mind that frameworks can be helpful to providers in giving them a structure for talking with the client, so they do not miss important steps. However, the framework is only good if it allows them to attend to the individual client's unique needs and concerns.
4. Refer the participants to Session 8, Option A, in their handbooks, and ask them to find the summary description of REDI (page 32). Briefly review the phases and steps. Note that the REDI framework is designed for integrated SRH counseling because:
   - It emphasizes the client's responsibility for making a decision and for carrying it out.
   - It provides guidelines for considering the client's sexual relationships and social context.
   - It addresses the challenges that a client may face in carrying out this decision and offers skills-development to help clients meet these challenges.

Activity B: Small-group work *(15 minutes)*

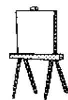
1. Post the flipchart with the following questions for small-group work. Explain that each group will consider one phase of REDI, and answer the questions for each step:
   * Which steps are you already doing in your counseling?
   * Which steps would require further training, whether for knowledge, for skills, or for making providers more comfortable? (Further training might also be considered useful for steps that they are already doing.)
   * Which steps would be difficult to implement, and why?
2. Assign one phase of REDI to each group, and distribute the separate prepared flipchart sheets accordingly (see page 36).
3. Ask the participants to refer to the more detailed version of REDI in their handbooks (pages 33 to 36) for a better understanding of each step.
4. Explain to the participants that for each step, they should review the description in the handbook, consider these questions, and check any boxes in the table that apply to their work setting. It is possible that they may check more than one box—or all three boxes—for some steps. If there are different opinions within the group, put a question mark in the box.
5. Ask each group to choose one member to fill in the table for their group.
6. Give the groups 10 minutes to complete their tables. Check each group quickly to ensure

that they understand the instructions. If some groups finish earlier, they can go on to other phases of REDI and discuss their answers to those questions among themselves.

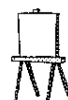
Rapport-building	Already doing	Need training	Challenges anticipated
1. Welcome the client			
2. Make introductions			
3. Introduce the subject of sexuality			
4. Assure confidentiality			



Exploration	Already doing	Need training	Challenges anticipated
1. Explore the client's needs, risks, sexual life, social context, and circumstances			
2. Assess the client's knowledge and give information, as needed			
3. Assist the client to perceive or determine his or her own pregnancy or HIV and STI risk			



Decision making	Already doing	Need training	Challenges anticipated
1. Identify what decisions the client needs to make			
2. Identify the client's options for each decision			
3. Weigh the benefits, disadvantages, and consequences of each			
4. Assist the client to make his or her own realistic decisions			



Implementing the decision	Already doing	Need training	Challenges anticipated
1. Make a concrete, specific plan for carrying out the decision			
2. Identify skills that the client will need to carry out the decision			
3. Practice skills, as needed, with the provider's help			
4. Make a plan for follow-up			

Activity C: Plenary/discussion *(25 minutes)*

1. Starting with "Rapport-building," ask the group reporter to post the group's flipchart and explain the group's findings. If there are question marks, ask for a brief explanation. Also ask for a brief explanation of "challenges." *(10 minutes for all four groups)*
2. Ask the participants what they learned from this exercise. *(5 minutes)*

> **➻ Training Tip**
>
> Participants should note that they are already doing many of the steps of integrated SRH counseling. The steps that they feel need more training will be addressed in this workshop. Anticipated challenges may be beyond the scope of this training. However, the trainers can share these anticipated challenges with participants' supervisors or program managers (who may be participating in this workshop or a separate orientation), and this can become part of training follow-up (see Sessions 30 and 31).

3. Facilitate a discussion by asking the following questions. (See the Discussion Summary in the Participant's Handbook [page 36] for possible responses.) *(10 minutes)*
   * How does this framework ensure that the counseling is client-centered?
   * How much time do providers in your facility generally spend counseling each client? Do you think this framework helps providers to work within this time frame? Do you think providers can save time with this framework? If yes, how? If no, why not?
   * Why does the framework address the "social context" of clients' decisions?
   * How does this framework ensure a client's informed and voluntary decision making?

Activity D: Discussion *(5 minutes)*

Note: This discussion is only necessary if the participants are already familiar with GATHER. If they are not familiar with GATHER, there is no need to introduce it.

1. Post the flipchart entitled "Comparing REDI and GATHER" (see below).

Comparing REDI and GATHER			
R	Rapport-building	**G**	Greet
E	Exploration	**A**	Ask/assess
D	Decision making	**T**	Tell
		H	Help
I	Implementing the decision	**E**	Explain
		R	Return visit

2. Beginning with "Greet," ask the participants to identify which steps of GATHER correspond to the phases of REDI. Draw lines between the corresponding steps and phases.

> **➻ Training Tip**
>
> There are many overlaps between the steps of REDI and GATHER. Rapport-building generally corresponds to Greet, with elements of Ask/Assess. Exploration incorporates Ask/Assess and Tell. Decision making includes the Help step and also elements of Ask/Assess and Tell. Implementing the decision includes Help, Explain, and Return Visit. Since the counseling process is different for each client, participants may have other ideas about the overlaps that also are valid.

3. Facilitate a brief discussion by asking the following questions:
   * What similarities can you identify between REDI and GATHER? What differences?

4. Note that GATHER can be adapted for integrated SRH counseling, and that the Participant's Handbook includes guidelines for doing that. However, REDI was designed specifically to address the client's comprehensive SRH needs and to focus the counseling process on actions that the client takes. Therefore, REDI is the framework that will be used for this training. Keep in mind that the counseling process applies the same skills, attitudes, and knowledge, whether the framework is REDI, GATHER, or something else.

Activity E: Summary *(5 minutes)*

1. Ask if the participants have any further comments or questions.
2. Note that they will spend the rest of the workshop developing and practicing counseling skills, addressing the attitudinal challenges for providers in integrated SRH counseling, and identifying key information needed in each area of service delivery.

Session 8
Counseling Frameworks
Option B: GATHER

Note: Option B is designed for participants who already use the GATHER model for family planning and who want to continue using this model for integrated SRH counseling. The decision on whether to use REDI or GATHER should be made during the planning phase of the workshop (see Introduction for the Trainers, page xix)

Objectives

- To incorporate sexuality, HIV and STI prevention, postabortion care, and maternal health care into the GATHER counseling framework
- To explain the importance of applying counseling frameworks to each client's unique situation
- To explain the importance of addressing the social context for decision making in integrated SRH counseling
- To describe how integrated SRH counseling supports informed and voluntary decision making by clients

Materials

- Flipchart paper and markers

Advance Preparation

1. This exercise is intended specifically for the 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. Discuss this issue with program planners and participants ahead of time, to determine if the participants have already been trained in GATHER.
2. Prepare a flipchart with the GATHER model written out (Activity A, Step 1).
3. Review Session 8, Option B, in the Participant's Handbook (page 37).

Time

1 hour

Training Activities	Time
A. Introduction	5 min.
B. Small-group work	20 min.
C. Plenary/discussion	20 min.
D. Presentation/discussion	15 min.

Session 8, Option B, Detailed Steps

Option B: GATHER

Activity A: Introduction *(5 minutes)*

1. Reintroduce the steps of GATHER for family planning and go over them with the participants, referring to the steps on the flipchart (see below).

G	GREET the client politely and warmly.
A	ASK the client about himself or herself.
T	TELL the client about the clinic and about family planning methods.
H	HELP the client make a decision that is best for him or her.
E	EXPLAIN (the method or treatment, or any other relevant issue).
R	Schedule a RETURN visit.

2. Explain that in this exercise they will be thinking about how to incorporate a broader definition of SRH into GATHER—specifically, about how to incorporate sexuality, HIV and STI prevention, postabortion care, and maternal health care into the steps of GATHER.

Activity B: Small-group work *(20 minutes)*

1. Divide the participants into six small groups.
2. Distribute flipchart paper and markers to each group.
3. Assign one step of GATHER to each group, and explain that each group will have 20 minutes to brainstorm about how to incorporate sexuality concerns, HIV and STI prevention, postabortion care, and maternal health care, as well as family planning, into its step. One group member is to list the ideas on the flipchart.

Activity C: Plenary/discussion *(20 minutes)*

Invite each group to present to the larger group its suggestions for expanding a particular step of GATHER to address sexuality, HIV and STI prevention, postabortion care, and maternal health care, as well as family planning.

Activity D: Presentation/discussion *(15 minutes)*

1. Refer the participants to their handbooks, Session 8, Option B, page 37.
2. Review with the participants "The Dual-Protection GATHER Approach," which appears on page 39 in their handbooks. Explain that this is one example of how to use GATHER to address both family planning and HIV and STI protection in counseling.

3. Facilitate a group discussion based on the following key discussion points:
   * What do you think of using the GATHER model for integrated SRH counseling?
   * What do you think is the most challenging step in using GATHER for integrated SRH counseling? 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? How have you adapated it to meet different clients' needs?
   * How can GATHER ensure that the counseling is client-centered?
   * How can GATHER address the "social context" of clients' decisions? Why is this important?
   * How can GATHER ensure a client's informed and voluntary decision making?

➻ Training Tip

The GATHER model does not currently include maternal health care. The maternal health care component is being developed and will be available at a later date. However, the participants should be encouraged to consider this on their own, especially those whose work contains elements of maternal health care.

Part II

The Role of Providers' Attitudes in Creating a Good Climate for Communication

The provider's attitude toward the client is a key factor in effective counseling. Yet many providers are personally challenged by the necessity to discuss SRH needs, beliefs, and behaviors that may differ from their own, or may have difficulties in addressing these issues with particular types of clients (e.g., unmarried women, adolescents, or men). These training sessions set the stage for discussions about providers' attitudes, values, and beliefs and their impact on clients—discussions that will be reinforced throughout the training during group work, discussions, and role plays.

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Session 9
Rapport-Building—
Respect, Praise, and Encouragement

Objectives

- To name the four steps of the "rapport-building" phase of REDI (or the main purpose of the "greet" step in GATHER)
- To explain the importance of showing respect for clients
- To describe at least two ways in which providers can show respect for clients
- To explain how praise and encouragement can help to build rapport between providers and clients

Materials

- Writing paper
- Flipchart paper, markers, and tape

Advance Preparation

1. Review Session 9 in the Participant's Handbook (page 43). Consider if or how you want to use the Participant Worksheet for this session. (See Note to Trainers, page 5.)
2. Prepare a flipchart with the four steps of "rapport-building," showing the headings only (Activity A, Step 1).
3. Prepare a brief explanation of the four steps of Rapport-Building, for Activity A, Step 1. (The Trainers' Tool, page 47, repeats this phase of REDI for easy reference.)
4. Prepare a flipchart defining *praise* and *encouragement* (Activity B, Step 2).

Time

45 minutes

Training Activities	Time
A. Discussion	10 min.
B. Discussion/large-group work	15 min.
C. Pairs exercise/discussion	15 min.
D. Summary	5 min.

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Session 9 Detailed Steps

Activity A: Discussion *(10 minutes)*

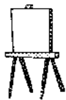
1. Post the flipchart (see below) showing the four steps of "rapport-building" and briefly review each step. Note that there will be a separate session on Step 3, "Introduce the subject of sexuality."

Rapport-building
1. Welcome the client 2. Make introductions 3. Introduce the subject of sexuality 4. Assure confidentiality

2. Ask the participants:
   * What does *respect* mean to you?
   * How do your clients show respect for you? How do you show respect for your clients? How is this different from the way in which you show respect for other people with whom you interact?
   * What role does respect play in building rapport with clients? How could respect (or lack of it) affect communications between providers and clients?

Activity B: Discussion/large-group work *(15 minutes)*

1. Ask the participants the following questions: (They should have their handbooks *closed* during this activity.)
   * What does *praise* mean to you? What does *encouragement* mean to you?
   * How could praise and encouragement be useful in building rapport with clients?



2. Post the flipchart sheet with the definitions of praise and encouragement (see below) and briefly review these, comparing them to the participants' responses.

> **Praise** means the expression of approval or admiration.
>
> **Encouragement** means giving courage, confidence, and hope.

3. Making sure that the participants have their handbooks closed, read one of the client's statements from the praise/encouragement chart in Session 9 in the handbook (page 44). Ask the participants what kind of response from the provider would show praise or encouragement, then read the response given in the chart and compare it to what the participants offered.
4. Continue with the rest of the client statements and possible provider responses.

Activity C: Pairs exercise/discussion *(15 minutes)*

1. Pair each participant with the person sitting next to him or her. Distribute pieces of writing paper, one sheet to each pair.
2. Ask each pair to think of one "client statement" that could be challenging for providers to respond to with respect, praise, or encouragement. Write this statement on one sheet of paper and fold it. Collect the papers, mix them up, and then redistribute them randomly.
3. Give the participants a few moments to read their "client statement" and to discuss with their partner what kind of response would show respect, praise, or encouragement. If the participants got their own statement, ask them to not let anyone else know, but simply act as if it came from someone else.
4. Ask one pair at a time to read their "client statement" and their response. Ask the group for other possible responses that would show respect, praise, or encouragement.
5. Continue until each pair has responded (or as time permits).

Activity D: Summary *(5 minutes)*

Ask the participants to discuss what they learned from this session and how they can apply it in their work.

Trainers' Tool

Phase 1: Rapport-Building

1. Welcome the client
   - Greet the client warmly
   - Help the client to feel comfortable and relaxed
2. Make introductions
   - Identify the reason for the client's visit
   - Ask general questions, such as name, age, number of children, etc.
3. Introduce the subject of sexuality
   - Explain the reasons for asking questions about sexuality
   - Put it in the context of HIV and STIs, and assure the client that you discuss HIV and STIs with all clients
   - Explain that the client does not have to answer all of your questions
4. Assure confidentiality
   - Explain the purpose of and the policy on confidentiality
   - Create an atmosphere of privacy by ensuring that no one can overhear your conversation, even if you are not able to use a separate room

Session 10
Provider Beliefs and Attitudes

Objectives

- To explain how providers' beliefs and attitudes can affect their interactions with clients, both positively and negatively
- To explain the importance of being aware of our own beliefs and attitudes, to avoid imposing them on clients or having them become barriers to communication

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Review Session 10 in the Participant's Handbook (page 47).
2. Review the list of "belief" statements included in the Trainers' Tool on pages 53 to 56. Select seven to use in this exercise, addressing each of the SRH services covered in this training (see Training Tip, below), and decide in which order to read them. (You may want to write your own, as necessary, to address specific local issues.)

> **➻ Training Tip**
>
> Sexual and reproductive health includes some of the most controversial and sensitive topics in most cultures around the world. However, specific issues and concerns differ from place to place. Therefore, it is important for you to read these statements carefully ahead of time. Choose only those that are most relevant to the beliefs and attitudes of service providers in your country. Add other statements, if necessary.
>
> Also, these statements are listed in no particular order; you will need to decide which you want to read first, second, and so on.

3. Make three large signs reading AGREE, DISAGREE, and UNSURE. Post these signs in three different locations, with space for people to gather near each sign.
4. Arrange the chairs and tables so people can move easily between the signs.

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Session 10

Time

45 minutes

Training Activities	Time
A. Introduction	5 min.
B. Large-group exercise	25 min.
C. Discussion	15 min.

Note: This session is adapted from: EngenderHealth, 2003.

Session 10 Detailed Steps

Activity A: Introduction *(5 minutes)*

1. Explain that this exercise is about our individual beliefs and the effects that they may have on our attitudes toward and interactions with clients. Ask the participants what the word *belief* means to them, and then ask how we form our beliefs.
2. Ask what are *attitudes*, and how our beliefs influence our attitudes.

Activity B: Large-group exercise *(25 minutes)*

1. Explain that you will lead a group exercise intended to help the participants examine their own beliefs about SRH and SRH clients.
2. Read one of the seven "beliefs" statements chosen from the list on pages 53 to 56, and ask the participants to decide if they agree with, disagree with, or are unsure how they feel about the statement.
3. After they decide, ask them to get up and stand under the sign (AGREE, DISAGREE, or UNSURE) that best reflects their opinion. Then ask one or two participants from each group to describe their thinking about this statement.
4. Repeat this process with more of the statements, for as long as time permits.

➻ Training Tip

The belief statements are *not* to be distributed as a handout, because the participants, or others who may read the materials later, may misunderstand the intent of this exercise and think that these statements reflect the beliefs of EngenderHealth and the trainers.

During this exercise, it is important to remind the participants that there are no "right" or "wrong" answers. People respond based on their own beliefs, and one purpose of the exercise is to help explore differences when they exist. Therefore, remain *neutral* throughout the exercise and maintain a balance among the different viewpoints presented.

For this exercise to be effective, it is essential for each participant to decide whether he or she agrees with, disagrees with, or is unsure about each statement. This will help them to know their own beliefs. Also, when they practice discussing their beliefs in front of others, it will help raise their awareness of how these beliefs can affect their interactions with clients (and with others).

To cover a range of issues in the time available, responses will have to be limited to just two or three per group per statement.

Activity C: Discussion *(15 minutes)*

1. Ask the participants to return to their seats.
2. Use the following questions to lead a discussion about this exercise:
   * Does everyone in the group have the same beliefs, or are there differences?
   * Which statements revealed the widest range of beliefs? What could explain these differences?
   * What happens when providers and clients hold different beliefs about SRH issues?
   * Why is it important for us, as providers, to be aware of our own personal attitudes and beliefs about SRH issues?
   * What can we do, as providers, when our beliefs about a particular SRH issue make us uncomfortable about talking with clients?

Trainers' Tool

****Do Not Distribute to the Participants****

Sexual and Reproductive Health Belief Statements

Gender and Sexuality

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

HIV/AIDS

17. People who do not use condoms can only blame themselves for getting HIV.
18. Health care providers have the right to know the HIV status of their clients.
19. A woman who knows that she is infected with HIV should not have a baby.
20. People with HIV should not have sex.
21. It is a crime for people who are infected with HIV to have sexual relations without informing their partner.
22. People who get HIV through sex deserve it because of the behaviors that they practice.
23. The government is doing an adequate job of responding to the needs of people with HIV.
24. Life is hopeless and not worth living if you have AIDS.

(continued)

Trainers' Tool

****Do Not Distribute to the Participants****

Sexual and Reproductive Health Belief Statements *(continued)*

HIV/AIDS (continued)

25. People with AIDS should be isolated from the rest of the community.
26. AIDS is mostly a problem of prostitutes.
27. Health care providers who are HIV-positive have a moral obligation to resign from their jobs.
28. 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.

Sexual Behavior

29. It is acceptable for people of the same sex to have sex with each other.
30. Homosexuals can change if they really want to.
31. Anal sex is normal behavior.
32. Sex without intercourse is not real sex.
33. To be "good," sex must end in orgasm.
34. It is acceptable for someone to have more than one sexual partner at the same time.
35. It should be recommended that couples not marry until they have had sexual intercourse.
36. Prostitutes provide a useful service.
37. Oral sex is wrong.
38. Men who use prostitutes are socially and sexually inadequate.
39. If people go too long without sex, it is bad for them.
40. The purpose of having sex is to show love for someone.
41. Any sexual behavior between two consenting adults is acceptable.
42. A person can lead a perfectly satisfying life while being celibate.
43. Celibacy goes against human nature.

Condoms

44. Condoms should be distributed to secondary school students who request them.
45. Condom use is a sign of caring and not distrust.
46. Condoms ruin the enjoyment of sex.

(continued)

Trainers' Tool

****Do Not Distribute to the Participants****

Sexual and Reproductive Health Belief Statements *(continued)*

Condoms (continued)

47. Couples can have an enjoyable sex life while using condoms every time they have sex.
48. Educating teenagers about condoms will only encourage them to have sex.
49. If my teenage son asked me for condoms, I would give them to him.
50. If my teenage daughter asked me for condoms, I would give them to her.

Judgments about Clients

51. Most uneducated women are incapable of making their own decisions about their sexual and reproductive life.
52. If providers are uncomfortable with homosexuality, it is acceptable for them to refer homosexual clients to other providers.
53. It is hard for me to understand why people who know how HIV is transmitted would continue to have unsafe sex.
54. Clients who have good, up-to-date information about HIV transmission will make good choices about keeping themselves safe.
55. Clients with two children or more should be sterilized.

Judgments about Postabortion Clients

56. Women who have multiple abortions should be sterilized.
57. Women who have induced an abortion deserve any pain that occurs during postabortion treatment procedures.

STIs

58. If people get an STI, it is their own fault.
59. Men are the main source and transmitters of STIs.

Adolescents and Young People

60. Our facility should make contraceptive methods available to adolescents.
61. Fourteen is too young for a boy to have sex.
62. Schools should provide sex education for children before puberty, starting at age 9 or 10.
63. In most cases, it is not worth discussing condoms with young people because they will never use them.

(continued)

Trainers' Tool

****Do Not Distribute to the Participants****

Sexual and Reproductive Health Belief Statements *(continued)*

Adolescents and Young People (continued)

64. Children should be taught about HIV and other STIs in school.
65. The parent of a teenage client who reports she is having sex has a right to know.

Note: Adapted from: EngenderHealth, 2002, Volume 1, pp. 70-72.

Session 11
Sexuality

Objectives

- To identify (to themselves) how their personal experiences of sexual development and learning affect their current views and feelings about sexuality issues
- To explain how their own views and feelings about sexuality might influence their approach to counseling clients on these issues
- (Optional) To list four elements of sexuality and describe how they encompass much of our life experience
- (Optional) To describe milestones in sexual and social development

Materials

- Writing paper, flipchart paper, markers, and tape
- Guided visualization script (see Trainers' Tool, page 63)

Advance Preparation

Part A. Reflections on How We Learned about Sexuality

1. Review Session 11 in the Participant's Handbook (page 49). Consider if or how you want to use the Participant Worksheet (Part A) for this session. (See Note to Trainers, page 5).
2. Make sure beforehand that the training room can be closed to outsiders during the guided visualization exercise.
3. Practice reading the script (see Trainers' Tool, page 63) several times prior to conducting the guided visualization, to get a sense for how long to pause between questions and how many questions to include.
4. For Activity C, decide whether you want to use large-group discussion (Option 1) or "listening pairs" (Option 2) after the guided visualization. Prepare a flipchart with the key discussion questions for whichever option you choose (page 60).

Part B. Aspects of Sexuality and Part C. Sexual and Social Development

5. Review Session 11 in the Participant's Handbook (page 49). These guidelines show how you can cover both Parts B and C. However, you may decide to present only on "aspects of sexuality" or only on "sexual and social development": either topic could be expanded into a full session of its own. Determine which option (either B, C, or both) best meets your participants' needs.
6. Consider if or how you want to use the Participant Worksheet (Part C) for this session.
7. If you do Part B, prepare the presentation on "Aspects of Sexuality," based on the Background Materials in the Participant's Handbook (page 52).

8. If you do Part C, prepare sheets of writing paper with the milestones listed in "Sexual and Social Development" in the Participant's Handbook (pages 53 to 54).
9. For Part C, prepare sheets of paper for a time line. On separate sheets of writing paper, write the numbers 0, 5, 10, 15, 20, 30, 40, 50, 60, 70, and 80. Post these in sequence on the wall to create the time line.

Time

1 hour

Training Activities	Time
Part A. Reflections on How We Learned about Sexuality	
A. Introduction/instructions	5 min.
B. Guided visualization	10 min.
C. Discussion	15 min.
Part B. Aspects of Sexuality	
D. Presentation/discussion	15 min.
Part C. Sexual and Social Development	
E. Large-group exercise	10 min.
F. Summary	5 min.

Note: This session is adapted from: EngenderHealth, 2000; and EngenderHealth, 2002.

Session 11 Detailed Steps

Part A. Reflections on How We Learned about Sexuality

Activity A: Introduction/instructions *(5 minutes)*

1. Review the first two learning objectives.
2. Explain to the participants that in this activity they will spend time reflecting, with eyes closed, as you read a series of questions that will guide them through memories and thoughts about growing up and learning about sexuality. They will then consider how these experiences shaped their own sense of sexuality and how these experiences may affect their work in counseling.
3. 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. They will sit with their eyes closed, and you will speak to them for about 10 minutes. During this time, no one else is to be allowed into the room, and no one will be watching them.

> **➻ Training Tip**
>
> No interruptions should be allowed during this session. Maintaining a comfortable, quiet, and private environment in the training room is critical to this exercise. Depending on the cultural context, the participants may feel comfortable remaining seated or may prefer to lie down as they listen to the script.

4. Ask if anyone has any questions.
5. Ask the participants to make themselves comfortable and to close their eyes.

Activity B: Guided visualization *(10 minutes)*

In a slow, reassuring voice, read aloud the script (see Trainers' Tool, page 63) to the participants, pausing between questions to enable them to reflect on memories and images.

> **➻ Training Tip**
>
> Although we do not ask people to share their personal memories or experiences, this exercise may bring up strong emotions among the participants, particularly among those with a history of sexual abuse or traumatic experiences. Be prepared to address these issues if they come up. For example, a trainer could watch the group to identify anyone who may be having difficulty with the exercise and talk to the person privately, without drawing the attention of the group, and see what would make the person more comfortable.

Activity C: Discussion *(15 minutes)*

Option 1—Large-group discussion (15 minutes):

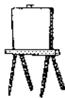
1. Emphasize that people should *not* share their personal life experiences, but rather discuss how it felt to think about those experiences.

2. Post the prepared flipchart with the three key questions (see below) and lead a discussion. Do *not* write the participants' responses on the flipchart.

> **Reflections on How We Learned about Sexuality**
>
> * How did it feel to do this exercise?
> * How could this kind of reflection be helpful to your counseling work?
> * In what ways does this exercise give you insight into how a client might feel about discussing his or her sex life with a health care provider?

Option 2—Listening pairs (15 minutes):

1. Divide the participants into pairs to discuss how they felt during the guided visualization, sharing only as much as they feel comfortable sharing.
2. After 5 minutes, bring the group back together.



3. Post the prepared flipchart with the three key questions (see below) and lead a discussion. Do *not* write the participants' responses on the flipchart.

> **Reflections on How We Learned about Sexuality**
>
> * How did you feel talking about these issues with another person?
> * How could this kind of reflection be helpful to your counseling work?
> * In what ways did talking with someone else about the guided visualization give you insight into how a client might feel about talking with a health care provider about the client's sex life?

> **➻ Training Tip**
>
> If you want to spend more time on the discussion, ask these additional questions:
>
> * Did anything about the exercise make you feel uncomfortable or surprised?
> * If the listening pair involves a man and a woman, how did you feel talking to someone of the opposite sex? How do you think clients would feel in the same situation?
> * 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' experience of sexual development and learning different? Do boys and girls get different messages about their bodies and sex? (If there is only one gender represented in the group, this may be difficult to discuss, as it will be based on assumptions.)

Part B. Aspects of Sexuality

Activity D: Presentation/discussion *(15 minutes)*

1. Explain that while people often associate the term *sexuality* with the terms *sex* or *sexual intercourse*, sexuality encompasses much more than that.
2. To help the group understand the complexity of sexuality, discuss four different aspects of sexuality in a *brief* lecture.
3. After describing each concept to the participants, see if they have any examples to demonstrate their understanding of each element.
4. Facilitate a brief discussion by asking:
   - Where is "sexual intercourse" included within the definition of sexuality? Does the term play a large or small role in the definition?
   - How does culture influence the various circles of sexuality?
   - Which aspects of sexuality are very different between males and females? Do men and women experience sensuality the same way? Do men and women view relationships the same way? Do men and women have the same sexual health needs?

> **➸ Training Tip**
>
> This agenda shows how you can do both Parts B and C. However, you may decide to include only "aspects of sexuality" or only "sexual and social development"; either topic can easily be expanded into a full session of its own. Review the materials in the Participant's Handbook and determine which option best meets your participants' needs.

Part C. Sexual and Social Development

Activity E: Large-group exercise *(10 minutes)*

1. For a fun (and frantic) closing exercise, distribute 16 prepared sheets of paper with the "sexual and social development" milestones from the Participant's Handbook. Point out the sheets of paper (numbered from 0 to 80) that you posted on the wall earlier. Explain that this is a time line. Ask the participants to quickly (in only 5 minutes) stand along the time line in chronological order for each milestone. Expect a lot of confusion, some bunching up, and a few arguments. This is all part of the learning experience, because there are very few "right" answers.

2. After 5 minutes, ask the participants to read their milestones, from the youngest to the oldest. It is okay for a large group to be bunched together in the age range of 3 to 12 years; do not force them to be in a straight line. Thank the participants for their efforts; ask them to return to their seats, open their handbooks to Session 11, and find the "Sexual and Social Development" section (page 53).

3. Note the earliest development in the list ("begins to have sexual responses") and see where that fell in their chronology. Note the latest development ("experiences sexuality in later life") and see where that fell in their chronology. Briefly ask the following questions:
   - When on the time line does most sexual development occur?

* Were you surprised about where any of the cards were placed? Which ones? Why?
* Which placements would be different for males and females? Which would be similar?

> **➽ Training Tip**
>
> Ideally, there will be about 16 participants, which will yield one developmental milestone for each participant in the large-group exercise. If there are more than 16 participants, you can create participant "teams." If there are fewer, then some of the wider-ranging milestones (e.g., "begins to show romantic interest" or "begins to engage in romantic activity") can be left out.
>
> Try to avoid arguments about where these milestones occur. Allow the participants to "bunch up" and not try to put the milestones in linear order. One of the lessons is that some of these milestones vary among individuals and among cultures.

Activity F: Summary *(5 minutes)*

Ask the participants:

* How have your thoughts about sexuality changed since the beginning of this session?
* How can you use what you have learned in your work?

Trainers' Tool

Guided Visualization Script

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

- Reach back into your memories, and picture yourself as a child of 5. What was your life like then? Who were the important people in your life?
- Remember yourself at age 10. Where did you live? Who were the important people in your life?
- As you were growing up as a young child, what types of messages did you receive from other people about touching your own body?
- What messages did you receive about the opposite sex? As you grew older, how did these messages change?
- Think about when you first learned where babies come from. How old were you? How did you feel about it?
- For women, how did you first learn about menstruation? How old were you? How did you feel about it?
- For men, how did you first learn about wet dreams (nocturnal emissions)? How old were you? How did you feel about it?
- When you were 12, how did you feel about your body?
- 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, or with a friend?
- 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?
- How did you feel about the idea of having sex yourself?
- Did you ever have thoughts about sex that you wished you did not have?
- 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?
- Think about your first sexual experience. How did you feel beforehand? How did you feel afterward? What was the communication with your partner like?
- How did the messages that other people gave you about sex affect your feelings?
- As you have grown older, have you become more comfortable with sex? What has helped you feel more comfortable?

When you are ready, open your eyes.

Note: Adapted from: EngenderHealth, 2002, Volume 2, pp. 62–66.

Session 12
Variations in Sexual Behavior

Objectives

- To identify their own biases and judgments related to various sexual behaviors
- To recognize differences in individual and cultural perspectives about sexual behavior, including differences in what is considered "normal" or "acceptable"
- To explain why it is important to be nonjudgmental about sexual behaviors when counseling clients about SRH
- To be more comfortable when discussing a range of sexual behaviors with clients

Materials

- Large cards or writing paper and scissors
- Markers—one for each participant, if possible
- Tape

Advance Preparation

1. Review Session 12 in the Participant's Handbook (page 57).
2. Review the list of behaviors (see Trainers' Tool, page 70), and select 25 to 30 to use in this session. Try to get a mixture of behaviors that people would be familiar with and those that they might not. Add new behaviors or omit others, based on the local situation. 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. Prepare the behavior cards. Use heavy paper or card stock if available, or sheets of letter-sized paper if not. Write one sexual behavior on each piece of paper. Print using a large marker and large letters, or print the pages using a computer in a large, bold typeface so the words can be read from a distance (see example, below).

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4. 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 *different colors of paper* for each of these three sheets, if possible. Post them high on the wall, ensuring that there is sufficient space between them to place three to five vertical columns of cards beneath each.
5. Prior to the exercise, prepare small pieces of tape, enough to affix all of the behavior cards to the wall.

Time

45 minutes

Training Activities	Time
A. Introduction/instructions	5 min.
B. Large-group exercise	15 min.
C. Discussion/summary	25 min.

Note: This session is adapted from: EngenderHealth, 2002.

Session 12 Detailed Steps

Activity A: Introduction/instructions *(5 minutes)*

1. Introduce the exercise by saying that this session will explore the range of sexual behaviors that people engage in and the attitudes and values that we have about those behaviors. Explain that this interactive exercise will allow everyone to examine their own personal values about different sexual behaviors but in a completely confidential way.
2. Tell the participants that you will give each person one or more cards with a sexual behavior written on it. Instruct them to determine how they personally feel about the particular behaviors written on their cards and to indicate this by writing one of these phrases on the back of the card:
   - *OK for me* (meaning that it is a behavior I personally would engage in)
   - *OK for others, but not for me* (meaning that it is a behavior I personally would *not* engage in, but is one that I have no problem with other people doing)
   - *Not OK* (meaning that it is a behavior no one should engage in because it is morally, ethically, or legally wrong)
3. Remind the participants that this exercise is meant to be *completely confidential*, so they should not show the behavior on their card or their response to it to anyone. To ensure confidentiality, before distributing the cards you may want to ask the participants to rearrange their seats or spread around the room so that no one can see the other participants' cards and responses.

Activity B: Large-group exercise *(15 minutes)*

1. Distribute the sexual behavior cards (facedown) and one marker each to the participants, attempting to give each person the same number of cards, until all of the cards have been distributed. Invite the participants to look at their cards and think about the behavior written on each.

> **➽ Training Tip**
>
> Instruct the participants that if someone gets a card with a behavior that he or she does not understand, he or she should signal you to ask for an individual explanation. If the behavior is explained in front of the group, that will take away the anonymity for that participant.

2. Repeat what is meant by "OK for me," "OK for others, but not for me," and "not OK," and ask if everyone understands.

3. Instruct the participants *not* to write their names on the cards. Ask them to mark on the back of each card their response to the behavior, without showing their cards to anyone. When they are done, they will place the cards with the behavior facedown in a pile in the center of the room (or a trainer can collect them, without looking at the behavior).

> **➻ Training Tip**
>
> It is helpful to continually remind the participants that this exercise is not about STI/HIV risk, but about values and judgments around sexual behaviors in general. Sometimes the participants may have difficulty separating their ideas about disease risk from their value judgments about behaviors.

