



Ibis
Reproductive
Health

FACILITATOR MANUAL

A workshop for health care personnel on addressing the sexual and reproductive health service needs of young women in South Africa

2013

“Young women should not be left behind;
we must give them the information”



FORDFOUNDATION

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Naomi Lince, Adila Hargey, Kelsey Otis, Kelly Blanchard, and Madina Agenor from Ibis Reproductive Health are responsible for most of the content. The overall approach is based on qualitative and quantitative research conducted by Ibis and conversations with stakeholders in Soweto, South Africa in 2008-2009.

The content for several of the modules was adapted from colleague organizations' existing training materials:

- Both values clarification exercises (Modules 1 and 2) and the communication exercises (Module 6) were adapted from EngenderHealth's "Youth Friendly Services: A Manual for Service Providers" (2002); ¹
- Module 4 uses materials developed by DISA Sexual and Reproductive Health Clinic; and
- Module 5 was adapted from Pathfinder's Comprehensive Health and Family Planning Training Curriculum (Module 16: "Reproductive Health Services for Adolescents"); ²
- Module 8 was adapted from the World Health Organization's (WHO's) "Integrating poverty and gender into health programmes: a sourcebook for health professionals: module on gender-based violence;" ³
- Module 9 is a placeholder for a session on family planning. Here we have included short descriptions of two larger sets of materials and activities: the Balanced Counseling Strategy Plus (BCS+) Toolkit developed by the Population Council in 2008 ⁴ and the Decision-Making Tool for Family Planning Clients and Providers created by the WHO and Johns Hopkins Bloomberg School of Public Health in 2005. ⁵ Note that the required materials for this module must be obtained separately from the Population Council or the WHO.

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Replication of this manual and its accompanying handouts is welcomed and may be done without permission, provided the material is distributed free of charge and that Ibis Reproductive Health is acknowledged. Please send notice of replication to **Joburg@ibisreproductivehealth.org** or call **+27 (0) 11 966 7741**.

1. <http://www.engenderhealth.org/files/pubs/gender/yfs/yfs.pdf>

2. <http://www.pathfinder.org/publications-tools/Module-16-Reproductive-Health-Services-for-Adolescents-Training-Curriculum.html>

3. http://www.wpro.who.int/NR/rdonlyres/E517AAA7-E80B-4236-92A1-6EF28A6122B3/0/Integrating_poverty_gender_sourcebook.pdf

4. http://www.popcouncil.org/pdfs/2012RH_BCSPlusUsersGuide.pdf

5. <http://www.k4health.org/toolkits/condoms/decision-making-tool-family-planning-clients-and-providers>

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Introduction

In early 2007, Ibis Reproductive Health and the Perinatal HIV Research Unit came together to undertake a project which would ultimately result in the creation of a workshop which could be implemented to improve public sector sexual and reproductive health care services for young women. This manual is the result of that work. The workshop was pilot tested with staff from three clinics in Soweto in September 2009.

We developed the various components for this workshop through review and adaptation of existing materials which focused on adolescent-friendly services, and by using our own original research with young women, health care personnel, and community stakeholders in Soweto, South Africa.

Intended Audience

This workshop manual was developed for use with health care personnel (e.g. nurses, counselors, health promoters, adolescent peer educators, etc.) working with young women in public sector clinics. It was piloted with personnel working in the antenatal care, family planning, HIV, and termination of pregnancy departments.

Aims

The overall aim of the workshop is to improve provision of adolescent friendly sexual and reproductive health services. The main objectives are to enhance communication skills (both communication with young people and communication about sexual and reproductive health more generally), and to reinforce counseling skills in the areas of family planning, HIV, gender-based violence, and termination of pregnancy, with a special focus on family planning methods and dual protection of HIV and pregnancy. This workshop takes a personal approach, helping participants explore their opinions related to adolescent sexuality and the potential for these opinions to positively or negatively impact on their delivery of services to young people.

Suggested Use and Potential for Adaptation of Manual

It is recommended that all of the modules contained in this manual be presented together in the sequence indicated. A full workshop agenda is provided for ease in facilitation. It includes times for breaks as well as an introduction and overall evaluation. These "extras" are recommended if a full workshop is to be delivered. In case delivering all of the modules together is not possible, the modules have been designed in such a way that they can be presented alone or in clusters. Aims and learning objectives are presented for each of the modules along with discussion guidelines, suggested activities, required supplies, and recommended questions for evaluation.

Module 9 is a placeholder for provision of a separate training on family planning provision. We have included short descriptions of two larger sets of materials and activities which were designed as stand-alone trainings and could easily be presented separately if needed. They are: the Balanced Counseling Strategy Plus (BCS+) Toolkit developed by the Population Council in 2008 and the Decision-Making Tool for Family Planning Clients and Providers created by the World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health in 2005. The former is recommended if the training is provided for individuals specializing in family planning provision; whereas the WHO tool is more appropriate for a broader audience that also includes family planning providers. Note: if the BCS+ Toolkit is used, we have created four additional "counseling cards" which we suggest adding to the Toolkit collection;

they cover gender-based violence and pregnancy options counseling.

Sample Workshop Agenda

Day One

08h30 to 09h00	Welcome and introductions
09h00 to 10h00	Module 1: How do I feel about adolescent sexuality?
10h00 to 11h00	Module 2: How do I feel about gender, family planning, HIV and other STIs?
11h00 to 11h15	Tea Break
11h15 to 12h45	Module 3: Background on young women and girl's sexuality and SRH
12h45 to 13h15	Lunch
13h15 to 14h45	Module 4: Let's talk about sex
14h45 to 15h00	Tea Break
15h00 to 16h00	Module 4: Let's talk about sex continued
16h00 to 16h15	Evaluation and closing

Day Two

08h30 to 08h45	Welcome and questions from day one
08h45 to 10h15	Module 5: Sexual identity and orientation
10h15 to 10h30	Tea Break
10h30 to 13h00	Module 6: Communicating with young people
13h00 to 13h30	Lunch
13h30 to 15h00	Module 6: Communicating with young people continued
15h00 to 15h15	Tea Break
15h15 to 15h45	Module 7: Answering difficult questions
15h45 to 16h00	Evaluation and closing

Day Three

08h00 to 08h15	Welcome and questions from day two
08h15 to 9h45	Module 7: Answering difficult questions continued
9h45 to 10h00	Tea Break
10h00 to 13h00	Module 8: Gender-based violence
13h00 to 13h30	Lunch
13h30 to 14h00	Module 8: Gender-based violence continued
14h00 to 15h00	Module 9: Family planning update
15h00 to 15h15	Tea Break
15h15 to 16h00	Module 9: Family planning update continued
16h00 to 16h15	Evaluation and closing

Day Four

08h00 to 08h15	Welcome and questions from day three
08h15 to 10h00	Module 9: Family planning update continued
10h00 to 10h15	Tea Break
10h15 to 13h00	Module 9: Family planning update continued
13h00 to 13h30	Lunch
13h30 to 14h15	Module 9: Family planning update continued
14h15 to 15h00	Final evaluations and closing

Workshop Supplies

General Supplies

- Flip chart stand
- Flip chart paper
- Flip chart markers
- Blank note cards or paper
- Prestik/Tape
- Pens
- Copies of the evaluation forms

Facilitator Supplies

Before the workshop begins, it is recommended that the facilitator read the entire manual to become familiar with the overall aims and activities. The facilitator should also ensure that he/she has copies of the following before beginning the workshop:

Module	Item	One copy/item	One copy/item per person
N/ A	Facilitator manual	X	
N/A	Workshop agenda		X
1	Appendix 1.1: Pages with "Strongly Agree,"	X	
1	Appendix 1.2 Values clarification statements		X
3	SRH PowerPoint presentation	X	
3	Appendix 3.1: SRH Power Point presentation print-out	X	
3	Appendix 3.2: SRH Quiz		X
4	Appendix 4.1: Frame for Vagina Drawing with examples		X
4	Sexual history taking PowerPoint presentation	X	
4	Appendix 4.2: Sexual history taking PowerPoint presentation print-out		X
5	Appendix 5.1: Definitions for sexual identity and orientation exercise	X (1/ group)	
5	Appendix 5.2: Sexual identity and orientation handout	X	
5	Appendix 5.3: Sexual identity and orientation case studies		X
6	Appendix 6.1: Characteristics of Effective and Ineffective Counselors		X
6	Appendix 6.2: Role play scenarios		X
7	Answering Difficult Questions Tool		X
8	Newspaper articles showing any recent accounts of reported violence against women (one copy of each report)	X	
8	Appendix 8.1: Definitions of GBV		X
8	Appendix 8.2: Myths about Women Abuse		X

8	Appendix 8.3: Power and control wheel		X
8	Appendix 8.4: Exploring the underlying causes of GBV - Miriam's Story		X
8	Appendix 8.5: Specific victim situations	X	
8	Appendix 8.6: Health Provider Response		X
9a	BCS + Toolkit - If using the BCS+ Toolkit		X
9	GBV and Pregnancy Option Cards		X
9	Appendix 9.1: Role play scenarios	X	
9b	WHO Decision-Making Tool - If using the WHO Decision-Making Tool		X
N/A	Appendix 10: Workshop evaluation form		X

WELCOME AND INTRODUCTIONS



Time:

30 minutes



Materials:

- Markers
- Flipchart paper or whiteboard/chalkboard
- Copies of the agenda

At the beginning of the workshop – on the first day – the facilitator should start by introducing him/herself and explain that ask the participants to introduce themselves.

Facilitate introductions of the participants by asking each one to say:

- His/her name,
- His/her position,
- How long s/he has been in that position, and
- One thing that s/he hopes to get out of the workshop.

Then she should provide an overview of the workshop aims, which are:

- To explore and discuss participants' opinions related to adolescent sexuality and the potential for these opinions to positively or negatively impact on and the delivery of sexual and reproductive health care services for young people,
- To learn about issues that young women are facing in South Africa today,
- To enhance participants' ability to communicate about these issues with young people, and
- To reinforce counseling skills in the areas of family planning, HIV, gender-based violence, and termination of pregnancy, with a special focus on family planning methods and dual protection of HIV and pregnancy.

Then clarify the ground rules for the workshop. Some suggestions are:

- This is a "safe space. We will ask participants to share some of their feelings about things, and we should all respect each other's opinions. We are not going to judge each other.
- There are no right or wrong answers, and there are no "silly" questions. Everyone should feel comfortable learning and asking questions.
- The facilitators respect participants' time, and will try to keep on time.
- We ask the participants also show respect for the facilitators by being on time and switching off their cell phones!
- (You may also ask the participants if there are any other ground rules that they would like to add.)

Then, briefly go over the agenda, letting the participants know the schedule for each day.

MODULE 01

How do I feel about adolescent Sexuality?

01



Aim:

To give participants a general understanding of their own and each other's values and opinions regarding adolescent sexuality and how these can affect service delivery.



Learning objectives:

- Participants will communicate their own and learn about each other's values and attitudes about adolescent sexuality.
- Participants will understand the impact that their personal values and attitudes may have on service delivery for young women.
- Participants will identify practical ways in which they can improve their current practice based on these discussions.



Time:

60 minutes



Materials:

- Appendix 1.1 - "Strongly Agree," "Agree," "Disagree," and "Strongly Disagree" signs
- Appendix 1.2 - values clarification statement list
- Markers
- Tape/Prestik
- Flipchart paper or whiteboard/chalkboard



Advance preparation:

- Display the signs saying, "Strongly Agree," "Agree," "Disagree," and "Strongly Disagree" (See appendix 1.1) around the room, leaving enough space between them to allow participants to stand near each one.
- Give each participant a values clarification statement list (appendix 1.2), and ask the group to complete it silently. The list includes the following statements:

<input type="radio"/> Young women should not indulge in sex before marriage.
<input type="radio"/> It is natural for young women to have sex, and they should be able to choose to do so.
<input type="radio"/> Condoms should be available to youth of any age.
<input type="radio"/> Sex education can lead to early sex or promiscuity.
<input type="radio"/> It is worse for an unmarried girl to have sex than for an unmarried boy to do it.
<input type="radio"/> Teenage girls should be discouraged from using family planning.
<input type="radio"/> Most young women are incapable of making their own decisions about their sexual and reproductive life.
<input type="radio"/> As providers, it is our role to take care of young women as though they were our own children and encourage them not to have sex.
<input type="radio"/> As providers, it is our role to help women protect themselves from HIV, STI's and unintended pregnancy by encouraging them to practice safe sex.



Instructions:

1. Explain to the participants that this activity is designed to give them a general understanding of their own and each other's values and attitudes about working with adolescents and adolescent reproductive health issues.
2. Explain that you will read aloud a statement from the list they were given. The participants will then stand near the sign that most closely represents their opinion. Also explain that after the participants have made their decisions, you will ask several of them to share their opinions with the group. Remind the participants that everyone has a right to his or her own opinion, and no response is right or wrong. Remind the participants that they must listen to each other. This activity is not about debate, but about dialogue. Instruct them to share their personal opinion to support their agreement or disagreement with each statement and not to rebut other participants' opinions.
3. Read aloud the first statement and ask the participants to stand near the sign that most closely represents their opinion. After the participants have made their decisions, ask for one or two volunteers from each group to explain why they feel that way.
4. Continue for each of the statements. Document after each statement the number of gathered for each of the "agree/disagree" statements.
5. Once all the statements (or as many as there are time for) have been read, ask the participants to return to their seats.
6. After reviewing the statements, facilitate a discussion by asking the following questions:
 - Which statements, if any, did you find challenging to form an opinion about? Why?
 - How did you feel expressing an opinion that was different from that of some of the other participants?
 - How do you think people's attitudes about some of the statements might affect their interactions with young clients or their ability to provide reproductive health services to adolescents?



Note:

For the sake of discussion, if the participants express a unanimous opinion about any of the statements, ask a volunteer to play the role of "devil's advocate" by expressing an opinion that is different from theirs.

7. Ask someone in the group to share a story about how s/he has a personal feeling about an issue and yet manages to provide services in such a way that her/his personal feeling is not apparent. An example might be providing full contraceptive counseling to a young person who is not married even if the provider doesn't believe in sex before marriage.
8. In conclusion, state that it is normal to have strong feelings and values about these topics. Tell the participants that learning to be aware of their own values will help them be more open to listening to different points of view. When adolescents notice that service providers are more accepting of differences, they will more openly and honestly assess and express their own values. This, in turn, can help young people assess the attitudes and beliefs that lead to high-risk behavior.

