Integrating Family Planning into Home-Based Care Programs:  
A Pilot Project in Mpumalanga, South Africa

By

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Abstract

HIV/AIDS places an increasing burden on health care systems in resource-constrained settings. This is particularly true in South Africa, one of the countries hardest hit by the epidemic. Although there is an emerging body of literature on the integration of HIV/AIDS into clinical services, I was not able to find articles on integration into community-based prevention programs.

I worked in collaboration with a South African organization dedicated to providing home-based care to people living with HIV/AIDS to explore the possibility of integrating basic communication and counseling skills into its ongoing programs. This paper describes the process I used, including a summary from the literature; site visits and assessments in Mpumalanga, South Africa; and priority-setting with the leadership at Project Support Association (PSA), the local partner organization.

The original intent of the program was to provide volunteers with additional information on long- and short-term contraceptive methods, implications of unprotected sexual intercourse, and referrals to appropriate diagnostic, treatment, and care services. However, the findings from the assessment clearly pointed in a different direction. I convinced the leadership at PSA that while accurate information is certainly an essential part of risk reduction, information alone is insufficient to result in behavior change. Basic communication skills could enhance the work of the PSA volunteers. Thus, basic communication skills, rather than a reinforcement of the volunteers’ existing knowledge, became the main thrust of the training manual.

The training manual I developed is attached as an addendum to this paper.
Background

As South Africa deals with an unparalleled HIV/AIDS pandemic, with an estimated five million people infected with HIV, public health resources are stretched to impossible limits. Many services related to sexual and reproductive health, as well as communicable or infectious diseases, must be provided within the context of HIV/AIDS. Department of Health statistics indicate for example that approximately one-quarter of the women attending antenatal clinics in 2001 were HIV positive. UNAIDS data show that the HIV prevalence is rising among the 20- to 34-year-old population in the country. Unprotected sexual activity is the driving force behind HIV/AIDS, as well as an epidemic of unintended pregnancy.

The United States government has created a special initiative, the President’s Emergency Plan for AIDS Relief, to achieve the following objectives in 15 resource-constrained countries, of which South Africa is one:

- Provide treatment to 2 million HIV-infected people
- Prevent 7 million new HIV infections
- Provide care to 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children

The scope and breadth of South Africa’s current health outcomes place increasing burden on the country’s formal health sector, resulting in the need to identify and maximize the use of alternative, more effective service delivery models. One approach is the use of home-based care (HBC) workers to provide care and support to people living with chronic illnesses, including HIV/AIDS. Unfortunately, HBC workers often have limited information, equipment, and access to drugs or other commodities. Still, HBC programs may prove pivotal, helping bridge to antiretroviral (ARV) programs as efforts to offer the life-saving treatment are expanded. As people previously deemed “end stage” gain access to
ARVs, their health will improve dramatically. The net effect may result in healthier adults who resume sexual activity.

Home-based care also provides an opportunity to deliver comprehensive sexual and reproductive health messages to more people living with HIV/AIDS and to their family members and partners. Building on existing trust and credibility, HBC workers may be uniquely positioned to promote responsible sexual health. Therefore, in addition serving as a link to life-saving medications and to providing care for people living with HIV/AIDS (PLWHA), HBC workers represent a potentially untapped prevention resource.

In 2003 the United States Agency for International Development (USAID) issued *Family Planning/HIV Integration: Technical Guidance for USAID-Supported Field Programs*. The “Dear colleague” cover letter sums up the rationale for integration:

> “... the HIV/AIDS epidemic is continuing to expand, touching all corners of the world and impacting on the lives of countless individuals and communities. At the same time demand for family planning (FP) is expanding and unmet need continues to increase globally. At this point in time it is more important than ever to emphasize and measure the added benefits and improved cost-effectiveness of integrated FP/HIV programming.”

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Literature on integration

A search on PubMed resulted in no hits for integration of family planning or reproductive health into existing HIV/AIDS prevention programs in community-based settings. There does, however, appear to be a growing body of literature on integrating service delivery, or clinical, aspects of HIV/AIDS and family planning. The June 2002 issue of *International Family Planning Perspectives*, for example, contains two articles, “Is Integration the Answer for Africa?” by John C. Caldwell and Pat Caldwell, and “When Does It Make Sense to Consider Integrating STI and HIV Services with Family Planning Services?” by Karen G. Fleischman Foreit, Karen Hardee, and Nokila Agarwal. The emphasis in each of the articles is limited to clinic-based service delivery programs. The first article discusses the diagnostic limitations family planning clinics face in offering laboratory testing of sexually transmitted infections (STIs) in the first article. The second discusses clinical and health promotion considerations, again limited to the clinical setting.