4. Mix up the cards and redistribute them to the participants, asking them to take as many cards as they put down.
5. 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 for me," or "Not OK"), according to what is indicated on the back of the card. Remind them to put the card in the category that is marked, even if they personally do not agree with it. Encourage them to line (queue) up to read and post their cards, and move quickly one after the other.

Activity C: Discussion/summary *(25 minutes)*

1. Once all of the cards have been posted, instruct the participants to gather around the wall and to take a few minutes to observe the placement of the cards.
2. Facilitate a group discussion based on the questions below. Do not move the cards if there is disagreement. Simply acknowledge the difference of opinion and leave the cards as they are.
   - 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 behavior 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?
   - 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?

➺ Training Tip

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. Some participants are more aware of variations in sexual behavior than others and can help their colleagues understand the range of behaviors.

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

3. Summarize by asking:
   * How can you apply to your work what you have learned in this exercise?

Trainers' Tool

Different Types of Sexual Behaviors

The following behaviors represent a wide range of sexual activities. Trainers should feel free to add new behaviors or omit some on this list, based on the local situation. For the average-sized group (12 to 15 participants), select 25 to 30 behaviors, to allow enough time for discussion. If there is more time (e.g., one hour), you can increase the number of behaviors included.

Hugging
Kissing
Giving oral sex
Receiving oral sex
Having group sex
Having anal sex
Having sex with someone of the same sex
Using objects or toys during sex
Getting paid for sex
Having sex in public places
Being faithful to one partner
Having sex with a person who is much younger
Masturbating
Manually stimulating your partner (using your hand)
Having vaginal sex
Watching pornographic movies
Having sex with many partners
Having sex with people whom you do not know
Initiating sexual encounters
Practicing sadism and masochism
Sex between a teacher and a student
Having oral-anal sex
Engaging in "dry sex"
Sex between a child and an adult relative
Having sex with someone other than your spouse (adultery)
Agreeing to have sex with someone who will not take no for an answer
Paying someone for sex
Having premarital sex
Having sex with animals (bestiality)
Having sex with a relative considered too close (incest)
Swallowing semen
Having sex with children (pedophilia)
Telling someone a lie just to have sex
Having sex with someone of another race or ethnicity
Having sex whenever your partner wants it
Having sex with someone who is married
Having sex with a disabled person
Having 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 is your duty
Rape
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

Session 13
Building Rapport with Male Clients and with Adolescent Clients

Objectives

- To describe the special needs and concerns of two types of clients—men and adolescents
- To explain the importance of building rapport immediately with male clients and adolescents

Materials

- Flipchart paper, markers, and tape

Advance Preparation

Review Session 13 in the Participant's Handbook (page 59), particularly to prepare for the minilecture and large-group exercise in Activities B and C and the presentation in Activity E.

Time

1 hour, 15 minutes	Training Activities	Time
	A. Introduction	5 min.
	B. Presentation	15 min.
	C. Large-group exercise	10 min.
	D. Discussion	10 min.
	E. Presentation/discussion	30 min.
	F. Summary	5 min.

Session 13 Detailed Steps

Activity A: Introduction *(5 minutes)*

1. Review the Essential Ideas from the Participant's Handbook, as an introduction to this session. (Participants should have their handbooks closed throughout this discussion.)
2. Explain to the participants that the session's purpose is to help them begin thinking about how they could increase their own comfort in talking with men and with adolescent clients.

> **➻ Training Tip**
>
> The short amount of time devoted to this topic is almost a "token" effort, but completely omitting men and adolescents from the curriculum would be worse. For providers who deal with adolescents and men, additional training is strongly recommended. Existing curricula and supplementary modules (now being developed) are cited in the Introduction for the Trainers (page xi).

Activity B: Presentation *(15 minutes)*

1. Give a minilecture based on the materials in "Understanding Men's Needs and Roles," found on page 59 of the Participant's Handbook. Begin by asking:
   * What are your biggest challenges in providing SRH counseling for men?
2. Involve the participants by using the scenarios, saying what might not work, and then asking a participant to give a better statement or question.

Activity C: Large-group exercise *(10 minutes)*

Using the table "Sample Phrases to Use When Addressing Men..." on page 62 of the Participant's Handbook, read the need or role, and then go around the room, asking each participant to suggest a sample phrase that would be appropriate.

Activity D: Discussion *(10 minutes)*

Explain that *rapport* means "a close and sympathetic relationship, agreement, or harmony." Having considered men's needs in counseling and their roles in decision making, ask the participants:

* What can happen if you do not build rapport quickly with a man who comes to your service site?
* How could building rapport help make SRH services more accessible to men?

Activity E: Presentation/discussion *(30 minutes)*

1. Give a minilecture based on the materials in "SRH Services and Counseling for Adolescents," found on page 63 of the Participant's Handbook. Begin by asking:
   * What are your biggest challenges in providing SRH counseling for adolescents?

2. Following the minilecture, ask the participants to suggest statements they could make to adolescent clients to "create an atmosphere of privacy, respect, and trust" (that is, to build rapport). Write their suggestions on a flipchart.
3. Discuss the questions:
   * What can happen if you do not build rapport quickly with an adolescent who comes to your service site?
   * How could building rapport help to make SRH services more accessible to adolescents?

Activity F: Summary *(5 minutes)*

Ask the participants:

* How can you use what you have learned to build rapport with male and adolescent clients?
* What else would you like to learn about integrated SRH counseling for men and adolescents?

Part III

Communication Skills

Good counseling requires good communication skills. The abilities to establish rapport, to elicit information, and to provide information effectively are necessary to support clients' informed and voluntary decision making. To effectively assess clients' needs, providers need to couple open-ended questions that encourage clients to talk about themselves with active listening skills and effective paraphrasing, to ensure comprehension. To give appropriate information, providers must be able to communicate their knowledge about SRH issues effectively. This requires the ability to explain things in language and terms the client understands (with or without the help of visual aids), and comfort in talking about issues related to sexuality. Developing rapport was introduced in Session 9. The training sessions that follow introduce the other essential communication skills.

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Session 14
Asking Open-Ended Questions

Objectives

- To describe two basic types of questions used when communicating with SRH clients
- To explain the importance of open-ended (and feeling/opinion) questions in assessing clients' needs and knowledge
- To reformulate closed-ended questions into open-ended questions
- To identify open-ended questions with which to explore sexuality issues related to HIV and STI risk, antenatal, postpartum, and family planning concerns, and other SRH issues

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Review Session 14 in the Participant's Handbook (page 67). The Participant Worksheet will be used in Activity D.
2. Prepare at least two flipcharts for Activity A (page 78).
3. Prepare five flipchart sheets for Activity D, with the headings: "Family Planning," "HIV/STI," "Antenatal and Postpartum," "Postabortion," and "Sexuality Issues."

Time

1 hour, 30 minutes

Training Activities	Time
A. Brainstorm	5 min.
B. Presentation	10 min.
C. Large-group work	20 min.
D. Small-group work	20 min.
E. Plenary	20 min.
F. Discussion/summary	15 min.

Note: This session is adapted from: EngenderHealth, 2003.

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Session 14 Detailed Steps

Activity A: Brainstorm *(5 minutes)*

1. Ask the participants:

   * What is the purpose of asking questions during counseling?

   (Since you will be referring quickly to the Participant's Handbook, do not write their answers on the flipchart.)

2. Post the prepared flipcharts where you can write on them (see below for example of flipchart).

Questions: Closed or Open?		
C	O	Questions

3. Ask the participants to brainstorm questions that typically are asked of SRH clients. Write each question in the "Questions" column, in full and exactly as it is given by the participant. Do not stop until you have at least 10 questions.

Activity B: Presentation *(10 minutes)*

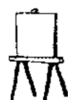
1. Ask the participants to open their handbooks to Session 14. Discuss the purposes of asking questions, comparing what is included in the section "Why Do We Ask Questions...? (page 67 in the Participant's Handbook) with what they discussed.
2. Then discuss two types of questions—closed-ended and open-ended—and the different purposes for each type. Review the examples.

Activity C: Large-group work *(20 minutes)*

1. Return to the "Questions" flipchart from the brainstorm. For the first question, ask the participants, "Is this closed-ended or open-ended?" Place a check mark in the "C" or "O" column. Continue for the rest of the list. *(5 minutes)*
2. Tally the number of closed-ended and open-ended questions and note the totals on the flipchart. (In virtually every training, this list will be predominantly closed-ended questions.)
3. Ask the participants:

   * What can you observe from this brief exercise about the kinds of questions most often asked in client-provider communications?

* Why does this happen?
* What effect would this have on counseling? *(10 minutes)*



4. Demonstrate how to change a closed-ended question into an open-ended question, using one from the list. Ask the participants to volunteer to do the same (if possible) for the rest. If most of the questions are appropriately closed (e.g., age, marital status, number of children, or date of last menstrual cycle, among others), ask for more examples of open-ended questions that would be useful in SRH counseling. List these additional questions on a separate flipchart. *(5 minutes)*

Activity D: Small-group work *(20 minutes)*

1. Divide the participants into five groups; give each group markers and one of the prepared flipcharts.
2. Refer the participants again to Session 14 in their handbooks; assign each group one of the topic areas from the "Asking Open-Ended Questions about SRH Concerns" Participant Worksheet (pages 69 to 70). Ask each group to:
   - Discuss what specific questions would be effective in helping the client to explore the issues listed under their topic area
   - Write these questions on the flipchart
3. Remind them that they should use open-ended questions as much as possible, and tell them they will have 15 minutes to work in their groups.
4. Quickly check with each group to see that they understand their instructions. Give them a time check after 10 minutes. Stop the groups after 15 minutes. It is okay if they have not covered all of the issues listed in the bullets (especially the fifth group). *(15 minutes)*

Activity E: Plenary *(20 minutes)*

One at a time, ask each group to post their flipchart on an easel or wall. Each group will have 4 minutes to present their questions and receive feedback from the others. A representative of each group will read the list of questions.

Activity F: Discussion/summary *(15 minutes)*

1. Lead a discussion by asking the participants:
   * How well do these questions address the specific issues identified in the worksheet?
   * How well did the group make use of open-ended questions?
   * What other questions would you suggest?
   * How comfortable do you think a provider would be in asking these questions?
   * How comfortable do you think a client would be in answering these questions?

   (You may not have time for all of these questions, so concentrate on the first three and do the last two as time permits.) *(10 minutes)*
2. Ask the participants to summarize what they have learned from this session. Add your own comments, as necessary, to cover the Essential Ideas for this session from the Participant's Handbook. Ask how they can use in their work what they have learned in this exercise. *(5 minutes)*

Session 15
Listening and Paraphrasing

Objectives

- To describe at least two purposes of listening as a key communication skill for counseling
- To list at least three indicators of effective listening
- To name at least two purposes of paraphrasing in counseling
- To demonstrate paraphrasing

Materials

- Flipchart paper, markers, and tape
- Trainers' Tool from Session 10 ("Sexual and Reproductive Health Belief Statements"), pages 53 to 56.

Advance Preparation

1. Review Session 15 in the Participant's Handbook (page 71). Consider if or how you want to use the Participant Worksheet for this session (see Note to Trainers, page 5.)
2. Prepare a flipchart on "Paraphrasing" (Activity B).
3. Select four statements from the "Sexual and Reproductive Health Belief Statements" (Session 10, pages 53 to 56) that were not used during that session.

Time

45 minutes

Training Activities	Time
A. Demonstration role play/discussion	15 min.
B. Presentation	5 min.
C. Small-group work	20 min.
D. Discussion	5 min.

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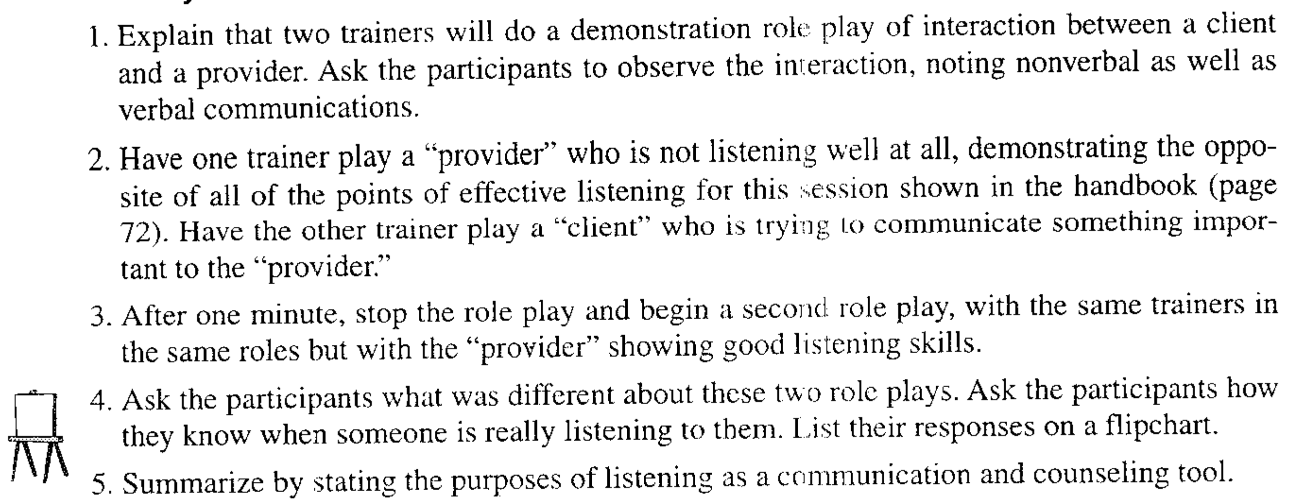
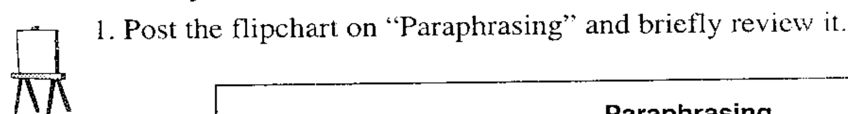
Session 15 Detailed Steps



Activity A: Demonstration role play/discussion *(15 minutes)*

1. Explain that two trainers will do a demonstration role play of interaction between a client and a provider. Ask the participants to observe the interaction, noting nonverbal as well as verbal communications.
2. Have one trainer play a "provider" who is not listening well at all, demonstrating the opposite of all of the points of effective listening for this session shown in the handbook (page 72). Have the other trainer play a "client" who is trying to communicate something important to the "provider."
3. After one minute, stop the role play and begin a second role play, with the same trainers in the same roles but with the "provider" showing good listening skills.
4. Ask the participants what was different about these two role plays. Ask the participants how they know when someone is really listening to them. List their responses on a flipchart.
5. Summarize by stating the purposes of listening as a communication and counseling tool.



Activity B: Presentation *(5 minutes)*

1. Post the flipchart on "Paraphrasing" and briefly review it.

> **Paraphrasing**
>
> *Paraphrasing* means restating the client's message simply and in your own words.
>
> The purposes of paraphrasing are to:
> - Make sure you have understood the client correctly
> - Let the client know that you are *trying* to understand his or her basic messages
> - Summarize or clarify what the client is trying to say

2. Demonstrate paraphrasing with a participant or co-trainer, using one of the believe statements.

Activity C: Small-group work *(20 minutes)*

1. Divide the participants into groups of three each. Explain that they will practice listening and paraphrasing in their groups three times. Ask them to decide, for this first time, which person will be the "speaker," which one will be the "paraphraser," and which one will be the "observer." Note that the roles will change for each practice session.
2. Give the following instructions: "I will read a statement. The 'Speaker' will have 1 minute to explain why he or she agrees with, disagrees with, or is unsure how he or she feels about

that statement. Then the 'paraphraser' will try to restate what the 'speaker' said, in his or her own words. Finally, the 'observer' will comment on the listening and paraphrasing skills that were or were not demonstrated. After that (about 5 minutes total), you will change roles, and I will read another statement."

3. Read aloud one of the statements from among the "Sexual and Reproductive Health Belief Statements" and ask the "speakers" to give their opinion—agree, disagree, or unsure—within their group. Stop them after 1 minute, and ask the "paraphrasers" to paraphrase. Stop them after 1 minute and ask the "observers" to give feedback. *(5 minutes total)*
4. Repeat this exercise twice (with different statements), so that each person has had a chance to practice listening and paraphrasing. *(10 minutes)*

Activity D: Discussion *(5 minutes)*

Ask the participants:

* What did you learn from this exercise on listening and paraphrasing?
* What was difficult? What was easy?
* How can you improve your skills?
* How can you use in your work what you have learned in this session?

Session 16
Using Language That Clients Can Understand

Objectives

- To be more comfortable using sexual terminology with clients
- To be able to refer to local words for sexual acts and body parts, to make the link between the words that the client understands and the words that the provider is comfortable using
- To demonstrate the use of simple language to explain sexual and reproductive anatomy and physiology to clients

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Review Session 16 in the Participant's Handbook (page 75).
2. Review the Training Tips (Activity A) to decide which headings to use for the language and sexuality exercise (Activities A through C) and how to organize the small-group work.
3. Prepare at least four two-column flipcharts with headings related to sexuality (body parts or sexual activities, such as male sexual anatomy, female sexual anatomy, sexual intercourse [penile-vaginal], or other sexual behaviors). Use one heading per flipchart. The left-hand column should say "medical terms," and the right-hand column should say "local slang" (see example below).

Male sexual anatomy	
Medical terms	Local slang

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Session 16

Time

1 hour, 15 minutes

Training Activities	Time
Part A. Language and Sexuality	
A. Introduction and instructions	10 min.
B. Small-group exercise	15 min.
C. Discussion	10 min.
Part B. Using Simple Language	
D. Introduction and instructions	15 min.
E. Small-group work	15 min.
F. Discussion	10 min.

Note: The "Language and Sexuality" section of this session is adapted from: EngenderHealth, 2002.

Session 16 Detailed Steps

Part A: Language and Sexuality

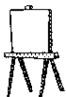
Activity A: Introduction and instructions *(10 minutes)*

1. Explain that SRH service providers often must address issues that make people—clients and providers alike—feel uncomfortable, such as sexual activities or body parts that are considered private. Clients who do not know the "medical" terms for what they are trying to describe may use slang words or common terms that might make some providers feel uncomfortable or may avoid saying the words altogether. On the other hand, providers may use words that clients do not understand but are too embarrassed to ask about. This can constitute a major barrier to communication.
2. Explain that in this exercise the participants will try to identify all of the terms that they can think of for various sexual acts and body parts, including both "medical" (or "scientific") terms and slang or common terms. To communicate effectively, the provider must *know* the words that a client will understand. However, the provider should not feel obliged to *use* throughout the counseling session words that are considered "offensive." Instead, the provider can identify the word that a client uses for a particular body part or activity and then explain to the client that when a particular medical term is used, it refers to that part or activity. (This may be a difficult distinction for providers to grasp; the trainer will probably need to repeat this several times both during this session and after.)

➻ Training Tip

The purpose of this activity must be explained clearly to the participants, as some might feel as if the trainers are just trying to get them to say "dirty" words. 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. While supporting their reaction, note that their discomfort could be an important learning opportunity, as it shows honestly how providers and clients might feel about hearing or using these words. Ask the participants how they can learn from this to communicate better with clients.

It is important to acknowledge issues that may arise when this exercise is conducted with a mixed-gender group. In some circumstances, the 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 the participants get beyond this discomfort, it is important to start this process in a sensitive and nonthreatening way. If necessary, trainers should consider conducting the exercise in single-sex groups or ensuring that the trainer is female when the participants are predominantly female.



3. Divide the participants into four groups. Post the prepared flipcharts on the wall.

> **➻ Training Tip**
>
> Instead of using broad categories for headings (e.g., "male sexual organs," "sexual behaviors," etc.), more specific terms can be provided to the participants, with more flipchart sheets (e.g., "penis," "scrotum," "masturbation," "oral sex," etc.).
>
> This activity also can be tailored to working with a specific population or subgroup (i.e., participants can brainstorm a list of words that might be used by different groups of people, such as adolescents, men, or older men and women, among others).

4. Explain the steps for this exercise:
   - Each group will start with one of the flipcharts and write down all of the words that the group members have heard of (both medical and local) to describe the heading on the sheet they have been given.
   - After a few minutes, the trainer will ask each group to move to the next flipchart. After reading what the first group wrote, they can write any additional medical or local slang terms that they have heard.
   - The groups will continue to move when time is called, until every group has had a chance to add words under all of the headings. A large-group discussion will follow.

> **➻ Training Tip**
>
> This activity can be structured in several different ways:
>
> - In the version presented here, you need wall space to post all of the flipcharts at the same time and room for the small groups to move easily among the papers. The physical movement and time allowed for informal reaction to the words is a good feature of this approach, as it allows for more "honest" responses.
> - If wall space is not available, small groups can take turns writing their words and then pass their flipchart to the next group to write additional words—that is, the flipchart can move while the people stay in the same place.
> - To save time, small groups can be assigned one or more headings and the results can be shared in plenary, without passing the flipchart to other groups. However, you need to allow time within the discussion period for the participants to react to the words of other groups.
> - If you are very short on time, this exercise can be conducted as a large-group brainstorm, with the trainer or volunteers writing down the words on the flipchart. However, this type of exercise tends to be dominated by a small number of more vocal, "braver" participants.

Activity B: Small-group exercise *(15 minutes)*

1. Randomly assign each group to one of the flipcharts, distribute markers, and ask them to start. Allow about 5 minutes for the first round of writing.
2. Then ask the groups to move to the next flipchart (give specific directions—e.g., move to the flipchart on your left). The following "rounds" should take less time, as there will be fewer words to add for each round. However, the participants will need time to read what is already entered on the flipchart.
3. After the last round is completed, ask the participants to return to their seats.

Activity C: Discussion *(10 minutes)*

Ask for different volunteers to read each column of each flipchart. Then facilitate a large-group discussion by asking:

* What was it like for you to hear and say these words?
* Which category had more terms—medical language or local slang? How do you explain that?
* Which local slang terms do you think you could use to communicate more effectively with clients? How would you do that?
* How could you respond if a client uses a term that you consider crude or inappropriate?
* How can this exercise help us to communicate better with clients?

Part B: Using Simple Language

Activity D: Introduction and instructions *(15 minutes)*

1. Explain that, besides needing to be able to bridge the gap between client and provider on sexuality-related words, providers need to be able to explain sexual and reproductive physiology and medical processes using simple, nonmedical terms. The purpose of this exercise is to give everyone a chance to practice the skills of giving simple explanations.
2. Ask the participants to open their handbooks and turn to Session 16. Find the explanations of sexual and reproductive anatomy and physiology and have the participants take turns reading each definition. Note that these are just guidelines: everyone will have their own way of saying things, but this is to show how simple the explanation can be.
3. Divide the participants into groups of three, with as much space as possible between the groups. Within each group, ask for a volunteer to be the first one to play the "provider" and another to be the "client." The third person will be an "observer." (The roles will be shifted for each of three role plays, so that by the end of this exercise each participant will have played each role.)
4. Explain that you will list several words on a flipchart, and that the "provider" will have 5 minutes to explain those words to the "client." Remind the participants that the "provider" needs to ask what the "client" already knows and to use local slang, as necessary, and the "client" can ask questions at any time.

Activity E: Small-group work *(15 minutes)*

1. Write the words *ovulation, sexual intercourse, conception,* and *contraception* on a flipchart in the front of the room. Ask the "providers" to start the role play.

> **➻ Training Tip**
>
> During the first role play, remember to move quickly from group to group, both to observe and to make sure that the instructions have been understood correctly. If one group is not following the instructions, correct them gently but immediately. If more than one group is confused, stop the role plays, explain the instructions again to all of the participants, and start over. If one participant in particular is having problems with the task, come back to that group after checking with the other groups, and provide additional guidance.

2. After 5 minutes, ask the "providers" to stop their explanations, whether they are finished or not. Ask the participants to switch roles.
3. Write the words *menstruation, miscarriage (spontaneous abortion),* and *induced abortion* on the flipchart and ask the new "providers" to begin.
4. After 5 minutes, stop the "providers" and ask the participants to switch roles again.
5. Write the words *sexually transmitted infection, discharge, oral sex,* and *anal sex* on the flipchart and ask the new "providers" to begin. Stop them after 5 minutes.

Activity F: Discussion *(10 minutes)*

Facilitate a discussion based on the following questions:

* What did you learn from this exercise?
* Which terms were the most difficult to explain? Why?
* Which terms were the easiest to explain? Why?
* Did the "providers" always check to see what the "clients" knew already, before beginning the explanation? What happened when they did not?
* Did you have enough time? How could you explain these terms in less time?
* How can you apply what you have learned in your work?

Session 17
Using Visual Aids to Explain Reproductive Anatomy and Physiology

Objectives

- To develop their own simple visual aids to use to explain the reproductive system to clients
- To explain the importance of being able to draw the reproductive system, even if they never do this with clients

Materials

- Overhead projector and preprinted transparencies of the male and female reproductive anatomy and physiology
- Plenty of writing paper and pencils

Advance Preparation

1. Copy the reproductive anatomy illustrations (Appendix J) onto transparencies.
2. Practice using the transparencies and explaining reproductive anatomy and physiology. You should be able to explain male anatomy and physiology in 15 minutes and female anatomy and physiology in 10 minutes. Refer to Session 16 in the Participant's Handbook (pages 76 to 78) for simple descriptions of anatomy and physiology to incorporate into your presentation.
3. Review Session 17 in the Participant's Handbook (page 79) for complete anatomy drawings and the relevant section from the Introduction for the Trainers (page xvii).
4. Make sure that the transparencies are in the correct order before starting the session

Time

45 minutes

Training Activities	Time
A. Pairs exercise	5 min.
B. Discussion	5 min.
C. Presentation/drawing	30 min.
D. Discussion	5 min.

Session 17 Detailed Steps

Activity A: Pairs exercise *(5 minutes)*

1. Hand out a blank sheet of paper to each participant. Make sure that all handbooks are closed.
2. Divide the participants into pairs. Ask each pair to use one sheet of paper to *draw* the external and internal reproductive anatomy for the man and the other sheet for the external and internal reproductive anatomy for the woman. Advise them to use pencils, if they have them.

> **➻ Training Tip**
>
> This simple exercise touches on a number of important issues for providers. Keep the following considerations in mind to make the most of this opportunity.
>
> - Expect a lot of nervous laughter when you ask the participants to draw the reproductive systems. This is normal, and good for the training, because it reflects how clients may feel when they see visual aids showing the reproductive system. However, this is also a serious exercise, with important learning objectives. It is important for the trainers to model acceptance and understanding of the laughter, but also to help the participants focus on the task and take it seriously.
> - Be careful about "dirty jokes." It is *very* easy to offend others and to seem disrespectful, particularly when teasing about the drawings. If joking and laughing seem to make some participants angry or withdrawn, gently turn it into a learning experience by pointing out how normal the joking is but by also asking how it might make clients feel.
> - Most medically trained participants will quickly tell you that they learned anatomy and physiology in their training and probably do not need this session. However, this session is not so much about what the participants *know*, but about their ability to *convey* what they know to others. This individual exercise is thus a gentle but humbling reminder for those participants that, while one may know some things in his or her head, it does not serve much purpose for the clients if he or she cannot explain this information clearly and simply.
> - Many participants will protest, "I am not an artist!" That is okay, as you are not asking them to be artists. In this session, they *will* learn how to make better drawings themselves or how to use existing materials more effectively. However, by drawing the reproductive systems themselves, the participants reinforce the mental learning process by using their hands *and* by creating
>
> *(continued)*

➻ Training Tip *(continued)*

their own visual representation. This will help them remember this information better and be more confident about explaining it to others, whether they use a drawing or not.

- Putting the participants in pairs is very important, as it allows both participants to laugh together about how little they remember from their previous training and about how awful their drawings are. Some participants will know more than others, and they will help each other to figure things out. Additionally, saying "this is *our* drawing" takes away the embarrassment of saying "this is *my* drawing." Finally, working together on it gives them practice in talking with another person about the parts of the body and processes that they usually discuss only in clinical terms (if at all).

Activity B: Discussion *(5 minutes)*

1. Ask the participants to hold up their drawings so that others can look around the room and see how everyone fared in the assignment.
2. Facilitate a discussion by asking:
   * What did you learn from doing this exercise?
   * Why did people laugh when they were doing this?
   * Did you learn about anatomy in your previous training? If yes, what was different about this approach?

Activity C: Presentation/Drawing *(30 minutes)*

1. Explain that you will now review basic reproductive anatomy and physiology, using simple drawings on transparencies. The participants will now work on their own, keeping their handbooks closed. Give each participant two blank sheets of paper and ask them to copy what they see on the transparency. Again, explain that this is not meant to make "artists" out of them, but to help them remember details of reproductive anatomy and better explain anatomy to clients. *(5 minutes)*
2. Present the transparency sheets in the correct sequence. Lay one transparency down, give the participants time to copy it, and then briefly explain what the parts are and how they work. Refer to the Participant's Handbook (Session 16) for a simple explanation of each organ and how it works.
3. Repeat the process with the next transparency. By laying them on top of each other, you start out simply and gradually build up to the complexity of the internal systems. You should need 15 minutes for male anatomy and physiology and about 10 minutes for female anatomy and physiology.

➸ Training Tip

In the trainer's set of transparencies, each one is a simple drawing showing a different aspect of the reproductive anatomy. (The male anatomy includes the bladder and urethra. These are not technically parts of the reproductive system, but need to be explained because the urethra is involved in ejaculation.) By using them in sequence, laying one on top of the others below, you can explain in a simplified, step-by-step manner the complexity of the internal organs and how they interconnect.

The participants have drawings of the complete systems in their handbooks. However, during the presentation, you will want them to follow along with the transparencies and draw the different parts (with their handbooks closed). This helps them to remember better and builds confidence in their ability to explain. Such an approach replicates a technique that has been used many times in vasectomy counseling trainings and in counseling trainings of trainers and has been found to be *very* effective. Experience has shown that after the exercise, the participants would often use breaks or other free time to work on their own anatomy charts.

You will need to be able to go through the transparencies in 15 minutes for the male anatomy and physiology and in 10 minutes for the female anatomy and physiology. (More time is allowed for the male because it is a little more complicated to draw and because the participants tend to be less familiar with the male reproductive systems than with the female reproductive systems.) Practice ahead of time to be sure you can do this, building in time for the participants to do their own drawings and for a few questions to be answered.

If an overhead projector is not available, the trainer can conduct this exercise by drawing the anatomy on flipcharts, in the same sequence that is used for the transparencies. Practice doing this so that you can do it quickly, but do not expect to be "perfect"; it is good for the participants to see that this can be done without being an expert artist.

Activity D: Discussion *(5 minutes)*

Facilitate a discussion based on the following questions.

- What did you learn in this session that you did not know before?
- How can you use what you have learned in your work?

Part IV

Helping Clients Assess Their Comprehensive SRH Needs and Providing Appropriate Information

In these sessions, participants begin applying attitudes and communication skills to carry out the counseling tasks that comprise the four general objectives for this training. Helping clients assess their own comprehensive SRH needs requires two-way communication between the client and the provider. The provider begins by asking appropriate questions; the client responds and the provider listens; the provider gives informtion that the client is lacking or corrects misinformation related to the client's needs; and then the provider helps the client consider how the information applies to him or her and his or her level of risk. This crucial phase of counseling thus is a combination of the first two general objectives—helping clients assess their need for a range of SRH services, information, and emotional support, and providing information appropriate to their problems and needs.

Session 18
Introducing the Subject of Sexuality with Clients

Objectives

- To be able to explain to clients why they will be discussing sensitive and personal issues in their counseling, such as STIs and sexual relationships and behaviors
- To list key points to cover with clients to help put them at ease in these discussions

Materials

None needed

Advance Preparation

Review Session 18 in the Participant's Handbook (page 85).

Time

45 minutes

Training Activities	Time
A. Introduction/brainstorm	5 min.
B. Discussion	15 min.
C. Role plays/discussion	15 min.
D. Demonstration role play, feedback, and summary	10 min.

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Session 18 Detailed Steps

Activity A: Introduction/brainstorm *(5 minutes)*

1. Note that to introduce the discussion of sexuality issues in a counseling session, the provider must overcome both his or her own nervousness and the client's possible embarrassment in response. Having a structured approach to beginning the discussion will both increase the provider's confidence and ensure that key issues of concern to clients are addressed. The provider must remember, however, that it is his or her responsibility to initiate these discussions and to put the client at ease.
2. Ask the participants:
   * How can providers introduce the subjects of sexuality, HIV and STIs, sexual relationships, and sexual behaviors in a way that puts clients at ease?
3. Encourage three to four responses. (Since you will be referring quickly to the Participant's Handbook, do not write their answers on the flipchart.)

Activity B: Discussion *(15 minutes)*

Refer the participants to Session 18 in their handbooks. Discuss each key point to cover with clients. For the examples, ask:

* How would you say this to clients in your own service setting?

Activity C: Role plays/discussion *(15 minutes)*

1. Divide the participants into pairs. Explain that the participants will role-play being the provider and introducing the subject of sexuality to a client, following the guidelines in the handbook. The participant in the client role will choose one of the client profiles as his or her role. They will have only 2 minutes for each role play and then will switch roles, with the new "client" choosing a new profile.
2. Before starting the first role play, check to see that each pair has identified who will be the "provider," who will be the "client," and which profile the "client" is playing. (It is okay for more than one group to role-play the same client profile at the same time.) *(5 minutes)*
3. Ask the participants to start their role play. Stop them after 2 minutes. Allow for 1 minute between role plays, to let the new "client" choose a different profile. Announce the time for the new role plays to start. Stop them after 2 minutes. *(5 minutes)*
4. Briefly request feedback from the participants by asking: *(5 minutes)*
   * How did it feel to play the role of the provider?
   * How did it feel to play the role of the client? What did you observe about the "provider's" body language and mannerisms as he or she explained the need to ask questions about your sexual life?

Activity D: Demonstration role play, feedback, and summary *(10 minutes)*

1. From your observations during the practice role plays, select one pair to demonstrate how to introduce the subject of sexuality to a client. *(2 minutes)*

2. Ask the rest of the participants to give feedback on the role play by asking:
   * What was going on between the "provider" and the "client"?
   * What did the "provider" do that was effective in this situation?
   * What might the "provider" consider doing differently next time?
3. Summarize the session by reviewing any of the Essential Ideas from the Participant's Handbook that were *not* covered during the feedback. Emphasize that it is the provider's responsibility to be comfortable enough to introduce the subject of sexuality and to help the client feel comfortable about responding to questions.