Suggestions for evaluation:

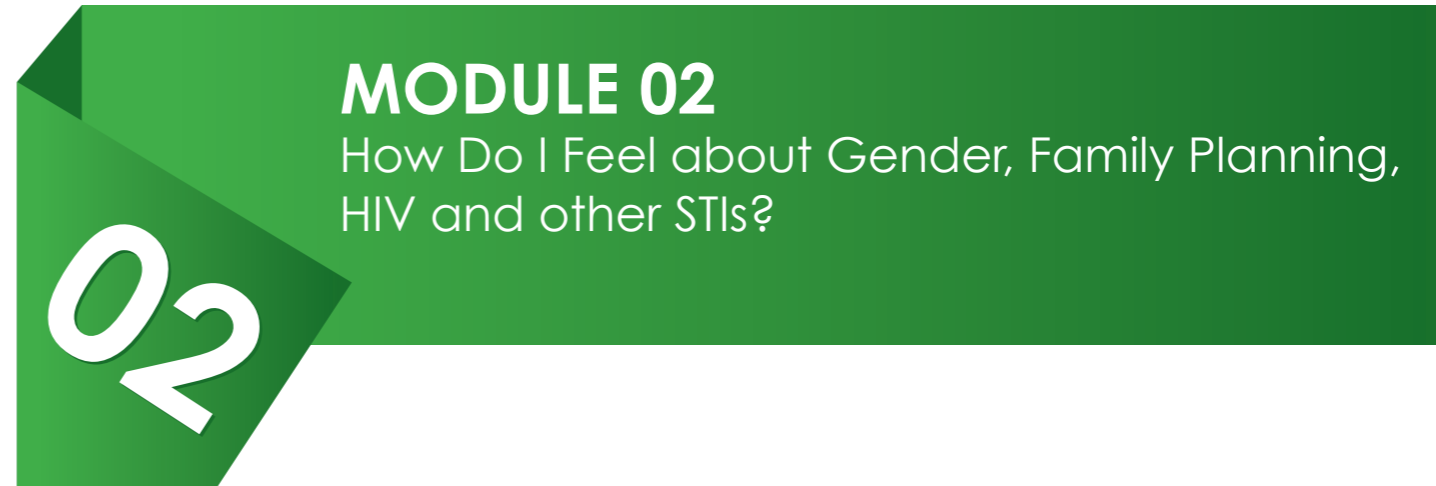
In any discussion that results from these exercises, the facilitator should note opinions expressed which suggest that critical thinking is taking place on these issues. The topic for discussion which is underlined above is particularly important to observe as well as reactions to point 8.

For a more formal evaluation, the facilitator should note how many people gather around each term (agree, strongly agree, etc.) at the beginning of the exercise. The exercise of moving around or stating "agree, disagree, etc." could be repeated at different intervals during the workshop to assess impact. For example, if there is time after Module 3 or at the very end of the workshop, repeat the exercise again.

Finally, questions included in the overall workshop evaluation (appendix 10) which specifically relate to this module may be helpful in assessing its success.

MODULE 02

How Do I Feel about Gender, Family Planning, HIV and other STIs?



Aim:

To give the participants a general understanding of their own and each other's values and attitudes about gender, family planning, HIV, and other STIs and how these might affect service delivery.

Learning objectives:

- Participants will communicate their own and learn about each other's values and attitudes about gender, family planning, HIV, and other STIs.
- Participants will understand the impact that their personal values and attitudes may have on service delivery for young women.
- Participants will identify practical ways in which they can improve their current practice based on these discussions.

Time:

60 minutes

Materials:

- Flipchart
- One note card per participant (minimum)
- Markers
- Tape/Prestik
- Pens or pencils

Advance preparation:

Write the following statements on a flipchart; one statement per flipchart page:

- Young women don't use condoms because...
- The reasons that young women get pregnant are...
- When it comes to the education that young women receive about protecting themselves during sex...
- When it comes to HIV, young women...
- When it comes to seeking reproductive health services, young women...



Instructions:

1. Tell the participants that this activity is designed to give them a general understanding of their own and each other's values and attitudes about working with adolescents and adolescent reproductive health issues. Tell them that they will be asked to share their opinions. Remind the participants that everyone has a right to his or her own opinion, and no response is right or wrong. Ask the group why it is important to be aware of your own values.
2. Distribute one note card and pen or pencil to each participant. Tell the participants not to write their name on the card.
3. Explain that you have written six incomplete sentences on the flipchart. You will display one sentence at a time. Instruct the participants to complete the sentence with the first idea that comes to mind. Tell them not to spend too much time thinking about their answer, and to be brief. Emphasize that they should be honest with their answers; nobody will know what they have written.
4. After the participants have written answers to all the incomplete sentences, ask the participants to pass their card to a central place where you can pick them up. Shuffle the cards, and redistribute one card to each participant. It does not matter if a participant gets his or her own card.
5. Read aloud each incomplete statement, and ask the participants to read aloud the answer written on the card they are holding. Tell the whole group to listen to the answers that are read from the cards. Make sure that they answer one at a time and speak loudly enough for everyone to hear.
6. After reading all the sentences and hearing responses from the group, facilitate a discussion by asking the following questions:

<input type="radio"/> What did you hear as you listened to the responses?
<input type="radio"/> Do you think that most of the responses were positive or negative?
<input type="radio"/> Do you think that the responses are the groups' honest attitudes and values? Why or why not?
<input type="radio"/> How can we deal with people who have dramatically different values and attitudes than we do?
<input type="radio"/> Which of the values and attitudes that you heard could negatively affect service provision to youth?
<input type="radio"/> What were some of the values and attitudes that you heard that could positively affect service provision to youth?
<input type="radio"/> What did you learn from this activity that will be helpful when working with youth?

7. Ask participants to share one thing that they learned in this activity that will be helpful for their future work with young women, if anything.
8. In summary, state that it is normal to have strong feelings and values about these topics. Tell the participants that learning to be aware of their own values will help them to be more open to listening to different points of view. When youth notice that service providers are accepting of differences, the adolescents will more openly and honestly assess and express their own values and perspectives.



Suggestions for Evaluation:

In the discussion that results from these exercises, the facilitator should note opinions expressed which suggest that critical thinking is taking place on these issues. The discussion for #7 will be particularly important.

For a more formal evaluation, the exercise could be repeated. For example, if there is time after Module 3 or at the very end of the workshop, repeat the exercise again.

Finally, questions included in the overall workshop evaluation (appendix 10) which specifically relate to this module may be helpful in assessing its success.

MODULE 03

Background on Young Women and Girls' Sexuality and SRH

03



Aim:

To provide participants with an overview of the sexual and reproductive health issues that young women in South Africa* are facing, using both data from our study and other published information.

*This could be modified for different contexts. The presentation which accompanies this session includes statistics for South Africa, but this could be replaced for other settings.



Learning objectives:

- Participants will become familiar with the latest information and statistics on adolescent pregnancy and risk for HIV infection.
- Participants will be able to describe ways in which health care providers can play a role in improving young women's sexual and reproductive health outcomes.
- Participants will identify practical ways in which they can improve their current practice based on these discussions.



Time:

90 minutes



Materials:

- Projector and screen (if available)
- PowerPoint presentation (if available)
- Appendix 3.1 - Handouts of presentation slides
- Appendix 3.2 - Handouts of SRH quiz



Instructions:

1. Introduce this module by explaining that the purpose is to share some information on issues that young women are facing, some of the problems we see in South Africa around adolescent sexuality, and some of the ways that health care providers might be able to help. Explain that it will be a lot of information, but they will have a copy of the presentation to take home and read again if they would like to do that.
2. Explain that you'd like to do an exercise first and see what the group knows about a few things. Tell everyone that they do not have to write their name on the quiz and there's no pressure to have the right answers. Hand out the short quiz. Ask the participants to complete it and collect it from them.

3. Proceed through the presentation, stopping for questions and discussion when necessary.
4. Facilitate a discussion by asking the following:

<input type="radio"/> Do you have any questions about the presentation?
<input type="radio"/> Do you think that the information provided in this presentation is similar to what you have experienced or know about young people's sexuality and the problems they face?
<input type="radio"/> Were you surprised about any of the statistics?
<input type="radio"/> How did the information you saw here compare to your answers on the quiz?
<input type="radio"/> Is there anything that you agree with?
<input type="radio"/> Is there anything that you disagree with?

5. Quickly go through the quiz, reading each question out loud and giving the group the correct responses (see below). Ask the group to share their thoughts on what they answered incorrectly.
6. Ask participants to discuss how having this kind of information can impact on their day-to-day work.
7. Conclude by explaining that it is important for health care providers to understand the problems that young people are facing, some of the reasons for them, and ways that health care providers can make a difference.



Suggestions for evaluation:

The facilitator should note opinions expressed which suggest that critical thinking is taking place on these issues. The discussion for #6 is especially important.

The facilitator can take the responses to the short quiz and tally them after the workshop to assess the baseline knowledge in the group before the presentation. If there is time, the quiz could be implemented again after the presentation by handing it out and asking participants to respond again. Another option is to take more time when going through the correct responses to the quiz and assess the discussion and debate regarding the right answers.

Finally, questions included in the overall workshop evaluation (appendix 10) which specifically relate to this module may be helpful in assessing its success.

Quiz Questions:	Quiz Answers:
1. In South Africa, the average age when young women start having sex is 15	FALSE – The average age for males is 16; for females it is 17.
2. Over 2/3 of young women in South Africa who have ever been pregnant report their pregnancies as unwanted.	TRUE
3. It is important to use different communication techniques with young people when providing information on sexual and reproductive health.	TRUE
4. Young women can safely use all of the same contraceptive methods that older women can use.	TRUE

Quiz Questions:	Quiz Answers:
5. Young women are more likely to get infected with HIV because (choose one): <input type="checkbox"/> They are biologically more vulnerable to infection. <input type="checkbox"/> Many young women have older men as partners. <input type="checkbox"/> Women are often unable to negotiate condom use due to economic dependency and gender-based violence <input type="checkbox"/> All of the above.	All of the responses are correct (i.e. option 4 is the answer)
6. About 10% of females are physically forced to have sex in South Africa.	TRUE
7. Women can get a TOP without giving a reason for it no matter what their gestational age is.	FALSE – TOP is allowed on demand for young women aged 12 and older if their pregnancy is less than 13 weeks gestation. From 13-20 weeks, there are specific criteria.
8. Many young women choose to fall pregnant so that they can get the child grant.	FALSE – There are no empirical data that support this idea.

MODULE 04

Let's talk about sex.

04



Aim:

To increase providers' comfort talking about topics related to sex and taking a sexual history.



Learning Objectives:

- Participants will understand their own and each other's feelings about talking about sex, sexual anatomy, and sexuality.
- Participants will learn how to take a comprehensive, non-judgmental sexual history.
- Participants will understand the impact that their personal values and attitudes may have on service delivery for young women.
- Participants will identify practical ways in which they can improve their current practice based on these discussions.



Time:

2.5 hours



Materials:

- Projector and screen (if available)
- PowerPoint presentation and/or overheads (if available)
- Appendix 4.1 - Picture frame print and sample vagina drawings
- Appendix 4.2 - Slides of sexual history taking presentation
- Pens or pencils
- Flip chart
- Flip chart makers
- Tape/Prestik



Instructions:

1. Introduce the session. (5 minutes) Explain to the participants that the aim of this activity is to assist them with being more comfortable talking about sex and sexuality and to assist them in understanding the need to take a comprehensive sexual history. Remind them that this workshop is a "safe space" where no one will be judged. Some of the activities in this session might be funny or make us uncomfortable at first, but we hope that the experience will be good in the end.

2. Explain to the participants that you are going to start with an activity that will help the group to get comfortable with some sexual terminology. (15 minutes)

- Ask participants for names that are used to describe or refer to vaginas. List them on a page of the flip chart. Ask for medical terms, common terms, slang, and things they hear from their clients.
- Next, on a new flip chart page, ask for all the terms for penis. List all of the medical, common, slang, and language from clients.
- Next, on a new flip chart page, ask for all of the terms for sex. List all of the medical, common, slang, and language from clients.
- Stick all of the pages up on the walls for participants to see.
- Facilitate a discussion around the results, asking questions such as:

- | |
|---|
| <input type="radio"/> How did it make you feel to say these different words? |
| <input type="radio"/> How does it feel to see the terms in writing? |
| <input type="radio"/> Are there terms that come up in your day-to-day work with young people that make you uncomfortable? How do you deal with that? |
| <input type="radio"/> Do you think some of your clients feel uncomfortable talking about some sexual things when they're at the clinic? Why is that? |
| <input type="radio"/> What are some ways that as health care personnel, we can help our clients to feel more comfortable talking about sex, anatomy, etc? |

3. Explain to the participants that the next activity will help us to think about our bodies and why it's important to feel comfortable dealing with bodies. (30 minutes)

- Begin by asking the group about their jobs and whether they have to see or talk about "private" body parts as part of their jobs.
- Explain that in this exercise we are going to see how comfortable we are with vaginas! Hand out the print of the picture frame that has the drawings of vaginas on one side. Look at the pictures and ask how it makes the participants feel to look at them. Are they embarrassed? If yes, why?
- Explain to participants that now they are going to draw their vagina. Ask them to flip over the handout. They can draw the vagina any size that they want in the picture frame. Be sure to mention that there is no prize for the best drawing! (If there are any men in the room, they can also draw a vagina. In this context, there will likely be more women than men.) Tell them that they have just five minutes to complete the drawing.
- Facilitate a brief discussion around the drawings focusing on the feelings of participants and levels of comfort. Ask questions such as:

- | |
|---|
| <input type="radio"/> How did it make you feel to have to draw your vagina? |
| <input type="radio"/> Do you think it's common for women to look at their own vaginas? How about young women? |
| <input type="radio"/> Do you think it's common for women to talk about their bodies? Again, how about young women? Do you think they are comfortable talking with health care workers about their bodies? Why or why not? |

4. Explain to the group that the next exercise focuses on how we talk to young people about sex. (40 minutes)

- Ask for 4-5 volunteers to share what they were told about sex when they were young. Who told them? What was definitely not said?
- Facilitate a discussion among the group asking questions such as:

- | |
|--|
| <input type="radio"/> Are there things that you wish that you had been taught when you were young? Who do you wish would have told you those things? How did you eventually find out that information? |
| <input type="radio"/> How do you feel about talking to your own children about sex? |
| <input type="radio"/> How do you think most young people get information about sex today? |
| <input type="radio"/> What role can health care personnel have in providing information on sex to young people? |

5. Explain that the final exercise is intended to build on the previous activities and help every one by giving them some practical information on how to take a sexual history. (For nurses, this is directly related to their work. If other types of health personnel are present, it would be good to discuss why this might be helpful before beginning.) (40 minutes)

- Hand out the Sexual History Taking presentation.
- Present the slides to the participants, stopping for questions and comments as necessary.
- Facilitate a discussion, asking questions such as:

- | |
|---|
| <input type="radio"/> What are some of your experiences with taking a sexual history? |
| <input type="radio"/> Is there anything that was presented here that is different from what you have normally done? |
| <input type="radio"/> Why do you think it might be helpful to use some of the techniques mentioned here? |

6. Ask participants to share one thing that they learned in this session that will be helpful for their future work with young women, if anything. (20 minutes)

7. In summary, state that it is normal to feel uncomfortable about some of these activities or topics. Tell the participants that learning to be aware of their own feelings will help them to be more open and able to help their clients. When a client feels that the health care worker is comfortable, s/he will also feel more comfortable.



Suggestions for Evaluation:

The facilitator should note opinions expressed which suggest that critical thinking is taking place on these issues. The discussion for items related to direct implications for day-to-day work (i.e. items that are underlined above) are especially important.