In September 2003, USAID published *Family Planning/HIV Integration: Technical Guidance for USAID-Supported Field Programs*. The document acknowledges that the evidence concerning family planning/HIV integration continues to evolve. Yet the document offers only the following in a section called, “Family Planning Information Can Be Integrated into Community Services Related to Home-Based Care”:

> “Home-based care agents in Kenya have received FP and reproductive health training and are able to provide these services within the home to both HIV-infected persons and other household members. While the need for FP may be slight when individuals are sick, these individuals may become

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sexually active if they begin to feel better after receiving care services.

"Caregivers, who are frequently adolescent females, may also benefit from information concerning FP. Information about FP may also be welcome among those individuals concerned about orphans or engaged in orphan care."

As part of its Working Paper Series, Family Health International (where I am employed) prepared a review of the literature through April 2004, called *Family Planning and the Prevention of Mother-to-Child Transmission of HIV*. This document explores the prevention of unintended pregnancy in HIV-infected women. While this review synthesizes and contributes to the body of knowledge on integrating family planning and HIV/AIDS, it too is limited to clinical settings, discussing provider attitudes, providing family planning via voluntary counseling and treatment (VCT), preventing later pregnancy among HIV-infected women who are already pregnant, and meeting contraceptive needs through antenatal clinic visits.

While there appears to be a great deal of enthusiasm for providing integrated sexual and reproductive health services, including family planning into HIV/AIDS services and vice versa, I was not able to identify articles related specifically to community-based programs that might alleviate the burden on formal health care systems.

This paper discusses the planning process I used to identify needs and develop the training curriculum; the situation analysis conducted with PSA staff, volunteers, and community members in Mpumalanga; the proposed intervention, as well as the subtle shift from an exclusive focus on integration to one that also emphasizes risk assessment and risk reduction communication; evaluation of the specific
training sessions and a brief overview of a broader research study to which I contributed; as well as some implications for proposed integration. In the final section, I share a personal perspective on the challenges and lessons learned throughout the process.

The planning process

Because careful planning is the foundation for successful project implementation, consideration was given to all aspects of the planning life cycle. The first steps in the process were to articulate a specific issue to address and to conduct an analysis of the current situation and the potential to affect the issue. Discussions with colleagues both in the United States and South Africa framed the increasing international donor support for HIV/AIDS prevention programs while reproductive health programs were facing funding shortfalls, which suggests the need for family planning services to be integrated into ongoing and expanding HIV/AIDS prevention, care, treatment, and support efforts. The nascent idea was to identify one such HIV/AIDS program in South Africa. As a result of the discussions, a potential partner, Project Support Association, Southern Africa, (PSA) was identified and the executive director approached about the possibility of enhanced service delivery to test one approach to integration.

Following initial discussions with PSA (see below for more information on the organization and its programs), an eight-month iterative planning process – starting with a desk review of PSA’s process reports, training curricula, and project documentation – was initiated. Concurrently a search was conducted on PubMed, using a combination of MESH headers: “home-based care, HIV prevention, reproductive health, family planning, and integration.” At the time, there were no relevant peer-reviewed journal articles that supported delivering family planning and responsible sexual decision-making through HIV care and support programs.
Without an evidence base to guide future planning and project implementation, a site visit, interviews with PSA program staff and volunteers, and selected home visits were conducted. Information from the volunteers is presented in the situation analysis section. A second site visit was organized the month before the planned training program in July to review priorities, to meet with new PSA training staff, to plan training and transportation logistics, and to review the proposed training content.

Description of PSA's programs

Established in the mid-1990s, Project Support Association, Southern Africa (PSA) is a nongovernmental organization (NGO) working to reduce the burden of HIV/AIDS in South Africa by implementing two core programs: peer mediated prevention and home-based care for the terminally ill, or “end stage” client. PSA initiated its HBC program in January 1999 to respond to the needs of PLWHA and their caregivers in communities in Mpumalanga province. Caregivers are usually family members and neighbors who tend to the daily health care needs of PLWHA. The HBC program provides support to household caregivers via trained PSA volunteers, called HBC “supporters,” and a link to formal health care providers through the use of professional nurse coordinators and referral to Department of Health services. In 2004, the PSA program is implemented in 51 urban and rural sites throughout the Mpumalanga province.