Session 19
The Risk Continuum

Objectives

- To identify risk for pregnancy, transmission of HIV, and transmission of other STIs for various practices
- To explain how one behavior can be high-risk for one condition and low-risk for another
- To identify ways to lower the risk for some behaviors
- To explain in simple terms which behaviors put people at risk for pregnancy, HIV, and other STIs

Materials

- White letter-size paper
- Three different colors of cards or paper
- Scissors
- Pens and markers
- Tape

Advance Preparation

1. Review Session 19 in the Participant's Handbook (page 89) for background on the risk continuum and on factors that influence risk.
2. Review the Training Tip for Activity B, and decide how you want to distribute the behavior cards.
3. Prepare four risk-level cards, using white letter-size cards or paper, with the following titles: "No Risk," "Low Risk," "Medium Risk," and "High Risk."
4. Prepare behavior cards using colored paper or cards; these cards should be about half the size of a sheet of letter-size paper. Each behavior will be written on *three* cards, with one card labeled "Pregnancy Risk," the second one labeled "HIV Risk," and the third labeled "STI Risk." Try to use one color of paper for all of the "Pregnancy Risk" cards (e.g., blue), a different color for all of the "HIV Risk" cards (e.g., yellow), and a third color for all of the "STI Risk" cards (e.g., pink). (See Trainers' Tool, page 107, for the behaviors and for details on preparation of the cards.)
5. Post the risk-level cards high on a wall, with plenty of space between each card and plenty of space below them for participants to post the behavior cards. Place the cards in the order shown below, to create a continuum from no risk to high risk.

No Risk	Low Risk	Medium Risk	High Risk

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6. Make sure that the space in front of the wall is cleared so the participants have enough room to move around as they post the behavior cards.
7. Prepare enough small pieces of tape in advance so the participants will be able to stick cards or pieces of paper to the wall quickly.

Time

1 hour

Training Activities	Time
A. Introduction	5 min.
B. Large-group exercise	20 min.
C. Discussion	30 min.
D. Summary	5 min.

Note: This session is adapted from: EngenderHealth, 2002.

Session 19 Detailed Steps

Activity A: Introduction *(5 minutes)*

1. Explain to the participants that, having already focused on the attitudes and communication skills necessary for effective counseling, in this next section of the training the group will consider the information needed by clients and providers, to help clients assess their own comprehensive SRH needs.
2. Explain that much of what happens in helping clients to explore their own needs is about helping clients to accurately perceive their own risk—whether for unintended pregnancy, STIs, or pregnancy complications—so they can make decisions that will reduce their level of risk. The concepts of risk and risk reduction pose a challenge to providers and clients alike. One reason is confusion about the facts of HIV and STI transmission and conception. Another is that the same behavior may be "risky" in one situation and yet not risky in another, or risky for pregnancy but not risky for HIV and STIs (and vice versa). This session tries to clarify the various levels of risk from different behaviors and for different outcomes.
3. Conduct a quick brainstorm: Ask the participants to describe, in simple terms, the behaviors that put people at risk for pregnancy, for STIs, and for HIV. (Hold no discussion at this point.) Explain that they will return to these concepts at the end of the session.

Activity B: Large-group exercise *(20 minutes)*

1. Make sure that the Participant's Handbooks are closed. Distribute all of the behavior cards to the participants, trying to ensure that each participant has the same number of cards.
2. Explain that each card has a risk label (pregnancy, HIV, or STI) *and* a behavior. The participants must determine what level of risk that behavior poses for pregnancy, HIV transmission, or STI transmission (whichever is written on the card). (*Note:* The "STI Risk" cards refer to risk for transmitting STIs *other than* HIV.) For example, if a card says "Pregnancy Risk" and "Masturbation," they must determine the level of risk that masturbation poses for pregnancy, using the four risk-level categories ("No Risk," "Low Risk," "Medium Risk," or "High Risk").
3. Point out the risk-level cards placed on the wall. Once the participants have determined the risk level for a behavior and a condition, they should go to the wall and, using the tape provided, place each of their cards on the wall, under the sign for that level of risk.

> **➻ Training Tip**
>
> ***Working individually or in pairs (teams)***
> This exercise can be conducted with individual participants placing the cards, or in pairs or small teams. If the participants are already knowledgeable on this subject, working individually is fine. However, if the participants do not know much in this area, there are advantages to putting two or more participants together, as they will
>
> *(continued)*

➻ Training Tip *(continued)*

Working individually or in pairs (teams) (continued)

have to justify to each other the placement of the cards, pooling their knowledge. Greater learning happens when the participants discuss these issues among themselves prior to hearing "the answer" from the trainer. Additionally, individual participants will not feel so awkward about having misconceptions about this subject if they can see that their colleagues are also confused.

Distribution of cards

The exercise's purpose is to clarify the participants' thinking about different types of risky behavior and how to explain this clearly to clients. Two options give you a slightly different approach for achieving that purpose.

Option A: The basic issues of risks for pregnancy, HIV, and STIs would be reinforced most effectively by giving each participant (or "team") a set of three cards *with the same behavior* and then having them decide the level of risk for that one behavior for pregnancy, HIV, or some other STI.

Option B: If the group is somewhat knowledgeable in these areas, it would be more challenging to mix the cards and distribute them randomly.

When participants get "stuck"...

For some of these cards, there is no "right" answer. The placement of the behavior in a risk category depends on many factors, such as whether either partner is infected (for HIV and STI risk), whether it is the fertile time of the woman's cycle (for pregnancy risk), or whether the spouse tells the truth about not having other relationships. So it is absolutely correct for the participants to say "it depends..." when trying to figure out where to place their card. The trainer should encourage the participants to do their best with the information (or lack thereof) that is given on the card. If that becomes too frustrating, the trainer can suggest that the participants write on the card to add the information they need to place it in a particular category. Encouraging this kind of thinking is precisely the goal of this exercise—to understand the basic factors of risk *and* the necessity of individualizing that information to each client's unique situation.

Activity C: Discussion *(30 minutes)*

1. Once all cards are placed, read the cards in each category, beginning with "No Risk," and ask:
   * Do you have questions about the placement of any behaviors in this category? Where do you think they should go and why?
2. Allow the participants to answer each other's questions whenever possible and to share their knowledge of the relative risks of various behaviors. Affirm accurate responses and correct any misconceptions that do not get resolved in discussion among the participants. Place the cards in their correct categories if they have been incorrectly placed.

> **➻ Training Tip**
>
> The purpose of the discussion is to explore all of the different conditions that can change the risk level of a behavior. Emphasize that "it depends..." is the right answer most of the time. (This applies to the table in the Participant's Handbook as well.) When there is disagreement about the placement of a card, encourage the participants to explain how they decided the risk level for those behavior cards.
>
> Sometimes the participants place behaviors that they find offensive in the "high risk" category, even if they present little risk for pregnancy or infection. If this happens in your group, recall how attitudes and judgments can influence a provider's assessment of risk in a client's behavior.
>
> ***Referring to the continuum in the Participant's Handbook***
> If participants have very little knowledge in this area, another option for discussion would be to refer them to the risk continuum table in their Participant's Handbook. Then they could compare their own placements of behaviors with what is shown in the table, and discuss the differences. However, once you do this, you will lose some of their focus for discussion, since many participants will be more focused on reading than on listening and thinking.
>
> If at all possible, it would be best to help them think through these issues on their own, and refer them to the continuum at the end of the session. You may want to schedule time later (during the warm-up or wrap-up) for questions related to the continuum.

3. After reviewing the categories, ask the following questions about the whole continuum (refer to the Participant's Handbook for possible responses):
   * Why are some behaviors found in both "no risk" and "high risk" categories?
   * How does the relationship between two individuals affect their level of risk for some behaviors?
   * How can some behaviors be moved to a lower level of risk?

Activity D: Summary *(5 minutes)*

1. Ask the participants again:
   * How would you explain to clients which behaviors put people at risk for pregnancy?
   * How would you explain to clients which behaviors put people at risk for STI transmission?
   * How would you explain to clients which behaviors put people at risk for HIV transmission?
2. Turn to Session 19 in the Participant's Handbook and review with the group the risk summary statements from the Essential Ideas. Point out the risk continuum table (if you have not done so already); suggest that they review it on their own, and offer to answer further questions related to the continuum at a later time in the training, as a follow-up to this exercise.

Trainers' Tool

SRH Risk Continuum: Sample Behavior Cards

Behaviors

- Abstinence
- Masturbation
- Vaginal sex using a condom
- Anal sex using a condom
- Oral sex on a man
- Oral sex on a woman
- Deep (tongue) kissing
- Anal sex without using a condom
- Sitting on a public toilet seat
- Unprotected vaginal sex with your spouse
- Rubbing genitals together without penetration, unclothed
- Unprotected vaginal sex with a monogamous, uninfected partner
- Vaginal sex with multiple partners, always using a condom

Make three cards for each behavior—one for each area of risk. If possible, make all of the risk cards the same color (e.g., all of the pregnancy risk cards would be blue, all of the HIV risk cards yellow, and all of the STI risk cards pink).

Example:

PREGNANCY RISK
UNPROTECTED VAGINAL SEX WITH A MONOGAMOUS, UNINFECTED PARTNER

HIV RISK
UNPROTECTED VAGINAL SEX WITH A MONOGAMOUS, UNINFECTED PARTNER

STI RISK
UNPROTECTED VAGINAL SEX WITH A MONOGAMOUS, UNINFECTED PARTNER

Risk Continuum for Pregnancy, HIV, and Other STIs

	No risk	Low risk	Medium risk	High risk
Pregnancy	• Abstinence • Masturbation • Oral sex on a man • Oral sex on a woman • Deep (tongue) kissing • Anal sex using a condom • Anal sex without using a condom	• Vaginal sex using a condom • Rubbing genitals together without penetration, unclothed • Vaginal sex with multiple partners, always using a condom		• Unprotected vaginal sex with your spouse • Unprotected vaginal sex with a monogamous, uninfected partner
HIV	• Abstinence • Masturbation • Sitting on a public toilet seat • Unprotected vaginal sex with a monogamous, uninfected partner	• Vaginal sex using a condom • Deep (tongue) kissing • Rubbing genitals together without penetration, unclothed • Vaginal sex with multiple partners, always using a condom	• Anal sex using a condom • Oral sex on a man • Oral sex on a woman	• Anal sex without using a condom • Unprotected vaginal sex with your spouse
Other STIs	• Abstinence • Masturbation • Sitting on a public toilet seat • Unprotected vaginal sex with a monogamous, uninfected partner	• Deep (tongue) kissing • Vaginal sex with multiple partners, always using a condom		• Oral sex on a man • Oral sex on a woman • Vaginal sex using a condom • Anal sex using a condom • Anal sex without using a condom • Unprotected vaginal sex with your spouse • Rubbing genitals together without penetration, unclothed

Note: This continuum can change depending on social and individual factors, such as involvement with other partners (for HIV and STI risk) or whether the woman is in her fertile time (for pregnancy risk), among others.

Session 20
Exploring the Context of Clients' Sexual Relationships

Objectives

- To explain why we need to ask questions about clients' sexual relationships
- To list at least three questions that participants can use to help clients explore their sexual lives, including social context and the circumstances under which they have sexual intercourse

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Review Session 20 in the Participant's Handbook (page 93).
2. Review REDI—Phase 2: Exploration, with a focus on steps for this session (reproduced in the Trainers' Tool, page 114).
3. Prepare three flipcharts with the headings for the areas to explore with clients ("Sexual Relationships," "Communicating with Partner," and "Partner's Other Relationships").

Sexual Relationships	Communicating with Partner	Partner's Other Relationships
Questions from the framework: • What sexual relationship(s) are you in? • What is the nature of your relationship (including violence or abuse)? • How do you feel about it?	**Question from the framework:** • How do you communicate with your partner about sexuality, family planning, and HIV and STIs?	**Question from the framework:** • What do you know about your partner's sexual behaviors outside your relationship?
Questions you could ask your clients:	**Questions you could ask your clients:**	**Questions you could ask your clients:**

4. For Activity B, think of one sample question for each category that would be easier for providers to ask their clients, given the social and cultural norms of their community. (See the Trainers' Tool, page 113, for some ideas. These will differ from one culture and community to the next.)

Session 20

Time

45 minutes

Training Activities	Time
A. Instructions	10 min.
B. Small-group work	15 min.
C. Plenary/discussion	20 min.

Session 20 Detailed Steps

Activity A: Instructions *(10 minutes)*

1. Ask the participants to turn to Session 8 in their handbooks and find Phase 2: Exploration in the detailed description of REDI. Refer them to Step 1, and the second bullet, "Explore the context of clients' sexual relationships."
2. Ask:

   * Why is it necessary to explore these areas of a client's personal life?

   (Responses should be close to what is contained in the session's Essential Ideas, on page 93 of the Participant's Handbook.)
3. Explain that the questions given in the REDI framework are a summary for providers: these are *not* necessarily the questions that they would actually use in counseling. The questions need to be restated in simpler language and in a way that would be acceptable to providers *and* clients in their own communities. The purpose of this session is to draft questions that they would feel comfortable asking a client and that would elicit the information needed to help the client accurately assess his or her risk for SRH problems.
4. Remind the participants about Session 18 (Introducing the Subject of Sexuality with Clients). Note that in the counseling session, they would have already identified the reason for the client's visit and introduced the subject of sexuality. Also, for the purpose of this session, they should assume that they would already have asked what the client knows about his or her situation, concerns, and desired outcome from this visit (Exploration, Step 1, first bullet). Now they are ready to ask some of the more sensitive questions about sexual behaviors and relationships.

Activity B: Small-group work *(15 minutes)*

1. Divide the participants into three groups. Distribute the flipcharts with the headings of the areas to explore.

> **➻ Training Tip**
>
> If the groups are too large (i.e., more than five participants per group), split the participants into six groups and assign two groups to each heading. They can record their questions on notepaper, and then a trainer can write them on the flipchart during the plenary. It may also prove interesting to compare the questions from the two groups.

2. Read the sample question that you developed for each flipchart heading. Ask for comments and improvements—that is, how to make the question more acceptable to both the provider and client in their own clinic settings. Explain that you want them to draft questions that they would feel comfortable asking a client and that would elicit the information needed for their assigned flipchart. Note that if they feel they could ask the question(s) already written

on the flipchart, this is fine, but that they should also add more questions, in case the clients do not understand.

3. Explain that they will have about 10 minutes to draft their questions and write them on the flipchart. Ask them to start.
4. Quickly visit each group to check that they understand the assignment and see if they have any questions.

Activity C: Plenary/discussion *(20 minutes)*

1. Have the first group (sexual relationships) post their flipchart and read the questions they drafted. Ask for comments or additions from the others. Add, as appropriate, from the Trainers' Tool (opposite) for this activity. Have each group present their questions in this way. *(15 minutes)*
2. Ask the participants:
   - How do you think clients would feel about your asking these questions?
   - What could you do to make the client more comfortable?
3. Note to the participants that, in a table for this session in their handbooks, they can fill in some of the questions that the teams drafted for this exercise.
4. Also note that in Session 14 (Asking Open-Ended Questions), they drafted questions to ask clients about their history, current health status, and concerns in specific areas of SRH. Combined with the questions developed in this session, they now have sample questions for all of the bulleted items in Step 1 of Exploration.

Trainers' Tool

Sample Questions to Explore the Context of a Client's Sexual Relationships

Questions from the REDI framework	Questions you could ask your clients
• What sexual relationships are you in? • What is the nature of your relationship (including violence or abuse)? • How do you feel about it?	[Confirm marital status. If not married, ask:] • Are you with somebody now? • How long have you been with this man or woman? [If married] • Is this your first marriage? [For all clients:] • What decisions can you make in your current relationship? • How many children do you have? • Are they all from the same father/mother? • How does he or she treat you? • How do you feel about that?
• How do you communicate with your partner about sexuality, family planning, and HIV and STIs?	• How do you talk about family planning with your partner? • If you do not talk with him or her, why not? • How do you talk about sex with your partner? • If you do not talk with him or her, why not? • How do you talk about HIV and STIs with your partner? • If you do not talk with him or her, why not?
• What do you know about your partner's sexual behavior outside of your relationship?	• How do couples deal with outside relationships in your community? • What do you know about your partner's outside relationships (if any)? • How do you feel about that? • Does he have other wives? [depending on the culture] • What do you know about signs of STIs? [If nothing, then briefly explain.] • Have you ever noticed anything like these signs in your partner? What about you?

Trainers' Tool

REDI—Phase 2: Exploration

1. Explore the client's needs, risks, sexual life, social context, and circumstances

- Assess what the client understands about his or her SRH condition or situation, what worries or concerns he or she might have, and what he or she specifically hopes to accomplish through this visit.
- Explore the context of the client's sexual relationships:
  - ➤ What sexual relationships is he or she in, what is the nature of the relationships (including any violence or abuse), and how does he or she feel about it?
  - ➤ How does he or she communicate with partners about sexuality, family planning, and HIV and STIs?
  - ➤ What does he or she know about his or her partners' sexual behavior outside of the relationship?
- Explore the client's pregnancy history and knowledge of and use of family planning methods, including condoms.
- Explore the client's HIV and STI history, present symptoms, and knowledge of partners' HIV and STI history.
- Explore other factors about the client's circumstances that may limit his or her power or control over decision making, such as financial dependence on partners, tensions within an extended family, and fear of violence, among others.

2. Assess the client's knowledge and give information, as needed (will be covered in Session 21)

3. Assist the client to perceive or determine his or her own pregnancy or HIV and STI risk (will be covered in Session 22)

Session 21
Information-Giving in Integrated SRH Counseling

Objective

- To identify basic information that clients need about SRH, regardless of the service that they request

Materials

- "New development" cards

Advance Preparation

1. Prepare "new development" cards for each client profile, to ensure that each one has a secondary SRH problem that needs to be addressed. These will be given out at the beginning of the session (see Training Tip, page 117, bottom).
2. Decide how the participants should be divided and profiles assigned (see Training Tip, page 116, bottom).
3. Review REDI—Phase Two: Exploration, Step 2 (see Trainers' Tool, page 119).
4. Review Session 21 in the Participant's Handbook (page 95) and background materials on each SRH service area (Participant's Handbook, Appendixes A to D). Prepare a presentation on "Key Messages in Integrated SRH Counseling" (Activity B), based on the table in the Participant's Handbook.
5. Prepare and copy any materials specific to the health needs of the country or community in which the participants are working, to use as additional handouts.
6. Locate the wallchart entitled: "Do you know your family planning choices?" (JHU/CCP, USAID, & WHO, 1999), and obtain enough copies so you have at least one for each participant.

Time

1 hour, plus 5 minutes of preparatory activity (preferably the day before this session)

Training Activities	Time
Preparatory activity	5 min.
A. Introduction	5 min.
B. Presentation	30 min.
C. Small-group work	25 min.

Session 21 Detailed Steps

Preparatory activity *(5 minutes)*

The day before this session is to be conducted:

1. Explain that the next day's sessions will involve the "client profiles" that were developed on the first day. Specifically, the client's knowledge and need for additional information in a variety of SRH areas will be assessed. Explain that they will have some time to prepare as a group before demonstrating for the large group in a practice role play (Session 23).

> **Training Tip**
>
> The agenda shows Session 21 as being part of Day 4 activities. If at all possible, client profiles should be assigned and "new development" cards distributed at the end of the preceding day (Day 3). In residential trainings, this would give the participants the opportunity to work together during the evening. However, if this is not possible, you may want to alert the participants at the beginning of the course to use any available time to review the basic background materials on SRH. They will have 1 hour total to work together on Day 4, but that will not be enough time to review the materials in any depth.

2. Divide the participants into five groups and assign each group a client profile.

> **Training Tip**
>
> This is the first of five sessions in which groups of participants will be assigned to practice counseling tasks and skills using client profiles. There are three options for how to organize this group work: keeping the same group of participants working with the same client profile throughout the course (Option 1), keeping the same group of participants, but changing the client profile (Option 2), or randomly assigning participants to profiles, changing with each day (Option 3). The trainer should decide how to organize the group work now, to avoid confusion later in the training.
>
> ***Option 1: Same Participants, Same Client Profile***
> This is the easiest format logistically, because the counseling practice will be broken down into sequential steps and each practice role play will continue where the previous one left off. In this way, the participants benefit from getting to know one client's situation very well. Also, although the participants get less "exposure" to the different client situations and less opportunity to learn from other participants, they will be able to observe all of the "clients" during practice role plays during and at the end of the training and will be able to learn from the other participants in other group work.
>
> *(continued)*

➻ Training Tip ***(continued)***

Option 2: Same Participants, Different Profiles
The benefit of this approach is that participants become familiar with the different client profiles and the issues that need to be addressed in counseling. It could be time-consuming to bring a new group of participants up-to-date on each "new" client each time they are assigned to a new profile. However, the time and confusion can be minimized if the participants keep the same profile for each day of the training. For example, they would be in one "client" group on Day 1, when they develop the profiles; they could then receive a different profile for Day 4 (the sessions on rapport-building and exploration), another one for Day 5 (the sessions on decision making and implementing the decision), and yet another—and possibly two—for the final counseling practice (Days 5 and 6).

Option 3: Different Participants, Different Profiles
Assigning participants to different groups and different client profiles each day allows for the maximum exposure to information and ideas. However, it will be the most confusing logistically. This option would probably work best when participants have had some counseling training and are experienced in at least one area of SRH.

3. Distribute the "new development" cards and explain that the participants now need to consider this new situation as part of the client's profile.

➻ Training Tip

Many of the client profiles may have been developed to focus on one SRH need. However, the participants need to be aware that each client can have several SRH needs at the same time. For that reason, the trainer should consider each client profile and write a "new development" card. This will describe either something that has happened to the client or new information that the client is sharing with the provider revealing an additional SRH need that must be addressed (see Introduction for Trainers, page xxiii).

4. Ask the participants to use whatever time is available between now and the next day to review Session 21 and the SRH background information in their handbooks (Appendixes A to D). They should identify which points should be covered with their assigned "client" and which points should be covered with *every* client, regardless of their SRH condition or need. (This corresponds with Step 2 of the Exploration Phase of REDI, and with Assess and Tell in GATHER.)

3. ***Warning!*** In counseling, there is never enough time to cover *all* of the information about *all* areas of SRH that affect a client. The key task here is to ask questions to determine which areas to focus on in *this* counseling session and which pieces of information the client needs the most. They will have only 10 minutes for their role plays on rapport-building *and* exploration (Session 23), but even that is more than some providers have for the entire counseling session.

Trainers' Tool

REDI—Phase 2: Exploration

1. **Explore the client's needs, risks, sexual life, social context, and circumstances (covered in Session 20)**

2. **Assess the client's knowledge and give information, as needed**
   - Assess the client's knowledge of pregnancy-related care (if appropriate), postabortion care (if appropriate), family planning, HIV, and STIs
   - Correct misinformation and fill in gaps, as needed

3. **Assist the client to perceive or determine his or her own pregnancy or HIV and STI risk (will be covered in Session 22)**

Session 22
Risk Assessment—
Improving Clients' Perception of Risk

Objectives

- To define *risk assessment* and explain why and how it is used in counseling
- To identify three reasons why it is difficult for people to perceive their own risks
- To describe two ways in which they can help clients perceive and understand their own risks for HIV and STI transmission and for unintended pregnancy

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Review Session 22 in the Participant's Handbook (page 97) for presentation guidelines (Activity B), plus Step 3 of the Exploration phase of REDI, with a focus on steps for this session (see Trainers' Tool, page 123).
2. Prepare a flipchart with the definition of risk assessment and why we do it (Activity A), found in the Participant's Handbook (page 98).
3. Prepare a flipchart with the six reasons why clients underestimate their risk (Activity B), found in the Participant's Handbook (pages 98 to 99).

Time

45 minutes

Training Activities	Time
A. Introduction	5 min.
B. Presentation/discussion	20 min.
C. Discussion	20 min.

Note: This session is adapted from: EngenderHealth, 2002.

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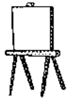
Session 22 Detailed Steps

Activity A: Introduction *(5 minutes)*

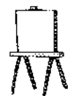
1. Explain to the participants that, having discussed different categories of risk and the behaviors and social factors that influence risk (Session 19), it is time to focus on the provider's role in helping the client to assess his or her own risk.
2. Ask the participants:
   * What does risk assessment mean to you?



3. After getting a couple of responses, post the flipchart with the definition of risk assessment and briefly explain it.

Activity B: Presentation/discussion *(20 minutes)*

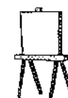
1. Explain that most people generally underestimate their own risks in life, and that this includes risks for transmission of HIV and STIs and for unintended pregnancy. Ask the participants to give a few reasons why people have difficulty in perceiving their risks for SRH problems.



2. Post the flipchart with the six reasons why clients underestimate their risk. Briefly explain each reason.
3. Facilitate a brief discussion by asking the following questions. (See the Participant's Handbook for possible responses.)
   * Why is a client's perception of his or her own risk so important?
   * Considering the reasons why clients underestimate their risk, which reasons apply to our "profiled" clients? Why?

Activity C: Discussion *(20 minutes)*

1. Ask the participants to refer to Session 8 (REDI—Phase 2: Exploration, Step 3), on page 34 of their handbooks ("Assist the client to perceive or determine his or her own pregnancy or HIV and STI risk"). In the large group, ask them to brainstorm how they would actually ask the questions in the first two bullets.



2. Discuss each suggestion briefly to see if people agree with the questions, and then write them on a flipchart.
3. Using one of the client profiles as an example, note that we should assume that the client has answered "no" to the first two questions, but that you know he or she is indeed at risk. Ask the participants:
   * How would you explain the risks of HIV or STI transmission and unintended pregnancy to this client?
   * What questions could you ask to help the client relate these risks to his or her own situation?
4. To summarize, ask the participants the following question. (Refer to the "Discussion Summary" in the Participant's Handbook, pages 99 to 100, for possible points to cover.)
   * What are some of the ways in which providers can help clients perceive and understand their own risks?

Trainers' Tool

REDI—Phase Two: Exploration

1. Explore the client's needs, risks, sexual life, social context and circumstances (covered in Session 20)

2. Assess the client's knowledge and give information, as needed (covered in Session 21)

3. Assist the client to perceive or determine his or her own pregnancy or HIV and STI risk

- Ask the client if he or she feels at risk for unintended pregnancy or for HIV and STI transmission, and explore why or why not
- Ask the client if he or she thinks that his or her partners may be at risk for unintended pregnancy or HIV and STI transmission, and explore the reasons
- Explain HIV and STI transmission and pregnancy risks (as necessary), relating them to the individual sexual practices of the client and his or her partners
- Help the client to recognize and acknowledge his or her risks for HIV and STI transmission or unintended pregnancy

Session 23
Counseling Practice I

Objectives

- To demonstrate the Rapport-building step of REDI (or the Greet step of GATHER)
- To demonstrate how to use open-ended questions to explore the client's needs, risks, sexual life, social context, and circumstances (REDI—Phase 2: Exploration, Step 1; or GATHER: Assess)
- To demonstrate how to assess the client's knowledge and to give information to fill gaps, as needed (REDI—Phase 2: Exploration, Step 2; or GATHER: Assess and Tell)
- To demonstrate how to help the client to perceive his or her own risk for HIV and STI transmission or unintended pregnancy (REDI—Phase 2: Exploration, Step 3; or GATHER: Assess and Tell)

Materials

- Pamphlets, educational flipcharts, sample family planning methods, and any other "props" for the role plays
- Flipchart paper, markers, and tape
- Flipcharts with all of the client profiles, posted where the participants can see them

Advance Preparation

1. Review Session 23 in the Participant's Handbook (page 101).
2. Review Sessions 8 (page 31) and 18 (page 85) from the Participant's Handbook, to prepare for demonstrating the Rapport-building phase of REDI.
3. Develop a client profile to be used for demonstration role plays throughout the rest of the workshop (the "sixth client").
4. Prepare a flipchart with the "sixth client" profile.
5. Prepare a flipchart with feedback guidelines for the role plays (see Trainers' Tool, page 128).
6. Prepare the room for demonstration role plays. This might include setting up a table and chairs for a counseling space, and being sure that all participants will be able to both see and hear the demonstration, as well as arranging flipcharts, clinic supplies, pamphlets, and other "props" that make the space look more like a counseling setting.

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Session 23

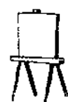
Time

2 hours, 30 minutes

Training Activities	Time
A. Demonstration role play/feedback	30 min.
B. Small-group work	35 min.
C. Practice role plays (10-min. role play, plus 5-min. discussion, performed five times)	1hour, 15 min.
D. Discussion	10 min.

Session 23 Detailed Steps

Activity A: Demonstration role play/feedback *(30 minutes)*



1. Post the flipchart entitled "Guidelines for Feedback after Role Play" and briefly discuss.
2. Explain that the training team will first conduct a demonstration role play for the Rapport-building and Exploration phases of REDI (or for Greet, Assess, and Talk for GATHER). Then, each "client" group will do a role play for the same phases.

3. Post the flipchart and share the "sixth client" profile with the participants.
4. Introduce the "client," the "provider," and any other players. *(10 minutes, total)*
5. Conduct the role play. As much as possible in this role play, use the questions developed by the participants in the previous sessions. *(10 minutes)*
6. Ask the participants for feedback, following the posted guidelines. *(10 minutes)*

Activity B: Small-group work *(35 minutes)*

Ask the participants to return to their client groups and prepare briefly to conduct a role play with their client. They will demonstrate the rapport-building and exploration phases of REDI that they have developed in the preceding sessions. They will have 10 minutes for the role play and 5 minutes for feedback.

Activity C: Practice role plays *(1 hour, 15 minutes)*

1. Ask one group to volunteer to go first. Briefly review the flipchart of the client profile for this group. Introduce the "provider" and the "client." Start the role play.
2. Stop the role play after 10 minutes. Spend 5 minutes discussing the role play, following the first two bullets of the feedback guidelines.
3. Repeat for the other four client groups.

> **➻ Training Tip**
>
> Following standard rules of feedback is important for keeping the discussions positive and is helpful for all of the participants (see Trainers' Tool, page 128). You may want to review these points, depending on how familiar the participants are with this training methodology.

Activity D: Discussion *(10 minutes)*

1. Facilitate a brief discussion around the following question:
   * What more do you [all participants] need to work on—knowledge, attitudes, or skills—to carry out these steps of counseling?

2. Note the participants' responses on a separate flipchart; this may provide you with guidance for further work during the training or during follow-up.

Trainers' Tool

Guidelines for Feedback after Role Plays

- [Ask the "client"] How did you feel during the role play? How were your needs met (or not)?
- What did the "provider" do well? What improvements would you suggest?
- What communication skills did the "provider" use?

Part V

Assisting Clients in Making Their Own Voluntary and Informed Decisions

At times, assisting clients in making voluntary and informed decisions may be a matter of confirming a decision that the client made before he or she even entered the clinic. In other instances, this may involve helping the client consider certain issues and weigh several options to reach his or her decision. While a provider's objective may be to help individuals make their decision, often the decision-making process is heavily influenced by gender expectations in the client's social setting or by power imbalances in personal relationships that may limit the client's decision-making capacity. Counseling can and should address all of these factors.

Session 24
Gender Roles

Objectives

- To define *gender* and *gender roles*
- To describe how gender roles can affect communication between SRH clients and providers and between clients and their partners
- To describe how gender roles can have a negative impact on SRH

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Review Session 24 in the Participant's Handbook (page 105).
2. Prepare two flipcharts, one with the heading "Act Like a Man" and the other titled "Act Like a Woman." Draw a large box on each paper, with enough room to write messages both inside and around the margins of the boxes.

Time

50 minutes

Training Activities	Time
A. Discussion	5 min.
B. Brainstorm	10 min.
C. Discussion	10 min.
D. Brainstorm	10 min.
E. Discussion	10 min.
F. Summary	5 min.

Note: This session is adapted from: EngenderHealth, 2000.

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Session 24 Detailed Steps

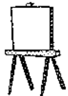
Activity A: Discussion *(5 minutes)*

1. Ask the participants if they have ever been told to "act like a man" or "act like a woman." Ask them 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?

> **➻ Training Tip**
>
> In some cultures, "act like a woman" does not have the same social meaning for women as "act like a man" does for men. If this is the case in your setting, try using "act like a lady" for the heading.

2. Tell the participants that this session will look more closely at these two phrases. Doing so will allow them to begin to see what messages we receive about being either male or female.

Activity B: Brainstorm *(10 minutes)*



1. Post the flipchart entitled "Act Like a Man." Ask the participants to share their ideas about what this means. These are society's expectations of how men should act and what men should feel and say. Write their comments inside the box.

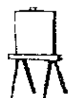
> **➻ Training Tip**
>
> Another way of conducting this activity is to ask small groups to prepare their own flipcharts and then share the results with the others. If there are enough men to make their own group, it can be very interesting to have them do their own versions of the male and female gender-role boxes, to compare these with comparable gender-role boxes prepared by groups of female participants.

2. If necessary, ask the following questions, to include expectations about sexual behaviors in the box.
   - ✱ What messages are given to men about engaging in sexual activity?
   - ✱ What messages are given to men about taking risks?
   - ✱ What messages are given to men about what to do when they are in pain or need help?
   - ✱ What messages are given to men about violence?
3. After completing the messages *inside* the box, ask the participants:
   - ✱ How are men treated when they try to act "outside of the box"?
   - ✱ What names are men called when they act "outside of the box"?
4. Write these names in the margin *outside* of the box.

Activity C: Discussion *(10 minutes)*

1. Explain that society uses these names to keep men inside this gender box.
2. Start a discussion by asking:
   * 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 SRH?
   * How do gender roles affect the interaction between a male client and a female provider?

Activity D: Brainstorm *(10 minutes)*



1. Post the flipchart entitled "Act Like a Woman." Ask the participants to share their ideas about what this means. These are society's expectations of how women should act and what women should feel and say. Write their comments inside the box.
2. If necessary, ask the following questions, to include expectations about sexual behaviors in the box.
   * What messages are given to women about engaging in sexual activity?
   * What messages are given to women about being assertive?
   * What messages are given to women about the importance of beauty?
3. After completing the messages *inside* the box, ask the participants:
   * How are women treated when they try to act "outside of the box"?
   * What names are women called when they act "outside of the box"?
4. Write these names in the margin *outside* of the box.