Questions included in the overall workshop evaluation (appendix 10) which specifically relate to this module may be helpful in assessing its success.

MODULE 05

Sexual Identity and Orientation

05



Aim:

To help providers better understand and respond to the needs of their patients regarding issues of sexual identity and orientation.



Learning objectives:

- Identify different types of sexual identity and orientation.
- Understand how sexual identity and orientation may be expressed during adolescence.
- Provide appropriate counseling on issues of sexual identity and orientation.



Time:

90 minutes



Materials:

- Flip chart
- Flip chart makers
- Tape/Prestik
- Appendix 5.1 – Definitions for sexual identity and orientation exercise
- Appendix 5.2 – Sexual identity and orientation handout
- Appendix 5.3 – Sexual identity and orientation case studies



Advance preparation:

- Prepare slips of paper with the definitions of sexual orientation and identity listed at the top of the sexual identity and orientation handout. Appendix 5.1 contains the definitions only. Print one copy per group and cut the definitions into separate slips. Note that each slip of paper should contain only the description, NOT the term it refers to, as the group exercise will involve participants thinking through which definition matches which term.
- Prepare five slips of paper with one case study written on each. Appendix 5.3 contains the case studies. Print one copy per group and cut each case study into a separate slip.



Instructions:

1. Provide an introduction which includes the following (5 minutes): Sexual orientation can be a difficult subject to address because it sometimes conflicts with personal, cultural, or religious values and attitudes regarding sexuality. However, as providers and counselors, it is important to understand that a range of sexual orientations and identities exist.

Adolescence is a time of sexual experimentation and defining a sexual identity. An adolescent client who is struggling with her/his sexual identity often experiences deep emotional turmoil that sometimes can lead to suicide. While providers and counselors may hold their own personal opinions regarding sexual orientation, it is their responsibility to provide accurate and unbiased information and services to all adolescent clients. Many gay and lesbian youth avoid health services for fear that they will be judged or that their sexual orientation will be disclosed to others. Providers and counselors can help clients overcome this fear by maintaining strict practices of confidentiality and serving clients in a non-judgmental manner.

2. Group exercise (25 minutes):

- a. Write each word defined in the sexual identity and orientation handout (appendix 5.2) on the flipchart and make sure you have the pre-prepared definitions for each word on small pieces of paper. Divide the group into two teams and divide the slips of paper between the two groups. Also give each group some Prestik or tape. Do not give participants their handout (appendix 5.2) until the end of this exercise.
- b. Ask each group to discuss the definitions and then match each one to the correct word on the flipchart. To do this, they should come to the front and tape their definitions next to the matching words on the flipchart.
- c. When the groups have finished, review their work and correct any misinformation. Ask participants if they have any questions or comments, and give participants the handout (appendix 5.2).

3. Review the bulleted list called “sexual orientation and identify” on the participant handout (appendix 5.2) and ask participants if there are any questions or comments (10 minutes).

4. Role playing exercise (50 minutes):

- a. Arrange chairs in a circle, placing two chairs in the center of the circle.
- b. Select two participants—one to play the role of a counselor or provider and the other to play the role of a client.
- c. Give the “client” a piece of paper describing the details of her/his character (i.e. one of the five case studies in appendix 5.3).
- d. Instruct the “client” not to directly reveal who her/his character is but to act according to what is written in the description.
- e. Instruct the “provider/counselor” that the goal of the exercise is to provide counseling in a nonjudgmental manner. The “provider/counselor” should make sure the information s/he gives the “client” is helpful and accurate.
- f. Ask the rest of the participants to sit in the outside circle and observe the interaction between the “client” and the “provider/counselor.”
- g. Ask the participants to begin. After about five minutes, stop the exercise and ask the following questions:
 - i. Did the “provider/counselor” provide accurate and helpful information to the “client” in a non-judgmental manner?
 - ii. If yes, what things did the “provider/counselor” do that led to a positive interaction?
 - iii. What could the “provider/counselor” have done to improve the interaction between her/himself and the “client”?
- h. Ask the “client” how the character s/he played felt in this situation.
- i. Repeat this exercise with the other case studies (keeping track of the time). For each case study, choose two different participants to act as the “provider/counselor” and the “client.”

5. Summarize the content covered in the module, and ask if there are any final questions or comments.



Suggestions for Evaluation:

The facilitator should note opinions expressed which suggest that critical thinking is taking place on these issues. The number of incorrect attempts to define the various terms should be noted in addition to participants' responses/observations after learning the correct answers. Finally, the facilitator should observe whether effective techniques are being used during the role playing exercise. Observations should be documented.

Questions included in the overall workshop evaluation (appendix 10) which specifically relate to this module may be helpful in assessing its success.

MODULE 06

Communicating with Young People

06



Aim:

Improve providers' skills for communication and counseling adolescents.



Learning objectives:

- Participants will be able to identify effective communication skills, including nonverbal communication, verbal encouragement, simple language, and clarification.
- Participants will be able to identify effective counseling skills.
- Participants will improve communication and counseling skills through role plays.
- Participants will identify practical ways in which they can improve their current practice based on these discussions.



Time:

4 hours



Materials:

- Flipchart
- Markers
- Appendix 6.1 - Handout: Characteristics of Effective and Ineffective Counselors
- Appendix 6.2 - Handout: Role play scenarios with instructions for the "client" and "service provider"



Advance preparation (10 minutes):

- Ask for two participants to volunteer to do some role-plays for the group which will demonstrate counseling skills.
- In a private space, away from the other participants, provide the volunteers participants with the handout called "Characteristics of Effective and Ineffective Counselors." Review the handout (appendix 6.1) together. Also give them the "Role play scenarios" handout (appendix 6.2).
- Explain to the two volunteers that they will do the first role scenario on the handout twice during this session. Explain that the first time they do the role play will be at the very beginning of the session and that they should attempt to demonstrate an ineffective interaction. Explain what that might look like given the list of effective and ineffective techniques.

Explain also that later in the session, they will reenact the same scenario, but as an effective counseling session. Spend some time going over the provided scenario (the first one on the list!), conceptualizing the role plays with the two participants, and make sure they have a clear vision of what they want to act out. Explain that they will have just five minutes to present each role play.

- Write the closed-ended questions from #11 below on a flipchart for later use.
- Write the statements for paraphrasing from #16 on the flipchart for later use.



Instructions:

Role Play #1 (20 minutes)

1. Tell the group that during this activity they will be discussing and reviewing some of the key concepts of interpersonal communication and discussing effective counseling techniques.
2. Explain to the group that the two participants who have volunteered will demonstrate two counseling sessions. Briefly explain the scenario for the first role play to the group, do not tell them that the first role play will demonstrate an ineffective session. Tell them to watch the interaction that takes place and to be prepared to discuss their observations after the role play.
3. Allow 5 minutes for the first role play to take place.
4. After the role play, ask the participants for their initial reactions and to identify what they think might have gone wrong during the counseling session. Write their responses on a flipchart.

Non-verbal Communication (15 minutes)

5. After listing all of the groups, responses, inform the group that a major part of communication does not involve any words at all. This is called "nonverbal communication." Ask the participants to give examples of both positive and negative nonverbal communication. Ask them to demonstrate actual nonverbal cues. Take notes on the flipchart. Examples may include the following:

Positive Nonverbal Cues
<input type="checkbox"/> Leaning toward a client
<input type="checkbox"/> Smiling
<input type="checkbox"/> Avoiding nervous mannerisms
<input type="checkbox"/> Presenting interested facial expressions
<input type="checkbox"/> Maintaining eye contact
<input type="checkbox"/> Making encouraging gestures, such as nodding your head

Negative Nonverbal Cues
<input type="checkbox"/> Reading from a chart
<input type="checkbox"/> Glancing at your watch
<input type="checkbox"/> Yawning
<input type="checkbox"/> Looking out the window
<input type="checkbox"/> Fidgeting
<input type="checkbox"/> Frowning
<input type="checkbox"/> Not maintaining eye contact

6. Ask the group to give their thoughts on the impact that positive and negative nonverbal language has on establishing and maintaining a good relationship with a client.
7. Tell the participants that, in fact, adolescents are extremely aware of and sensitive to nonverbal messages. Discuss why that might be true.

Verbal Encouragement (20 minutes)

8. Tell the participants that another important aspect of effective communication is called "verbal encouragement." This lets the client know that the service provider is interested and paying attention.
9. Ask the participants to give examples of verbal encouragement that service providers can use to encourage clients to feel comfortable divulging personal information. Take notes on the flipchart. Examples may include the following:

<input type="checkbox"/> "Yes."
<input type="checkbox"/> "I see."
<input type="checkbox"/> "Right."
<input type="checkbox"/> "Okay."
<input type="checkbox"/> "Really? Tell me more about that."
<input type="checkbox"/> "That's interesting."

10. Tell participants that a part of verbal encouragement involves asking "open-ended questions." These require the person answering the questions to reply with full answers, rather than a simple "yes" or "no." Questions that require only a "yes" or "no" response are called "closed-ended questions."
11. Ask the participants to change the following closed-ended questions to open-ended questions. (The closed-ended questions should have been written on the flipchart in advance.) Write examples of the participants' responses on the flipchart.

Closed-Ended Questions	Possible Open-Ended Revisions to Questions
Do you want counseling?	Please tell me why you are here today. What can I help you with?
Do you have any questions about puberty?	What sort of questions do you have about puberty?
Are you scared to talk with me?	Why are you scared to talk with me?
Do you have problems at home?	Tell me about your home life.
Were you upset when your friends made fun of you?	How did you feel when your friends made fun of you?
Are you sexually active?	If you are comfortable enough, please tell me about your sexual activity.

12. After completing collection of the participants' suggestions, provide some of the suggestions mentioned above for open-ended questions. Discuss how the responses to the closed- and open-ended questions might be different and how they would impact on the quality of the services provided.

Communicating in Simple Terms (10 minutes)

- Tell the participants that when they speak with adolescents, it is important to use "simple language" that youth can understand. Ask the participants to provide examples of sexual and reproductive health terms that an adolescent may not understand. Write these on the flipchart.
- Then ask the participants to provide words that could be used instead of the sexual and reproductive health terms. Write these on the flipchart beside the words generated in #13.

Paraphrasing (20 minutes)

- State that appropriate responses from a service provider can also enhance the client-provider relationship. "Paraphrasing" is a way to make sure that the service provider has accurately understood what the client is communicating. It also lets the client know that the service provider is interested in what he or she is saying. Provide this example of paraphrasing:

Client: "I want to use pills, but my sister says they will make me sick and weak."
Service provider: "So, you have some concerns about the side effect of pills."

- Display the flipchart that lists the following statements. Explain that these are statements made by clients.

Client Statements	
<input type="checkbox"/>	"I don't use condoms because I hear they don't work."
<input type="checkbox"/>	"I don't like the injection because it makes me wet and I get fat."
<input type="checkbox"/>	"I don't like pills because someone might see me taking them."
<input type="checkbox"/>	"I'm tired of hearing about HIV—it's not going to happen to me."
<input type="checkbox"/>	"Whenever I ask somebody about preventing pregnancy they just tell me not to have sex."

- Then ask the participants to turn to the person next to them and pretend that s/he is the client who made the statement(s). Ask the participant to imagine him/herself as the provider and paraphrase each of the statements. They should take turns being the client or provider.
- After five minutes, reconvene the group and ask volunteers to share their examples of ways to paraphrase the statements.
- Ask the group to share their feelings about the exercise. How did it feel to hear the provider paraphrasing the statement or concern?

Role Play #2 (30 minutes)

- Explain to the group that they are now going to look at how communication skills can improve counseling. Tell the participants to imagine that they are family planning clients. Based on the previous exercises and discussions and the participants' experiences in working with clients, ask them to list behaviors that they would want the counselor or nurse to exhibit. List them on the flipchart. Responses might include the following (if not listed, add them after the group has finished):

<input type="checkbox"/>	Use simple language when needed
<input type="checkbox"/>	Be open to communication and answering questions
<input type="checkbox"/>	Always place clients' needs first
<input type="checkbox"/>	Conduct counseling in a private setting that ensures confidentiality
<input type="checkbox"/>	Give the clients his or her full attention
<input type="checkbox"/>	Never make judgmental remarks to clients
<input type="checkbox"/>	Respect the clients regardless of their age, educational level, ethnicity, sex, language, marital status, religion, or socioeconomic status

- Ask the two role-play volunteers to reenact the role play. (You may need to remind them privately that this is supposed to be the effective counseling session.) This time they will implement as many skills—positive nonverbal cues, verbal encouragement, simple language, and paraphrasing—as possible during the interaction.
- After the role-play, ask the participants for their observations.
- After the group shares its responses to the second role-play, facilitate a discussion by asking the following questions:

<input type="checkbox"/>	What was the difference between the first and second role play?
<input type="checkbox"/>	Which skills are the most important to use during a counseling session with adolescents?
<input type="checkbox"/>	Which of these skills might be easier for you to implement in your day-to-day work?
<input type="checkbox"/>	Which might be harder to implement? Why? What could you do about that?
<input type="checkbox"/>	Which of these skills are ones that you would want to improve on?

- Remind the participants that it is important to be conscious of their interactions with adolescents. It is also important to help youth feel comfortable during their first visit and encourage them to come for other visits if they need to. Remind the participants that adolescents are extremely aware of and sensitive to nonverbal messages. Explain that improving communication and counseling skills will contribute to quality services for youth.

Group Role Plays (60 minutes)

- Tell the participants that during this next activity everyone will practice effective communication and counseling skills.
- Provide all of the participants with the handouts called "Characteristics of Effective and Ineffective Counselors" (appendix 6.1) and the "Role play scenarios" handout (appendix 6.2). Review the handouts together.
- Divide the participants into small groups of three or four people.
- Tell the participants that there is time to do two role plays in each group. For each one, one person in each group will play the "client" and one will play the "service provider." Point out that the group has already seen the first scenario on the handout. The two remaining scenarios will be acted out in this session.
- Explain that each role play should not take longer than five minutes. Explain that while the role plays are happening between two people in each group, the other participant(s) in the group will observe the interaction, try to understand the client's perspective, and identify which of the service provider's behaviors appear to be effective or ineffective in dealing with the client.

30. Give the groups 15 minutes (no more!) to complete both role plays.
31. Reconvene the group.
32. Facilitate a discussion by asking questions such as:

<input type="radio"/> What did the two role plays have in common?
<input type="radio"/> What was different about the two role plays?
<input type="radio"/> What were some of the effective counseling strategies that the service provider characters used in the role plays?
<input type="radio"/> Did any strategies work in both role plays?
<input type="radio"/> What strategies were unique to each role play?
<input type="radio"/> Are there other techniques that may have been useful in dealing with the client?
<input type="radio"/> What went well during the role plays?
<input type="radio"/> What could have been done better?
<input type="radio"/> What are the most important points to keep in mind when working with adolescents?