Potential HBC volunteers are recruited from the communities in which the program is implemented and must complete a four-and-a-half-day training on home-based care and service delivery. The training covers a range of topics, including infection control; referral systems; practical HBC skills, such as bathing clients in bed and changing linens; ways to address common medical problems such as fever and diarrhea; spiritual needs of clients and caregivers; and elements of palliative care. In addition to this introductory training, PSA conducts annual refresher trainings as well. The attrition from the HBC program is almost
nonexistent; many of the original training cohorts continue to provide care to PLWHA in their communities.

In addition to providing care and support to PLWHA, the HBC project has the potential to reach clients, caregivers, and other family members with important comprehensive reproductive health messages and client-centered risk reduction counseling skills. While some HBC clients are at the later stages of AIDS (referred to as “end stage” clients), others continue to be sexually active (referred to as “chronic” clients) and may lack the proper knowledge and skills to reduce their risk for unintended pregnancy and STI and possibly the risk for infecting a partner during sexual activity. Moreover, primary caregivers and family members of PLWHA may also be at risk of unintended pregnancy and STI, including HIV. The existing program provides a point of access to these individuals who may be more receptive to risk reduction and behavior change messages.

PSA also operates a peer-education program in many of the HBC program sites. Currently, PSA operates 46 peer-education prevention programs. Peer-educators are mostly single mothers involved in teaching and educating community members about STI/HIV, voluntary counseling and testing (VCT), and addressing stigma associated with HIV/AIDS. They also make referrals and distribute condoms.

Historically, the peer education and HBC programs, while supportive of each other, have been implemented vertically and have attracted different types of volunteers. For example, many of the HBC supporters are older married women, whereas many of the peer-education volunteers are young single women. Recently, PSA has worked to develop a comprehensive training, ranging from the prevention aspects covered in its peer education approach to the care and support topics addressed in its HBC programs. There are several sites in which all of the volunteers have been cross-trained in both prevention and care and support.
The ultimate aim of my collaboration with PSA was to incorporate client-centered risk reduction communication into this new comprehensive volunteer program. While PSA volunteers have received basic information about preventing STI/HIV and unintended pregnancy, this particular project focuses on providing volunteers with enhanced communication skills so that they, in turn, can assess a person’s readiness/receptiveness to prevention messages and referrals, and tailor those, as appropriate. The additional training will reinforce what PSA volunteers already know about pregnancy and STI/HIV and help identify and correct any misconceptions they might have. More importantly, the volunteers will be trained to go beyond imparting information; they will learn risk reduction communication skills. The expected outcome is better communication between the volunteers and caregivers, family members, and others to reduce their risk for unintended pregnancy and STI/HIV.

Specifically, client-centered risk reduction communication on sexual and reproductive health issues will be integrated into the basic package of services provided by PSA volunteers who have been cross-trained in prevention, care, and support in two sites.

**Situation Analysis**

I traveled to Mpumalanga to explore the feasibility of integrating family planning and reproductive health into PSA’s ongoing and established HBC program. The goals of the trip were to:

- Conduct an assessment of the reproductive health information and skills needs of household caregivers and other family members of PLWHA
- Identify and prioritize the RH training needs of HBC supporters
- Assess the current training infrastructure of PSA

The assessment consisted of unstructured, informal discussions with PSA staff members, volunteers, and clients. Since no personally identifying information
was collected, there was no need to submit the proposed assessment to FHI’s internal Protection of Human Subjects Committee, (PHSC).¹

Following FHI guidelines, discussions were held with the manager of our PHSC to determine whether institutional review board (IRB) approval was needed. Given that the information to be gathered is intended to inform the development of a specific intervention and will not be used for publication or dissemination purposes, and that there will be no identifying information other than the location of the site visit and the number of participants, no IRB approval was required.