Activity E: Discussion *(10 minutes)*

1. Explain that society uses these names to keep women inside this gender box.
2. Start a discussion by asking:
   * How can "acting like a woman" affect a woman's relationship with her partner and children?
   * How can social norms and expectations to "act like a woman" have a negative impact on a woman's SRH?
   * How do gender roles affect the interaction between a female client and a male provider?

Activity F: Summary *(5 minutes)*

Ask the participants:

* What can SRH providers do to overcome the negative impact of gender roles on men's and women's SRH?

Session 25
The Effect of Power Imbalances on SRH Decision Making

Objectives

- To identify four categories of behavior that people use to control their partners in different types of sexual relationships
- To describe how such behaviors can affect the ability of partners to make and carry out decisions regarding SRH
- To explain the concept of social vulnerability to HIV and STIs or unintended pregnancy

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Review Session 25 in the Participant's Handbook (page 107). Consider if or how you want to use the Participant's Worksheet (case studies) with this session.
2. Prepare a flipchart showing the four types of behavior that people use to control their partners (Activity A).
3. Prepare four flipcharts, each with one of the four behaviors as a heading (Activity B).
4. Determine what resources exist in the participants' communities to which clients could be referred for gender-based violence, including physical, emotional, and sexual abuse, and obtain contact information for these resources. Prepare a flipchart with the contact information (Activity C).

Time

45 minutes

Training Activities	Time
A. Introduction	5 min.
B. Small-group work	10 min.
C. Discussion	15 min.
D. Presentation/summary	15 min.

Note: This session is adapted from: EngenderHealth, 2002.

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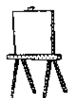
Session 25 Detailed Steps

Activity A: Introduction *(5 minutes)*

1. Introduce the session by noting that for various reasons "power imbalances" may exist between clients and providers. This will be discussed in more detail in Session 26.
2. This session focuses on power imbalances between partners. Explain to the participants that making SRH decisions that require a partner's cooperation is sometimes not easy. It is even more challenging, however, in a relationship where there is a power imbalance between partners or where one partner abuses the other. This session first considers the impact of gender and power on SRH decision making, then broadens the discussion to consider other social factors that affect SRH decision making.
3. Normally, when we think of "power" or "power imbalances" in relationships, we think of physical force. However, physical force is not the only type of controlling behavior that people experience in their relationships. Ask the participants:

   ✱ What other kinds of behavior could be used to control a sexual partner?

> **➻ Training Tip**
>
> Participants or trainers may have experienced these controlling behaviors themselves. Thus, it is important to acknowledge this at the beginning of the session, by saying that this activity might bring up strong emotions for some participants and that they can speak privately with a trainer to discuss what would make them more comfortable.

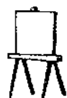


4. After a few responses, post the prepared flipchart (see below) showing all four behavior categories. Briefly describe each category, and give one example of each (see Participant's Handbook, page 108).

Behaviors people use to control their partners
• Physical • Emotional/psychological • Financial • Sexual

5. Explain that this session will explore how these behaviors can affect SRH decision making and access to services.
6. In addition, note that, in most cultures, this kind of power is directed by men against women. We will at first focus on such examples, but please be aware that this is not always the case.

Activity B: Small-group work *(10 minutes)*



1. Divide the participants into four groups. Assign a category of behavior—physical, emotional or psychological, financial, and sexual—to each group, and distribute the flipcharts accordingly. (The participants should have their handbooks closed for this activity.)

> **➽ Training Tip**
>
> Ten minutes is a very brief time for the group work. To save time, make the four groups by clustering people who are sitting next to each other. If there are more than 16 participants, you can assign people to work in pairs—again, with the person sitting next to him or her—and have two or more pairs working on the same category.

2. Ask each group to brainstorm behaviors under their category that people use to control their partners. Have one member of the group list these behaviors on the flipchart.
3. After 10 minutes (total), ask the groups to stop.

Activity C: Discussion *(15 minutes)*

1. Ask each group to post their flipchart and read the controlling behaviors from their list. (If more than one group worked on the same category, have them take turns reading from their lists while a trainer writes the behaviors on the prepared flipchart for that category.) Others can add to the lists after the group has reported, and the trainers can add from the lists in the Participant's Handbook (page 108).

> **➽ Training Tip**
>
> You will see that many types of controlling behaviors will overlap categories. For example, many examples of sexual abuse are also physical abuse. This overlap is understandable and reinforces the way in which controlling behavior can affect so many aspects of a person's life.

2. After all of the groups have reported, ask:
   * How do you think these behaviors would affect an individual's ability to make and carry out SRH decisions?
3. Note that many of these behaviors are included in the definition of "gender-based violence." Although there is not enough time to cover this issue in this workshop, participants should be aware of resources in their area for referral if a client seems to be at risk for physical or emotional harm from his or her partner. Post the flipchart with the names and contact information for whatever resources you were able to find in your preparation for this session.

Activity D: Presentation/summary *(15 minutes)*

1. Give a short presentation, based on "Social Vulnerabilities and HIV and STI Risk" in the Participant's Handbook (pages 109 to 110).

> **➻ Training Tip**
>
> If time permits, first ask the participants what they think about each topic (e.g., "Why are women more vulnerable to HIV/STI infection?" "Why are youth more vulnerable...?" or "What government policies contribute to people's vulnerability?").

2. If time allows, ask the participants how these same factors apply to other areas of SRH, such as pregnancy prevention and safe motherhood. (Except for the biological factors, the same social forces apply to pregnancy prevention and safe motherhood, with women and youth limited in their access to information, financial resources, and health care services and in their decision-making power.)

> **➻ Training Tip**
>
> The Participant's Handbook also includes a Participant Worksheet consisting of case studies on power imbalances in SRH decision making (pages 111 to 116). These will help the participants more fully understand and apply these concepts. They can be used as an additional session, either as case studies or as role plays, or as "homework" to be completed after the session. Note that the "answers" to the case-study questions are provided.

Session 26
Helping Clients Make Decisions—Counseling Practice II

Objectives

- To identify the steps in the decision-making phase of integrated SRH counseling (REDI—Phase 3, Decision making; GATHER: Help)
- To list at least one open-ended question to ask clients for each of the four steps
- To describe the role of the provider in helping the client to make his or her own informed decisions and in supporting the client's sexual and reproductive rights
- To demonstrate helping a client to make his or her own decision

Materials

- "Props" to be used during the demonstration role play
- Flipchart paper, markers, and tape
- Prepared flipchart with guidelines for feedback (from Session 23)

Advance Preparation

1. Review Session 26 in the Participant's Handbook (page 117).
2. Prepare a flipchart with the four steps of the Decision-making segment of REDI (page 141).
3. Prepare five flipcharts, each with one of the steps of decision making as a heading. The third step will be divided for two groups, as shown here:

1. Identify what decisions the client needs to make in this session

2. Identify the client's options for each decision

3(a). Weigh the benefits, disadvantages, and consequences of each option
- Options meet clients' individual needs
- Provide more information as necessary

3(b). Weigh the benefits, disadvantages, and consequences of each option
- Who else would be affected?
- Others' reactions

4. Assist the client to make his or her own realistic decisions

Session 26

Time

1 hour, 30 minutes

Training Activities	Time
A. Introduction	10 min.
B. Small-group work	15 min.
C. Plenary discussion	20 min.
D. Demonstration role play/feedback	20 min.
E. Practice role plays	15 min.
F. Discussion	10 min.

Session 26 Detailed Steps

Activity A: Introduction *(10 minutes)*

1. Divide the participants into five groups. If they need to change seats, ask them to take their handbooks and their pens or pencils with them.

> **➛ Training Tip**
>
> These are the five "client profile" groups for the next two counseling practice sessions. Depending on which option you chose in Session 21, these will be the same groups as the previous day or different.
>
> In Activity E, you will assign them a client profile for their practice role plays. Again, this needs to be consistent with the option you chose in Session 21 (i.e., either the same as the day before or different).

2. Ensure that the participants keep their handbooks closed during the following activity. Explain that helping clients make their own decisions is one of the most difficult steps in counseling, despite years of GATHER training (which includes a "Help" step). Ask the participants why this might be true. Facilitate a brief discussion, making sure that the points in the Participant's Handbook discussion summary (page 118) are covered.

3. Post the prepared flipchart (shown below) with the steps for the decision-making phase of REDI, and briefly review it.

> **Decision Making: Steps in Counseling**
>
> 1. Identify what decisions the client needs to make in this session
> 2. Identify the client's options for each decision
> 3. Weigh the benefits, disadvantages, and consequences of each option
> 4. Assist the client to make his or her own realistic decisions

Activity B: Small-group work *(15 minutes)*

1. Ask the participants to turn to Session 8 in their handbooks and find the detailed description of the decision-making phase of REDI.

2. Assign one step to each group (with the third step split between two groups). Distribute the prepared flipcharts and the markers. Ask the participants to brainstorm questions to ask clients for their step and to list them on the flipchart.

3. Remind them to use open-ended questions as much as possible. Ask them to discuss in their group how to explain key points to the client and to make notes for reporting in the plenary discussion (but not on the flipchart).

Activity C: Plenary discussion *(20 minutes)*

Ask one member of each group to post their flipchart and read their questions. They should also share their notes about how to explain key points to the client. Trainers and the other participants can add to the questions or make comments. *(4 minutes per group)*

Activity D: Demonstration role play/feedback *(15 minutes)*

1. Have several members of the training team conduct a demonstration role play for the decision-making phase of counseling, using the "sixth client" profile from Session 23 (page 125). As much as possible, use the questions developed by the participants for each step. *(10 minutes)*
2. Ask the participants for feedback on how well the role play demonstrated the steps of decision making and on what improvements they would suggest. *(5 minutes)*
3. Remind the participants that power imbalances may exist due to differences in the status of clients and providers. It is difficult to demonstrate the impact of status in a role play. However, consider: *(5 minutes)*
   * What impact could a power imbalance have on this interaction?
   * What could the provider do to overcome the barriers caused by this imbalance?

Activity E: Practice role plays *(15 minutes)*

1. Have the groups move as far away from each other as possible, to cut down on distractions during the role plays (which will be conducted simultaneously).
2. Assign one of the client profiles to each group (see Training Tip, Activity A). Have the group decide who will be the "provider." (It should be someone who has not already practiced counseling.)
3. Explain that each group will do a 10-minute role play of the decision-making phase of counseling with this client. Ask the groups to remember what happened with this "client" during the rapport-building and exploration role plays (Session 23, page 125) and to imagine that they are continuing the counseling from that point. Explain that because the role plays will be conducted simultaneously, discussion will take place in the large group following the role plays.
4. Ask the "providers" to begin. Have the training team monitor as many of the groups as possible, moving around as necessary. Stop the role plays after 10 minutes.

Activity F: Discussion *(10 minutes)*

1. Post the flipchart on feedback guidelines from Session 23 (page 128).
2. Facilitate a discussion on all three bullets.

Trainers' Tool

REDI—Phase 3: Decision making

1. Identify what decisions the client needs to make in this session

- Help the client to prioritize the decisions, to determine which are the most important to address today
- Explain the importance of the client's making his or her own decisions

2. Identify the client's options for each decision

- Many providers and clients feel that in most areas of SRH, clients' decision-making options are limited. An important role of the provider is to lay out the various decisions that a client could make, to explore the consequences of each. This empowers the client to make his or her own choice, which is a key element of supporting the client's sexual and reproductive rights.

3. Weigh the benefits, disadvantages, and consequences of each option

- Make sure that the discussion centers on options that meet clients' individual needs, taking into account their preferences and concerns
- Provide more detailed information, as necessary, on the options that the client is considering
- Consider who else would be affected by each decision
- Explore with the clients how he or she thinks that partners or family members may react to the course of action (i.e., suggesting condom use or discussing sexuality with partners)

4. Assist the client to make his or her own realistic decisions

- Ask the client what is his or her decision (i.e., what option he or she chooses)
- Have the client explain in his or her own words why he or she is making this decision
- Check to see that this decision is the choice of the client, free of pressure from spouse, partner, family members, friends, or service providers
- Help the client assess whether his or her decision can actually be carried out, given his or her relationships, family life, and economic situation, among other issues

Part VI

Helping Clients Develop the Skills to Carry Out Their Decisions

Making a decision about an SRH problem or need is only the first step toward the client's meeting his or her need. The client then must leave the clinic and carry out this decision on his or her own. Some decisions (for example, condom use) will require consistent action on the part of the client *and* partners. Other decisions (for example, to convince a partner to be tested for STIs or HIV) require the client to influence someone else's behavior. These sessions examine ways in which the provider can help prepare a client to carry out his or her decision, including helping the client develop communication strategies and skills.

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Session 27
Helping Clients Develop an Implementation Plan—Counseling Practice III

Objectives

- To identify practical ways for helping clients make a plan to carry out their SRH decision
- To list the skills that clients might need to develop to carry out their plan

Materials

- Flipchart paper, markers, and tape
- Prepared flipchart with guidelines for feedback, from Session 23

Advance Preparation

1. Review Session 27 in the Participant's Handbook (page 121) and REDI—Phase 4: Implementing the Decision (see Trainers' Tool, page 150). (The handbook includes a "sample plan" for a client who wants dual protection. It is not used in this session, but it can be a resource for the participants or trainers.)
2. Prepare a flipchart showing the four steps of implementation (REDI—Phase 4, page 148).

Time

45 minutes

Training Activities	Time
A. Discussion	15 min.
B. Demonstration role play/feedback	10 min.
C. Practice role plays	15 min.
D. Discussion	5 min.

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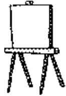
Session 27 Detailed Steps

Activity A: Discussion *(15 minutes)*

1. Introduce the activity by telling the participants that it is important for the client, having made a decision, to have a specific plan for how he or she will carry out this decision and to develop the skills needed for communication and behavior change.
2. Ask the participants to turn to Session 8 in their handbooks and find REDI—Phase 4: Implementing the Decision.



3. Post the prepared flipchart on implementation and briefly review the four steps.

> **Implementing the Decision:**
> **Counseling Steps**
>
> 1. Make a concrete, specific plan for carrying out the decision
> 2. Identify skills that the client will need to carry out the decision
> 3. Practice skills, as needed, with the providers' help
> 4. Make a plan for follow-up

4. Note that in this session, the participants will practice developing an implementation plan to help clients carry out their decision (Step 1). (The next session will focus on developing skills for partner communication and negotiation, Steps 2 and 3.)
5. Focus on Step 1 in the Participant's Handbook (Session 8, page 35). Ask for a volunteer to read the first bullet out loud. Note that sample questions are already given for condom use. Ask the participants what other questions they would ask for different decisions (using client profiles as examples). Note how open-ended questions are used.
6. Repeat this process for the rest of the bullets.

Activity B: Demonstration role play/feedback *(10 minutes)*

1. Using several members of the training team, conduct a demonstration role play for helping the client to make an implementation plan, using the "sixth client" profile. As much as possible, use the questions from the bullets.
2. Ask the participants for feedback on how well the role play demonstrated Step 1 of Implementing the Decision.

Activity C: Practice role plays *(15 minutes)*

1. Divide the participants into the same five groups as in Session 26, with the same client profiles. Have each group decide who will play the "provider" (it should be someone who has not already practiced counseling) and who will play the "client."

2. Explain that they will do a 10-minute role play of helping the "client" to make a plan for carrying out the decision that was made in the last role play, continuing where they left off. Discussion will be conducted in the large group after the role plays.
3. Ask the "providers" to begin. Have the training team monitor as many of the groups as possible, moving around as necessary. Stop the role plays after 10 minutes.

Activity D: Discussion (5 minutes)

Post the feedback guidelines flipchart (from Session 23, page 128) and facilitate a discussion on all three bullets.

Trainers' Tool

REDI—Phase 4: Implementing the Decision

1. Make a concrete, specific plan for carrying out the decision

- Be *specific*. If a client says that he or she is going to do something, find out when, under what circumstances, and what his or her next steps will be in each situation. Asking a client "What will you do next?" is important in developing a plan to reduce risk. For example, if a client says that 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?" and "Where will you keep them so you will have them with you when you need them?"
- Ask about possible consequences of the plan: "How will your partners react?" "Do you fear any negative consequences?" "How will the plan affect relationships with your partners?" "Can you communicate *directly* about the plan with your partners?" and "Will indirect communication be more effective at first?"
- Ask about social supports. Who in the client's life can help the client carry out the plan? Who might create obstacles? How will the client deal with a lack of support or with individuals who interfere with the client's efforts to reduce risk?
- Make a "Plan B"—that is, if the plan does not work, then what can the client do?

2. Identify skills that the client will need to carry out the decision

- Partner communication and negotiation skills
- Condom-use skills
- Skills in using other family planning methods

3. Practice skills, as needed, with the provider's help

- Partner communication and negotiation skills
  - ➤ Discuss the client's fears or concerns about communicating and negotiating with partners about condom use, family planning, maternal health concerns, safer sex, or sexuality, and offer ideas for improving communication and negotiation
  - ➤ For a client who feels that it may be difficult to negotiate condom use for HIV and STI prevention, discuss whether it might be easier to introduce condoms for pregnancy prevention
  - ➤ Role-play with the client possible communication and negotiation situations
- Condom-use skills
  - ➤ Demonstrate correct condom use on a penis model, describe the steps, and ask the client to repeat the demonstration to be sure that he or she understands
  - ➤ Discuss strategies for making condom use more acceptable to partners
  - ➤ Provide samples of condoms (if possible) and make sure that the client knows where and how to obtain more

(continued)

Trainers' Tool

REDI—Phase 4: Implementing the Decision *(continued)*

- Skills in using other family planning methods
  - Make sure that the client understands how to use other family planning methods that he or she has selected by asking the client to repeat back basic information and by encouraging him or her to ask for clarification

4. Make a plan for follow-up

- Invite the client to return for a follow-up visit to provide ongoing support with decision making, negotiation, and behavior change
- Explain timing for medical follow-up visit or contraceptive resupply
- Make referral for services not provided at your facility

Session 28
Helping Clients Develop Skills in Partner Communication and Negotiation

Objectives

- To identify possible reasons that clients may have for not talking with their partners about SRH concerns
- To recognize deeper personal and social issues behind clients' difficulties in discussing SRH issues with partners
- To help clients discuss SRH issues more effectively with partners, even in relationships marked by violence or a power imbalance between partners

Materials

- Flipchart paper, markers, and tape
- Prepared flipchart with guidelines for feedback, from Session 23 (page 128)
- Prepared flipchart with contact information for local resources for people in violent or abusive relationships (from Session 25, page 137)

Advance Preparation

1. Review Session 28 in the Participant's Handbook (page 125).
2. Prepare a two-column flipchart for Activity A (see page 154). Be sure to make the left-hand column wider than the right-hand column. (See the Participant's Handbook, page 126, for an idea of what the flipchart might look like when it is filled out.)

Time

1 hour

Training Activities	Time
A. Brainstorm/discussion	15 min.
B. Brainstorm	10 min.
C. Demonstration role play	15 min.
D. Practice role plays	15 min.
E. Discussion	5 min.

Note: This session is adapted from: EngenderHealth, 2002.

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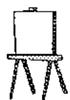
Session 28 Detailed Steps

Activity A: Brainstorm/discussion *(15 minutes)*

1. Introduce this session by noting that even after attending a workshop like this, providers and trainers alike still may have trouble in talking with their *own* partners about sexuality issues and SRH concerns. Yet talking with their partners is a key component of most clients' implementation plans. So, in this session, participants will discuss the difficulties that clients may have in talking openly with their partners about sexuality and the ways in which providers can help them develop communication skills and strategies.
2. Ask the participants to brainstorm responses to the following question: (Participants should have their handbooks closed during this activity.)
   * What are some reasons why clients may not talk with their partners about SRH concerns?



3. Record the responses in the left-hand column of the prepared flipchart (see the table "Barriers to Talking...," on page 126 of the Participant's Handbook, for ideas for this activity, if necessary).

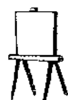
Barriers to Talking with Partners about SRH Concerns	
Clients' Reasons	Deeper Personal and Social Factors

4. For each reason listed, ask the participants to discuss the deeper personal issues (e.g., fears) and social factors that are behind it. After agreeing on each one, write the response in the right-hand column, next to the reason.
5. If fear of violence or abuse does not come up in the brainstorming, note that under the best of circumstances women may find it challenging to discuss sexuality issues with a partner. Ask how this is further complicated when there is a power imbalance or violence or abuse in the relationship (see Discussion Summary, page 127 in the Participant's Handbook, for discussion points). Refer to the posted flipchart on local resources for people in abusive or violent relationships.

Activity B: Brainstorm *(10 minutes)*

1. Ask the participants to brainstorm answers to the following questions:
   * What are some possible suggestions that you, as providers, can make to your clients for discussing sexuality issues and SRH concerns with their partners?

* What are your options when a client absolutely refuses to discuss SRH concerns with his or her partner?



2. Record their suggestions on a separate flipchart, supplementing as necessary from the Participant's Handbook. Acknowledge that some suggestions may be about reducing the client's risk for harm. (In other words, these would be realistic options, or "survival strategies," for clients who are in potentially violent situations.)

Activity C: Demonstration role play *(15 minutes)*

1. Using members of the training team, demonstrate helping the client develop partner communication and negotiation skills, using the "sixth client" profile and working from the implementation plan that was developed in the last demonstration role play. Try to use some of the suggestions listed on the flipchart, including conducting a role play *with the client*, to help the client practice communicating with his or her partner (see the Participant's Handbook, page 126). *(10 minutes)*
2. After the role play, ask for feedback or questions from the participants. *(5 minutes)*

Activity D: Practice role plays *(15 minutes)*

1. Divide the participants into pairs. Spread out the pairs across the room as much as possible, to minimize distractions from the other role plays. Within each pair, decide who will play the "provider." (Since there is time for only one role play, it should be someone who has not yet had a chance to practice counseling.) The "client" can choose whichever client profile he or she wishes.
2. Explain that the participants are to do a 10-minute role play about helping the "client" develop partner communication and negotiation skills, working from the implementation plan that was developed for that client in the earlier session. There will be discussion in the large group after the role plays.
3. Ask the "providers" to begin. Have the training team monitor as many of the pairs as possible, moving around as necessary. Stop the role plays after 10 minutes.

Activity E: Discussion *(5 minutes)*

Post the feedback guidelines flipchart and facilitate a discussion on all three bullets.

Part VII

Final Steps in Implementing Integrated SRH Counseling

The final sessions in this curriculum help the participants to actually practice or apply integrated SRH counseling by putting all of the components together. The participants are now given the opportunity to practice a complete counseling session in counseling role plays or in a clinical practicum, using skills and approaches covered in previous sessions and receiving feedback.

It is important for trainers and providers to recognize that applying new counseling skills acquired in training requires more than training itself: Administrators and supervisors need to be supportive of new practices and approaches, to help participants and their co-workers adjust to and sustain any changes that are required. Also, providers need follow-up from trainers and supervisors to help them overcome problems, continue to improve their skills, and maintain their commitment to providing integrated SRH counseling.

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Session 29
Counseling Practice—Final

Objective

- To demonstrate integrated SRH counseling skills in role plays (or in a practicum), assessing the client's needs and risks, addressing content issues and counseling concerns, and applying the principles and approaches discussed in this training

Materials

- Props for role plays (i.e., visual aids and materials that would normally be found in a health care or counseling setting)
- Client profile flipcharts (from Session 6)

Advance Preparation

1. Organize transportation and other logistics for a clinical practicum, if possible.
2. Review Session 29 in the Participant's Handbook (page 131) for specific questions to ask for more in-depth role-play feedback by observers.
3. Review the Detailed Steps for Session 29 and determine which option to use for the role-play assignments in the final counseling practice session.
4. Prepare a flipchart with the eight headings in bold from the "Observation and Feedback Guide for Counseling Practice" on pages 131 and 132 of the Participant's Handbook.
5. Prepare an additional flipchart with feedback guidelines for the "provider" and the "client" in the role plays (see below).

Role-Play Feedback

* "Provider": Which counseling skills are you trying to apply? What do you think you are doing well? What do you think you can improve on?

* "Client": Is the "provider" addressing your needs? Do you feel like you are being heard? Are there questions that you want to ask or things that you need to say that you do not feel you can? Why?

6. Post the client profile flipcharts from Session 6 where all participants can see them.

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Session 29

Time

Variable, depending on the needs of the participants; a minimum of 4 hours

Training Activities	**Time (minimum)**
A. Small-group work	30 min.
B. Role plays/feedback (1st round)	30 min. per group; 20 min. role play, plus 10 min. feedback (2 hours, 30 min., total for all five groups)
C. Role plays/feedback (2nd round)	45 min. (15 min. preparation, plus 30 min. role play and feedback)
D. Summary/discussion	15 min.

Session 29 Detailed Steps

Introduction

Counseling practice time can be structured in many ways. Factors will include the number of participants, the participants' skill levels, the amount of time available, whether participants are staying overnight at the workshop venue (which allows for preparation and practice time in the evenings), and whether a clinical practicum site is available. The training team will need to determine which approach to counseling practice best fits the participants' needs and circumstances.

A counseling practicum (i.e., in a clinic setting with actual clients) is the best practice opportunity for participants and should be arranged, if at all possible. The counseling practicum would be held at a nearby service setting. When working with actual clients, a member of the training team or an experienced provider from the service site (who is familiar with the principles of the training) *must* monitor each of the participants while he or she is counseling. Clients must be asked for their permission to be counseled by a trainee and to have observers present. Allow plenty of time for discussion afterward, back at the workshop venue.

If a practicum is not possible, the counseling practice can be conducted through role plays. Depending on the option chosen for counseling practice during the training (i.e., same or different groups of participants, with same or different client profiles), you will decide how to assign groups and client profiles for these two final counseling practice sessions.

Once the assignment of groups and profiles has been determined, the sequence of activities is basically the same:

1. Allow preparation time for the participants, in their role play groups
2. Conduct the first round of role plays with all other participants observing, and give feedback (see first bullet, below)
3. Conduct another round of role plays (see second bullet, below), with time for preparation before and feedback after
4. Summary discussion

The development of client profiles was intended to ensure that the participants become familiar with a *range* of SRH problems and concerns during this training. This training was also designed to allow for numerous opportunities for the participants to practice specific counseling skills throughout the workshop. (By this time in the training, all of the participants should have had a chance to do a practice role play at least once.) Therefore, consider the following points when planning how to use your time for the final counseling practice sessions:

- For all participants to learn about the *range* of issues and needs to address in integrated SRH counseling, in the first round of role plays each client profile "team" should do a demonstration role play while the rest of the participants observe. The discussion can then focus on issues and content of counseling for particular clients and for particular needs, as well as counseling skills.

- To permit more participants to get practice with *counseling skills,* the second round of role plays should be conducted concurrently (i.e., with all groups practicing at the same time). The number of concurrent groups would be determined by the number of training team members, since you must have a member of the training team to observe each role play and facilitate feedback. Depending on how much time is available, these concurrent rounds can be repeated several times, giving many more participants a chance to practice counseling skills.

Activity A: Small-group work *(30 minutes)*

1. Explain the structure and timing of the counseling practice. For role plays, explain that each group will have 20 minutes to conduct their role play of the entire counseling session, with 10 minutes for feedback.

2. Post and briefly review the feedback guidelines flipchart (or refer the participants to pages 131 and 132 in their handbook).
3. Divide the participants into five groups and assign client profiles.
4. Instruct the participants to use the remaining time to prepare for their role plays, in their role-play groups.

Activity B: Role plays/feedback *(2 hours, 30 minutes)*

1. Ask for a group to volunteer to begin the role plays. Before the role play begins, briefly review the client profile for that role play (from Session 6).
2. Have the group conduct the role play. *(20 minutes)*

3. Facilitate feedback, referring first to the "provider" and "client" role-play feedback flipchart. Then refer to the "Observation and Feedback Guide" for comments from other participants. *(10 minutes)*
4. Repeat Steps 1, 2, and 3 for the remaining four groups. *(2 hours)*

Activity C: Role plays/feedback *(45 minutes for each "round")*

1. Assign new client profiles. (Putting participants into new groups is optional.) Spread the groups around the room, or send some into break-out rooms, since they will all be conducting their role plays at the same time.
2. Ask the participants to briefly prepare for a role play with the new client profile. *(15 minutes)*
3. Ask each group to begin their role play. A member of the training team must be with each group and should stop the role play after 20 minutes.
4. Have the training team member with each group facilitate feedback, using the "provider"/ "client" sheet first and then the "Observation and Feedback Guide." *(10 minutes)*
5. Conduct as many more rounds of concurrent role plays as time permits. *(45 minutes for each round)*

Activity D. Summary discussion *(15 minutes)*

Ask participants (and trainers) to summarize the most important things that they learned from these counseling practice sessions.

Session 30
Meeting Providers' Needs and Overcoming Barriers to Offering Integrated SRH Counseling

Objectives

- To describe three areas of the needs of health care staff and give examples of how these apply to integrated SRH counseling
- To identify barriers to providing integrated SRH counseling in the work setting and strategies for overcoming those barriers
- To name at least two strategies for saving time in counseling and to explain how these can be applied in the participants' own work setting

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Review Session 30 in the Participant's Handbook (page 133).
2. Prepare a flipchart entitled "The Needs of Health Care Staff," listing the three categories (Activity A).
3. Prepare at least two two-column flipcharts for listing barriers to integrated SRH counseling and strategies for overcoming barriers (see Activity B and the Trainers' Tool, pages 166 to 167). Make the "strategies" column wider than the "barriers" column.
4. Review the Trainers' Tool (page 168) for ideas for facilitating the discussion on strategies to overcome barriers to integrated SRH counseling (Activity C).

Time

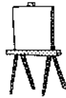
45 minutes

Training Activities	Time
A. Presentation	5 min.
B. Brainstorm	5 min.
C. Discussion	25 min.
D. Presentation	10 min.

Session 30 Detailed Steps

Activity A: Presentation *(5 minutes)*

1. Explain that, having faced a bit of the reality of integrated SRH counseling through the counseling practice, the participants should consider what providers need if they are to be able to offer effective counseling and how they can overcome barriers that might exist or problems that could occur.

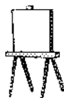


2. Post the prepared flipchart on the needs of health care staff, briefly describing the three categories and why they are important (see Participant's Handbook, page 134). Note to the participants that you will return to these categories a bit later in the session.

The Needs of Health Care Staff

- Facilitative supervision and management
- Information, training, and development
- Supplies, equipment, and infrastructure

Activity B: Brainstorm *(5 minutes)*



1. Post the two-column prepared flipcharts on barriers (see below).

Barriers to Integrated SRH Counseling	Strategies for Overcoming Barriers

2. Ask the participants to think about what might make it difficult for them to provide integrated SRH counseling when they get back to their work sites.
3. List the participants' responses in the barriers column.

Activity C: Discussion (25 minutes)

1. Starting with the first barrier on the list, ask the participants which needs category this falls into.
2. In the right-hand column, write "F" for "facilitative...," "I" for "information...," or "S" for "supplies...," depending on the participants' discussion.
3. Then ask what could be done to solve this problem or overcome this barrier. Note that the type of need this barrier reflects could give them a clue about how to overcome that barrier. After a brief discussion, summarize the participants' ideas in the right-hand column (see Trainers' Tool, pages 166 to 167, for examples).
4. Continue the same procedure for the rest of the barriers.

Note: Administrators and supervisors must address the need to motivate and reward providers for making the changes that may be necessary to providing integrated SRH counseling. The Trainers' Tool on page 168 lists 10 ideas for motivating staff; these may be duplicated and distributed to the administrators and supervisors who participate in this training.

Activity D: Presentation *(10 minutes)*

1. Note that "not having enough time" is a constant theme in counseling associated with any kind of health care. This is so for a number of reasons, over which many providers have very little control. This discussion will focus on the things that we *can* do to make the best use of time in integrated SRH counseling.
2. Give a brief presentation on the strategies for saving time noted in the Essential Ideas on page 133 of the Participant's Handbook. Some of these may already have been covered during the brainstorm and discussion, so just review them briefly.

➳ Training Tip

One strategy that is out of the providers' control, but that could be addressed through this training, is to promote greater support for integrated SRH counseling from program managers and supervisors. For example, if managers and supervisors understand the importance of the extra time needed to do an adequate risk assessment, they might adjust some of the working conditions that limit time for counseling. (Presumably, some managers and supervisors attended this training.) Alternatively, a shorter version of this workshop has been developed for program managers and supervisors, both to foster better supervision for trainees once they return to their work sites and to encourage greater support for implementing changes that may be necessary for the provision of quality counseling.

Trainers' Tool

Here are some examples of barriers that providers may identify and *possible* strategies to address those barriers. (*Note:* These should not be presented as "the answers," nor should you try to cover *all* of these barriers and strategies.) Strategies need to be developed that address the specific barriers in different service sites or programs.

F = Facilitative supervision and management
I = Information, training, and development
S = Supplies, equipment, and infrastructure

Barriers to Integrated SRH Counseling	Strategies for Overcoming Barriers
Lack of time for counseling	**F:** • Clinic flow is reorganized to use time more efficiently and free up staff for counseling. • Staff who are assigned to counseling are not required to do other tasks. • Frontline staff are involved in intake and in group education, to cover basic informational tasks of counseling. (The strategies depend on the nature of the problem, but many of them are influenced by administrators and supervisors.)
Lack of space to ensure privacy	**F/S:** • Large rooms (e.g., waiting areas) can be partitioned off or curtained to provide visual privacy. • One area of a large room can be set aside, with chairs arranged far enough away to provide listening privacy. • Multiple usage of semiprivate spaces (e.g., examining rooms or administrative offices) that are not always in use.
Lack of support from co-workers and supervisors for changes necessary (e.g., space and time)	**F/I:** • Supervisors need to explain to the entire staff about the importance of counseling and the changes that may be necessary. • Supervisors will likely need to be oriented to the importance and needs of counseling. • Other staff can also be oriented about the importance of counseling and their own roles.
Lack of awareness among other staff	**F/I:** • Supervisors need to communicate to all staff about the importance of counseling. • Orientation programs should be conducted for the entire staff.