33. Ask the participants what, if anything, that they learned in this session might help them with their day-to-day activities? Why is that? How will that work exactly? (20 minutes)
34. Conclude by explaining the importance of effectively communicating with young clients. They are often anxious and embarrassed when asking for help regarding contraception or other reproductive health services. Adolescents may have trouble trusting adults and are extremely sensitive to any judgmental attitudes they perceive in adults. It is important for service providers to communicate non-judgmentally and empathically to ensure that youth are open about their sexual experience and reproductive health needs.

Suggestions for Evaluation:

The facilitator should note opinions expressed which suggest that critical thinking is taking place on these issues. The discussion for items related to direct implications for day-to-day work (e.g. item 33) are especially important.


The facilitator should walk around and listen in on the group role play exercise to observe whether effective techniques are being used. Observations should be documented.


Questions included in the overall workshop evaluation (appendix 10) which specifically relate to this module may be helpful in assessing its success.

MODULE 07

Answering difficult questions


07

 **Aim:**
Improve providers' ability to respond to difficult questions asked by young clients.


 **Learning Objectives:**

- Participants will identify areas of sexual or reproductive health that they might feel uncomfortable talking about with clients.
- Participants will learn strategies for responding to questions the "difficult questions" identified.
- Participants will identify practical ways in which they can improve their current practice based on these discussions.

 **Time:**
2 hours

 **Materials:**

- Flipchart
- Markers
- "Difficult Questions" tool (one for each participant) developed by Ibis Reproductive Health

 **Instructions:**

1. Introduce the session by telling the participants that during this session they will identify some areas that might be difficult to talk about in their day-to-day work and develop and practice strategies for responding to difficult questions that clients may ask. Remind the participants that part of the role of service providers is to give accurate information on reproductive health. Sometimes this means answering questions that we are uncomfortable with. (5 minutes)

Eliciting Difficult Topics / Questions (15 minutes)

2. Begin by opening to a clean page in the flipchart and asking the group to share some of the things that their clients ask them that they find difficult to answer. Ask specifically about young clients and young women clients. List all of the topics on the chart.

3. Ask the group to discuss how they handle these kinds of “difficult questions” now. Ask them to share any “success stories” that they might have.

Difficult Questions Tool – Group Role Plays (40 minutes)

4. Hand out the “Difficult Questions” tool developed by Ibis Reproductive Health.
5. Explain that the tool contains information that might be helpful when trying to answer some difficult questions about sexual and reproductive health. Ask them to take a few minutes to flip through the tool and begin to read the sample questions and responses.
6. Ask the group for their immediate feedback on the tool. What are their first impressions? Considering the list that they put together in exercise #3, are there topics that are missing? Are there topics that they were surprised to see in the tool?
7. Explain that you are now going to do some role playing to see how the tool might work. Each group of two people chosen for a role play will have five minutes to prepare and five minutes to present. One person should be the health care worker, and one person should be the client.
8. Ask for volunteers to do a role play one of the difficult questions in the tool. Randomly open the tool to a card. Tell the group that the role play will focus on the information on that card.
Repeat the process of picking volunteers and cards until three cards have been chosen and assigned to three pairs of volunteers.
9. Allow the three groups of volunteers about five minutes to prepare. At this point, tell the group that they should take notes on the upcoming role plays and critique the technique based on what they know about effective counseling.
10. Then allow each role play group five minutes to perform in front of the group. The client should ask the difficult question, and the provider should use the tool to respond in a non judgmental way.
11. Ask the group to comment on the role plays and facilitate discussion by asking:

<input type="radio"/> What were some of the effective counseling strategies that the service provider characters used in the role plays?
<input type="radio"/> Did any strategies work in both role plays?
<input type="radio"/> What strategies were unique to each role play?
<input type="radio"/> Are there other techniques that may have been useful in dealing with the client?
<input type="radio"/> What went well during the role plays?
<input type="radio"/> What could have been done better?
<input type="radio"/> Was there any information that was presented that seemed incomplete or maybe incorrect?
<input type="radio"/> What are the most important points to keep in mind when working with adolescents and talking about “difficult topics”?

Difficult Questions Tool – Individual Role Plays (30 minutes)

12. Divide the group into pairs and explain that now they will all have the opportunity to practice using the cards.
13. Explain that they should each randomly select a card (no picking an easy one!). Then each person will have five minutes to be the provider and discuss the topic on that card with the client. (The client should turn to the same card and ask the questions there.)
14. Allow a total of 10 minutes. Both persons in the pair should be the provider one time.
15. Reconvene the group and facilitate a discussion by asking questions such as,

<input type="radio"/> As the “provider,” how did it feel to have to provide “sensitive information” to the “client”?
<input type="radio"/> What were the most difficult things about responding?
<input type="radio"/> As the “provider”, how did you manage your personal feelings about the topic while counseling the “client”?
<input type="radio"/> As the “client” was it obvious that the “provider” was uncomfortable? Did that affect the session?
<input type="radio"/> Would it be more or less easy to discuss difficult topics in English or other local languages?

Discussion

16. Open up the discussion and ask if there are other strategies or tools that they could use to help them feel more comfortable talking about certain topics in their day-to-day activities. (10 minutes)
17. Ask the participants what, if anything, that they learned in this session might help them with their day-to-day activities? Why is that? How will that work exactly? (20 minutes)
18. Conclude by reminding the group of the importance of effectively communicating with young clients and the importance of being able to set aside our personal feelings and judgments when we are working as health care professionals. It is important for service providers to communicate non-judgmentally and empathically to ensure that youth are open about their sexual experience and reproductive health needs.

 **Suggestions for Evaluation:**

The facilitator should note opinions expressed which suggest that critical thinking is taking place on these issues. The discussion for items related to direct implications for day-to-day work (e.g. item 17) are especially important.

The facilitator should walk around and listen in on the group role play exercise to observe whether effective techniques are being used. Observations should be documented.

Questions included in the overall workshop evaluation (appendix 10) which specifically relate to this module may be helpful in assessing its success.

MODULE 08

Gender-based violence

08

Aim:
To improve participants understanding of gender-based violence (GBV) and to improve their skills on supporting victims of GBV.

Learning objectives:

- Demonstrate an understanding of GBV, including its definitions, various dimensions, prevalence and health consequences.
- Demonstrate familiarity with approaches for supporting victims of GBV.

Time:
3 hours 30 minutes

Materials:

- Flipchart
- Flip chart markers
- Tape or Prestik
- Appendix 8.1 - Definitions of GBV
- Appendix 8.2 - Myths about Women Abuse
- Appendix 8.3 - Power and control wheel
- Appendix 8.4 - Exploring the underlying causes of GBV - Miriam's Story
- Appendix 8.5 - Specific victim situations
- Appendix 8.6 - Health Provider Responses

Advance preparation:

- Put up on the wall accounts of GBV from newspapers, magazines and other sources.

Instructions:

Definitions

1. Explain to the participants that the first exercise is called Defining Violence Against Women and that they will be working in groups to define GBV. (40 minutes)
2. Divide the participants into small groups, give each group a piece of flip chart paper, and ask them to list different types of GBV.
3. Ask each group to present their work and define GBV for the larger group.
4. Distribute the handout on definitions of GBV (appendix 8.1). Check if the group's definitions include the following (Discuss any that may not be easily understood.):

<input type="checkbox"/> Physical harm or suffering
<input type="checkbox"/> Sexual harm or suffering
<input type="checkbox"/> Psychological harm or suffering
<input type="checkbox"/> Threats of physical, sexual, psychological harm or suffering
<input type="checkbox"/> Coercion
<input type="checkbox"/> Arbitrary deprivation of liberty
<input type="checkbox"/> Acts in public as well as in private life
<input type="checkbox"/> Violence perpetuated or condoned by the state

5. Discuss whether they would like to add other forms of violence to their flip chart lists.
6. Ask participants to walk around and read the accounts of GBV on the wall and discuss the extent to which the definition on the handout includes all these types of instances.
7. Ask participants if they would want to change the definition on the handout in any way.

Myths

8. Explain to the participants that the next exercise will work on their own to answer a questionnaire on the myths about violence. (30 minutes)
9. Distribute the handout (appendix 8.2) on myths about violence.
10. Ask the participants to complete the questionnaire on their own. After ten minutes go over the correct responses with them and discuss their responses.
11. Summarize the discussion with the following definition: "Violence is any attempt to control or dominate another person."

Causes of GBV

12. Explain to the participants that the next exercise will look at the underlying causes of GBV. (30 minutes)
13. Brainstorm on why people use violence.
14. Distribute the Power and Control Wheel (appendix 8.3) and discuss the various forms of violence noted on it.
15. Distribute to participants: "Miriam's Story" (appendix 8.4)
16. Go over the case study in steps and ask participants to identify the factors that contributed to Miriam's experience of GBV.

GBV in our communities

17. Explain to the participants that for the next exercise they will brainstorm their ideas about the extent of GBV and also the consequences of GBV in their communities. (30 minutes)
18. Record the ideas/responses on the flip chart and discuss what the participants see as the role of health care providers.

Role playing

19. Explain to the participants that the final exercise in this module will involve role playing to acquaint them with asking about violence and how to provide support. (60 minutes)
20. Distribute appendix 8.6 to the group. Review the content.
21. Choose three pairs of volunteers. In each pair, one person will be the health provider and the other will be the victim of GBV. Give each victim one of the scenarios listed in appendix 8.5.
22. The health providers should take a history and provide care and support to the victim. Give each group 10 minutes for the role play.
23. After each role play, debrief those who participated in the role plays and then have a discussion with the larger group on the challenges involved in the care of women experiencing GBV and how they might overcome these challenges.
24. Ask participants to share one thing they learned in this session that will be helpful to them in their work. (20 minutes)



Suggestions for Evaluation:

The facilitator should note opinions expressed which suggest that critical thinking is taking place on GBV. Questions included in the overall workshop evaluation (appendix 10) which specifically relate to this module may be helpful in assessing its success.

MODULE 09

Family planning update

09

NB: Module 9 is a placeholder for a session on family planning. Here we have included short descriptions of two larger sets of materials and activities: the Balanced Counseling Strategy Plus (BCS+) Toolkit developed by the Population Council in 2008 and the Decision-Making Tool for Family Planning Clients and Providers created by the WHO and Johns Hopkins Bloomberg School of Public Health in 2005. Note that the required materials for this module must be obtained separately from the Population Council or the WHO.

The workshop was originally piloted with the BCS+ Toolkit, so guidance for using this Toolkit is provided below. However, either tool would serve the purpose of improving approaches for family planning provision.



Aim:

(BCS+) To improve participants' ability to provide women with counseling on a full range of family planning methods. (Ibis's additions) Review strategies for abortion-related counseling and referral.



Learning Objectives:

- (BCS+) Participants will be familiar with the four counseling stages of the BCS+ decision-making algorithm: pre-choice stage, method choice stage, post-choice stage, and STI/HIV prevention, risk assessment, and counseling and testing stage.
- (Ibis) Participants will be familiar with pregnancy options counseling and referral strategies.



Time:

Dependent on material. If using the BCS+ Toolkit, 7 hours
(6 hours 45 minutes for the BCS+ and 15 minutes for Ibis's extra cards)



Materials:

- BCS+ toolkit, including one BCS+ tool for each participant
- BCS+ Facilitator Guide
- Pregnancy options counseling and referral cards (developed by Ibis Reproductive Health)
- Gender –based violence extended counseling card (developed by Ibis Reproductive Health)



Instructions:

NB: The first forty minutes of the BCS+ training includes “ice-breakers” that may not be necessary if the group has already been together for modules 1-8 of this workshop. Also, the “Pre-Choice Stage” of the BCS+ training includes a short, 20-minute values clarification exercise which may be seen as similar to the first module in provided in this workshop. Again, this may not be necessary if the BCS+ is provided in the context of the workshop explained in this manual. Finally, as part of the BCS+ training, a tool is provided to training participants which includes several cards containing information on contraceptives and counseling on other sexual and reproductive health concerns such as cervical cancer and gender-based violence. Ibis Reproductive Health has created four new cards which may be added to the BCS+ tool. These new cards focus on gender-based violence extended counseling and pregnancy options counseling.

1. Introduce the BCS+ training using the instructions provided in the BCS+ Facilitator Guide.
2. Implement the BCS+ training UP TO AND INCLUDING the “STI/HIV prevention/risk assessment, and counseling and testing stage” session using the instructions provided in the BCS+ Facilitator Guide (and taking into account the suggestions above).
3. Hand out the new pregnancy options counseling and referral cards developed by Ibis. Explain that these are NOT part of the BCS+ tool, but that participants can include it in the tool after BCS+ card #1 if they wish to do so.
4. Show the participants how BCS+ card 1 of 20 ends with a pregnancy test. Explain that if the test is negative, the counseling can proceed to the contraception cards, but if the test result is positive, they can refer to Ibis's pregnancy options counseling and referral cards.
5. Briefly go over the counseling and referral advice on the pregnancy options counseling and referral cards. Remind participants that the cards contain only suggested talking points and that different situations may require modifying the responses. It is important to be sensitive to individual women's needs.
6. Hand out the new the extended counseling GBV card developed by Ibis. Explain that this is NOT part of the BCS+ tool, but that participants can include it in the tool after BCS+ card #20 if they wish to do so.
7. Explain that the BCS+ card provides some questions for determining if a client might have experienced gender-based violence. Then explain that the new GBV card from Ibis may help by providing a bit more information on counseling and referral for people how may have experienced GBV.
8. Continue implementing the BCS+ training using the Facilitator Guide. This will include conducting the two role play sessions with participants.
9. Save some time to allow for role playing with the cards from Ibis (See appendix 9.1).
10. Ask the participants what, if anything, that they learned in this session might help them with their day-to-day activities? Why is that? How will that work exactly? (20 minutes)
11. Conclude by emphasizing the need to keep the tools that they have received with them at all times when working in order to best be able to effectively inform and provide their clients with adequate counseling and referrals.



Suggestions for Evaluation:

The BCS+ Facilitator Guide provides instructions for evaluating the training.

Questions included in the overall workshop evaluation which specifically relate to this module may be helpful in assessing its success.

WORKSHOP EVALUATION AND CONCLUSION

Throughout this manual “suggestions for evaluation” were presented as part of each module. These referred to activities which could be implemented during the module, immediately after each module, or later in the workshop.

A formal evaluation form has been designed which can be used to assess the participants' feedback on the modules and the workshop as a whole. The suggested use for evaluation form is as follows:

- Explain to the participants that the facilitators would like to hear their opinions regarding each module and the workshop as a whole. To gather this information, the facilitators would like them to complete a quick evaluation form each day. They should NOT put their names on the forms.
- At the end of day one (which includes Modules 1-4), hand out the evaluation form for Day 1 (See appendix 10) and ask the participants to complete it and hand it in to the facilitator. Explain that this section asks questions about the modules covered on day one.
- At the end of day two (which includes Modules 5-6), hand out the evaluation form for Day 2 (See appendix 10) and ask the participants to complete it and hand it in to the facilitator. Explain that this section asks questions about the modules completed on day two.
- At the end of day three (which includes Modules 7-8), hand out the evaluation form for Day 3 (See appendix 10) and ask the participants to complete it and hand it in to the facilitator. Explain that this section asks questions about the modules completed on day three.
- At the end of day four (which includes Module 9), hand out the evaluation form for Day 4 (See appendix 10) and ask the participants to complete it and hand it in to the facilitator. Explain that this section asks questions about the modules completed on day four and for the workshop as a whole.