During an initial meeting with PSA staff the field visit plans were finalized. As a result of the discussions, a mixture of urban (u) and rural (r) sites were selected including Bethal (r), Elukwatini (r), Ermelo (u), Leandra (r), Witbank (u), and Kwamlhanga (r). Approximately 30 volunteers participated in informal discussions at each site. Volunteers included HBC workers, peer educators (mostly single, unemployed mothers, often a euphemism for commercial sex worker), and youth club representatives. In one site, Witbank, volunteers working with orphans and vulnerable children (OVC) also participated. In addition to facilitating the discussions, I visited the homes of several clients of the HBC program.

There are differences in the training approach for the various types of volunteers. For example, the HBC and OVC training focuses primarily on care and treatment, as well as emotional support, for those affected by HIV and AIDS². The peer

¹ Prior to planning the initial trip in January 2004, I met with the staff representative of FHI’s PHSC to discuss the assessment, the kind of information that was to be collected, and the limited use of the findings, to inform subsequent training sessions rather than for publication or comparison.

² It is important to note that the HBC component is not limited to people with HIV/AIDS. There is no screening process, no requirement for proof of HIV status to receive support from PSA, so as not to increase stigma and discrimination in local communities. There is a presumption that most clients are HIV positive, many either disclosing their status, or drugs regimens, although some may only disclose tuberculosis, which is a common co-infection in Mpumalanga. Stigma and discrimination were mentioned as concerns and may be addressed by minor modifications to the uniform worn by PSA volunteers, which currently consists of the globally recognized ribbon on a
educators and youth club volunteers have been trained in prevention of HIV transmission, with an emphasis on sexual abstinence and condom use.

The volunteer program consists of an annual event to train volunteers in their respective areas, for example care and treatment for HBC and OVC, and prevention for youth clubs and peer educators. Weekly meetings are held in each of the sites to provide supervision and support to volunteers. Given the limited timeframe and the language differences, I was not able to observe any volunteer supervision activities, so the quality of those interactions remains uncertain.

The training approach follows a cascading methodology. PSA staff receive the initial training in the content areas, then adapt the sessions for the coordinators and zone leaders, who subsequently train the local volunteers in each of the 52 sites through the Mpumalanga region. The training sessions are offered in English and in the local, native language. Two staff members, Anita and Johan, provide training in reproductive health. Given their responses to some exploratory questions, they would benefit from additional training in sexual and reproductive health.

Independently of this project, PSA has initiated a pilot program to integrate care and treatment aspects with prevention of HIV transmission into one comprehensive training approach. If successful, the comprehensive approach would serve as the basis for future training sessions, resulting in all volunteers being cross-trained in comprehensive HIV prevention, care, and support. The integrated training approach seems to be a result of requests from the volunteers themselves; many of the peer educators, for example expressed a desire to be trained in HBC, for example.

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knot polo shirt. I raised this concern with PSA senior management who agreed to redesign the outfit.

3 The effectiveness PSA volunteers cross-trained in prevention and care and support is beyond the scope of this project; rather it serves as a foundation upon which family planning and reproductive health communication is built.
The structure of the discussions in each of the sites followed the same basic informal, unstructured format:

1) Areas or topics of current training
2) Common questions asked by clients, or others in the communities
3) Specific questions on sexual or reproductive health
   a. Probing questions on family planning
   b. Probing questions on contraception or contraceptives
   c. Probing questions on STIs
4) Attitudes on sexual activity, including for those who are HIV-positive
5) Additional areas in which the volunteers would like to receive training

The first item was used as an ice breaker to get the group discussants accustomed to sharing their ideas on a familiar topic. This laid the foundation for open discussion by assuring them that there were no right or wrong answers, and that all opinions were welcome. Once the group felt comfortable with me and the translation team, I guided the discussion to more probing issues to explore content areas for and attitudes about the future training program. The following section summarizes the findings from items two through four above.

Common Questions, Item 2
When asked about the kind of questions people in community pose, the responses clustered around several main themes:

- Issues associated with volunteering, e.g., how much are the volunteers getting paid, why would anyone want to work for free, why do volunteers clean others’ houses, why do volunteer look after others’ children.
- Volunteers’ behavior, e.g., have the volunteers been tested, do they practice what they preach, why do they use gloves to handle certain things in a client’s home, what can the volunteers offer.
- General questions about HIV and AIDS, e.g., where does it come from, is it curable, are condoms 100% effective/safe, can the volunteers look at someone and know if s/he is HIV-positive, do STIs, if left untreated lead
to HIV, why or how do children get HIV if it’s transmitted sexually, are all blood samples routinely tested for HIV, including those for syphilis testing and in antenatal clinics.