(continued)

Trainers' Tool *(continued)*

Barriers to Integrated SRH Counseling	Strategies for Overcoming Barriers
Embarrassment about raising issues of sexuality	**F/I:** • Supervisors reinforce the importance of raising issues of sexuality, acknowledge that it can be embarrassing for providers, and help with problem solving (e.g., through role-playing). • Follow-up to training should address this issue (whether providers mention it or not) and provide reinforcement for overcoming the embarrassment. • "Peer support groups" of providers who have gone through the training can help each other by acknowledging that embarrassment is normal and by providing tips for getting over it.
Reluctance to identify needs that cannot be met on-site	**F/I:** • Information should be provided about where services are provided off-site. • Supervisors need to motivate providers to utilize referral systems.
Pressure from administrators to meet service-delivery targets	**F/I:** • Supervisors and administrators need to be oriented to the benefits of meeting clients' needs (as opposed to meeting "targets"). • Administrators and supervisors need to be clear about the purpose of service-delivery "targets" for planning purposes and not impose them as "quotas" for individual providers.

Trainers' Tool

Top 10 Ways for Administrators and Supervisors to Motivate Staff

1. Personally *thank* employees for doing a good job—one-on-one, in writing, or both—in a timely way, often, and sincerely.
2. Take time to *meet with* and *listen* to your staff.
3. Provide *specific* and *frequent* feedback to staff about their performance, being sure that performance expectations and standards have been clearly explained. Support them in their efforts to improve performance.
4. *Recognize, reward,* and *promote* high performers, based on clearly stated performance expectations; handle low or marginal performers so that they improve or leave.
5. Keep staff *informed* about how the organization is doing, about upcoming services or products, about strategies for being competitive, about the organization's financial position, and about any new policies, among other things.
6. *Involve* staff in decision making, especially in decisions that affect them, as involvement leads to commitment and ownership.
7. Give staff an opportunity to learn new skills and to develop, and encourage them to do their best.
8. Show all staff how you can help them meet their *work* goals while achieving the *organization's* goals. Create a partnership with each employee.
9. Create a working environment that is *open, trusting,* and *fun.* Encourage new ideas, suggestions, and initiative. Learn from, rather than punish for, mistakes.
10. Celebrate successes—of the organization, of the department, or of individual staff members. Take time for team-building and morale-building meetings and activities. In short, be creative.

Session 31
Individual Plans for Applying What Was Learned in This Training

Objectives

- To identify three changes that the participants want to make in their work immediately to implement what they have learned in this training, and explain why
- To make action plans with specific activities, barriers that might be encountered, and strategies for overcoming them

Materials

- Flipchart paper, markers, and tape
- Copies of the "Action Plan Framework" (from the Participant's Handbook)—one for each participant
- Flipchart of "Barriers and Strategies" from Session 30
- Daily wrap-up flipcharts

Advance Preparation

1. Review Session 31 in the Participant's Handbook (page 135).
2. Make enough copies of the "Action Plan Framework" (on page 137 of the Participant's Handbook) to have one for each participant.
3. Post all of the Daily Wrap-Up flipcharts where the participants can see them.
4. If you have access to a copying machine during the training, make a copy of each participant's completed action plan before the end of the workshop. Return the original to the participant, and keep the copy for use during the follow-up visits (see Session 32). If this is not possible, keep the original action plans, make copies later, and return the originals to the participants as soon as possible.

Time

1 hour

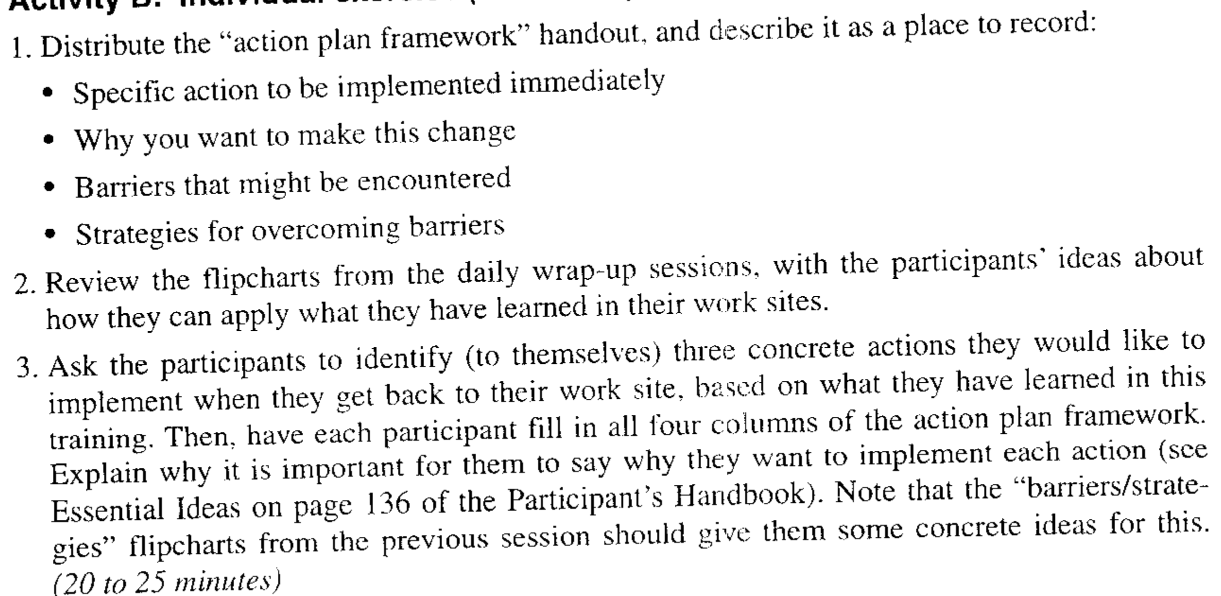
Training Activities	Time
A. Introduction	5 min.
B. Individual exercise	30 min.
C. Plenary	20 min.
D. Summary	5 min.

Session 31 Detailed Steps

Activity A: Introduction *(5 minutes)*

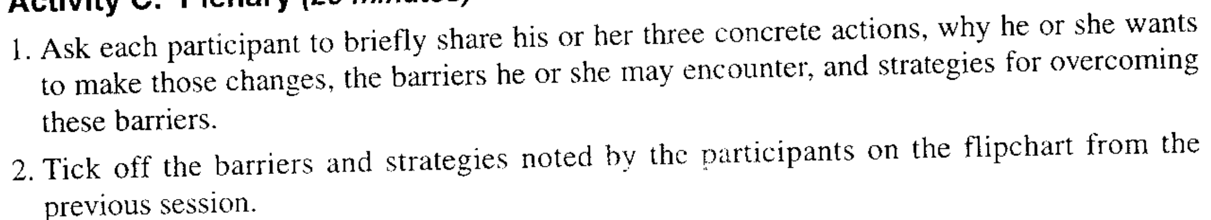
Review the training goal and objectives (Session 1) and the purpose of integrated SRH counseling (Session 2).

Activity B: Individual exercise *(30 minutes)*



1. Distribute the "action plan framework" handout, and describe it as a place to record:
   - Specific action to be implemented immediately
   - Why you want to make this change
   - Barriers that might be encountered
   - Strategies for overcoming barriers
2. Review the flipcharts from the daily wrap-up sessions, with the participants' ideas about how they can apply what they have learned in their work sites.
3. Ask the participants to identify (to themselves) three concrete actions they would like to implement when they get back to their work site, based on what they have learned in this training. Then, have each participant fill in all four columns of the action plan framework. Explain why it is important for them to say why they want to implement each action (see Essential Ideas on page 136 of the Participant's Handbook). Note that the "barriers/strategies" flipcharts from the previous session should give them some concrete ideas for this. *(20 to 25 minutes)*

Activity C: Plenary *(20 minutes)*



1. Ask each participant to briefly share his or her three concrete actions, why he or she wants to make those changes, the barriers he or she may encounter, and strategies for overcoming these barriers.
2. Tick off the barriers and strategies noted by the participants on the flipchart from the previous session.

Activity D: Summary *(5 minutes)*

1. Collect the participants' action plans. Have them copied, ideally before the participants leave. If this is not possible, explain to the participants that the action plans will be returned to them as soon as feasible.
2. Ask the participants what similarities and differences they noted in each other's action plans.
3. Point out any patterns that emerged from the "barriers/strategies" that the participants identified.
4. Note that the next and final session will discuss follow-up strategies, which include ways of checking to see how they are doing in carrying out their action plans.

Session 32
Training Follow-Up

Objective

- To describe the follow-up plans of the host institution, of the participants' own institutions, and of the trainers

Materials

None needed

Advance Preparation

1. Review Session 32 in the Participant's Handbook (page 139).
2. If plans for follow-up and evaluation activities were not made prior to the start of the workshop (see "Before the Training Course" in the Introduction for the Trainers, page xix), discuss follow-up and evaluation with the host institutions for this training prior to this session and determine what follow-up will be conducted, by whom, and when.
3. Arrange for a representative of the host institution to address the group about follow-up and evaluation plans.

Time

30 minutes

Training Activities	Time
A. Presentation	15 min.
B. Presentation/discussion	15 min.

Session 32 Detailed Steps

Activity A: Presentation *(15 minutes)*

Describe the training follow-up plan. This may include follow-on or in-service workshops to focus on specific content areas for SRH counseling, as well as technical assistance site visits—to see how the participants are doing in implementing their action plans, to provide guidance for further development of skills, and to assist with problem solving.

Activity B: Presentation/discussion *(15 minutes)*

1. Have the host institution representative go into as much detail about follow-up and evaluation plans as he or she is able.
2. Ask if the participants have any questions.

> **➸ Training Tip**
>
> Research has clearly shown that one-time trainings with little or no follow-up have a very limited impact. The commitment to follow-up by the host institution, the trainers, or both must be negotiated before this training is scheduled. This may include regular site visits to the participants' workplaces, to follow up on their progress in implementing the action plans and to provide technical assistance for the further development of their skills and problem-solving abilities (see "After the Training Course" in the Introduction for the Trainers, page xxv).
>
> The trainer can start this session with Activity A, but a representative of the local host institution should go into detail in Activity B. The participants will need to start looking to this institution as the coordinator for follow-up activities and assistance.

Session 33
Workshop Evaluation and Closing

Trainers' Objectives

- To administer the self-assessment posttest
- To evaluate the participants' impressions of the training and to get suggestions for improving future workshops
- To formally thank all involved in this workshop, to wish everyone well, and to close the proceedings

Materials

- Copies of the self-assessment posttest (one per participant)
- Corrected copies of the participants' self-assessment pretests
- Copies of the evaluation form (one per participant)
- Certificates of participation (one per participant)

Advance Preparation

1. Identify and invite guests for the closing ceremony.
2. Make enough copies of the self-assessment posttest to have one for each participant.
3. Make enough copies of the evaluation form to have one for each participant.
4. Prepare a certificate of participation (as appropriate for each setting) for each participant.
5. Identify one of the participants to give closing remarks on behalf of the participants. (Preferably, this would be done earlier in the day.)
6. Summarize the workshop for any guests attending the closing ceremony (this can be done by a participant as well), and prepare the guests to give brief comments. If possible, invite them to attend the entire afternoon session, when participants will be discussing action plans and sharing with others what they learned.

Time

1 hour, 30 minutes

Training Activities	Time
A. Posttest	45 min.
B. Evaluation	15 min.
C. Closing ceremony	30 min.

Session 33 Detailed Steps

Activity A: Posttest *(45 minutes)*

1. Administer the self-assessment posttest. *(30 minutes)*
2. When everyone is finished, review the answers to the self-assessment posttest, while the participants correct their own papers. *(10 minutes)*
3. Hand back the pretests, so the participants can compare their scores before and after the workshop. *(5 minutes)*
4. Collect all self-assessment posttests, so the scores can be recorded for pretest-posttest analysis. Remind the participants of your commitment to keep scores confidential. (Participants can keep the pretests.)

Activity B: Evaluation *(15 minutes)*

1. Distribute the evaluation forms.
2. Allow 15 minutes for the participants to complete them.
3. Collect all copies of the evaluation.

Activity C: Closing ceremony *(30 minutes)*

Conduct a closing ceremony appropriate to the setting. Thank the participants and celebrate the completion of the training.

Appendix A
Sample Training Agendas

Sample Training Agendas

Agenda for the Training of Providers: Six Days

Day and Time	Session	Time
Day 1		
Morning	1 Welcome and Introduction	1 hour, 15 minutes
	2 Defining Sexual and Reproductive Health and Integrated SRH Counseling	1 hour
	3 Why Address Sexuality?	45 minutes
	4 The Problem Tree—Roots and Consequences of SRH Problems	1 hour
	Total time	**4 hours, 15 minutes**[1]
	Lunch break	
Afternoon	After-Lunch Warm-Up[2]	15 minutes
	5 Supporting Clients' Informed and Voluntary Decision Making	1 hour
	6 Client Profiles for Sexual and Reproductive Health Decision Making	1 hour
	Daily Wrap-Up	30 minutes
	Total time	**3 hours**[1]
Day 2		
Morning	Daily Warm-Up	15 minutes
	7 Clients' Rights, Client-Provider Interaction, and Counseling	1 hour, 45 minutes
	8 Counseling Frameworks: Option A. REDI	1 hour
	or	
	8 Counseling Frameworks: Option B. GATHER	1 hour
	9 Rapport-Building—Respect, Praise, and Encouragement	45 minutes
	Total time	**4 hours**[1]
	Lunch break	

(continued)

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Agenda for the Training of Providers: Six Days *(continued)*

Day and Time	Session	Time
Day 2 *(continued)*		
Afternoon	10 Provider Beliefs and Attitudes	45 minutes
	11 Sexuality	1 hour
	12 Variations in Sexual Behavior	45 minutes
	Daily Wrap-Up	15 minutes
	Total time	**3 hours**[1]
Day 3		
Morning	Daily Warm-Up	15 minutes
	13 Building Rapport with Male Clients and with Adolescent Clients	1 hour, 15 minutes
	14 Asking Open-Ended Questions	1 hour, 30 minutes
	15 Listening and Paraphrasing	45 minutes
	Total time	**4 hours**[1]
	Lunch break	
Afternoon	16 Using Language That Clients Can Understand	1 hour, 15 minutes
	17 Using Visual Aids to Explain Reproductive Anatomy and Physiology	45 minutes
	18 Introducing the Subject of Sexuality with Clients	45 minutes
	Daily Wrap-Up	10 minutes
	Group assignments for Session 21 (see Trainers' Manual)	5 minutes
	Total time	**3 hours, 15 minutes**[1]
Day 4		
Morning	Daily Warm-Up	15 minutes
	19 The Risk Continuum	1 hour
	20 Exploring the Context of Clients' Sexual Relationships	45 minutes
	21 Information-Giving in Integrated SRH Counseling	1 hour
	22 Risk Assessment—Improving Clients' Perception of Risk	45 minutes
	Total time	**4 hours**[1]
	Lunch break	
Afternoon	23 Counseling Practice I	2 hours, 30 minutes
	Daily Wrap-Up	15 minutes
	Total time	**3 hours**[1]

(continued)

Agenda for the Training of Providers: Six Days *(continued)*

Day and Time	Session	Time
Day 5		
Morning	Daily Warm-Up	15 minutes
	24 Gender Roles	50 minutes
	25 The Effect of Power Imbalances on SRH Decision Making	45 minutes
	26 Helping Clients Make Decisions—Counseling Practice II	1 hour, 30 minutes
	27 Helping Clients Develop an Implementation Plan—Counseling Practice III	45 minutes
	Total time	**4 hours, 20 minutes**[1]
	Lunch break	
Afternoon	28 Helping Clients Develop Skills in Partner Communication and Negotiation	1 hour
	29 Counseling Practice—Final [beginning]	1 hour, 30 minutes
	Daily Wrap-Up	15 minutes
	Total time	**3 hours**[1]
Day 6		
Morning	Daily Warm-Up	15 minutes
	29 Counseling Practice—Final [continued]	3 hours
	30 Meeting Providers' Needs and Overcoming Barriers to Offering Integrated SRH Counseling	45 minutes
	Total time	**4 hours, 15 minutes**[1]
	Lunch break	
Afternoon	31 Individual Plans for Applying What Was Learned in This Training	1 hour
	32 Training Follow-Up	30 minutes
	33 Workshop Evaluation and Closing	1 hour, 30 minutes
	Total time	**3 hours, 15 minutes**[1]

[1] All "total times" include time for a 15-minute break. Trainers will decide when to schedule these breaks, based on local preferences.

[2] An after-lunch warm-up is scheduled for the first day, to help "break the ice" and encourage communication among participants. You can select one of your favorite warm-ups for this session. There are no other "after-lunch warm-ups" scheduled on the following days, because all of the after-lunch sessions are highly interactive and include group activities. If you want to conduct additional warm-ups after lunch, you will need to adjust the schedule and extend the time allotted for the afternoon sessions.

Appendix A

Agenda for the Training of Frontline Staff: Two Days

Day and Time	Session	Time
Day 1		
Morning	Welcome and Introduction (Session 1)	45 minutes
	Defining Sexual and Reproductive Health and Integrated SRH Counseling (Session 2)	1 hour
	Why Address Sexuality? (Session 3)	45 minutes
	The Problem Tree—Roots and Consequences of SRH Problems (Session 4)	1 hour
	Total time	**3 hours, 45 minutes[1]**
	Lunch break	
Afternoon	After-Lunch Warm-Up[2]	15 minutes
	Supporting Clients' Informed and Voluntary Decision Making (Session 5)	1 hour
	Sexual and Reproductive Health Decision Making (Session 6)[3]	1 hour
	Daily Wrap-Up	30 minutes
	Total time	**3 hours[1]**
Day 2		
Morning	Warm-Up	15 minutes
	Clients' Rights, Client-Provider Interaction, and Counseling (Session 7)	1 hour, 30 minutes
	Counseling Frameworks, with Emphasis on Rapport-Building/Greeting (Session 8)	45 minutes
	Provider Beliefs and Attitudes (Session 10)	45 minutes
	Total time	**3 hours, 30 minutes[1]**
	Lunch break	
Afternoon	After-Lunch Warm-Up[2]	15 minutes
	Information-Giving in Integrated SRH Counseling (Session 21)	1 hour
	Integrated SRH Counseling: A Demonstration[4]	45 minutes
	Workshop Evaluation and Closing (Session 33)	45 minutes
	Total time	**3 hours[1]**

[1] All "total times" include time for a 15-minute break. Trainers will decide when to schedule these breaks, based on local preferences.

[2] Select one of your favorite warm-ups for this session.

[3] This session should be based on Session 6, but will not involve the development of client profiles.

[4] This session will involve a demonstration role play based on the various counseling practice sessions that are part of this curriculum.

(continued)

Agenda for the Training of Administrators and Supervisors: Three Days

Day and Time	Session	Time
Day 1		
Morning	Welcome and Introduction (Session 1)	45 minutes
	Defining Sexual and Reproductive Health and Integrated SRH Counseling (Session 2)	1 hour
	Why Address Sexuality? (Session 3)	45 minutes
	The Problem Tree—Roots and Consequences of SRH Problems (Session 4)	1 hour
	Total time	**3 hours, 45 minutes[1]**
	Lunch break	
Afternoon	After-Lunch Warm-Up[2]	15 minutes
	Supporting Clients' Informed and Voluntary Decision Making (Session 5)	1 hour
	Sexual and Reproductive Health Decision Making (Session 6)[3]	1 hour
	Daily Wrap-Up	15 minutes
	Total time	**2 hours, 45 minutes[1]**
Day 2		
Morning	Daily Warm-Up	15 minutes
	Clients' Rights, Client-Provider Interaction, and Counseling (Session 7)	1 hour, 45 minutes
	Counseling Frameworks (Session 8)[4]	45 minutes
	Provider Beliefs and Attitudes (Session 10)	45 minutes
	Total time	**3 hours, 45 minutes[1]**
	Lunch break	
Afternoon	After-Lunch Warm-Up[2]	15 minutes
	Introducing the Subject of Sexuality with Clients (Session 18)	45 minutes
	The Risk Continuum (Session 19)	45 minutes
	Risk Assessment—Improving Clients' Perception of Risk (Session 22)	45 minutes
	Daily Wrap-Up	15 minutes
	Total time	**3 hours[1]**

(continued)

Agenda for the Training of Administrators and Supervisors: Three Days *(continued)*

Day and Time	Session	Time
Day 3		
Morning	Daily Warm-Up	15 minutes
	Information-Giving in Integrated SRH Counseling (Session 21)	1 hour
	The Effect of Power Imbalances on SRH Decision Making (Session 25)	45 minutes
	Helping Clients Make Decisions and Develop an Implementation Plan[5]	45 minutes
	Integrated SRH Counseling: A Demonstration[6]	30 minutes
	Total time	**3 hours, 30 minutes[1]**
	Lunch break	
Afternoon	After-Lunch Warm-Up[2]	15 minutes
	Meeting Providers' Needs and Overcoming Barriers to Offering Integrated SRH Counseling (Session 30)	1 hour, 15 minutes
	Training Follow-Up (Session 32)	30 minutes
	Workshop Evaluation and Closing (Session 33)	45 minutes
	Total time	**3 hours[1]**

[1] All "total times" include time for a 15-minute break. Trainers will decide when to schedule these breaks, based on local preferences.

[2] Select one of your favorite warm-ups for this session.

[3] This session should be based on Session 6 in this book, but will not involve the development of client profiles.

[4] This session can review both REDI (Option A) and GATHER (Option B), but should emphasize the general principles of counseling that both of these approaches share.

[5] This session should combine the main points of Sessions 26 and 27 from this book.

[6] This session will involve a demonstration role play based on the various counseling practice sessions that are part of this curriculum.

Appendix B
Daily Warm-Ups and Daily Wrap-Ups

Daily Warm-Ups and Daily Wrap-Ups

Daily Warm-Up

Trainers' Objectives

- To help the participants refocus on their participation in the workshop
- To review the previous day's discussions and learning in terms of the client's perspective
- To preview the day's sessions and learning objectives

Materials

- Flipchart paper, markers, and tape

Advance Preparation

1. Prepare to conduct your favorite icebreakers or other warm-up activities, in a 5-minute time frame. Short games, songs, or physical activities can help participants get energized and focused on being back in the workshop setting and interacting with fellow participants. You can also ask participants to lead the group in songs or short group activities.
2. Prepare one or two questions to ask the participants, to help them think about the profiled clients' perspectives, based on the previous day's sessions and discussions. For example, on the day after the session on "Reflections on How We Learned about Sexuality" (Session 11), you might ask the participants, "How might each of the profiled clients have learned about sexuality?" Similar questions can be asked about sexual and reproductive rights, the attitudes and beliefs statements, and the clients' reactions to any of the exercises on counseling skills and steps later in the training.
3. Decide how to preview the day's sessions. You may want to refer the participants to each session's Learning Objectives in their handbooks (the bulleted items preceding the Essential Ideas), or you may want to post session objectives on flipcharts. If you choose to post flipcharts, these will need to be prepared in advance.

Time

15 minutes

Training Activities	Time
A. Welcome/logistics	5 min.
B. Icebreaker	5 min.
C. Discussion/presentation	5 min.

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Daily Warm-Up Detailed Steps

Activity A: Welcome and logistics (5 minutes)

1. Welcome the participants back to the workshop.
2. Make announcements and address any "housekeeping" or logistical issues that need to be discussed.

Activity B: Icebreaker (5 minutes)

Conduct a short icebreaker.

Activity C: Discussion/presentation (5 minutes)

1. Briefly review the sessions of the previous day. Ask the prepared question(s) based on the previous day's sessions, to help the participants think about the profiled clients' perspectives.
2. Preview the day's sessions (as you determined during Advance Preparation).

Essential Ideas for the Warm-Up

- The numerous role plays and practice sessions in this curriculum usually focus on the knowledge, attitudes, and skills of the participant who is playing the "provider." But equally important learning can happen for the person who is playing the "client." Role-playing the client involves thinking about a client as a whole person and being able to understand how the lives of clients outside the facility influence communication within the service-delivery setting.
- Thinking about the client's perspective can help providers to identify similarities between themselves and clients. Paying attention to similarities between clients and providers can be as helpful as noticing the differences, since the things that we share help build a bridge of understanding and communication between clients and providers.

Daily Wrap-Up

Trainers' Objectives

- To recap the information and ideas covered during that day
- To identify one thing that each participant could do in his or her work to apply what he or she learned today
- To provide feedback to the trainer about how well the workshop is going, issues that remain unclear, and ways to improve the workshop

Materials

- Flipchart paper, markers, and tape

Advance Preparation

Before the first wrap-up session, create two flipcharts entitled "Needs More Discussion" and "How Can I Apply in My Work What I Have Learned Today?"

Time

15 minutes

Training Activities	Time
A. Discussion	15 min.

Daily Wrap-Up Detailed Steps

> **➻ Training Tip**
>
> These are suggestions for getting valuable feedback from participants at the end of each day. You may have other ideas and approaches for the daily wrap-up; feel free to try other exercises or vary your approach to asking these questions.
>
> **However,** be sure to cover the last question, "What is *one* thing I can do to apply what I have learned from today's sessions?" This will be important to look back on for their "action plans" (Session 31).

Activity A: Discussion (15 minutes)

1. Briefly review the topics covered in that day's sessions.
2. Ask the participants the following question. Encourage everyone to say something, but do not write this on a flipchart.
   * What was the most important thing you learned from today's sessions?
3. Post the flipchart entitled "Needs More Discussion." Ask if there are any areas that remain unclear or that need more discussion. Note these areas on the flipchart.
4. Ask the participants the following question.
   * What suggestions do you have for making things go well tomorrow?

   Do not write their answers on a flipchart, but thank the participants for their comments and note that you will try to follow the recommendations as much as possible.

> **➻ Training Tip**
>
> After the first day, the "Needs More Discussion" flipchart will be revisited each day. Before asking if any areas remain unclear from *this* day, briefly review the list from the preceding days and ask which (if any) have been covered adequately by now. These can be crossed out; the others will remain on the list.
>
> It is hoped that you will be able to address these unclear issues at some point during the workshop. These "wrap-up" sessions are *not* intended to be used for that purpose, unless you find that there is enough time at the end of the day to do so.

5. Post the flipchart "How Can I Apply in My Work What I Have Learned Today?" Then ask the participants:
   * What is *one thing* that you could do when you get back to your work site to apply what you learned from today's sessions?

6. List the participants' responses on the flipchart. Do not write the same answers more than once, but make tally marks alongside each to indicate how many times this answer was given.

➔ Training Tip

- Save the "How Can I Apply..." flipchart sheets for each day. At the end of the workshop, during Session 31, refer back to these ideas from each day, to help the participants start working on their action plans.
- In asking for one idea from each participant about how to apply what he or she has learned, one participant might have an idea to which everyone else will say, "Yes, I would do the same thing." While such a response could in theory be accurate and significant, it is important to encourage people to think independently. Thus, on the first day, you might put participants into pairs to discuss this issue briefly and ask each pair to report. If you feel that this is not necessary to get a range of answers, then brainstorming works well, too.

Essential Ideas for the Wrap-Up

- This daily recap is meant to help participants focus on realistic changes they can make immediately (i.e., as soon as they return to work) to enhance their communications and counseling with clients.
- Too often, trainings end with action plans that never get applied because the potential changes that participants identify are too many, are too big, or require the approval of others if they are to happen. By identifying *one* thing in each day's learning that participants *really* think they can do when they return to their work site, we hope to provide a foundation for real and lasting change and for application of the ideas and approaches presented in this training.
- It is important to be realistic about what is expected from providers. We often talk about providers and what is expected of them as if they were superhuman and should be able to provide high-quality counseling to all clients at all times, even under the most adverse conditions. This daily exercise allows providers to have more realistic expectations of themselves, which should help them avoid becoming discouraged about implementing this training's approaches.

Appendix C
Promoting Informed and Voluntary Decision Making to Support Clients' Rights and Address Clients' Needs

PREVIOUS PAGE

Promoting Informed and Voluntary Decision Making to Support Clients' Rights and Address Clients' Needs

Presentation and Notes

The following are slides that can be used for presentations about how clients' informed and voluntary decision making about their sexual and reproductive health is rooted in human rights. If you have access to an overhead projector, these can be photocopied onto transparencies; if no projector is available, the content of the slides can be copied onto flipcharts. Following the slides are notes, commentaries, and training suggestions that can be used to supplement the information in the slides.

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Slide 1

Promoting Informed and Voluntary Decision Making to Support Clients' Rights and Address Clients' Needs

EngenderHealth, 2003

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Slide 2

During this presentation...

- 60 women will die from preventable complications of pregnancy and childbirth
- 228 girls will undergo female genital cutting
- 240 women in the United States will be battered by their partners
- 250 women will contract HIV

Source: Panos Institute. 1998. *Using human rights to gain reproductive rights.* Panos Briefing No. 32, London.

Slide 3

Sexual and Reproductive Health Care Includes:

- Family planning information, counseling, and services
- Prevention and treatment of sexually transmitted infections (STIs) and reproductive tract infections (RTIs)
- Diagnosis and treatment of HIV and AIDS
- Antenatal, postpartum, and delivery care
- Health care for infants
- Management of abortion-related complications
- Prevention and treatment of infertility
- Information, education, and counseling on human sexuality, SRH, and parenthood
- Diagnosis and treatment of reproductive system cancers

Source: ICPD Programme of Action, 1994, paragraphs 7.2, 7.3, and 7.6.

Slide 4

Reproductive Rights: ICPD, 1994

The rights of individuals and couples:

- To decide freely and responsibly the number, spacing, and timing of their children
- To have the information and means to do so
- To attain the highest standard of sexual and reproductive health
- To make decisions concerning reproduction free of discrimination, coercion, and violence

Source: ICPD Programme of Action, 1994, paragraph 7.3.

Slide 5

Reproductive and Sexual Rights: FWCW, 1995

The human rights of women include:

- Their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination, and violence.

Source: Fourth World Conference on Women Platform for Action, 1995, paragraph 96.

Slide 6

Considerations for Making Reproductive and Sexual Rights a Reality

- What rights are "officially" recognized and protected by law?
- How do public awareness and perceptions reflect the differing perspectives of government, religion, local communities, and individuals?
- What is the status of women? Of youth?
- How do customs and traditions influence the exercise of existing rights?

Clarifying Terms

- **Informed consent:** A medical, legal, and rights-based construct whereby the client agrees to receive medical treatment, to use a family planning method, or to take part in a study (ideally) as a result of his or her informed choice.
- **Informed choice:** An individual's well-considered, voluntary decision based on options, information, and understanding.
- **Informed and voluntary decision making:** Informed choice, applied to any health care situation.

Slide 8

Why Informed and Voluntary Decision Making for Reproductive Health?

- Medical ethics/human rights
- Policy requirements
- Quality of care: client satisfaction
- Program benefits confirmed by research
- Practical benefit to clients

Slide 9

Informed and Voluntary Decision Making Is a Good Program Strategy

Research tell us that informed choice leads to:

- Better method use and client compliance with treatment regimens
- Continued method use
- Satisfied clients, who in turn are good program promoters

Slide 10

Research Also Tells Us That...

Giving people a choice of family planning makes a difference.

- Contraceptive use is highest when a variety of contraceptive choices are readily available (Ross et al., 2002)
- When people get the method they prefer, they are more likely to continue using it (Pariani, 1991)
- Increased continuation contributes more to contraceptive prevalence rates than an increase in new users (Jain, 1989)

Slide 11

More evidence from research...

One of the major reasons why clients discontinue pills and injectables is that they are not adequately informed about side effects.

Source: EngenderHealth studies in Cambodia (2000) and Nepal (2001)

Slide 12

Consequences of *Not* Ensuring Informed Choice in Family Planning

- Improper method use, resulting in unintended pregnancy
- Fear of and dissatisfaction with side effects, leading to discontinuation
- Failure to recognize serious warning signs, leading to health risks
- Dissatisfaction with quality of interaction or with method given, leading to drop-out, poor word of mouth, and low use of services

Slide 13

And Yet…
The Reality of Informed and Voluntary Decision Making in Practice

Individuals' ability to exercise their rights to make informed and voluntary family planning and reproductive health decisions is hindered by:

- Social and cultural factors
- Laws and policies
- Service-delivery practices
- Providers' attitudes
- Resource constraints

Slide 14

Research and Observation Tell Us:

Counseling often does not meet clients' informational and emotional needs

- Incomplete information or information overload
- Little or no preparation for side effects
- Failure to address fears and concerns

Many providers lack

- Good communication skills
- A client-centered approach
- The knowledge that they need for effective counseling
- Comfort in discussing SRH
- Adequate management and supervisory support

Slide 15

An Expanded Conceptual Framework

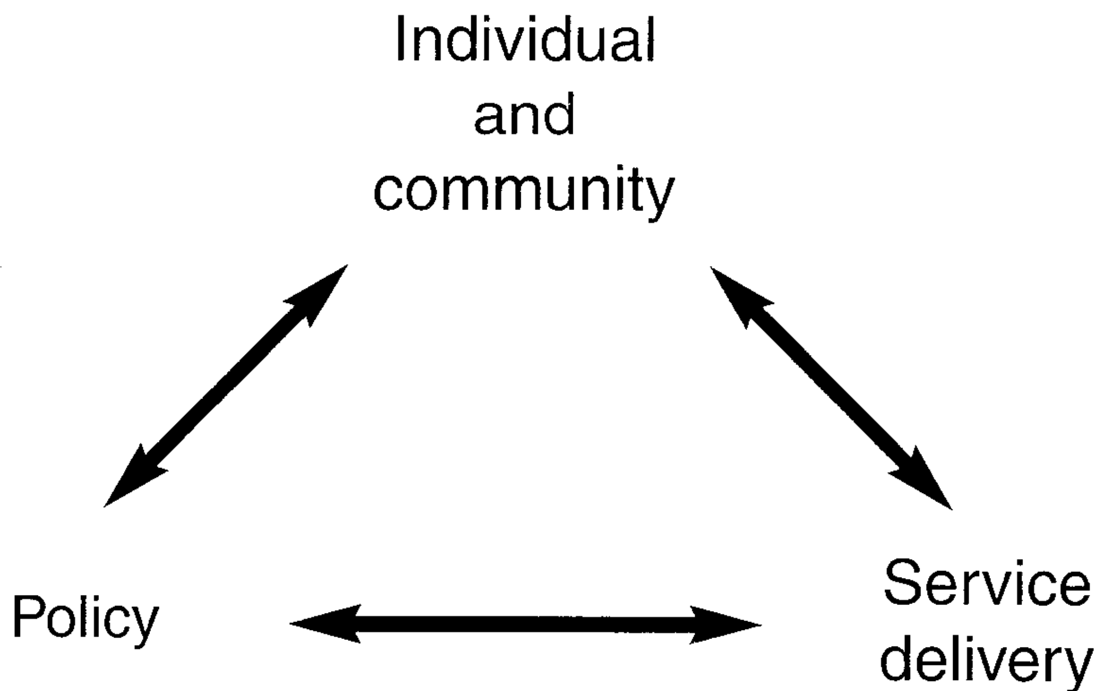
Basic elements that support informed and voluntary SRH decision making:

1. Service options are available.
2. The decision-making process is voluntary.
3. People have appropriate information.
4. Good client-provider interaction, including counseling, is ensured.
5. The social and rights context supports autonomous decision making.