It is recommended that the facilitators review the feedback on the evaluation forms in real time, i.e., immediately after it is collected. This will help to ensure that any questions or comments that need to be addressed with the group can be addressed before the workshop is closed.

After the workshop, the evaluation forms collected should be reviewed, and suggestions for improvement or modification of the workshop should be discussed and implemented where possible.

Ibis Reproductive Health would appreciate receiving a summary of the feedback on the workshop if that is at all possible. Send feedback to Joburg@ibisreproductivehealth.org.

01

APPENDIX 01

1.1: Agree-Disagree cards for posting
1.2: Values clarification statements

**STRONGLY
AGREE**

APPENDIX 1.1

AGREE

DISAGREE

STRONGLY DISAGREE

Appendix 1.2 – Values clarification statements

For each statement, indicate whether you strongly agree, agree, disagree or strongly disagree.

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
1. Young women should not indulge in sex before marriage.				
2. It is natural for young women to have sex, and they should be able to choose to do so.				
3. Condoms should be available to youth of any age.				
4. Sex education can lead to early sex or promiscuity.				
5. It is worse for an unmarried girl to have sex than for an unmarried boy to do it.				
6. Teenage girls should be discouraged from using family planning.				
7. Most young women are incapable of making their own decisions about their sexual and reproductive life.				
8. As providers, it is our role to take care of young women as though they were our own children and encourage them not to have sex.				
9. As providers, it is our role to help women protect themselves from HIV, STI's and unintended pregnancy by encouraging them to practice safe sex.				

APPENDIX 03

- 3.1 Background on Young Women and Girl's Sexuality and SRH in South Africa - Presentation
- 3.2 SRH Quiz

Young Women's Sexuality & Sexual and Reproductive Health (SRH) in South Africa



Outline

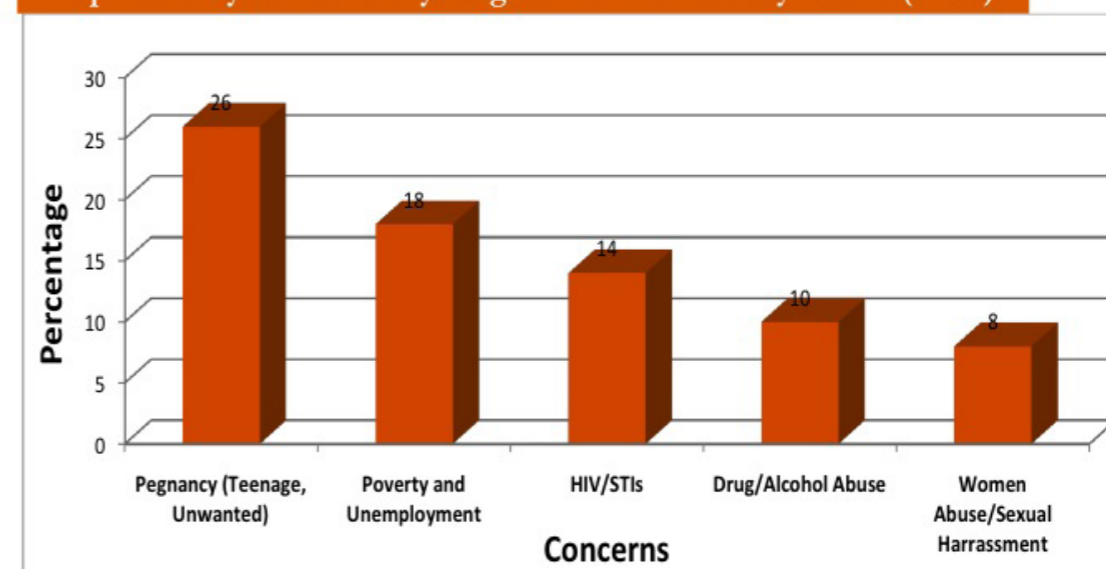
- Background on the study by Ibis Reproductive Health
- Adolescent Pregnancy
- Gender Based Violence
- Contraceptive Use
- Termination of Pregnancy
- Young Women and HIV
- Sexual and Reproductive Health services for adolescents
- The Role of Health Care Providers

“Soweto Study” Background

- Ibis Reproductive Health, in collaboration with the Perinatal HIV Research Unit (PHRU), conducted research in Soweto, South Africa from 2008-2009.
- Participants were asked about adolescent sexuality, the biggest SRH issues young women are facing and ways to address them, and about SRH services at local clinics.

Study population	Number of Interviews
Young Women (ages 18-24) recruited in public sector clinics and a shopping mall	50
Providers recruited from public sector clinics (HIV/STIs, antenatal, family planning, and TOP departments)	30
Community Stakeholders recruited from the community	25

Top five daily concerns of young women from survey results (n=50)



Characteristics of young women in Soweto study

Characteristic	Median [Range] OR n(%)
Age	21 [18-24]
Currently attending school (high school or tertiary)	12 (24%)
Currently working	10 (20%)
Currently living with:	
Parents	21 (42.9%)
Partner	11 (22.4%)
Other family member	15 (30.6%)
Other	2 (4.1%)

Teenage Pregnancy

- Teenage pregnancy = women aged 15-19 who are mothers or who have ever been pregnant
- Teenage pregnancy rate = events per 1,000 women aged 15-19
- Proportion of women aged 20-24 (**married or unmarried**) who give birth before 20:
 - 30% in developing countries,
 - 50% in Sub-Saharan Africa (up to 70% in some countries),
 - 30-40% in Latin America and the Caribbean,
 - 25% in South/Southeast Asia (up to 64%),
- Considering **unmarried adolescents only**, the highest regional rate of premarital birth by age 20 - 14.5% - occurs in East and Southern Africa.

Teenage pregnancy – South Africa

There are conflicting studies/data regarding pregnancy in South Africa:

- **Demographic and Health Survey**
 - 1998 - 35% of women had had a child by the age of 19
 - 2003 – Decreased to 27%
- **Department of Education**
 - 2004 - 51 pregnancies for every 1,000 female learners
 - 2008 - 62.8 per 1,000

Why is teenage pregnancy a concern?

- Unplanned pregnancy/**unsafe abortion**
 - Half of unplanned pregnancies end in induced abortion.
 - 21.6 million unsafe abortions occur annually, 25% occur in sub-Saharan Africa.
 - In South Africa, death attributable to unsafe abortion is increasing.
- Health risks are exacerbated by fact that young women have **poor access to or poor utilization of health care services.**
- Contributes to **infant morbidity and mortality**

Why is teenage pregnancy a concern?

- Early pregnancy and unplanned childbirth have far-reaching physical, psychological and social consequences.
- Early pregnancy **contributes to maternal morbidity and mortality.**
 - The risk of death from pregnancy for women aged 15-19 is twice that of those aged 20-24.
 - Pregnancy and childbirth-related deaths are the number one killers of 15-19-year-old girls worldwide.
 - Early childbearing can lead to health complications increasing the risk of infertility in later life.

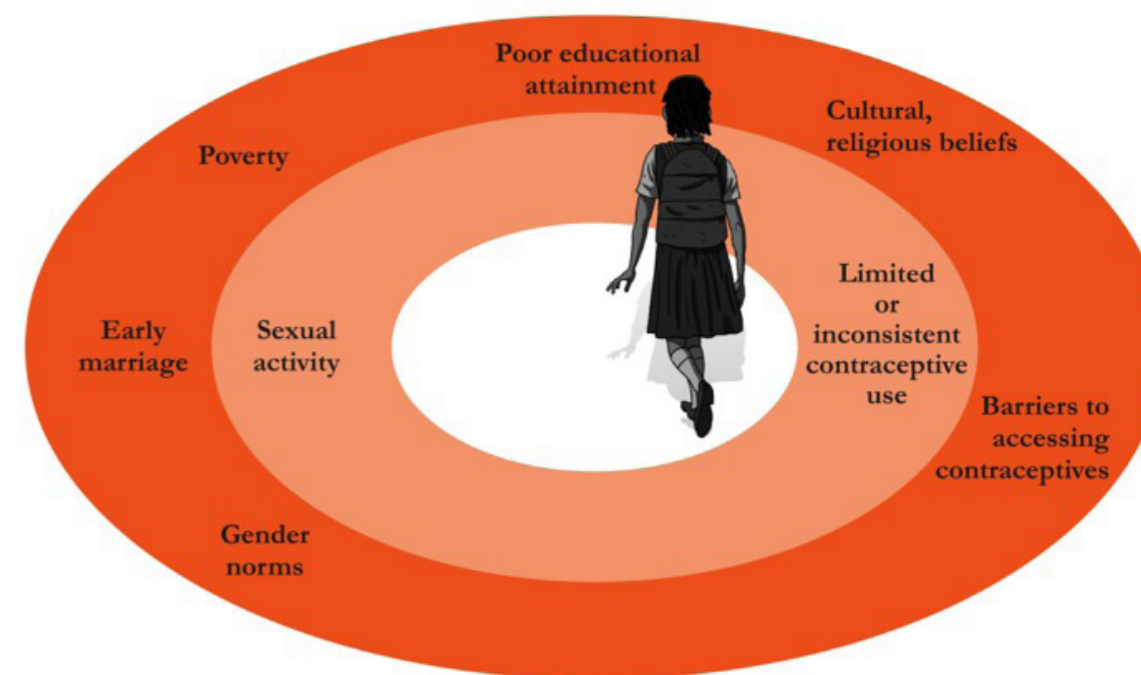
Why is teenage pregnancy a concern?

- Links to **HIV and STIs**
 - 5 million people are living with HIV in South Africa.
 - Young women are disproportionately affected.
- Links to **gender-based violence**
 - Young pregnant women experience high rates of physical abuse.
- **Socioeconomic consequences**
 - Leaving school prematurely
 - Lower family income, intergenerational transmission of poverty
 - Stigmatization

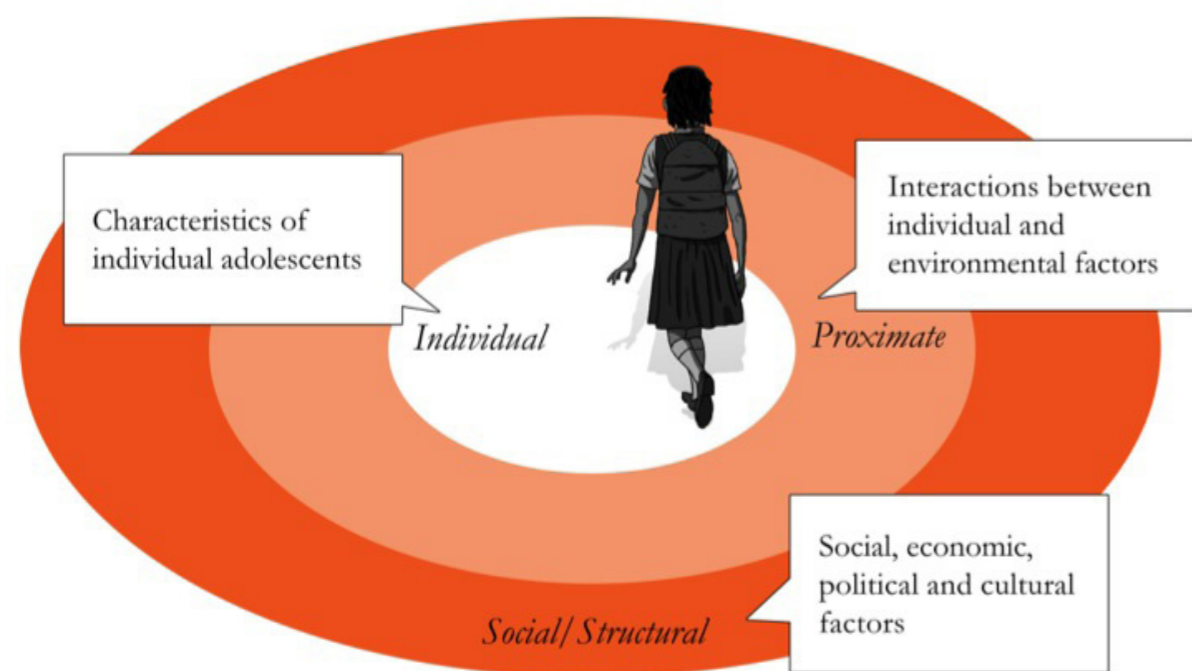
Teenage pregnancy – South Africa

- In South Africa teenage fertility (resulting in a live birth) is
 - Comparable to many middle-income countries and
 - Lower than many other African countries, but
 - Occurs more frequently out-of-wedlock.
- The media in South Africa have recently portrayed teen pregnancy as a growing epidemic resulting from irresponsible behavior on the part of young women.
- But what are the contributing factors?

Examples of contributing factors



Contributing factors



Age at first sex

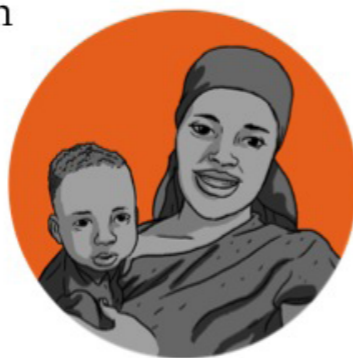
- In South Africa...
 - The median age at first sex among 15-24 year olds is 16 years for males and 17 years for females.
 - 48% percent of 15–19 year olds and 89% of 20–24 year olds have ever had sex.
 - Among sexually experienced females, 33% of 15–19 year olds and 59% of 20–24 year-olds have ever been pregnant.
 - Over 2/3 of young women in South Africa who have ever been pregnant report their pregnancies as unwanted.

Forced Sex and Gender-based violence

- 10% of females are physically forced to have sex in South Africa
- 54% of all rapes occur before the age of 18 years.
- In 8 out of 10 cases, the victim knows the perpetrator.
- 1 in 5 women will be gang-raped by 3-10 men, with an intimate partner often involved.
- Mean age of perpetrator at 1st rape – 17yrs

Desire to have children

- Some young women desire to have children as pregnancy can be associated with proving love and commitment.
- Contrary to popular belief, the South African Child Support Grant is not the main reason that young women fall pregnant.
- Teenage fertility has declined since the program started in 1995, and most beneficiaries are older women.



Contraceptive Use

According to the Demographic and Health Survey (2003):

- Contraceptive Prevalence Rate (CPR), which represents married women, for South Africa is 65%. However, CPR varies.
 - For women with no education - 38%
 - For women with post-matric qualifications - 75%
- 68% of currently sexually active young women aged 15-24 are currently using a contraceptive method.

Why is adolescent contraceptive use low?

- Misinformation and inaccurate ideas about reproduction
- Concerns about side-effects, including permanent infertility
- Use of traditional and religious contraceptive practices
- Barriers to accessing contraceptives
 - Contraceptive method mix/access are limited, especially for young women.
 - Reluctance from health staff to accept early sexual activity in adolescents, especially pre-marital sexual activity
 - Stigmatization/mistreatment from health staff
 - Limited clinic hours, transport costs

Young women are more likely to use contraception if they...

- Are at school
- Completed high school
- Are in a long-term relationship
- Have good communication with partner
- Have a close relationship with parent or guardian

Young Women and HIV

Age Group	HIV Prevalence
15-19 years	Males: 2.5% Females: 6.7%
20-24 years	Males: 5.1% Females: 21.1%
25-29 years	Males: 15.7% Females: 32.7%

Termination of Pregnancy (TOP)

- TOP is legal on demand in South Africa up to and including 12 weeks gestation
- From 13 to 20 weeks, women may have an abortion in cases of rape, severe fetal abnormality, severe maternal physical or mental disease, or if continued pregnancy would result in severe social or economic conditions
- These services can be accessed legally without parental consent starting at age 12

Young Women and HIV

Why are women more vulnerable to HIV infection?

- Biologically more vulnerable to infection and its consequences
 - At least twice as likely as men to contract HIV from unprotected intercourse
- Gender inequities prevent many women from being able to protect themselves from infection. Violence, coercion, and economic dependency render millions of women unable to negotiate condom use or to abandon partners who put them at risk.
- Young women often have older men as partners

Young Women and HIV

- New rate of HIV infections in South Africa among women aged 15-24 is five times that of men
- One in five sexually active young women (21%) is HIV positive
- In South Africa, 43% of men and 57% of women have ever had an HIV test

What Can We Do as Service Providers?

- As service providers, we are in a unique position to help young women access these services and make good, informed decisions about their sexual and reproductive health that will impact their lives forever.
- Providers interviewed in Ibis' s Soweto study noted that education is key to young women accessing services and information on family planning. It was also noted that providers can play a role in empowering young women to make informed decisions.



Young women seek SRH information from...

- Health institutions (doctors and nurses)
- Family members
- Friends
- School
- The media
- Neighbors or community members

How can providers make a difference?

- Providers can provide comprehensive information and services to young women in a non-judgmental manner and be sensitive to young women' s concerns and the issues they face.
- Special counseling techniques are important for providers working with young women because of this unique time in their lives.

SRH Services for Young Women

- Young women need access to the same services that older women do, though many issues will be new to them and they may need added support.
- Services for young women should include:
 - Family Planning
 - HIV Counseling and Testing
 - Counseling on dual use of condoms and other contraceptive methods
 - Termination of Pregnancy (TOP)
 - Emergency contraception and post-exposure prophylaxis
 - Gender based violence (GBV) counseling and referrals
 - PMTCT and other pregnancy services

SRH Services for Young Women

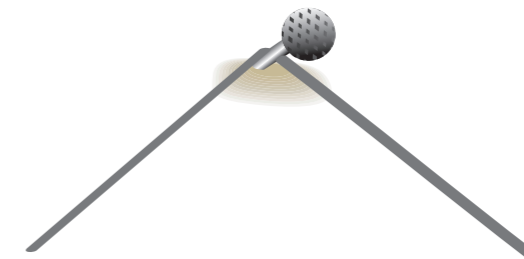
- Remember these important tips!
 - Young women do not need parental consent to obtain SRH services.
 - A TOP can legally be obtained by a young woman without parental consent starting at age 12.
 - Young women should have access to a variety of contraceptive methods. What method is best should be decided by the young woman and her provider.

Appendix 3.2: SRH Quiz

Please circle the correct answer	True	False
1. In South Africa, the average age when young women start having sex is 15.		
2. Over 2/3 of young women in South Africa who have ever been pregnant report their pregnancies as unwanted.		
3. It is important to use different communication techniques with young people when providing information on sexual and reproductive health.		
4. Young women can safely use all of the same contraceptive methods that older women can use.		
5. Young women are more likely to get infected with HIV because (choose one): They are biologically more vulnerable to infection Many young women have older men as partners Women are often unable to negotiate condom use due to economic dependency and gender-based violence All of the above		
6. About 10% of females are physically forced to have sex in South Africa.		
7. Women can get a TOP without giving a reason for it no matter what their gestational age is.		
8. Many young women choose to fall pregnant so that they can get the child grant.		

APPENDIX 04

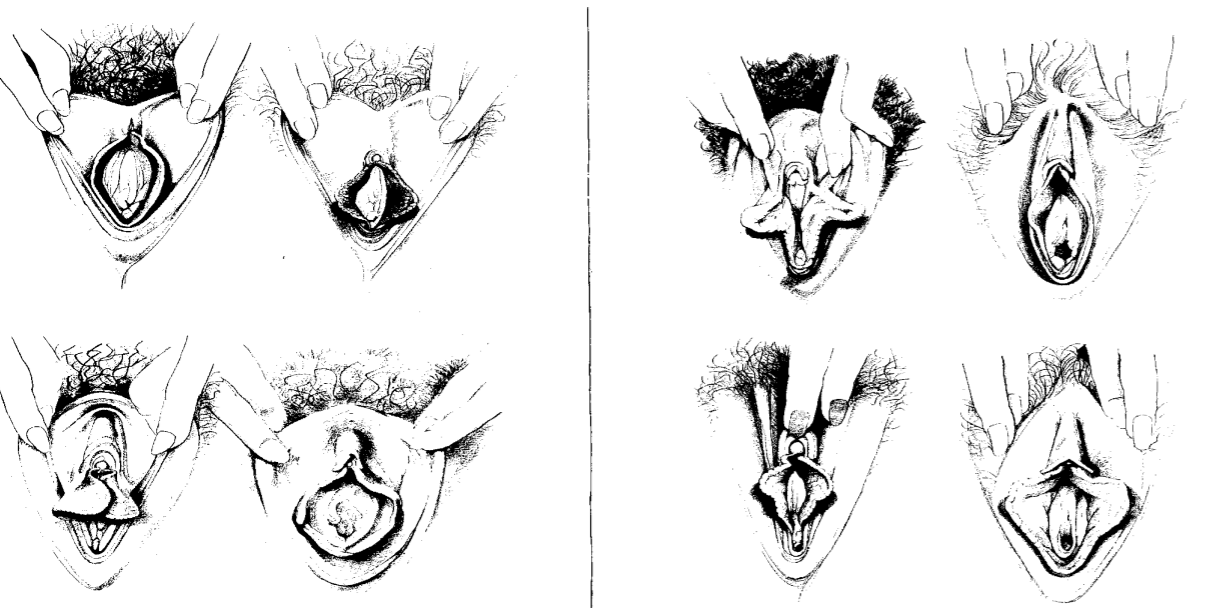
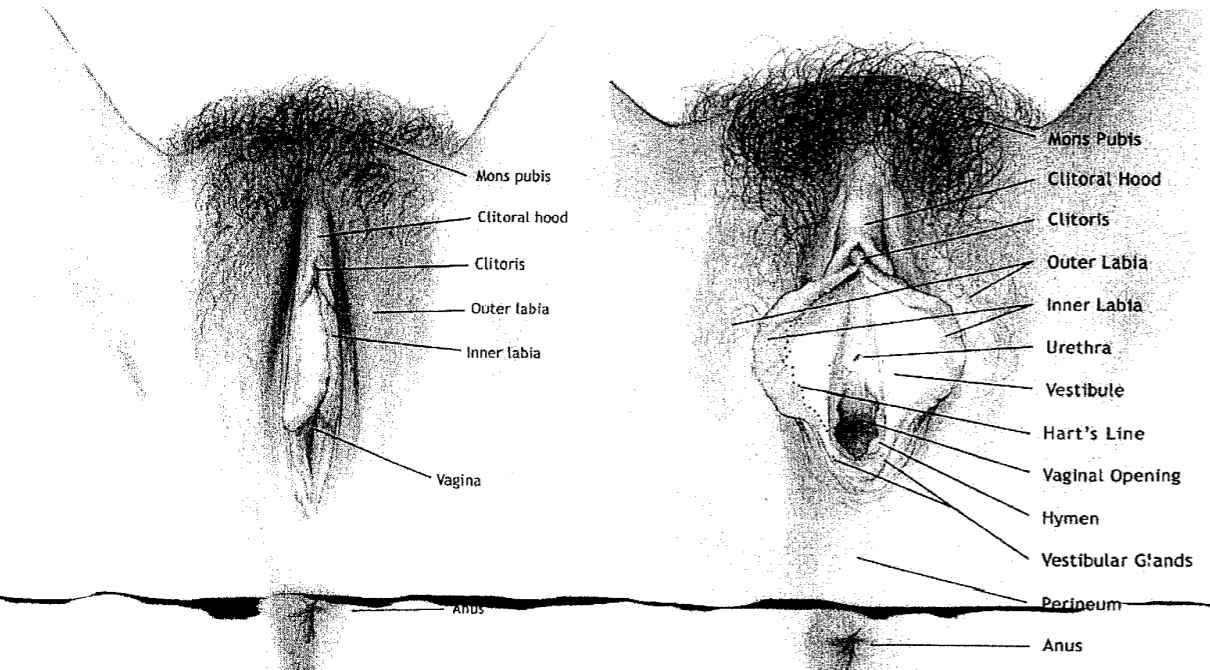
- 4.1 Picture Frame and Vagina Drawings
- 4.2 Sexual History Taking Presentation



My Self Portrait



Genitals (Vulvas):



Sexual History Taking

Created by Elna McIntosh
DISA Sexual and Reproductive Health Clinic

Overview

- About sexual history taking
- General principals
- Taking the history
- Practice



Reflection on own feelings & beliefs

- Awareness of own comfort & knowledge re sexuality and drug use
- Reflect on own feelings and acknowledge personal conflicts; your role is to provide a comprehensive health service
- To help with discussing sensitive topics which conflict with your own beliefs:
 - Use appropriate non judgmental language that you are comfortable with
 - Take time to consider your own beliefs and think about how you will respond when confronted with a challenging issue
 - Reflect on past conversations that were uncomfortable and consider different approaches

General principals: Setting the scene

- Starting is often the most challenging part
- Set the scene for the client – make them feel comfortable
- Explain what you are going to talk about and why
 - Risk assessment to determine tests required and care
- Discussion begins with general issues and progress to more detailed and specific questioning e.g.:
 - Client's reason for visit
 - Previous visit/s to sexual health services
 - General medical, surgical, social history
 - BBV risks
 - GBV risks
 - Sexual risks
 - Prevention and harm reduction messages
 - Management plan

Why take a sexual health history?

Sexual history taking...

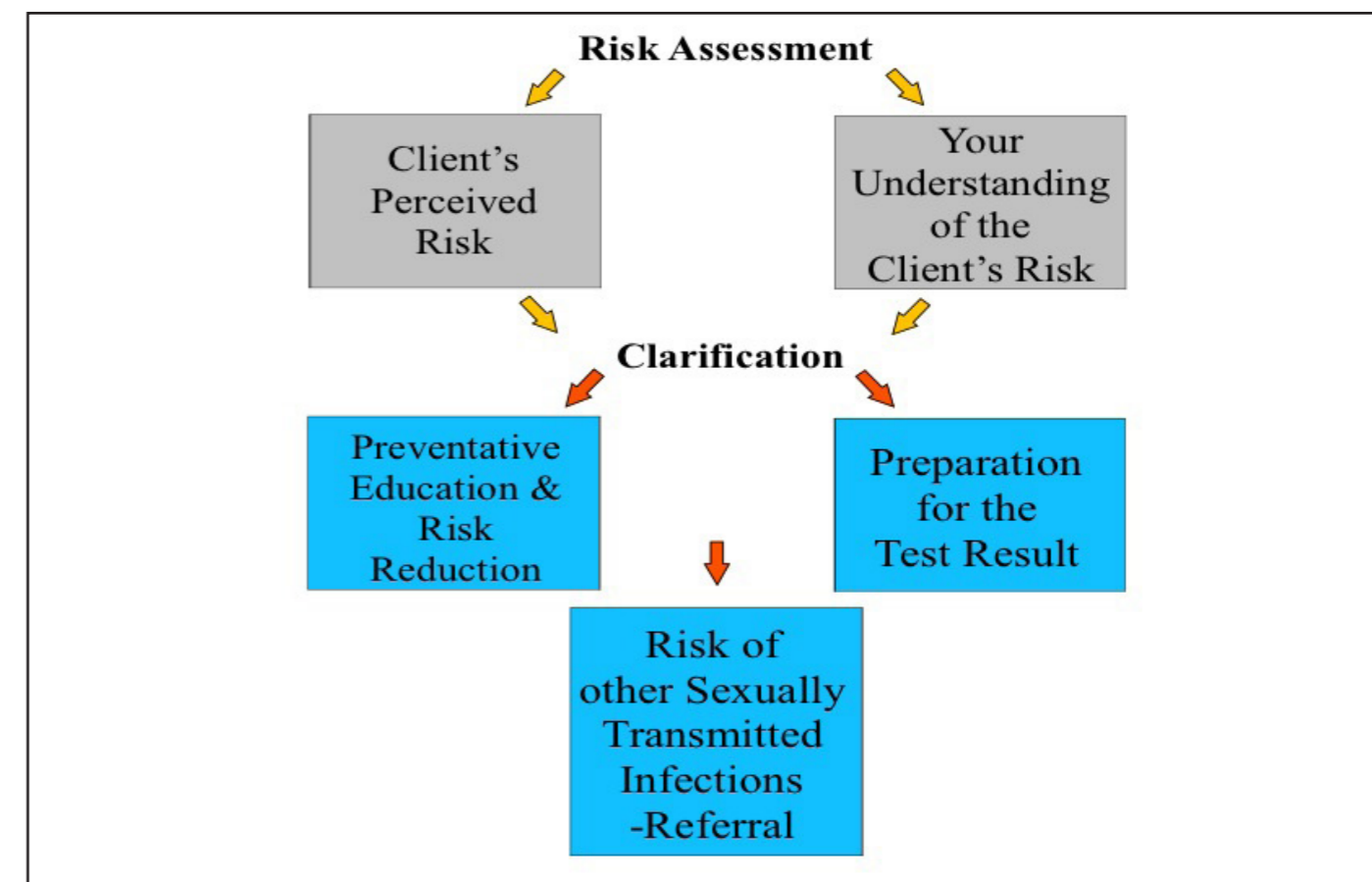
- Underpins the quality of your consultation with a client
- Engages the client in their sexual health care
- Assists clients to discuss their needs and allay possible shame or fears re sexual health, sexual orientation, behaviors, etc
- Identifies risk factors for blood borne viruses (BBVs) and sexually transmissible infections (STIs)
- Determines what tests are appropriate
- Identifies opportunities for education, prevention and harm reduction strategies

General principals: Language

- When talking about sensitive subjects like sex & drug use, people may use vague language which can lead to misunderstanding
- Use language you are comfortable with
- Familiarise yourself with the language your client group uses – e.g. 'fits' for needles and syringes. Helps facilitate clearer communication
- If unfamiliar with clients' terminology; ask. Better to ask than make incorrect assumptions
- Care with language that has judgemental overtones
 - Drug abuser vs. drug user
 - Affairs vs. sexual contacts
 - Prostitute vs. sex worker
 - Promiscuous vs. more than one partner
- Use non-gender specific terms re client's sexual contacts or relationships until sexual orientation has been established

General principals: Interviewing techniques

- **Ask open ended questions**
 - “How can I help you” and “Tell me what the problem is” rather than closed questions e.g. “Has this happened before?”, “Did you practice safe sex?”
- **Reflection**
 - Simple and effective technique of repeating what has been said
 - Can help to clarify misunderstanding and lets you know you have been understood
- **Silence**
 - Powerful interviewing technique
 - Enables client and clinician to reflect on what has been said, organize their thoughts and to respond accordingly
 - May also signal that client is about to disclose something difficult for them
- **Body language**
 - Be aware of posture and location of yourself and client
 - Mirroring of behaviour (adopting a similar posture to the client) helps convey a message of empathy and facilitates an open discussion



Before you begin, remember...