Source: EngenderHealth. 2003. *Choices in family planning: Informed and voluntary decision making.* New York.

Slide 16

Influences Affecting Informed and Voluntary Decision Making in SRH



Individual and Community Factors...

That Affect Decision Making

- Sociocultural expectations and beliefs
- Rights context and individual status
- Sources and quality of information
  - ➤ Family and friends
  - ➤ Public information and education: media campaigns, articles, and radio or TV broadcasts
  - ➤ Outreach workers

Slide 18

Service-Site Factors...

That Affect Decision Making

- Providers' attitudes, knowledge, and skills in SRH
- Quality of counseling and time allocated for it
- Client education materials
- Method and service options available on-site
- Fee structure for SRH services

Policy and Program Factors...

That Affect Decision Making

- Policies concerning an individual's right to access SRH services, regardless of age or marital status
- Laws concerning an individual's decision-making rights with respect to SRH care
- Integration of SRH services
- Targets, quotas, or performance-based funding in family planning services
- Per-case referral or provider payments in family planning services

Slide 20

Applying the Expanded Framework:

Fostering a Supportive Social, Policy, and Service-Delivery Environment for Informed and Voluntary Decision Making

- Help service providers to consider and address client issues that extend beyond the clinic
- Join or create alliances to advocate for social and policy change
- Ensure access to service options
- Increase individual and community participation

Slide 21

The Value of Informed and Voluntary Decision Making

Supporting clients' informed and voluntary decision making:

- Helps people exercise their right to make and act on their own decisions about their health and reproduction
- Helps meet clients' needs and increase clients' satisfaction
- Helps meet programmatic goals

Supplementary Notes and Commentary for the Presentation

Slide 1

Promoting
Informed and Voluntary
Decision Making
to Support Clients' Rights
and Address Clients' Needs

EngenderHealth, 2003

Notes to Slide 1:

The objectives of this session are:

- To consider reproductive and sexual rights stipulated by international conferences and agreements, and discuss how these rights apply to the local situation
- To define informed and voluntary decision making (informed choice) and explain how it differs from informed consent
- To describe three levels of factors that influence informed and voluntary decision making—community and individual factors, policy factors, and service-delivery factors
- To discuss how informed and voluntary decision making applies to specific SRH needs and services

Slide 2

During this presentation...

- 60 women will die from preventable complications of pregnancy and childbirth
- 228 girls will undergo female genital cutting
- 240 women in the United States will be battered by their partners
- 250 women will contract HIV

Source: Panos Institute 1998. Using human rights to gain reproductive rights. Panos Briefing No. 32. London.

Notes to Slide 2:

- What do these numbers mean to us?
- How do reproductive and sexual rights apply to these situations?
- Let us try to remember the individuals represented by these statistics as we go through this presentation.

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Slide 3

Sexual and Reproductive Health Care Includes:

- Family planning information, counseling, and services
- Prevention and treatment of sexually transmitted infections (STIs) and reproductive tract infections (RTIs)
- Diagnosis and treatment of HIV and AIDS
- Antenatal, postpartum, and delivery care
- Health care for infants
- Management of abortion-related complications
- Prevention and treatment of infertility
- Information, education, and counseling on human sexuality, SRH, and parenthood
- Diagnosis and treatment of reproductive system cancers

Source: ICPD Programme of Action, 1994, paragraphs 7.2, 7.3, and 7.6.

Notes to Slide 3:

This is a review of the list of services discussed in Session 2. Ask the group if they have anything to add.

Slide 4

Reproductive Rights: ICPD, 1994

The rights of individuals and couples:

- To decide freely and responsibly the number, spacing, and timing of their children
- To have the information and means to do so
- To attain the highest standard of sexual and reproductive health
- To make decisions concerning reproduction free of discrimination, coercion, and violence

Source: ICPD Programme of Action, 1994, paragraph 7.3.

Notes to Slide 4:

"Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have information and means to do so, and the right to attain the highest standard of sexual and reproductive health….[and] the right to make decisions concerning reproduction free of discrimination, coercion, and violence."

Slide 5

Reproductive and Sexual Rights: FWCW, 1995

The human rights of women include:

- Their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination, and violence.

Source: Fourth World Conference on Women Platform for Action 1995, paragraph 96

Notes to Slide 5:

One year after the International Conference on Population and Development was held in Cairo, the international community reaffirmed and expanded the rights articulated in the Cairo Programme of Action to include sexual rights as well as reproductive rights.

Slide 6

Considerations for Making Reproductive and Sexual Rights a Reality

- What rights are "officially" recognized and protected by law?
- How do public awareness and perceptions reflect the differing perspectives of government, religion, local communities, and individuals?
- What is the status of women? Of youth?
- How do customs and traditions influence the exercise of existing rights?

Notes to Slide 6:

Reproductive and sexual rights still are a "foreign" concept in many parts of the world. For rights to feel "real" for people, they need to be defined and presented in ways that are culturally appropriate and meaningful to each person. These factors should be important when such a definition is being developed:

- What do people know of their rights? If people are not aware of their rights, they certainly cannot exercise them. How are rights perceived? Are they meant to benefit the individual? Do they threaten the family?
- What are the customs and traditions that influence the exercise of reproductive and sexual rights? How can these rights be presented in ways that reinforce traditional values? For example, respect and value for the family can be strengthened by giving couples the right to decide when they should have children and how many they should have.
- What are the different perspectives on rights? National governments, religious groups, and communities may have very different perspectives on issues of reproductive and sexual rights. How do these perspectives influence the individual's sense of what their rights are and what they mean?

Slide 7

Notes to Slide 7:

Much of the language of reproductive and sexual rights focuses on the right to make decisions "freely and responsibly." Thus, one of the most concrete and significant ways in which we can support a rights-based approach to SRH is to support informed ("responsibly") and voluntary ("freely") decision making by individuals and couples.

The concept of **informed and voluntary decision making** applies broadly to any health care decision and assumes that **individuals have both the right and the ability to make their own health care decisions.** How does this concept relate to other similar concepts, such as informed consent and informed choice?

Informed consent: A signed informed consent form does *not* guarantee "informed choice." In some instances, a client might sign without understanding the information provided, or a client may "consent" to a method or procedure without feeling that he or she has any choice in the matter. In addition, informed consent is meant to protect the client's right to make a voluntary and informed decision, but some providers use it primarily to protect themselves or the institution against subsequent accusations of coercion from clients.

Informed choice: The concept of "informed choice" means that, with or without a signed document, the client should be making a voluntary and well-informed decision. This term originally was associated with family planning, wherein an individual freely chooses whether to use a contraceptive, and which one. Although informed choice can apply to any SRH service, some providers have difficulty understanding "informed choice" outside of family planning services, because only one treatment option may exist (e.g., there is only one medication for syphilis, and thus no "choice") or because the individual's medical condition requires the provider to make emergency decisions for the (usually female) client (e.g., in postabortion care or emergency obstetric care).

Informed and voluntary decision making: This is basically the same as "informed choice," but we use this term to underscore the importance of the decisions that individuals *do* make in *every* area of reproductive and sexual health—even when options are limited and the need is urgent.

Slide 8

Notes to Slide 8:

We have talked about the human rights that underpin informed and voluntary decision making. Sometimes ensuring clients' informed choice is explicitly required in service guidelines and policies.

Informed and voluntary decision making is recognized as an essential element of good-quality services, which increase client satisfaction. Helping clients make informed and voluntary decisions about their reproductive health also has practical benefits to programs and to clients, which we will talk about in the next few slides.

Slide 9

Notes to Slide 9:

Better method use and client compliance lead to a reduction in unintended pregnancies and to improved health.

Continued method use results from clients' getting the method they want and being prepared for side effects.

Slide 10

Research Also Tells Us That…

Giving people a choice of family planning makes a difference.

- Contraceptive use is highest when a variety of contraceptive choices are readily available (Ross et al., 2002)
- When people get the method they prefer, they are more likely to continue using it (Pariani, 1991)
- Increased continuation contributes more to contraceptive prevalence rates than an increase in new users (Jain, 1989)

Notes to Slide 10:

The full sources supporting these points are as follows:

"Contraceptive use is highest when a variety of contraceptive choices are readily available"—Ross, J., et al. 2002. Contraceptive method choice in developing countries. *International Family Planning Perspectives* 28(1):32–40.

"When people get the method they prefer, they are more likely to continue using it"—Pariani, S., Heer, D. M., and Van Arsdol, M. D. 1991. Does choice make a difference to contraceptive use? Evidence from East Java. *Studies in Family Planning* 22(6):384–390.

"Increased continuation contributes more to contraceptive prevalence rates than an increase in new users"—Jain, A. K. 1989. Fertility reduction and the quality of family planning services. *Studies in Family Planning* 20(1):1–16.

Slide 11

More evidence from research…

One of the major reasons why clients discontinue pills and injectables is that they are not adequately informed about side effects.

Source: EngenderHealth studies in Cambodia (2000) and Nepal (2001)

Notes to Slide 11:

Informing clients about what to expect and about what is normal reduces fear and dissatisfaction, and eases adjustment to proper method use and client satisfaction.

Slide 12

Consequences of *Not* Ensuring Informed Choice in Family Planning

- Improper method use, resulting in unintended pregnancy
- Fear of and dissatisfaction with side effects, leading to discontinuation
- Failure to recognize serious warning signs, leading to health risks
- Dissatisfaction with quality of interaction or with method given, leading to drop-out, poor word of mouth, and low use of services

Notes to Slide 12:

The consequences of method failure or discontinuation often are unintended pregnancy, and as a result client dissatisfaction with the program. This in turn can lead to low levels of service utilization and of contraceptive prevalence.

Extreme cases in which providers make decisions for clients and do not tell them that a procedure has been performed (e.g., postpartum IUD insertion or sterilization performed without informed choice or consent) can destroy the credibility of entire programs.

Slide 13

And Yet...
The Reality of Informed and Voluntary Decision Making in Practice

Individuals' ability to exercise their rights to make informed and voluntary family planning and reproductive health decisions is hindered by:

- Social and cultural factors
- Laws and policies
- Service-delivery practices
- Providers' attitudes
- Resource constraints

Notes to Slide 13:

Some of the challenges:

- Reproductive rights and informed choice are still new concepts in some cultures and programs.
- Some donors, governments, and family planning programs set goals for service performance and results, which may be perceived as "targets" by program managers or service providers. This may create a systematic bias for or against particular methods, which can compromise clients' free choice.
- Some program planners still consider counseling a luxury for which they do not have sufficient resources. Convincing them that counseling is a key to service quality, client satisfaction, and achievement of program goals can be challenging.

Slide 14

Research and Observation Tell Us:

Counseling often does not meet clients' informational and emotional needs
- Incomplete information or information overload
- Little or no preparation for side effects
- Failure to address fears and concerns

Many providers lack
- Good communication skills
- A client-centered approach
- The knowledge that they need for effective counseling
- Comfort in discussing SRH
- Adequate management and supervisory support

Notes to Slide 14:

- Providers do not assess what the client needs and wants and do not tailor the interaction and information to the individual; they tend to give standard information whether the client needs it or not.
- Providers often fail to elicit information about the client's medical and contraceptive history.
- Most family planning providers fail to assess the client's risk of HIV and AIDS and to discuss the protection that different methods offer.
- Many providers have a poor attitude toward clients and treat them without kindness and respect.
- Some providers deliberately tell clients only positive information, believing that if they describe side effects, risks, and discomforts, they will scare clients away.

Slide 15

An Expanded Conceptual Framework

Basic elements that support informed and voluntary SRH decision making:
1. Service options are available.
2. The decision-making process is voluntary.
3. People have appropriate information.
4. Good client-provider interaction, including counseling, is ensured.
5. The social and rights context supports autonomous decision making.

Source: EngenderHealth. 2003. *Choices in family planning: Informed and voluntary decision making.* New York.

Notes to Slide 15:

EngenderHealth (formerly AVSC International) developed an expanded framework for informed and voluntary decision making, to offer practical guidance to service providers and program planners. This framework identifies five basic elements that support informed and voluntary decision making; a recently developed "tool kit" guides program managers, decision makers, service providers, and community leaders in assessing factors within each element that support or hinder informed choice in their settings, and developing action plans.

For each element, the framework suggests indicators that one can look for to assess whether these elements are in place. The following are examples of indicators:

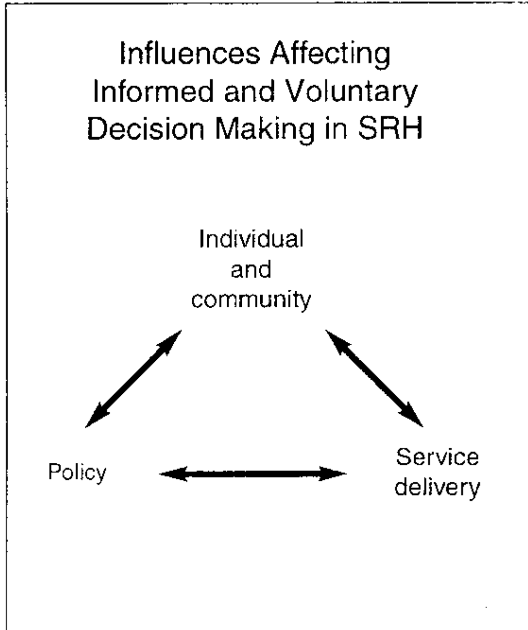
1. Service options are available.
   - Services are available where and when people need them.

- A choice of services is offered.
- Linkages exist with other health services, and referral mechanisms are in place.

2. The decision-making process is voluntary.
   - People are free to decide whether to use services, without coercion or constraint.
   - People are free to choose among available service options, without coercion or constraint.
   - A range of service options is accessible to all categories of clients, including unmarried individuals and adolescents.
   - Service providers are objective regarding all clients and all services.
   - Individuals' right to choose is respected and supported.
3. People have appropriate information.
   - People have access to appropriate and accurate information about services and options.
   - People understand their risk of STIs and HIV or AIDS and the protection provided by different family planning method options.
   - Service providers assess clients' knowledge, fill in gaps, and correct any misinformation.
   - Comprehensible posters and flipcharts are clearly in clients' view.
   - Samples of family planning methods are available for clients to see and touch.
   - Clients understand their options, essential information about their chosen method or treatment, and how it may affect their personal situation.
4. Good client-provider interaction, including counseling, is assured.
   - Clients actively participate in discussions and are encouraged to ask questions.
   - All staff have good communication skills.
   - All staff use language and terms clients can understand.
   - All staff have complete and correct information about SRH and available services.
   - All staff are respectful, nonjudgmental, and sensitive to power imbalances.
   - All staff maintain clients' privacy and confidentiality.
   - Trained staff are assigned to counsel clients as a routine component of services.
   - Counseling serves as the checkpoint to ensure voluntary and informed decision making.
   - The service setting is organized, clean, and cheerful, to put clients at ease.
   - Auditory and visual privacy are assured for counseling, regardless of the setting.
   - Adequate seating is available during counseling for staff, clients, and anyone else the clients choose.
5. The social and rights context supports autonomous decision making.
   - Laws, policies, and social norms support the following, plus other related rights:
     - Gender equity
     - Individuals' right to decide whether and when to have children, and how many
     - Clients' right to access SRH information and services, regardless of age, gender, marital status, or sexual orientation
     - The right to make decisions concerning SRH free of discrimination, coercion, and violence

(*Note:* This framework applies to the full array of SRH services, as well as family planning. It is adapted from: EngenderHealth. 2003. *Choices in family planning: Informed and voluntary decision making*. New York.)

Slide 16



Notes to Slide 16:

Decision making about SRH is complex and individualized, and is often influenced by an interplay of factors related to: individual circumstances; the legal, social, and rights context in which an individual lives; policies affecting information and services; and service-delivery practices.

Considering the complexity of the individual's decision-making process regarding SRH and the factors beyond service delivery that influence the quality of SRH care provided, an accurate and complete understanding of informed and voluntary decision making can only be achieved when *all* of these factors—community, policy, and service delivery—are considered, both in themselves and in terms of how they influence each other.

The next three slides give examples of factors in each area.

Slide 17

Notes to Slide 17:

Individual and community factors include all of the family, educational, religious, and social messages that people experience as they grow up and live in a particular community, plus the unique way in which the individual processes and interprets all of these factors. On the one hand, an individual's sense of what he or she needs and wants in terms of his or her own SRH is a very personal experience, yet on the other hand it is very heavily influenced by community expectations of what is right or wrong, good or bad, and acceptable or unacceptable.

These influences are particularly powerful in determining what people feel that they can or cannot talk about, and with whom. Such communication opportunities and constraints are key to the "informed" element of informed choice. The community also plays a powerful role in determining who is expected (or allowed) to make decisions about SRH and what kinds of choices are acceptable.

SRH decision making is a complex process that starts *before* the client comes to the clinic. The first decision is whether to seek services; many potential clients choose not to do so. Some elements of this aspect of the decision-making process include:

- The client's ability or inability to make independent decisions (i.e., who holds power in the family?)
- Personal attitudes and preferences
- Knowledge or misinformation (from such sources as other satisfied or unsatisfied clients; paid or volunteer outreach workers; information, education, and communication campaigns; and common rumors or misconceptions)

A variety of cultural and community factors influence clients' decision making about all aspects of their lives. The following are just a few examples:

- *Social and cultural background.* This includes such factors as religious beliefs about contraception, a preference for sons, a perception that a large family signifies wealth or serves as insurance for old age, and a woman's value being seen chiefly in terms of her fertility. Marginalized groups, including poor, uneducated women and youth, often lack access to choices and have limited ability to make autonomous decisions.
- *Rights context.* This may involve the right to decide when to have children and how many to have, the right to be treated with respect and dignity, the right to a range of family planning methods, the right to complete and comprehensible information, and the right to information and services related to HIV, AIDS, STIs, and other health conditions. The client's individual status (in terms of socioeconomic status, age, gender, marital status, educational attainment, or sexual orientation) influences his or her awareness of and ability to assert these rights.
- *Sources and quality of information.* In all cultures, family and friends are a primary source of information about SRH. Others include public media and outreach efforts by health workers.

Slide 18

Notes to Slide 18:

Service-site factors can be viewed from at least three perspectives—the client's, the provider's, and the supervisor's. All three perspectives need to be considered when the impact of service-delivery practices on informed and voluntary decision making is being assessed. This includes what services are actually provided, by whom they are provided, and the quality of care that is offered, as perceived by the client. The level and nature of training for providers needs to be considered, because it is unfair to expect providers to offer services in a manner for which they have not been trained. The role (and training) of supervisors is also important, because it is difficult for providers to make changes if they do not receive institutional support and ongoing guidance for those changes. Remember also that providers and supervisors are just as much influenced by the norms of their home community as clients are.

Some clients make a firm choice before coming to the clinic, although that choice may or may not be voluntary and well-informed. Others come to the clinic to seek help from a health professional, to learn about and be able to choose among method or service options. Regardless of external factors, clinic staff should serve as the *checkpoint* to determining where the client is in the decision-making process and then should meet that client's individual needs, either confirming that informed and voluntary decision making has been made or helping the client to make the decision. In the reality of program implementation and day-to-day service delivery, there are additional challenges to informed and voluntary decision making.

Specifically, the provider's role in ensuring informed and voluntary decision making is to:

- Give clients real options and correct information (assessing what they already know and want, filling the gaps to meet their needs, and correcting misinformation)
- Help clients exercise their right to decide
- Help clients confirm or reach appropriate decisions (i.e., choose services that are reasonable for their circumstances, lifestyle, and health status, and make sure that they do not have unrealistic expectations)

Note: You may want to prepare a flipchart showing these three points, to keep posted throughout the training.

Slide 19

Notes to Slide 19:

Policy and program factors can compromise clients' options, their access to information or services, and their ability to decide for themselves.

Policies can include laws, governmental goals, programming objectives, and service-delivery guidelines. Factors that influence policies include politics, economics, demographic pressures, religion, and cultural expectations, with medicine and public health playing an important but often limited role. Policies are meant to guide program managers and service providers in terms of their scope of work and the quality of care expected of them. However, many policies' actual meaning and intent are not adequately communicated to the people who are meant to be guided by them.

Note: Laws and policies regarding access to services and the right to make one's own decisions may be positive or negative. For example, targets and quotas, performance-based funding or reporting, and payments to providers or clients are generally considered to be potential threats to informed choice in family planning.

The Tiahrt Amendment (1998)

One example of a policy factor that affects informed choice in family planning is the Tiahrt Amendment, an amendment to an appropriations bill passed by the U.S. Congress in 1998. This amendment specifically addressed issues of informed choice and voluntarism in family planning service-delivery projects supported by the U.S. Agency for International Development (USAID). Actually, most countries in which USAID supports family planning programs have much broader guidelines concerning quality of care, informed choice, and voluntarism than the Tiahrt Amendment requires. The difference is that the Tiahrt Amendment is an actual law—rather than a guideline—requiring that USAID report any violations to the U.S. Congress.

The Tiahrt Amendment identifies five specific requirements for USAID-assisted family planning projects:

- Targets or quotas must not be used.
- Incentives and financial awards may not be used to reward clients for accepting a family planning method or to reward program personnel for recruiting family planning clients.
- Benefits or rights must not be tied to the acceptance of a family planning method.
- Clients must receive comprehensible information on health benefits and risks, inadvisable conditions (e.g., conditions under which a method should not be used), and adverse side effects associated with the family planning method selected.
- Experimental contraceptive methods must be provided in the context of a scientific study in which participants are advised of their potential risks and benefits.

Slide 20

Notes to Slide 20:

Looking at the impact and interaction of all three areas of influence on informed choice—policy, service delivery, and community—may foster a supportive rights and policy environment for informed choice, one that encourages healthy client decision making. Specific strategies include:

- Embracing an expanded framework of informed choice that extends beyond the clinic walls to incorporate broader social aspects of decision making and access to services, and recognizing the impact of cultural factors on couple-provider interaction and on clients' ability to make autonomous decisions
- Forging alliances and creating or joining multisectoral coalitions to advocate for social and policy change to support, promote, and protect clients' rights and informed choice
- Ensuring access to service options
- Increasing client and community participation in public information efforts, program design, and program evaluation, to better understand and meet client needs and to make programs more accountable to the community they serve

Slide 21

Notes to Slide 21:

- There is a moral imperative to ensuring that clients make informed and voluntary decisions based on their recognized rights. (It is the right thing to do.)
- Ensuring informed and voluntary client decisions maintains or improves quality of care, which increases client satisfaction.
- Ensuring informed and voluntary client decisions meets program goals as a result of increased method adoption, improved method and medication use, improved compliance with treatment regimens, and increased continuity of care.

Appendix D
Participants' Self-Assessment of Knowledge and Attitudes: Pretest/Posttest

Participants' Self-Assessment of Knowledge and Attitudes: Pretest/Posttest

Name (or number): ______________________________ **Date:** ______________

Decide whether each of the following statements is T *(true) or* F *(false). Write your response for each statement in the space provided.*

1. ____ In integrated SRH counseling, the purpose of listening to clients is to allow the service provider to obtain enough information from the client to be able to decide how to tailor the discussion and the information presented.
2. ____ In integrated SRH counseling, closed-ended questions are more effective for meeting clients' needs than open-ended questions, because they allow the service provider to see more clients in less time.
3. ____ In integrated SRH counseling, being able to reflect on the pros and cons of all alternatives enables clients to find their own solutions to their problems.
4. ____ A principal purpose of integrated SRH counseling is to help service providers assist clients to take responsibility for making and implementing decisions concerning their problems.
5. ____ In integrated SRH counseling, it is not appropriate for service providers to share their personal reactions to their clients' sexual behavior.
6. ____ In integrated SRH counseling, service providers should always use clinical terminology with clients, to enable clients to improve their knowledge.
7. ____ The same sexual behavior may be risky in one situation and not in another.

The following are multiple-choice questions. Please circle the correct response for each question. Unless otherwise indicated, there is only one correct response for each question.

8. Which of the following is *not* a responsibility of service providers in counseling young people?
   a. Be a reliable, factual source of information about SRH
   b. Create an atmosphere of privacy, respect, and trust
   c. Advise the client about the morality of his or her behavior
   d. Engage in a dialogue or an open discussion with the client

9. Which of the following is *not* required for a client to be able to make an informed choice?
   a. Service provider's recommendation
   b. Availability of appropriate information
   c. Voluntary decision-making process
   d. Availability of adequate service options

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Self-Assessment

10–13. Which of the following indicates that a service provider is effectively listening to a client? (There are four correct responses.)

a. Occasionally paraphrasing or summarizing what the client has said
b. Looking at the client when he or she is talking
c. Thinking about what you will say next to the client
d. Writing or reading notes when the client is speaking
e. Asking specific questions related to what the client has told you
f. Interrupting the client to give him or her advice
g. Nodding your head or making encouraging sounds when the client is talking

Please answer the following questions in the space provided.

Define the terms:

14. Informed choice

15. Informed consent

Name five client rights that apply to the provision of SRH services.

16. ______________________________

17. ______________________________

18. ______________________________

19. ______________________________

20. ______________________________

Name five types of health services that are considered to be the components of SRH care.

21. ______________________________

22. ______________________________

23. ______________________________

24. ______________________________

25. ______________________________

Self-Assessment

Name four categories of behavior that people use to control their partners in sexual relationships.

26. ______________________________

27. ______________________________

28. ______________________________

29. ______________________________

Match the terms with their definitions, by placing the number of the definition in front of the term to which it applies.

______ Gender

______ Gender role

30. Socially and culturally defined attitudes, behaviors, expectations, and responsibilities for males and females

31. How an individual or society defines "female" or "male"

The following are examples of questions that a provider might ask in the context of an SRH consultation. Review the questions below, and write C (for closed-ended*) and O (for* open-ended*), as appropriate, in the space provided.*

32. _____ Do you remember what to do if you miss one pill?

33. _____ How old are you?

34. _____ How do you feel now?

35. _____ When did the bleeding start?

36. _____ How would you feel about using the pill?

37. _____ Is your home far from this clinic?

38. _____ How did you feel when you first found out you were pregnant?

39. _____ What do you plan to do to protect yourself from getting pregnant again?

40. _____ How would you feel about not having any more children?

41. _____ How many children do you have?

42. _____ What questions or concerns does your husband or partner have about your condition?

43. _____ Do you realize that a tubal sterilization is permanent?

44. _____ What do you know about HIV and STIs?

45. _____ Do you have any idea if your partner has other sexual partners?

Self-Assessment

For REDI:

In SRH counseling, the acronym "REDI" refers to certain steps in counseling. What is the step represented by each of these letters?

46. **R:** ______________________________

47. **E:** ______________________________

48. **D:** ______________________________

49. **I :** ______________________________

Review the activities below, and write the letter for the activity, as appropriate, in the space provided next to the corresponding step of REDI.

50. **R:** ________

51. **E:** ________

52. **D:** ________

53. **I :** ________

Activities:

a. Help the client consider how his or her family might react to his or her choice of actions.
b. Offer ideas for improving communication and negotiation with the client's partner.
c. Ask about the client's relationships and behaviors that might put him or her at risk for an unintended pregnancy or a sexually transmitted infection.
d. Assure the client of confidentiality.

For GATHER:

In counseling, the acronym "GATHER" refers to certain steps in counseling. What step is represented by each of the letters?

46. **G:** ______________________________

47. **A:** ______________________________

48. **T:** ______________________________

49. **H:** ______________________________

50. **E:** ______________________________

51. **R:** ______________________________

Self-Assessment

Review the activities below, and write the letter for the activity, as appropriate, in the space provided next to the corresponding step of GATHER.

52. **G:** ________

53. **A:** ________

54. **T:** ________

55. **H:** ________

56. **E:** ________

57. **R:** ________

Activities:

a. Assist the client to identify his or her options and the pros and cons of each.
b. Ask the client to repeat the instructions. Listen carefully to make sure that he or she remembers and understands important information.
c. Briefly describe the prevention and treatment measures in which the client is interested.
d. Explain what will happen during the visit.
e. Ask the client what he or she knows about the prevention or treatment measures that are of interest.
f. Invite the client to come back at any time for any reason.

Answers to:

Participants' Self-Assessment of Knowledge and Attitudes: Pretest/Posttest

Decide whether each of the following statements is T *(true) or* F *(false). Write your response for each statement in the space provided.*

1. __F__ In integrated SRH counseling, the purpose of listening to clients is to allow the service provider to obtain enough information from the client to be able to decide how to tailor the discussion and the information presented.
2. __F__ In integrated SRH counseling, closed-ended questions are more effective for meeting client's needs than open-ended questions, because they allow the service provider to see more clients in less time.
3. __T__ In integrated SRH counseling, being able to reflect on the pros and cons of all alternatives enables clients to find their own solutions to their problems.
4. __T__ A principal purpose of integrated SRH counseling is to help service providers assist clients to take responsibility for making and implementing decisions concerning their problems.
5. __T__ In integrated SRH counseling, it is not appropriate for service providers to share their personal reactions to their clients' sexual behavior.
6. __F__ In integrated SRH counseling, service providers should always use clinical terminology with clients, to enable clients to improve their knowledge.
7. __T__ The same sexual behavior may be risky in one situation and not in another.

The following are multiple-choice questions. Please circle the correct response for each question. Unless otherwise indicated, there is only one correct response for each question.

8. Which of the following is *not* a responsibility of service providers in counseling young people?
   a. Be a reliable, factual source of information about SRH
   b. Create an atmosphere of privacy, respect, and trust
   (c.) Advise the client about the morality of his or her behavior
   d. Engage in a dialogue or an open discussion with the client

9. Which of the following is *not* required for a client to be able to make an informed choice?
   (a.) Service provider's recommendation
   b. Availability of appropriate information
   c. Voluntary decision-making process
   d. Availability of adequate service options

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Self-Assessment: Answers

10–13. Which of the following indicates that a service provider is effectively listening to a client? (There are four correct responses.)

- (a.) Occasionally paraphrasing or summarizing what the client has said
- (b.) Looking at the client when he or she is talking
- c. Thinking about what you will say next to the client
- d. Writing or reading notes when the client is speaking
- (e.) Asking specific questions related to what the client has told you
- f. Interrupting the client to give him or her advice
- (g.) Nodding your head or making encouraging sounds when the client is talking

Please answer the following questions in the space provided.

Define the terms:

14. Informed choice

Correct answers should have at least three of the following elements, although exactly the same wording is not required:

Informed choice **is an individual's well-considered, voluntary decision based on options, information, and understanding.**

15. Informed consent

Correct answers should have at least three of the following elements, although exactly the same wording is not required:

Informed consent **is a medical, legal, and rights-based construct whereby the client agrees to receive medical treatment, to use a family planning method, or to take part in a study, (ideally) as a result of his or her informed choice.**

16–20. Name five client rights that apply to the provision of SRH services.

Any five of the following are correct, although exactly the same wording is not required:

Information

Access to services

Informed choice

Safety of services

Privacy and confidentiality ***(can be listed separately)***

Dignity, comfort, and expression of opinion ***(can be listed separately)***

Continuity of care

Self-Assessment: Answers

21–25. Name five types of health services that are considered to be the components of SRH care.

Any five of the following are correct, although exactly the same wording is not required:

Family planning information, counseling, and services

Prevention and treatment of STIs and RTIs

Diagnosis and treatment of HIV and AIDS

Antenatal, postpartum, and delivery care

Health care for infants

Management of abortion-related complications

Prevention and treatment of infertility

Information, education, and counseling on human sexuality, SRH, and parenthood

Diagnosis and treatment of cancers of the reproductive system

Name four categories of behavior that people use to control their partners in sexual relationships.

26. **Physical**
27. **Emotional/Psychological**
28. **Financial**
29. **Sexual**

Match the terms with their definitions, by placing the number of the definition in front of the term to which it applies.

__**31**__ Gender

__**30**__ Gender role

30. Socially and culturally defined attitudes, behaviors, expectations, and responsibilities for males and females
31. How an individual or society defines "female" or "male"

The following are examples of questions that a provider might ask in the context of an SRH consultation. Review the questions below, and write C *(for* closed-ended*) and* O *(for* open-ended*), as appropriate, in the space provided.*

32. __**C**__ Do you remember what to do if you miss one pill?
33. __**C**__ How old are you?
34. __**O**__ How do you feel now?

Self-Assessment: Answers

35. __C__ When did the bleeding start?
36. __O__ How would you feel about using the pill?
37. __C__ Is your home far from this clinic?
38. __O__ How did you feel when you first found out you were pregnant?
39. __O__ What do you plan to do to protect yourself from getting pregnant again?
40. __O__ How would you feel about not having any more children?
41. __C__ How many children do you have?
42. __O__ What questions or concerns does your husband or partner have about your condition?
43. __C__ Do you realize that a tubectomy is permanent?
44. __O__ What do you know about HIV and STIs?
45. __C__ Do you have any idea if your partner has other sexual partners?

For REDI:

In SRH counseling, the acronym "REDI" refers to certain steps in counseling. What is the step represented by each of these letters?

46. **R:** **Rapport-building**
47. **E:** **Exploration**
48. **D:** **Decision making**
49. **I :** **Implementing the decision**

Review the activities below, and write the letter for the activity, as appropriate, in the space provided alongside of the corresponding step of REDI.

50. **R:** **d**
51. **E:** **c**
52. **D:** **a**
53. **I :** **b**

Activities:

a. Help the client consider how his or her family might react to his or her choice of actions.
b. Offer ideas for improving communication and negotiation with the client's partner.
c. Ask about the client's relationships and behaviors that might put him or her at risk for an unintended pregnancy or a sexually transmitted infection.
d. Assure the client of confidentiality.

Self-Assessment: Answers

For GATHER:

In counseling, the acronym "GATHER" refers to certain steps in counseling. What step is represented by each of the letters?

46. **G:** **Greet**
47. **A:** **Ask/Assess**
48. **T:** **Tell**
49. **H:** **Help**
50. **E:** **Explain**
51. **R:** **Return visit/Referral**

Review the activities below, and write the letter for the activity, as appropriate, in the space provided next to the corresponding step of GATHER.

52. **G:** d
53. **A:** e
54. **T:** c
55. **H:** a
56. **E:** b
57. **R:** f

Activities:

a. Assist the client to identify his or her options and the pros and cons of each.
b. Ask the client to repeat the instructions. Listen carefully to make sure that he or she remembers and understands important information.
c. Briefly describe the prevention and treatment measures in which the client is interested.
d. Explain what will happen during the visit.
e. Ask the client what he or she knows about the prevention or treatment measures that are of interest.
f. Invite the client to come back at any time for any reason.

Appendix E
Participant Evaluation Form

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Participant Evaluation Form

Please answer all sections of this evaluation form, using the reverse side for comments, if needed. Your responses will assist the training organizers in determining what modifications, if any, should be made to this program.

I. Overall Evaluation

Please check the choice that best reflects your overall evaluation of this training:

❑ Very good ❑ Good ❑ Fair ❑ Poor ❑ Very poor

II. Achievement of Objectives

The general objectives of the training are to ensure that you have the knowledge, attitudes, and skills necessary to carry out the key tasks of integrated sexual and reproductive health (SRH) counseling. For each task (below), please circle the appropriate number to indicate the degree to which you feel that objective was achieved: 5 = totally achieved; 4 = mostly achieved; 3 = somewhat achieved; 2 = hardly achieved; and 1 = not at all achieved.

For any objectives given a rating of 1, 2, or 3, please indicate in the Comments/Suggestions column why you feel that it was somewhat, hardly, or not at all achieved and please offer any suggestions you might have to improve it.

Key counseling task	Score					Comments/Suggestions
1. Help clients assess their own needs for a range of SRH services, information, and emotional support	5	4	3	2	1	
2. Provide information appropriate to clients' identified problems or needs	5	4	3	2	1	
3. Assist clients in making their own voluntary and informed decisions	5	4	3	2	1	
4. Help clients develop the skills needed to carry out those decisions	5	4	3	2	1	

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Participant Evaluation Form

III. Other Aspects of the Training

For each of the following questions, check the response that best represents your opinion. Please add any other comments you have.

1. How relevant to your work was the overall workshop?

❑ Extremely ❑ Mostly ❑ Somewhat ❑ Not very ❑ Not at all

- What aspects of the workshop were the *most* important or useful for you? Why?

____

____

____

- What aspects of the workshop were the *least* important or useful for you? Why?

____

____

____

- Additional comments: ______________________________

____

____

____

2. How well did the course content meet your expectations?

❑ Totally ❑ Mostly ❑ Partially ❑ Not at all

- Comments:

____

____

____

3. How well did the training methods contribute to achieving the workshop objectives?

❑ Extremely well ❑ Mostly ❑ Moderately ❑ Minimally ❑ Not at all

- Comments:

____

____

____

3. How well did the training methods used contribute to achieving the workshop objectives? *(continued)*
   - The *most* effective training methods were:

     ____

     ____

     ____

   - The *least* effective training methods were:

     ____

     ____

     ____

4. How well did the materials distributed in the workshop contribute to your learning?

   ❑ Extremely well ❑ Mostly ❑ Moderately ❑ Minimally ❑ Not at all

   - Comments:

     ____

     ____

     ____

For the next two questions, please refer to your agendas for the names of the sessions (topics) in this workshop.

5. Which three sessions were the *most* useful, and why?

   a. ______________________________

   ____

   ____

   b. ______________________________

   ____

   ____

   c. ______________________________

   ____

   ____

6. Which three sessions were the *least* useful, and why?

   a. ______________________________

   ____

   ____

Participant Evaluation Form

6. Which three sessions were the *least* useful, and why? *(continued)*

   b. ______________________________

   ____

   ____

   c. ______________________________

   ____

   ____

7. Please check any of the following that you feel could have improved the workshop.

   _____ a. Use of more realistic examples and applications
   _____ b. More time to become familiar with theory and concepts
   _____ c. More time to practice skills and techniques
   _____ d. More effective group interaction
   _____ e. More effective training activities
   _____ f. Concentration on a more limited and specific topic
   _____ g. Consideration of a broader and more comprehensive topic
   _____ h. Other

   - Comments:

   ____

   ____

   ____

8. What three things could the organizers of this training have done to make the training more effective for you?

   a. ______________________________

   ____

   ____

   b. ______________________________

   ____

   ____

   c. ______________________________

   ____

   ____

Appendix F
Trainer Evaluation Form

Trainer Evaluation Form

You have just facilitated a training course on integrated SRH counseling. Please answer the following questions; these will help us evaluate and improve this course from your, the trainer's, perspective. You may give your form to the organizers of this training, or you may send it directly to:

Advances in Informed Choice Team
EngenderHealth
440 Ninth Avenue
New York, NY 10001 U.S.A.
Telephone: 212-561-8000 Fax: 212-561-8067
e-mail: info@engenderhealth.org

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1. How well did the objectives of this course reflect the skills that providers need to carry out their tasks in integrated SRH counseling?

❑ Extremely well ❑ Mostly ❑ Fairly well ❑ Not very well ❑ Not at all

Comments:

____
____
____

2. To what extent were the participants able to master the skills taught in the training?

❑ Completely ❑ Mostly ❑ Partially ❑ Minimally ❑ Not at all

Comments:

____
____
____

3. Please evaluate the following aspects of the Trainers' Manual.

a. How clear and thorough were the instructions (methodology and content) for conducting sessions?

❑ Excellent ❑ Above average ❑ Average ❑ Below average ❑ Poor

Comments:

____
____
____

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Trainer Evaluation Form

3. Please evaluate the following aspects of the Trainers' Manual. *(continued)*

   b. Almost all of the content to be covered in this curriculum was included in the Participant's Handbook. How well did this prepare you to conduct the sessions?

   ❑ Extremely well ❑ Very well ❑ Somewhat ❑ Not very well ❑ Not at all

   Comments:

   c. How logical was the sequencing of sessions, both to facilitate the transition from session to session and to facilitate participants' learning?

   ❑ Extremely ❑ Very ❑ Somewhat ❑ Not very ❑ Not at all

   Comments:

4. To what extent were the materials distributed to participants:

   a. Relevant to their learning needs?

   ❑ Extremely ❑ Very ❑ Somewhat ❑ Not very ❑ Not at all

   Comments:

   b. Adequate in scope and depth for reinforcing their learning?

   ❑ Extremely ❑ Very ❑ Somewhat ❑ Not very ❑ Not at all

   Comments:

Trainer Evaluation Form

5. How would you rate the amount of time allocated to each session?

❑ Ideal ❑ About right ❑ Adequate ❑ Slightly inadequate ❑ Totally inadequate

Comments:

____

____

____

6. What would you suggest to improve this training?

____

____

____

Please use this space for more extensive comments.

Thank you!

Appendix G
Outcome Evaluation Using Observation of Client-Provider Interactions

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Outcome Evaluation Using Observation of Client-Provider Interactions

The true test of the success, or outcome, of integrated SRH counseling training is whether the participants are conducting such counseling at their service sites and how well they are doing it. This and the following two appendixes offer tools for evaluating the outcome of this training through observation of client-provider interaction, through interviews with providers, and through anonymous interviews with clients. All three perspectives should be considered to get a complete picture of the possible impact of the training on providers and clients. As noted in "Before the Training Course" (Introduction for the Trainers, page xvii), trainers should determine the evaluation plan with program planners and site administrators prior to conducting the course.

The Observation Guides presented here are guidelines for observing the counseling interaction between providers who have been through this training and actual clients. Observation is basically meant to answer the questions "Is the provider applying integrated SRH counseling skills in service delivery?" and "If so, how well?" If a baseline observation was conducted before the training, observations following the training can also indicate changes in the provider's attitudes and skills, which may be attributable to the training.

Who Can Conduct Outcome Evaluation?

Since competency in counseling is evaluated through observation of counseling and through interviews with participants and clients, such evaluations are necessarily somewhat subjective. To make the observation process as reliable as possible from one evaluation to another, the same individuals should conduct the evaluations each time, and these evaluators should be competent in the skills being evaluated. The trainers should *not* do the evaluations, although they can help orient local evaluators to the desired outcomes of the training.

When Should Observation of Counseling Be Conducted?

To assess the impact of the training on providers' skills, counseling observation needs to be conducted both *before* and *after* the training (for example, three or six months following training). If it is not possible to do the "baseline" observations before the training, the Observation Guide can still be used following the training, to determine if and how well trainees are utilizing the skills learned. (However, you do lose the chance to attribute any "improvement" to the training.)

How Can This Information Be Used?

The results of outcome evaluation can be used in many ways.

- *Program planners and administrators* will want to know if the training had the desired effect on service delivery (i.e., establishing integrated SRH counseling services). If it did not, these tools provide clues for what the barriers are and whether they are training-related or can be traced to other aspects of service delivery.
- *Providers* will want to know how clients respond to this approach to counseling and how they can improve their skills.
- *Trainers* will want to know if their training approaches were effective in imparting appropriate knowledge, attitudes, and skills for integrated SRH counseling and how these approaches can be strengthened.

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- Finally, *EngenderHealth* would like to know the outcomes of these trainings in different countries, so that lessons learned can be shared both across the agency and throughout the health and development community.

Observation Guides

The expected outcome of this training is the improvement of skills in providing integrated SRH counseling *and* the effective application of these skills in the participants' service settings. The indicators of skill improvement reflect the general objectives of the training, which are based on tasks necessary for carrying out integrated SRH counseling, and on the knowledge, attitudes, and skills necessary for carrying out these tasks. The attached Observation Guides provide a guideline for monitoring performance on these indicators.

Two versions of the Observation Guide follow. The decision on which to use depends on whether the workshop has used REDI or GATHER as the framework upon which the training is based.

The steps of the REDI framework can be applied to any of the types of services a client may seek (family planning, STI and HIV, maternal health care, or postabortion care). The evaluator should observe the "general skills and establishment of positive client-provider interaction" throughout the visit and apply the indicators of the steps of REDI as the consultation progresses.

In the GATHER framework, within each step are general indicators that apply to that task, followed by subsections addressing indicators for family planning clients and STI and HIV clients. The evaluator should observe service-provider performance in terms of the "general skills and establishment of positive client-provider interaction" throughout the visit and should apply the "generic" indicators for each step of GATHER for all clients. For family planning and STI and HIV clients, the evaluator can also observe the specific indicators given.

Specific Instructions

- To help improve providers' skills, as well as the training itself (see below), the completed Observation Guides will be shared with others; thus, these forms are *not* confidential. The provider should be made aware of this before the observations begin.
- Ideally, the evaluator would observe each provider interacting with several clients. The Observation Guide provides columns for rating up to four interactions. If an observer evaluates more than four client-provider interactions for one provider, additional forms should be used.
- A separate Observation Guide should be used for each provider evaluated.
- Following the observations, the evaluator should meet with the provider to discuss them.
- Copies of the completed observation guides should be given to the provider, to the provider's supervisor, and to a representative of the training team. The evaluator should give the original forms to a local EngenderHealth staff member or send them to:

Advances in Informed Choice Team
EngenderHealth
440 Ninth AvenueNew York, NY 10001 U.S.A.
Telephone: 212-561-8000
Fax: 212-561-8067
e-mail: info@engenderhealth.org

Observation Guide: REDI Framework

Instructions: Evaluate the performance of the provider in implementing each task or activity, using the following codes:

1 = Needs improvement
2 = Adequate
3 = Competent
N = Not applicable

Name: ______________________ **Service site:** ______________________

Observer: ______________________ **Date** ______________________

Observation Guide: REDI

Task/Activity	Rating per client-provider interaction
General skills and establishment of positive client-provider interaction	
Demonstrates respect for the client; does not judge the client	
Shows friendliness by smiling	
Ensures privacy in the consultation room	
Uses simple and clear language	
Asks open-ended questions	
Asks the client to paraphrase, as necessary, to ensure that the client understands his or her questions and explanations	
Encourages the client to ask questions and express concerns	
Answers all of the client's questions	
Indicates throughout the consultation that he or she is listening to the client	
Paraphrases the client to ensure understanding of the client's message	
Does not interrupt the client unless absolutely necessary	
REDI	
Rapport-building	
Welcomes the client with warmth and with respect	
Offers the client a seat	
Introduces himself or herself	
Identifies the reason for the client's visit	
Introduces the subject of sexuality and explains the need to ask certain personal questions	
Assures the client of confidentiality	
Explains what will happen during the visit (as appropriate)	

Appendix G

Observation Guide: REDI

Task/Activity	Rating per client-provider interaction			
Exploration				
Asks the client about:				
• His or her needs, problems, and concerns				
• His or her sexual relationships, including:				
➤ Sexual relationships in which he or she is involved				
➤ Concerns about violence or abuse				
➤ Client's communication with a partner about sexuality, family planning, and HIV and sexually transmitted infections (STIs)				
➤ Client's knowledge about partners' sexual behaviors outside of the relationship				
Asks the client about his or her:				
• Pregnancy history				
• Knowledge and use of family planning methods, including condoms				
• HIV and STI history and symptoms				
• Knowledge of partners' HIV and STI history				
Asks the client about his or her ability to make his or her own decisions on having sex and about the influence of any of the following factors:				
• Client's financial dependency on his or her partner(s)				
• Pressures from extended family				
• Fear of violence				
Asks the client what he or she knows about:				
• Pregnancy-related care (if appropriate)				
• Postabortion care (if appropriate)				
• Family planning				
• HIV				
• STIs				
Provides the client with information about the above topics, as needed				
Helps the client determine his or her (or his or her partners') risk for:				
• HIV and STI transmission				
• Unintended pregnancy				
Decision making				
Helps the client determine what decisions he or she needs to make today				
Explains the importance of the client's making his or her own decisions				
Helps the client consider all of the alternatives and options				
Helps the client consider the pros and cons of each alternative or option (including side effects and the possibility of complications)				

Observation Guide: REDI

Task/Activity	Rating per client-provider interaction
Decision making ***(continued)***	
Provides additional information, as appropriate, to help the client consider alternatives and options	
Helps the client consider how his or her family might react to his or her choice of alternatives	
Helps the client make his or her own decision, regardless of the views of others	
Asks the client to explain in his or her own words why he or she made the particular decision	
Helps the client assess whether his or her decision could actually be carried out (given relationships, family situation, economic status, etc.)	
Implementation	
Helps the client make a plan for carrying out the decision, asking:	
• When are you going to do what you decided to do?	
• Under what circumstances are you going to do it?	
• What will your next steps be?	
Asks about:	
• Possible consequences of the client's plan (potential health benefits vs. risks, partners' reactions, client's concerns about economic support, client's concerns about violence, etc.)	
• The client's ability to communicate his or her plan to partners	
Asks about social supports or barriers:	
• Whom the client could count on to support him or her in the decision	
• Who might create obstacles, and what the client can do about that if it happens	
Helps the client make an alternate plan if this one does not work out	
Helps the client identify skills needed to carry out this decision	
Helps the client develop communication and negotiation skills (as necessary):	
• Discusses the client's concerns about communicating and negotiating with partners or other family members concerning this decision	
• Offers ideas for improving communication and negotiation	
• Helps the client practice communicating through role plays	
Helps the client develop condom-use skills (as necessary):	
• Demonstrates to the client how to use a condom and has the client repeat the demonstration to reinforce his or her understanding	
• Discusses how the client can make condom use more acceptable to his or her partners	
• Gives the client samples of condoms and tells him or her where and how to obtain more	

Appendix G

Observation Guide: REDI

Task/Activity	Rating per client-provider interaction			
Implementation *(continued)*				
Helps the client develop other skills in using family planning methods				
• Asks client to state in own words how to use the family planning method chosen by the client				
• Helps the client plan how to manage common side effects and what to do if warning signs occur				
Helps the client make a follow-up plan:				
• Explains timing for medical follow-up visit and/or contraceptive re-supply and schedules visit (as needed)				
• Invites the client to come back at any time for any reason (e.g., for ongoing support with decision making, negotiation, etc.)				
• Refers the client for needed or requested services unavailable on-site				
Asks if the client has other comments that he or she would like to share that have not already been covered by the questions above				

Observation Guide: GATHER Framework

Instructions: Evaluate the performance of the provider in implementing each task or activity, using the following codes:

1 = Needs improvement
2 = Adequate
3 = Competent
N = Not applicable

Name: ______________________ **Service site:** ______________________

Observer: ______________________ **Date** ______________________

Observation Guide: GATHER

Task/Activity	Rating per client-provider interaction
General skills and establishment of positive client-provider interaction	
Demonstrates respect for the client; does not judge the client	
Shows friendliness by smiling	
Ensures privacy in the consultation room	
Uses simple and clear language	
Asks open-ended questions	
Asks the client to paraphrase, as necessary, to ensure that the client understands his or her questions and explanations	
Encourages the client to ask questions and express concerns	
Answers all of the client's questions	
Indicates throughout the consultation that he or she is listening to the client	
Paraphrases the client to ensure understanding of the client's message	
Does not interrupt the client unless absolutely necessary	
GATHER	
Greets and welcomes clients	
Greets the client with respect and kindness, introduces himself or herself, and offers the client a seat	
Asks what he or she can do for the client; determines the purpose of the visit	
Explains what will happen during the visit	
Assures the client of the confidentiality of all information that is shared	
Encourages and responds to the client's questions	

Appendix G

Observation Guide: GATHER

Task/Activity	Rating per client-provider interaction			
Asks clients about themselves and their concerns				
Assists the client in:				
• Clarifying his or her reproductive health needs, concerns, and problems				
• Asking questions				
• Determining decisions or actions that the client needs or wants to make during this visit				
Obtains the client's medical and social history (as appropriate to the client's needs and concerns, using the checklist for the corresponding service):				
• Asks simple and brief questions				
• Explains terms as needed				
• Explains the routine nature and purpose of risk-assessment questions regarding pregnancy, sexually transmitted infections (STIs), and HIV or AIDS, among others				
Asks about the client's:				
• Reproductive health plans (desired number of children, spacing of births, etc.)				
• Perception of risk (regarding pregnancy or STIs, and HIV and AIDS)				
• Risk behaviors as pertinent to the client's concerns (e.g., pregnancy and STIs and HIV)				
• Other health, interpersonal, or social concerns				
• Feelings about their concerns, risks, etc. (as appropriate)				
Explains the purpose of the questions (as appropriate)				
Looks at the client while he or she (the client or service provider) speaks				
Encourages and responds to the client's questions				
Tells clients information appropriate to their SRH needs and knowledge				
Begins the discussion with the client's preference or most urgent need				
Asks what the client already understands about his or her SRH situation and desired course of action				
Tailors information to the client's need, knowledge, and personal situation				
Uses words familiar to the client				
Uses appropriate information, education, and communication materials in an effective manner				
Asks open-ended questions to verify the client's understanding of important information				
Encourages and responds to the client's questions				
Corrects false information and rumors, as needed				

Observation Guide: GATHER

Task/Activity	Rating per client-provider interaction			
Helps clients to make decisions to meet their SRH needs				
Through active listening, including asking open-ended questions, helps the client:				
• Take "ownership" of his or her problem and responsibility for his or her decisions				
• Identify options and pros and cons of each				
• Make decisions based on weighing pros and cons of all options (including side effects and the possibility of complications), relative to the client's values and social context				
• Act on decisions taken				
➤ By asking concrete, specific questions about steps to be taken				
➤ By encouraging the client in terms of steps taken				
Confirms the client's decision				
Assists the client to identify:				
• Possible barriers to implementing the decision				
• Ways of overcoming these barriers				
Assists the client to practice skills (e.g., communication skills) to overcome barriers (if appropriate)				
For clients who decline treatment or choose not to practice any behavior change:				
• Explains possible complications or consequences of unmanaged condition or unchanged behavior				
• Offers his or her services if the client wishes to use them later				
Explains instructions for managing SRH problem/implementing decisions				
Explains how to use the chosen method or treatment option				
Reviews common side effects, the warning signs or symptoms of more serious complications, and what to do if they occur				
Provides written instructions and reviews them with the client				
Asks open-ended questions to verify the client's understanding of important information				
Encourages and responds to questions from the client				
Return visit/referral				
Sets up follow-up visit, as needed				
Invites the client to come back at any time for any reason				
Refers the client for needed or requested services unavailable on-site				
Thanks the client for coming				

Appendix H
Outcome Evaluation Using Provider Interviews

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Outcome Evaluation Using Provider Interviews

The true test of the success, or outcome, of integrated SRH counseling training is whether the participants are conducting such counseling at their service sites and how well they are doing it. This and the appendixes immediately preceding and following it offer tools for evaluating the outcome of this training through observation of client-provider interaction, through interviews with providers, and through anonymous interviews with clients. All three perspectives should be considered to get a complete picture of the possible impact of the training on providers and clients. As noted in "Before the Training Course" (Introduction for the Trainers, page xvii), trainers should determine the evaluation plan with program planners and site administrators prior to conducting the course.

The Provider Interview Form gives a template for exploring the individual provider's perspective on how well he or she has been able to apply what he or she learned in the training, and what challenges may have been encountered. It is meant to complement the information provided in the Observation Guides, and to answer the question "Why not?" if it is found that the provider is not implementing integrated SRH counseling with clients. It also requests suggestions for improving the training.

Who Can Conduct Outcome Evaluation?

Since competency in counseling is evaluated through observation of counseling and through interviews with participants and clients, such evaluations are necessarily somewhat subjective. To make the observation process as reliable as possible from one evaluation to another, the same individuals should conduct the evaluations each time, and these evaluators should be competent in the skills being evaluated. The trainers should *not* do the evaluations, although they can help orient local evaluators to the desired outcomes of the training.

When Should Provider Interviews Be Conducted?

Since this interview reflects on the provider's experience following the training, it would only be carried out at the time of the posttraining observations.

How Can This Information Be Used?

The results of outcome evaluation can be used in many ways:

- *Program planners and administrators* will want to know if the training had the desired effect on service delivery (i.e., establishing integrated SRH counseling services). If it did not, these tools provide clues for what the barriers are and whether they are training-related or can be traced to other aspects of service delivery.
- *Providers* will want to know how clients respond to this approach to counseling and how they can improve their skills.
- *Trainers* will want to know if their training approaches were effective in imparting appropriate knowledge, attitudes, and skills for integrated SRH counseling and how these approaches can be strengthened.
- Finally, *EngenderHealth* would like to know the outcomes of these trainings in different

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countries, so that lessons learned can be shared both across the agency and throughout the health and development community.

Specific Instructions

- The evaluator should fill out one form for each provider interviewed.
- To encourage candor in the provider's comments, the interviewer *must* maintain confidentiality. Therefore, the provider's name should *not* be recorded on the form. The site name also should *not* be recorded on the form, since there may be only one provider interviewed at any site, and this would allow the individual provider to be identified.
- The evaluator should compile a summary of the providers' interviews after at least four have been conducted in at least two sites. The summary *only* should be shared with the supervisors, site or program managers, and a representative of the training team. This should be explained to the provider before the interview is started.
- The evaluator should give the original interview forms and a copy of the summary to a local EngenderHealth staff member or send them to:

Advances in Informed Choice Team
EngenderHealth
440 Ninth Avenue
New York, NY 10001 U.S.A.
Telephone: 212-561-8000
Fax: 212-561-8067
e-mail: info@engenderhealth.org

If the provider answers Question 1 by saying he or she has "not found it appropriate to initiate SRH counseling with clients," make notes on why this is so, and then skip to Question 5 and complete the rest of the interview. Questions 5 through 8 ask specific questions about problems that have been encountered, and these would definitely be relevant for a trainee who has not done any SRH counseling with clients.

Provider Interview Form

Interviewer:____________________________________ **Date:**________________

Instructions

Obtain a copy of the participant's action plan (from Session 31 of the training) ahead of time (for Question 7).

Introduce yourself. Explain to the service provider that:

- The purpose of the counseling training that you participated in was to improve your counseling skills to address the range of clients' SRH needs and concerns.
- The purpose of this interview is to learn how you have been able to apply your training to the provision of SRH services, the challenges you may have encountered, and how the training might be modified to better prepare participants for counseling tasks in SRH service provision.
- Many of the questions are open-ended questions that enable you (the service provider) to share your responses and reactions without being confined to a predetermined range of answers.
- The results of this interview with you and other participants will be shared with program managers, supervisors, and trainers, to make improvements at your work site and in the training itself. If there is only one trainee from your work site, it may be difficult (if not impossible) to ensure confidentiality. However, candor will be appreciated and will yield the most helpful responses.

Questions

Check off the service provider's response to each question, or fill in additional explanation, as appropriate.

1. What has been your experience in counseling clients in SRH since you participated in the integrated SRH counseling training?

   ❑ I initiate counseling with all clients.

   ❑ I initiate counseling with certain kinds of clients. Examples:

   ____

   ____

   ____

   ____

   ❑ I have not found it appropriate to initiate SRH counseling with clients [Go to Question 5]. Explain:

   ____

   ____

   ____

   ____

Provider Interview Form

2. What has been the reaction of clients when you have initiated SRH discussions with them? (check as many as apply)
   - ❑ Clients seem to have welcomed the discussions (have been open and interested in discussing their issues).
   - ❑ Clients have seemed uncomfortable, but have answered questions when asked.
   - ❑ Clients have been mostly closed or resistant to discussing anything beyond the primary reason they came to the facility.

3. What do you do to establish rapport and trust with clients?

____

____

____

____

4. Consider various areas of counseling that were emphasized in the training.

   (a) Helping clients identify and address their individual SRH needs, including the social and sexual context

   - Describe your approach.

   ____

   ____

   ____

   ____

   - How effective do you feel this approach has been? Explain.

   ____

   ____

   ____

   ____

   - What obstacles have you encountered in using this approach?

   ____

   ____

   ____

   ____

(a) Helping clients identify and address their individual SRH needs, including the social and sexual context (continued)

- What have you done when confronted by these obstacles? What support or assistance do you need?

(b) Giving essential information to clients

- Describe your approach.

- How effective do you feel this approach has been? Explain.

- What obstacles have you encountered in using this approach?

- What have you done when confronted by these obstacles? What support or assistance do you need?

Provider Interview Form

(c) Helping clients assess their own and their partners' risk of unintended pregnancy or HIV and STI infection

- Describe your approach.

___

- How effective do you feel this approach has been? Explain.

___

- What obstacles have you encountered in using this approach?

___

- What have you done when confronted by these obstacles? What support or assistance do you need?

___

(d) Helping clients reduce their risk

- Describe your approach.

___

(d) Helping clients reduce their risk (continued)

- How effective do you feel this approach has been? Explain.

- What obstacles have you encountered in using this approach?

- What have you done when confronted by these obstacles? What support or assistance do you need?

(e) Helping clients make their own decisions

- Describe your approach.

- How effective do you feel this approach has been? Explain.

Provider Interview Form

(e) Helping clients make their own decisions (continued)

- What obstacles have you encountered in using this approach?

- What have you done when confronted by these obstacles? What support or assistance do you need?

(f) Helping clients implement their own decisions: Risk assessment

- Describe your approach.

- How effective do you feel this approach has been? Explain.

- What obstacles have you encountered in using this approach?

(f) Helping clients implement their own decisions: Risk assessment (continued)

- What have you done when confronted by these obstacles? What support or assistance do you need?

(g) Helping clients communicate with a partner about SRH concerns

- Describe your approach.

- How effective do you feel this approach has been? Explain.

- What obstacles have you encountered in using this approach?

- What have you done when confronted by these obstacles? What support or assistance do you need?

Provider Interview Form

5. Remind the provider that the general objectives of the training were to enable participants to carry out the following tasks:
   - Help clients assess their own needs for a range of SRH services, information, and emotional support
   - Provide information appropriate to clients' identified problems and needs
   - Assist clients in making their own voluntary and informed decisions
   - Help clients develop the skills they will need to carry out those decisions

   Ask him or her to consider the following questions in terms of their ability to carry out these tasks.

   A. REDI or GATHER
   - In what ways has REDI or GATHER been useful in carrying out these counseling tasks, listed above?

   ____

   ____

   ____

   ____

   - What problems have you encountered in applying REDI or GATHER?

   ____

   ____

   ____

   ____

   B. Open-ended questions
   - In what ways have they been useful?

   ____

   ____

   ____

   ____

   - What problems have you encountered in posing them?

   ____

   ____

   ____

   ____

C. Listening

- In what ways has this been useful?

- What problems have you encountered in applying this skill?

D. Paraphrasing

- In what ways has paraphrasing been useful?

- What problems have you encountered in applying it?

6. What types of clients, clients' attitudes, or clients' behaviors do you find most challenging in SRH counseling?

Provider Interview Form

6. What types of clients, clients' attitudes, or clients' behaviors do you find most challenging in SRH counseling? *(continued)*
   - In what ways are they challenging to you?

     ____
     ____
     ____
     ____

   - What do you do when confronted by these clients, attitudes, or behavior?

     ____
     ____
     ____
     ____

7. How would you describe your progress in implementing your action plan?

   ____
   ____
   ____
   ____

   - What obstacles have you encountered in implementing your action plan?

     ____
     ____
     ____
     ____

   - What success have you had in overcoming these obstacles? What additional support or assistance do you need?

     ____
     ____
     ____
     ____

Provider Interview Form

8. What suggestions do you have for improving the training, to better prepare participants to carry out the tasks of integrated SRH counseling?

Appendix I
Outcome Evaluation Using Client Interviews

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Outcome Evaluation Using Client Interviews

The true test of the success, or outcome, of integrated SRH counseling training is whether the participants are conducting such counseling at their service sites and how well they are doing it. This and the preceding two appendixes offer tools for evaluating the outcome of this training through observation of client-provider interaction, through interviews with providers, and through anonymous interviews with clients. All three perspectives should be considered to get a complete picture of the possible impact of the training on providers and clients. As noted in "Before the Training Course" (Introduction for the Trainers, page xvii), trainers should determine the evaluation plan with program planners and site administrators prior to conducting the course.

The Client Interview Form included here is to be used to gather feedback from clients about their perception of the quality of the counseling services they have received. Again, it is best used in conjunction with the Observation Guides and Provider Interview Form.

Who Can Conduct Outcome Evaluation?

Since competency in counseling is evaluated through observation of counseling and through interviews with participants and clients, such evaluations are necessarily somewhat subjective. To make the observation process as reliable as possible from one evaluation to another, the same individuals should conduct the evaluations each time, and these evaluators should be competent in the skills being evaluated. The trainers should *not* do the evaluations, although they can help orient local evaluators to the desired outcomes of the training.

When Should Client Interviews Be Conducted?

Client interviews can be conducted both before and after the training, to get some sense of the clients' perceptions of change over time. Since other factors may influence quality of care and clients' perceptions of it, changes in quality (from the client's perspective) cannot be directly attributed to the training. However, these interviews may yield valuable insights into the clients' experience, which can be addressed in future trainings or training follow-up.

How Can This Information Be Used?

The results of outcome evaluation can be used in many ways:

- *Program planners and administrators* will want to know if the training had the desired effect on service delivery (i.e., establishing integrated SRH counseling services). If it did not, these tools provide clues for what the barriers are and whether they are training-related or can be traced to other aspects of service delivery.
- *Providers* will want to know how clients respond to this approach to counseling and how they can improve their skills.
- *Trainers* will want to know if their training approaches were effective in imparting appropriate knowledge, attitudes, and skills for integrated SRH counseling and how these approaches can be strengthened.

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- Finally, *EngenderHealth* would like to know the outcomes of these trainings in different countries, so that lessons learned can be shared both across the agency and throughout the health and development community.

Specific Instructions

- The client's name should *not* be recorded on the interview form, to maintain confidentiality and to encourage the client to be comfortable giving feedback that he or she may believe is critical of the provider or the service site.
- The site name *should* be recorded, however, since this feedback would be valuable to share with providers and supervisors at each site.
- The evaluator should compile a summary of the providers' interviews after at least four have been conducted in at least two sites. Copies of this summary should be given to providers and supervisors at each site, plus to a representative of the training team.
- The evaluator should give the original interview forms and a copy of the summary to a local EngenderHealth staff member or send them to:

Advances in Informed Choice Team
EngenderHealth
440 Ninth Avenue
New York, NY 10001 U.S.A.
Telephone: 212-561-8000
Fax: 212-561-8067
e-mail: info@engenderhealth.org

Client Interview Form

Interviewer:______________________________ **Date:**____________

Site:______________________________

Instructions

Introduce yourself to the client and explain that:

- You are interviewing clients about their experience in seeking and obtaining SRH services at this facility.
- The purpose of your interviewing clients is to get feedback about their perceptions of the quality of services they received. This will enable facility staff to continue to improve the quality of their services.
- In this context, you would like to ask the client some questions about the services he or she just received. The client's answers will be "yes" or "no." You will not be asking any questions about the client himself or herself.
- It is important that the client be frank about his or her impressions, to help clinic personnel improve. The client's feedback will be anonymous—that is, no names will be connected with his or her responses.
- Ask the client for his or her permission to be interviewed for this purpose.
- This will take about 15 to 20 minutes. Would he or she have time for that?

If the client agrees, proceed with the interview using the following questions. Record the client's answers in the spaces provided. Check the column "NA" if the question is not applicable to the client you are interviewing.

Client Interview Form

	Yes	No	NA
General skills and establishment of positive client-provider interaction			
In general, did the staff with whom you met:			
Show you respect (did not judge you, what you think, or what you have done)?			
Ensure your privacy in the consultation room?			
Talk in a language and use terms that you could easily understand?			
Ask you to repeat some of the explanations to reinforce your understanding?			
Listen to you without interrupting and show interest in what you had to say?			
Encourage you to talk about yourself and to ask questions?			
Answer your questions clearly?			