- When discussing risks with client, focus on behaviour, not what 'group' they belong to
- Do not assume that because your client belongs to an identified 'risk group' that they have been at risk
- Check for specific risk behaviour
- Other variables which may influence client's behaviour
 - Intoxication / drug use
 - Condom availability
 - Partners insistence
 - Time constraints
 - Intellectual capacity
 - Self-esteem
 - Social factors; homelessness, poverty etc

APPENDIX 05

5.1 Definitions for sexual identity and orientation exercise

5.2 Sexual Identity and Orientation Handout

5.3 Sexual Identity and Orientation Case Studies

Appendix 5.1: Definitions for sexual identity and orientation exercise

Print one copy per group. Cut the definitions into individual slips.

1. Refers to physiological attributes that identify a person as a male or female (genital organs, predominant hormones, ability to produce sperm or ova, ability to give birth).

2. Refers to widely shared ideas and norms concerning women and men including ideas about what are "feminine" and "masculine" characteristics and behavior. Gender reflects and influences the different roles, social status, and economic and political power of women and men in society.

3. Sexual orientation in which a person is physically attracted to people of the opposite sex.

4. Sexual orientation in which a person is physically attracted to people of the same sex.

5. Sexual orientation in which a person is physically attracted to members of both sexes.

6. Person who dresses and acts like a person of the opposite gender. Both heterosexuals and homosexuals can behave this way. It may be just a phase, or it can be permanent.

7. Person desires to change or has changed her/his biological sex because her/his body does not correspond to her/his sexual identification. Sexual orientation varies.

8. Person who lives as the gender opposite to their anatomical sex (i.e. man living as woman but retaining his penis & sexual functioning). Sexual orientation varies.

Appendix 5.2: Sexual Identity and Orientation Handout

DEFINITIONS OF SEXUAL ORIENTATION & IDENTITY

Sex refers to physiological attributes that identify a person as a male or female (genital organs, predominant hormones, ability to produce sperm or ova, ability to give birth).

Gender refers to widely shared ideas and norms concerning women and men including ideas about what are "feminine" and "masculine" characteristics and behavior.

Gender reflects and influences the different roles, social status, and economic and political power of women and men in society.

Heterosexuality—Sexual orientation in which a person is physically attracted to people of the opposite sex.

Homosexuality—Sexual orientation in which a person is physically attracted to people of the same sex.

Bisexuality—Sexual orientation in which a person is physically attracted to members of both sexes.

Transvestism—Person who dresses and acts like a person of the opposite gender. Both heterosexuals and homosexuals can behave this way. It may be just a phase, or it can be permanent.

Transsexual— Person desires to change or has changed her/his biological sex because her/his body does not correspond to her/his sexual identification. Sexual orientation varies.

Transgendered— Person who lives as the gender opposite to their anatomical sex (i.e. man living as woman but retaining his penis & sexual functioning). Sexual orientation varies.

SEXUAL ORIENTATION AND IDENTITY

- Adolescence is a time of sexual experimentation and defining a sexual identity. Therefore, sexual behavior or conduct in adolescence does not necessarily equal sexual orientation.
- Sexual conduct can be an act of rebellion.
- Some gangs require initiation rites such as gang rape or homosexual acts.
- Provider's need to stress that homosexual, bisexual, and transsexual/transgendered behavior is normal regardless of the provider's personal views.
- Adolescence is a period of change, and an adolescent's sexual identity may not be her/his permanent identity.
- On the other hand, adolescence is a period when sexual identity starts to be defined.
- An adolescent who realizes s/he may be gay, bisexual, or transgendered may feel isolated and depressed, which in extreme cases can lead to suicide. It is the provider's responsibility to help the adolescent cope with her/his sexual orientation and accept her/himself.
- The provider does not have to be an expert on sexual orientation. Providing an understanding ear and referring the adolescent to resources is often enough.

Appendix 5.3: Sexual Identity and Orientation Case Studies

Print one copy. Cut the scenarios into individual slips.

- o **Client 1:** You are an 18-year-old woman. You are only attracted to women. Your family has made it clear that when you finish secondary school at the end of the year, you should think about getting married (i.e. to a man). You go to the counselor/provider for advice. You want to know if s/he can give you some type of medicine that will make you attracted to men instead of women.
- o **Client 2:** You are a 15-year-old male. You often dress up in women's clothing and imitate female behavior. Because of this habit, you are ridiculed by your community and your family is ashamed of you. You see nothing wrong with dressing as a woman and intend to continue this behavior. Your parents have sent you to see the counselor/provider because they think you just need to be straightened out.
- o **Client 3:** You are a 16-year-old heterosexual male. However, in order to make money, you exchange sexual favors (including anal intercourse) with men for money. You have heard that HIV is only spread through sex, and since you only have sex (vaginal intercourse) with your girlfriend, you are not worried about catching the virus. Some of the older boys tease you about being "gay," and you are concerned that having sexual relations with men will make you gay.
- o **Client 4:** You are a 17-year-old male and have recently been having dreams that involve you kissing or caressing another man. You have a girlfriend whom you are sexually attracted to, so you don't understand why you are having these dreams.
- o **Client 5:** You are a 14-year-old female. As long as you can remember, you have felt as if you really should have been born a boy. You enjoy doing tasks that are seen as male activities, and all of your friends are young men. You realize that you are different from other girls in your community. You cannot relate to them and are not interested in any of the same things as them. Your family has been pressuring you to act more like a young woman, especially as you become more physically mature. You want to please your family, but you wish you could live life as a boy.



APPENDIX 06

- 6.1 Characteristics of Effective and Ineffective Counselors
- 6.2 Role Plays for Counseling

Appendix 6.1: Characteristics of Effective and Ineffective Counselors (EngenderHealth 2002)

Characteristics of Effective and Ineffective Counselors

Effective Counselors
• Exhibit genuineness: they are reliable, factual sources of information
• Create an atmosphere of privacy, respect, and trust
• Communicate effectively: for example, they engage in a dialogue or open discussion
• Are nonjudgmental: they offer choices and do not criticize the client's decisions
• Are empathetic
• Are comfortable with sexuality
• Make the client comfortable and ensure his or her privacy
• Talk at a moderate pace and appropriate volume
• Present messages in clear, simple language that the client can understand
• Ask questions of the client to make sure that he or she understands the message
• Demonstrate patience when the client has difficulty expressing him- or herself or understanding the message
• Identify and remove obstacles

Ineffective Counselors
• Interrupt conversations: they talk to other people and/or speak on the telephone during a counseling session
• Are judgmental: for example, they make decisions for the client
• Do not make the client comfortable and ensure his or her privacy: for example, they provide counseling in the presence of other people without the client's consent and break confidentiality
• Are poor nonverbal communicators: for example, they look away and frown
• Lack knowledge on reproductive health issues
• Are uncomfortable with sexuality
• Are difficult to understand: they talk at a fast pace and an inappropriate volume or use language that their clients cannot understand
• Do not ask questions of the client to make sure that he or she understand the message
• Do not demonstrate patience when the client has difficulty expressing him- or herself or understanding the message
• Are not empathetic: for example, they are rude and not understanding of the clients problems or needs

Appendix 6.2: Role Plays for Counseling

Print one copy. Cut the scenarios into individual slips.

Scenario 1:

Young Woman: you are an 18 year old woman who is sexually active and would like to be tested for HIV. It is your first time visiting the clinic and you are nervous and don't know what to expect. You would like more information about the test but are shy and don't say much to the nurse who is helping you.

Nurse: a young woman, 18 years old, comes into your clinic asking for an HIV test. She is very quiet and obviously nervous and says that she has never visited the clinic before and never been tested for HIV before. You counsel her about the test and perform the test.

Scenario 2:

Young Woman: you are a married 23 year old woman with two children who would like to stop having children so that you can pursue a college degree. You have never used a family planning method before and aren't sure what to expect at the clinic. You have heard from a friend that the injections hurt and make you fat, and so you do not want to use that method.

Nurse: a young married woman, 23 years old, comes in and says that she is interested in learning more about family planning because she already has two children and does not want any more at this time. She has never been to the clinic. You try to help her identify and start using a method of family planning.

Scenario 3:

Young Woman: you are a 19 year old unmarried woman who is HIV positive. You have a new boyfriend and want to know if it is Ok to have sex with him given that you are HIV positive.

Counselor: a 19 year old unmarried woman who is HIV positive comes to you for advice about whether or not she can have sex with her new boyfriend. You counsel her on using condoms for HIV prevention and ask her whether she is interested in preventing pregnancy at this time.

Appendix 8.1: Definition of GBV

United Nations Declaration on the Elimination of Violence against Women

Article 1

For the purposes of this Declaration, the term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Article 2

Violence against women shall be understood to encompass, but not be limited to, the following:

(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

(c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

APPENDIX 08

8.1 Definition of GBV

8.2 Myths about Woman Abuse

8.3 Power and Control Wheel

8.4 Exploring the underlying causes of GBV

8.5 Victim situations

8.6 Health provider responses

1. Source: <http://www.un.org/documents/ga/res/48/a48r104.htm> 20 December 1993

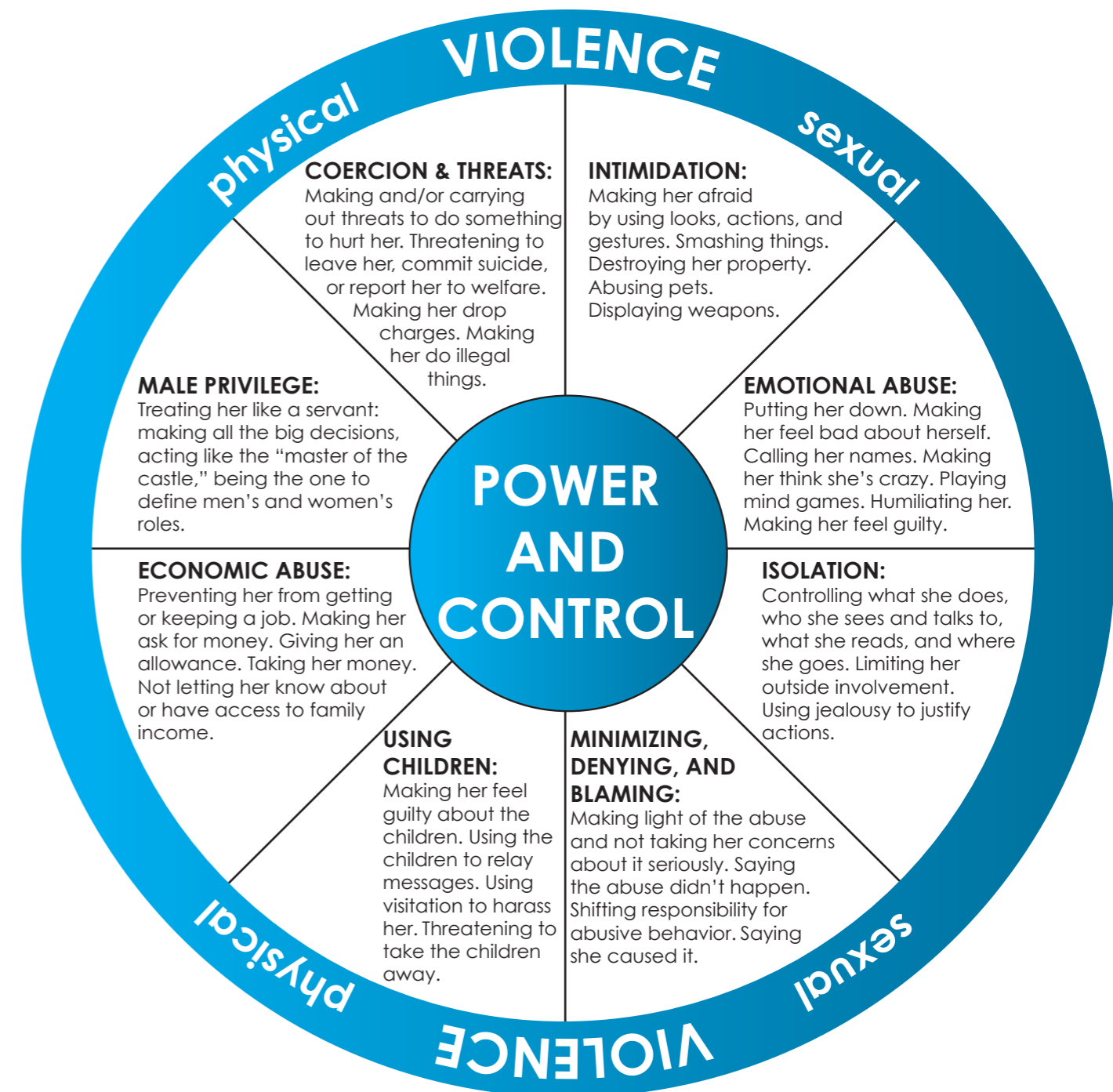
Appendix 8.2: Myths about Woman Abuse

Myths and facts about woman abuse

Read the following statements and mark the appropriate column indicating whether you agree or disagree.

	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
1. Assaulted women could just leave their partners if they really wanted to.					
2. Some women deserve the violence they experience.					
3. Poverty causes family violence.					
4. Alcohol causes family violence.					
5. As long as children are not abused, they are not affected by witnessing violence in the home.					
6. Violence is a private family matter.					
7. The community has no right to intervene in family violence.					
8. If someone is abusive in a dating relationship, he or she will stop when married.					
9. A violent fight can "clear the air", it probably will not happen again.					
10. When a man abuses a woman, he tries to control her.					
11. When a man and woman share equal power in a marriage, it is bound to cause some violent fights.					
12. If someone swears at or intimidates another person, this is abuse.					
13. Schools should have a role in increasing awareness of the effects of violence and how to prevent it.					

Appendix 8.3: Power and Control Wheel



Appendix 8.4: Exploring the underlying causes of GBV

Exploring the Underlying Causes

Miriam's story

Miriam is 36 years old and the mother of six children. She grew up in a village 400 kilometers away from the capital city of her country. She stopped schooling after her second grade. Her parents were poor, and the school was three kilometers away from the village. Her father believed that educating a girl was like 'watering the neighbor's garden'.