Appendix I

Client Interview Form

	Yes	No	NA
Rapport-building			
Did the staff with whom you met:			
Welcome you with kindness and with respect?			
Make you feel comfortable?			
Introduce himself or herself?			
Ask what he or she could do for you?			
Explain why he or she would be asking sensitive and personal questions?			
Assure you that whatever you said would not be shared with others?			
Explain what would happen during the visit?			
Exploration			
Did the staff with whom you met:			
Ask you about:			
• Your sexual relationships?			
• How you communicate with your partner (or partners) about sexuality, family planning, HIV, and sexually transmitted infections (STIs)?			
• Your knowledge about your partner's (or partners') sexual behaviors outside of your relationship?			
Ask you about your:			
• Previous pregnancies, and the outcomes of those pregnancies?			
• Use of family planning methods, including condoms?			
• Own HIV and STI history?			
• Knowledge of your partner's (or partners') history of HIV or STIs?			
Ask you how you make decisions about your own sexual and reproductive health and behaviors?			
Ask you what you know about:			
• Pregnancy-related care, including antenatal care, nutrition, exercise, or rest (if appropriate)?			
• Postabortion care (if appropriate)?			
• Family planning?			
• HIV?			
• STIs?			
• Provide you information about any of the above (as appropriate)?			
Explain your possible risks for:			
• Pregnancy?			
• HIV and STIs?			

Client Interview Form

	Yes	No	NA
Exploration *(continued)*			
Help you determine your (or your partner's) risk for:			
• HIV or STI transmission?			
• Unintended pregnancy?			
Ask you about other health needs or concerns?			
Decision making			
Did the staff with whom you met:			
Explain the importance of making your own decisions?			
Ask if you already made a decision?			
If you had, ask you to explain in your own words why you made the decision?			
Help you consider all of your options?			
Help you consider the advantages and disadvantages of each option (including common side effects of family planning methods being considered)?			
Help you consider how your partner or family might react to your choice of options?			
Help you confirm or make the decision that you feel best fits your medical and personal circumstances?			
Help you receive the service or method you wanted, or understand why a different option would be considered better for you?			
Implementing the decision			
Did the staff with whom you met:			
Encourage you to think about how you would put your decisions into practice?			
Ask you:			
• How you would communicate your plan to your partner?			
• Whom you could count on to support you in your decision?			
• Who might create obstacles for you, and what you can do about that if it happens?			
• To offer ideas for improving communication and negotiation with your partner?			
Help you make an alternate plan if this one does not work out?			
Demonstrate how to use a condom (if applicable) and have you repeat the demonstration to reinforce your understanding?			
Give you samples of condoms and tell you where and how to obtain more?			
Give clear instructions about how to use the medical treatment recommended for you or the family planning method that you chose?			
Invite you back for a follow-up visit (for ongoing support with decision making, negotiation, or condom use, as appropriate)?			

Client Interview Form

	Yes	No	NA
Implementing the decision *(continued)*			
Tell you about other services available elsewhere and how to access them?			
Were you happy with the service you received?			
Would you refer a friend or relative to this service provider?			

What other comments would you like to share that we have not covered in these questions?

Is there anything that the provider could have done differently to better meet your needs? (If the client says yes, ask for his or her suggestions and write thos here.)

Appendix J
Using Visual Aids to Explain Reproductive Anatomy and Physiology—Transparency Guides

Using Visual Aids to Explain Reproductive Anatomy and Physiology—Transparency Guides

This appendix provides a set of simple drawings showing different aspects of the male and female reproductive systems, to accompany Session 17. These drawings should be made into transparencies. (See the Training Tip on page 94, if you are not able to use transparencies.) By presenting the transparencies in sequence (laying one on top of the others below), you can demonstrate in a simple, step-by-step manner the complexity of the internal organs and how they interconnect. (See Session 16 in the Participant's Handbook [page 75] for simple explanations of what the organs are and how they work.)

You should allot about 15 minutes to go through the transparencies for the male anatomy and physiology and about 10 minutes to cover the female anatomy and physiology. (More time is allowed for the male because it is a little more complicated to draw and because the participants tend to be less familiar with the male reproductive systems than with the female reproductive systems.) Practice ahead of time to be sure you can do this, building in time for the participants to make their own drawings and for a few questions to be answered.

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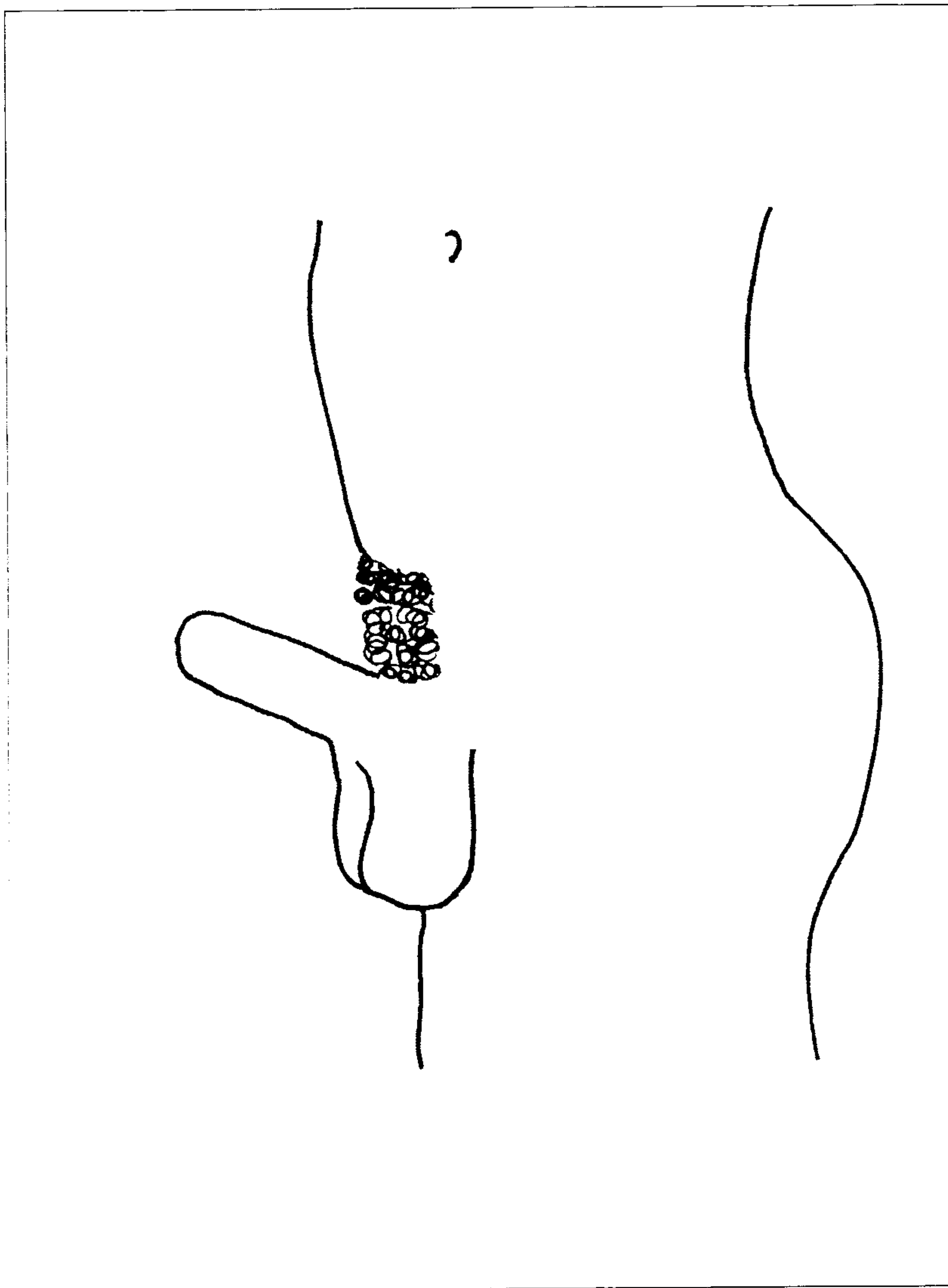
Male — 1



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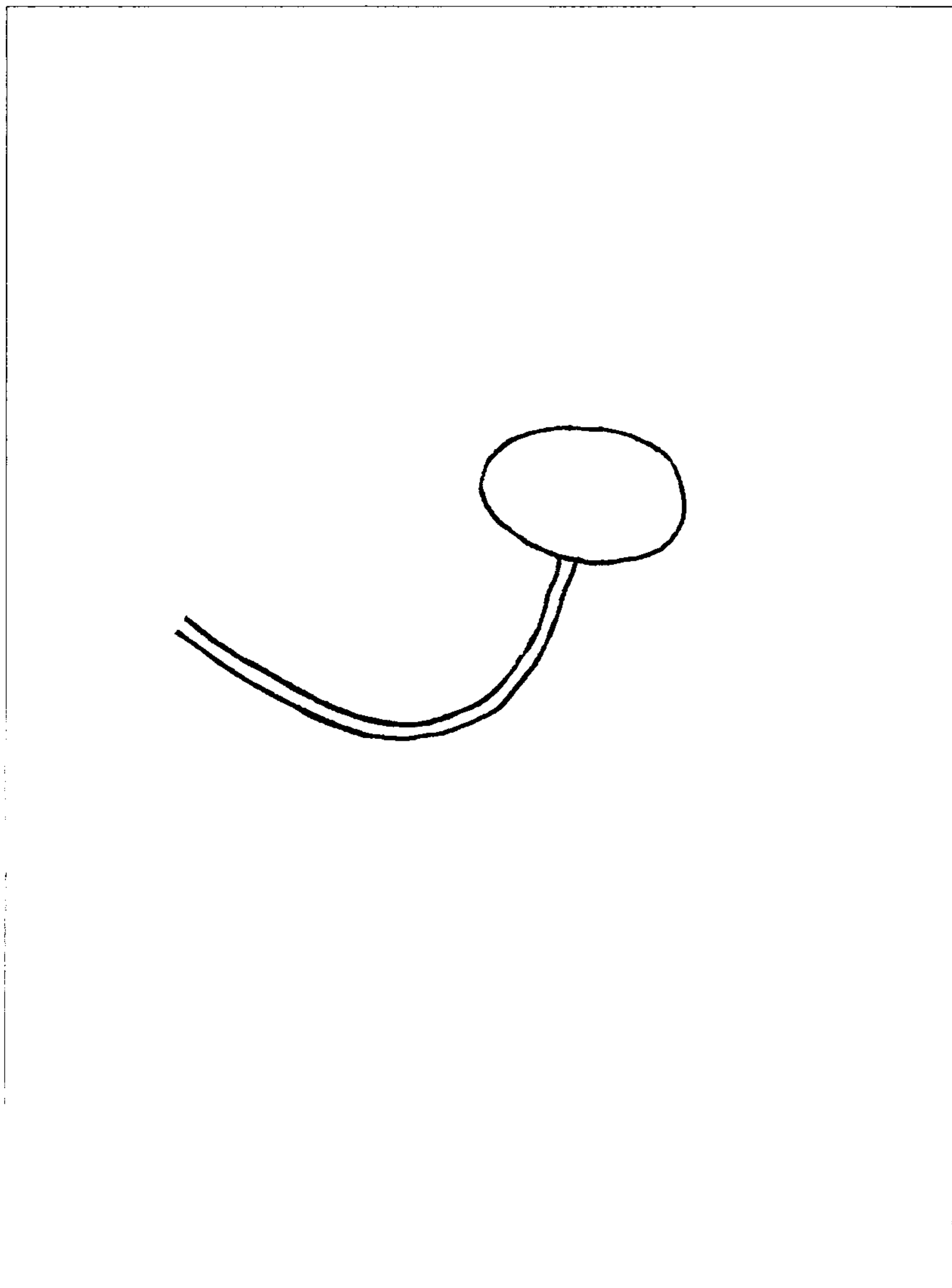
Male — 2



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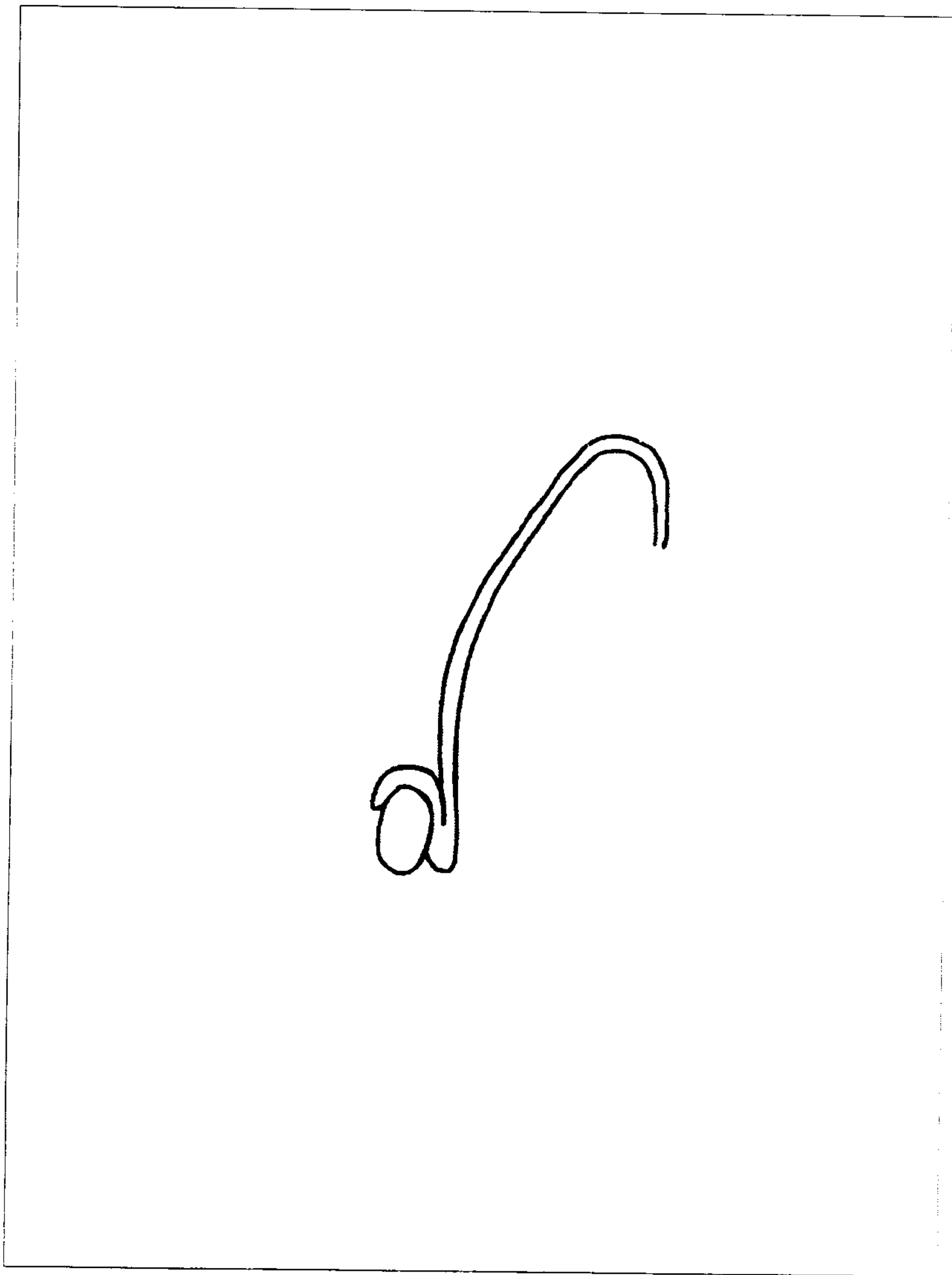
Male — 3



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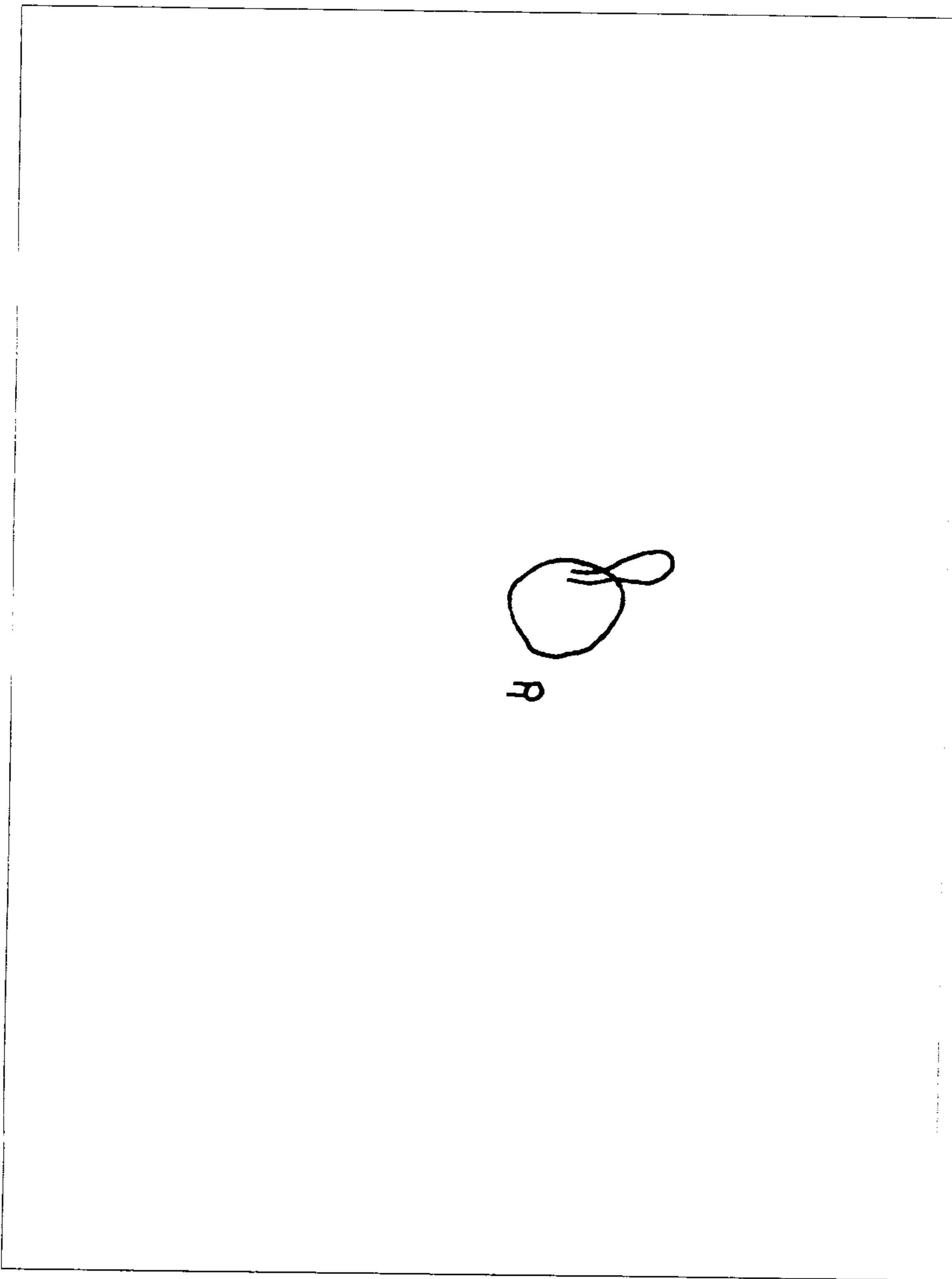
Male — 4



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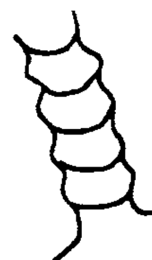
Male — 5



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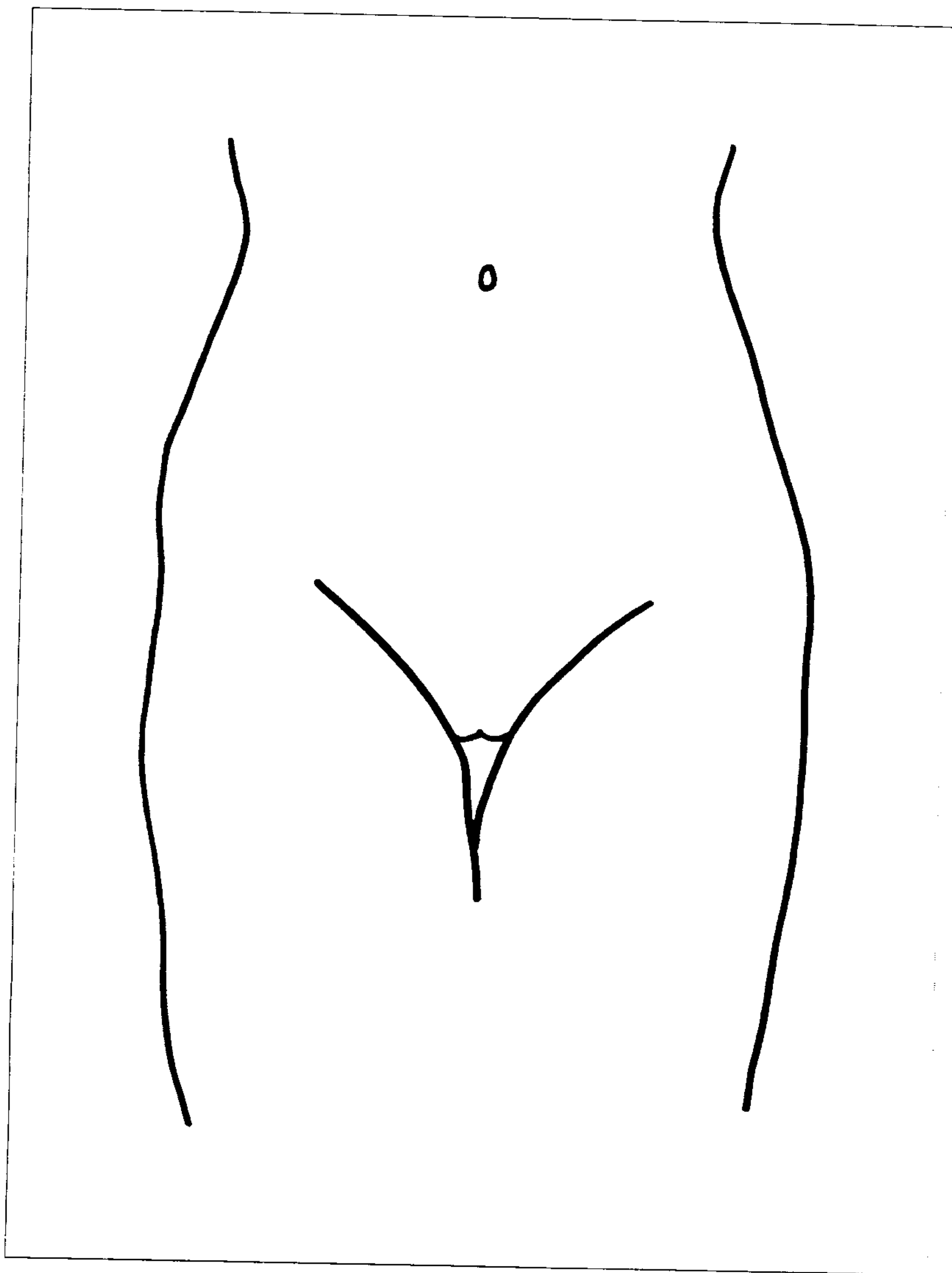
Female — 1



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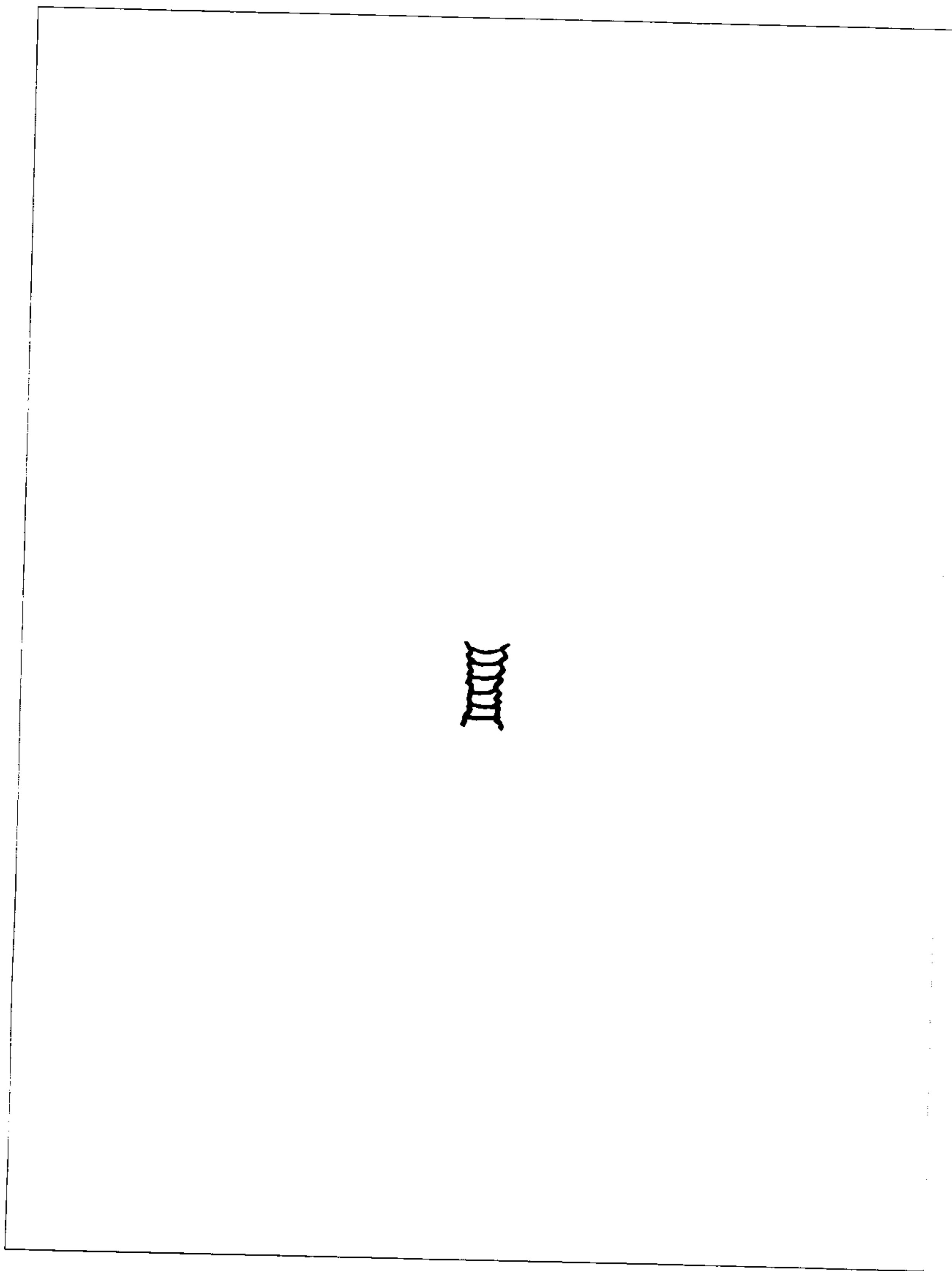

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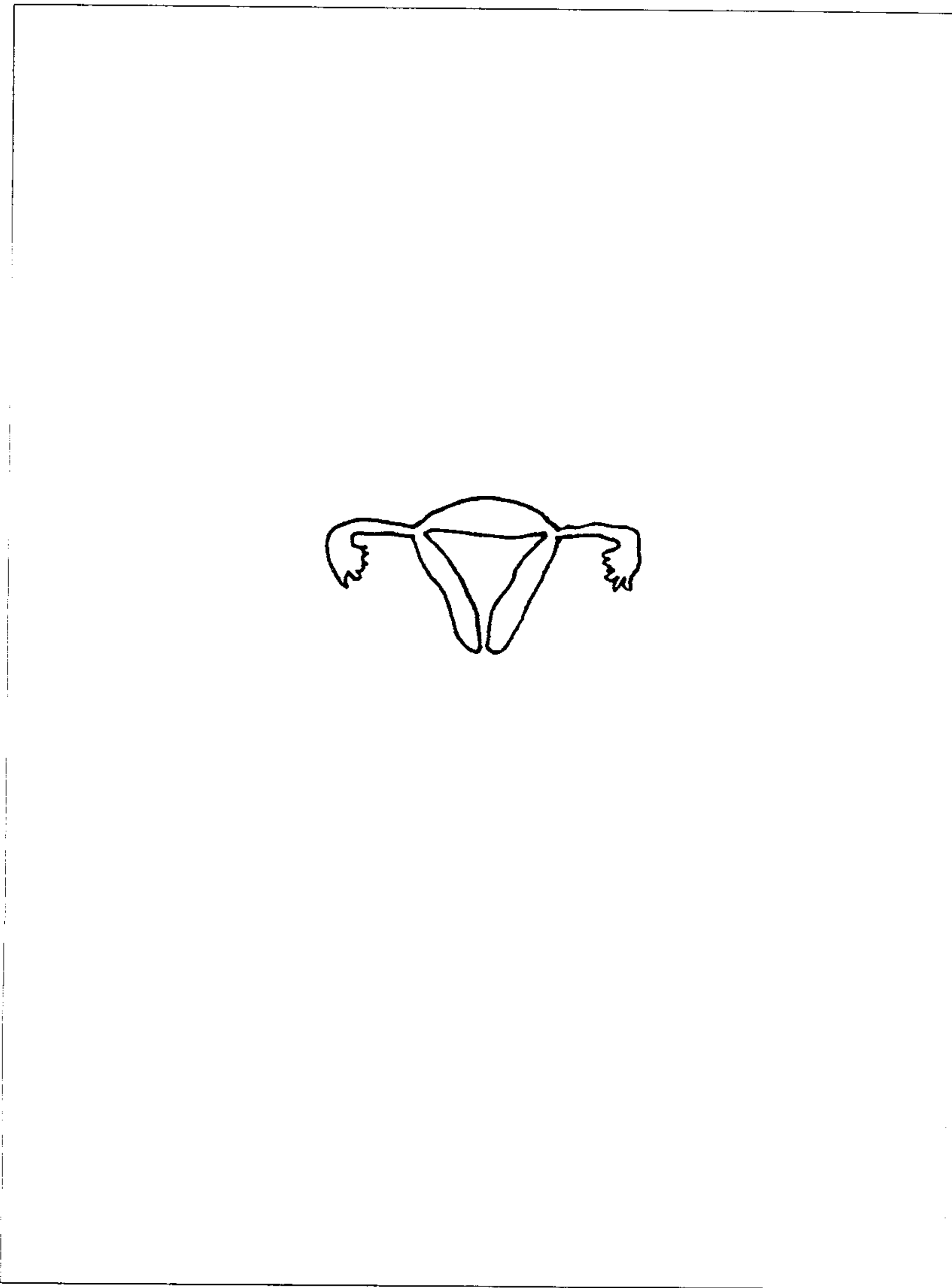

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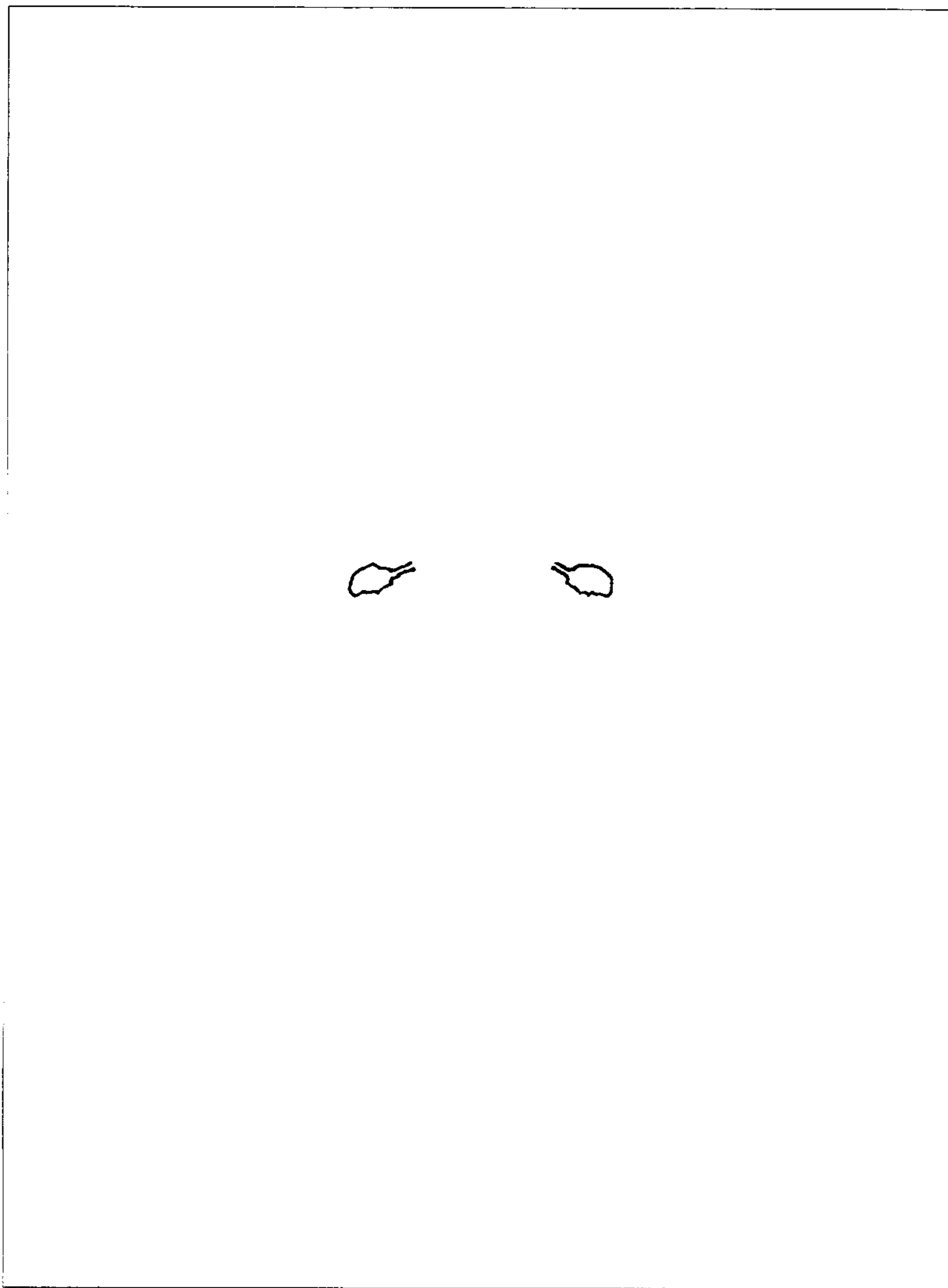

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