When she was 12, Miriam was circumcised, as was the custom in her tribe. At 16, she was married to a man three times her age. Her father received a substantial lobola. The very next year, she gave birth at home to a baby boy. The baby was stillborn. The health centre was 10 kilometers away, and anyway, did not attend deliveries. Miriam believed that the baby was born dead because of the repeated beatings and kicks she had received all through her pregnancy. Instead, she was blamed for not being able to bear a healthy baby.

Miriam's husband considered it his right to have sex with her, and regularly forced himself on her. Miriam did not want to get pregnant again and again, but had little choice in the matter. She had no time to go to the health clinic, and when she went sometimes because her children were sick, she was hesitant to broach the subject of contraception with the nurses. Her life with her husband was a long saga of violence. Miriam struggled to keep body and soul together through her several pregnancies and raising her children. She had to farm her small plot of land to feed the children, because her husband never gave her enough money. She approached the parish priest several times for help. He always advised her to have faith in God and keep her sacraments.

One day her husband accused Miriam of 'carrying on' with a man in the village. He had seen Miriam laughing and chatting with the man, he claimed. When she answered back, he hit her with firewood repeatedly on her knees saying 'you whore! I will break your legs'. Miriam was badly injured; she thought she had a fracture. For weeks she could not move out of the house. But she did not have any money to hire transport to go to the health centre. Unable to go to the market to trade, she had no income and literally starved. Miriam was terrified of further violence. She had had enough. As soon as she could walk, she took her two youngest and left the village. She now lives in a strange village, a refugee in her own country, living in fear of being found by her husband and brought back home.

Appendix 8.5: Victim situations

Print one copy. Cut the scenarios into individual slips.

Victim Situation One

A young woman rape victim brought in by the police to a health facility

Victim Situation Two:

A woman seeking antenatal care who has a past history of violence by her husband

Victim Situation Three

A mother bringing in a girl of ten suffering from genital sores

Appendix 8.6: Health provider responses

Health Provider Responses – Tools
Screening tools for gender-based violence

a. IPPF's screening tool for gender-based violence

- Have you ever felt hurt emotionally or psychologically by your partner or another person important to you?
- Has your partner or another person important to you ever caused you physical harm?
- Were you ever forced to have sexual contact or intercourse?
- When you were a child, were you ever touched in a way that made you feel uncomfortable?
- Do you feel safe returning to your home tonight?

b. Three brief questions to screen for gender-based violence

- Have you ever been hit, kicked, punched or otherwise hurt by someone within the last year? If so, by whom?
- Do you feel safe in your current relationship?
- Is there a partner from a previous relationship who is making you feel unsafe now?

Introducing the screening questions

a. Asking directly

- Before we discuss contraceptive choices, it might be good to know a little bit more about your relationship with your partner.
- Because violence is common in women's lives, we have begun asking all clients about abuse.
- I don't know if this is a problem for you, but many of the women I see as clients are dealing with tensions at home. Some are too afraid or uncomfortable to bring it up themselves, so I've started asking about it routinely.

b. Asking indirectly

- Your symptoms may be related to stress. Do you and your partner tend to fight a lot?
- Have you ever gotten hurt?
- Does your husband have any problems with alcohol, drugs, or gambling? How does it affect his behavior with you and the children?
- When considering which method of contraception is best for you, an important factor is whether you can or cannot anticipate when you will have sex. Do you generally feel you can control when you have sex? Are there times when your partner may force you unexpectedly?
- Does your partner ever want sex when you do not? What happens in such situations?

What do women disclosing violence want of health care providers?

A study from Wisconsin, USA of 115 women who had been battered by their male partners offers some insights. According to them, supportive behavior would include the following:

Medical support

- taking a complete history;
- detailed assessment of current and past violence;
- gentle physical examination; and
- treatment of all injuries.

Emotional support

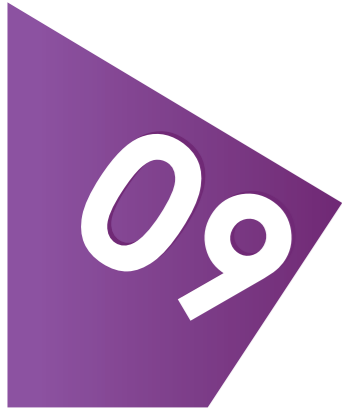
- confidentiality;
- directing the partner to leave the room;
- listening carefully; and
- reassuring the woman that the abuse is not her fault and validating her feelings of shame, anger, fear and depression.

Practical support

- telling the patient that spouse abuse is illegal;
- providing information and telephone numbers for local resources such as shelters, support groups and legal services;
- asking about the children's safety;
- helping the patient begin safety planning.

1. Source: IPPF Western Hemisphere's website www.ipfwhr.org, and B: Feldhaus et al. Accuracy of three brief screening questions for detecting partner violence in the emergency department. *Journal of the American Medical Association* 277(17): 1357-1361, 1997.
2. Heise L, Ellsberg M, Gottemoeller M. Ending violence against women. *Population Reports*, Volume XXVI, No. 4, December 1999.

1. Source: Hamberger LK, Ambuel B, Marbella A, et al. Physician interaction with battered women: the women's perspective. *Archives of Family Medicine* 1998; 7:575-582.



APPENDIX 09

9.1 Role Plays

Appendix 9.1: Role Plays

Print one copy. Cut the scenarios into individual slips.

You are a 23 year old married woman with two children. Your husband just lost his job and you are two months pregnant. You are concerned that if you have another baby you will not be able to take care of your other two children. You are afraid to talk to anyone in your family because they do not believe in abortion, and you know that your husband would like to have the child. You are scared about abortion and have never had one before.

You are an 18 year old unmarried woman. You have been dating your boyfriend for two years and love him very much. One problem is that sometimes he comes to your house drunk late at night and pressures you to have sex with him. You had sex a couple of months ago when you didn't want to and he did not use a condom. You are not using any other form of contraception. You have not had your menstrual period for about six weeks and you are scared that you might be pregnant.

APPENDIX 10

Sample Training Evaluation Form

Sample Training Evaluation Form

PARTICIPANT EVALUATION FORM

Date: _____

Location: _____

Facilitator: _____

Part 1. Participant Background Information

This questionnaire is confidential. Your name is not required.

1. Please check the box that describes your job function:

- Nurse
- Sister
- Counselor
- Social Worker
- Operations Manager
- Midwife
- Other please specify: _____

2. Please check the box that describes the department you work in:

- HIV
- Family Planning
- TOP
- Ante Natal
- Other please specify: _____

3. How long have you been in your current position:

- Less than 1 year
- 1-5 years
- 5-10 years
- More than 10 years

Part 2. Evaluation of Workshop Modules

We would greatly appreciate your feedback on each workshop module. Please rate the following statements as to whether or not you agree with them by checking the appropriate box.

MODULE 1: HOW DO I FEEL ABOUT ADOLESCENT SEXUALITY?

Statement	Strongly Agree	Some-what Agree	Neutral	Some-what Dis-agree	Strong-ly Dis-agree	N/A (Did not at-tend)
1. The directions for the module were clear.						
2. I enjoyed the activity.						
3. I learned new information.						
4. The topic is applicable to my work.						
5. I felt comfortable participating in this module.						
6. The facilitator was engaging and she kept the session interesting.						
7. The facilitator moderated the discussion well.						
8. The facilitator was open to diverse viewpoints.						

9. If this module was applicable to your work, please explain how you might use the information or skills learned at work:

10. The most useful part of the module was:

11. The most useful part of the module was:

12. Please provide any additional comments about this module or suggestions for improvement:

MODULE 2: HOW DO I FEEL ABOUT GENDER, FAMILY PLANNING, HIV AND OTHER STIS?

Statement	Strongly Agree	Some-what Agree	Neutral	Some-what Dis-agree	Strongly Dis-agree	N/A (Did not at-tend)
1. The directions for the module were clear.						
2. I enjoyed the activity.						
3. I learned new information.						
4. The topic is applicable to my work.						
5. I felt comfortable participating in this module.						
6. The facilitator was engaging and she kept the session interesting.						
7. The facilitator moderated the discussion well.						
8. The facilitator was open to diverse viewpoints.						

9. If this module was applicable to your work, please explain how you might use the information or skills learned at work:

10. The most useful part of the module was:

11. The most useful part of the module was:

12. Please provide any additional comments about this module or suggestions for improvement:

MODULE 3: BACKGROUND ON YOUNG WOMEN AND GIRL'S SEXUALITY AND SRH

Statement	Strongly Agree	Some-what Agree	Neutral	Some-what Dis-agree	Strong-ly Dis-agree	N/A (Did not attend)
1. The information was presented clearly.						
2. I enjoyed the module.						
3. I learned new information.						
4. The topic is applicable to my work.						
5. I felt comfortable participating in this module.						
6. The facilitator was engaging and she kept the session interesting.						
7. The facilitator moderated the discussion well.						
8. The facilitator was open to diverse viewpoints.						
9. The facilitator was knowledgeable about the topic.						

10. If this module was applicable to your work, please explain how you might use the information or skills learned at work:

11. The most useful part of the module was:

12. The most useful part of the module was:

13. Please provide any additional comments about this module or suggestions for improvement:

MODULE 4: LET'S TALK ABOUT SEX

Statement	Strongly Agree	Some-what Agree	Neutral	Some-what Disagree	Strong-ly Dis-agree	N/A (Did not attend)
1. The information was presented clearly.						
2. I enjoyed the module.						
3. I learned new information.						
4. The topic is applicable to my work.						
5. I felt comfortable participating in this module.						
6. The facilitator was engaging and she kept the session interesting.						
7. The facilitator moderated the discussion well.						
8. The facilitator was open to diverse viewpoints.						
9. The facilitator was knowledgeable about the topic.						

10. If this module was applicable to your work, please explain how you might use the information or skills learned at work:

11. The most useful part of the module was:

12. The most useful part of the module was:

13. Please provide any additional comments about this module or suggestions for improvement:

MODULE 5: SEXUAL IDENTITY AND ORIENTATION

Statement	Strongly Agree	Some-what Agree	Neutral	Some-what Disagree	Strong-ly Dis-agree	N/A (Did not at-tend)
1. The information was presented clearly.						
2. I enjoyed the module.						
3. I learned new information.						
4. The topic is applicable to my work.						
5. I felt comfortable participating in this module.						
6. The facilitator was engaging and she kept the session interesting.						
7. The facilitator moderated the discussion well.						
8. The facilitator was open to diverse viewpoints.						
9. The facilitator was knowledgeable about the topic.						

10. If this module was applicable to your work, please explain how you might use the information or skills learned at work:

11. The most useful part of the module was:

12. The most useful part of the module was:

13. Please provide any additional comments about this module or suggestions for improvement:

MODULE 6: COMMUNICATION WITH YOUNG PEOPLE

Statement	Strongly Agree	Some-what Agree	Neutral	Some-what Disagree	Strong-ly Dis-agree	N/A (Did not at-tend)
1. The information was presented clearly.						
2. I enjoyed the module.						
3. I learned new information.						
4. The topic is applicable to my work.						
5. I felt comfortable participating in this module.						
6. The facilitator was engaging and she kept the session interesting.						
7. The facilitator moderated the discussion well.						
8. The facilitator was open to diverse viewpoints.						
9. The facilitator was knowledgeable about the topic.						

10. If this module was applicable to your work, please explain how you might use the information or skills learned at work:

11. The most useful part of the module was:

12. The most useful part of the module was:

13. Please provide any additional comments about this module or suggestions for improvement:

MODULE 7: ANSWERING DIFFICULT QUESTIONS

Statement	Strongly Agree	Some-what Agree	Neutral	Some-what Disagree	Strong-ly Dis-agree	N/A (Did not at-tend)
1. The information was presented clearly.						
2. I enjoyed the module.						
3. I learned new information.						
4. The topic is applicable to my work.						
5. I felt comfortable participating in this module.						
6. The facilitator was engaging and she kept the session interesting.						
7. The facilitator moderated the discussion well.						
8. The facilitator was open to diverse viewpoints.						
9. The facilitator was knowledgeable about the topic.						

10. If this module was applicable to your work, please explain how you might use the information or skills learned at work:

11. The most useful part of the module was:

12. The most useful part of the module was:

13. Please provide any additional comments about this module or suggestions for improvement:

MODULE 8: GENDER-BASED VIOLENCE

Statement	Strongly Agree	Some-what Agree	Neutral	Some-what Disagree	Strong-ly Dis-agree	N/A (Did not at-tend)
1. The information was presented clearly.						
2. I enjoyed the module.						
3. I learned new information.						
4. The topic is applicable to my work.						
5. I felt comfortable participating in this module.						
6. The facilitator was engaging and she kept the session interesting.						
7. The facilitator moderated the discussion well.						
8. The facilitator was open to diverse viewpoints.						
9. The facilitator was knowledgeable about the topic.						

10. If this module was applicable to your work, please explain how you might use the information or skills learned at work:

11. The most useful part of the module was:

12. The most useful part of the module was:

13. Please provide any additional comments about this module or suggestions for improvement:

MODULE 9: FAMILY PLANNING

Statement	Strongly Agree	Some-what Agree	Neutral	Some-what Disagree	Strong-ly Dis-agree	N/A (Did not attend)
1. The information was presented clearly.						
2. I enjoyed the module.						
3. I learned new information.						
4. The topic is applicable to my work.						
5. I felt comfortable participating in this module.						
6. The facilitator was engaging and she kept the session interesting.						
7. The facilitator moderated the discussion well.						
8. The facilitator was open to diverse viewpoints.						
9. The facilitator was knowledgeable about the topic.						

10. If this module was applicable to your work, please explain how you might use the information or skills learned at work:

11. The most useful part of the module was:

12. The most useful part of the module was:

13. Please provide any additional comments about this module or suggestions for improvement:

Part 3. Overall Evaluation

Please mark your response to each question with an X.

1. How do you rate the workshop overall?

Excellent Good Average Poor

2. The length of the three-day workshop was:

Too Long Just right Too short

3. The workshop met my expectations.

Strongly Agree Somewhat Agree Neutral

Somewhat Disagree Strongly Disagree

4. The order of the modules seemed appropriate.

Strongly Agree Somewhat Agree Neutral

Somewhat Disagree Strongly Disagree

5. I plan to share what I learned in this workshop with my co-workers.

Strongly Agree Somewhat Agree Neutral

Somewhat Disagree Strongly Disagree

6. I will be able to apply what I learned in the workshop to my work.

Strongly Agree Somewhat Agree Neutral

Somewhat Disagree Strongly Disagree

7. I will not be able to apply what I learned in the workshop because (check all that apply):

- My supervisor(s) won't support me
- My co-workers won't support me
- The community won't support me
- I won't have enough time
- I don't feel comfortable using the new language or skills
- I don't agree with the suggestions for working with young women
- Other (please specify): _____
- Not Applicable

Please respond on the lines below each question and use the back of the evaluation if you need more space.

8. What did you like most about the workshop? Were there any modules that you particularly enjoyed?

9. What did you like least about the workshop?

10. Was there any other topic that you wish had been covered?

11. Do you have other comments or suggestions?