- Myths and misconceptions around condoms, e.g., they have worms, the lubrication on condoms contains HIV, condoms cause HIV and AIDS, and others.

**Sexual and Reproductive Health Questions, Item 3**

The participants in each of the discussions were asked specifically about questions others in their communities ask them regarding family planning, contraception, and STIs.

Issues associated with *family planning and contraception* included:

- Myths and misconceptions about contraceptive methods, e.g., injections cause HIV infection; injections cause pregnancy; babies have been born with pieces of condoms stuck to their heads; babies have been delivered with a loop (IUD) in their hands; contraceptives cause erectile dysfunction; condoms cause prostitution; injections result in decreased feeling and sexual satisfaction; IUDs cause cancer; men feel pain during sexual intercourse with someone who takes the pill; pills produce a “bad smell” in the vaginal area, or smelly discharge; injections cause infertility; among others.

- Other contraception issues, e.g., condoms cause rash; pills and other contraceptives may lead to weight gain, or cause headaches; pills cause spotting; injections cause vaginal wetness, which seems to be undesirable in some communities.

- Cultural values, norms, and perceptions around sexuality, e.g., womanhood is defined by the ability to children, particularly a male child; how to deal with a teen in the household who gets pregnant; marriage forces women to have children; even HIV-positive women are expected to have children until they have at least one male child; ejaculation must take
place in a person, not into plastic or rubber; people who abstain from sexual activity for too long will suffer from mental retardation or “madness;” sex is “flesh against flesh;” the Bible tells people to have children; and others.

- The number of children a woman has is influenced by many factors, e.g., religious reasons (the Bible encourages many children), desire to marry (the father of the child should marry her is she gets pregnant), cultural norms on having a male child (the husband, father wants more children), financial reasons (more federal grant monies are available to women with more children), among others.

Issues associated with sexually transmitted infections include:

- Traditional healers curing HIV/AIDS and STIs
- The ability of a person to have more than one STI
- STIs, including HIV, only happen when there is ejaculation, so coitus interruptus does not lead to STIs
- Condoms cause STIs, including HIV
- Having sex with a virgin will cure STIs
- Syphilis, left untreated causes HIV
- Gonorrhea, left untreated causes condyloma

Attitudes on Sexual Activity, Item 4

Although there were some minor differences between the attitudes of volunteers in the rural versus urban areas, many of the comments and observations clustered around:

- A disconnect between when a young person “should” start having sex, and when they actually do. The general sense seemed to be that young females and males are starting sexual activity as early as 12 and 14, respectively, although some anecdotal evidence suggests it may begin much earlier.
There was much discussion on how many children a woman “should” have, with many suggesting six or seven as an average. It is worth noting that some participants offered comments such as, “that’s a decision every couple needs to make for themselves.” In the few instances where males were present, they seemed to suggest that women should have more children than their female counterparts.

Many of the participants felt that HIV-positive people should not be engaging in any sexual activity. Some felt that re-infection was a major concern. Others, it seemed, were distrustful of the prevention value of condoms.

There were extreme opinions on opposite poles about whether HIV-positive women should have a child. Some emphatically stated that HIV-positive women should not have children, citing the impact of orphans on communities. Others thought the cultural value of having at least one child, and preferably a male, was more important.

Additional Training, Item 5

The volunteers identified and prioritized the following top ten areas for additional training:

- First aid
- Use of blood pressure devices
- Voluntary counseling and testing (VCT)
- Counseling, including rape counseling
- Family planning
- Rapid testing
- STIs
- Helping someone accept their status
- Child and wife abuse
- Conflict management
Due to the scope of the project, and the content previously covered in existing core and refresher training, stakeholders agreed that the training to be developed would focus on communication about risk assessment and reduction.

**Specific goals or aims of the proposed program**

Although the original intent of the program was to provide additional information on long- and short-term contraceptive methods, implications of unprotected sexual intercourse, and referrals to appropriate diagnostic, treatment, and care services, the findings from the assessment clearly pointed in a different direction. The volunteers expressed their desire to learn more about counseling and communication skills. I discussed this departure from the original plan with PSA leadership. Through month-long discussions I learned that the information aspects of family planning methods and devices, signs and symptoms of STIs, and the dual protection offered by condoms would be covered through planned refresher training sessions and ongoing volunteer supervision.

I was able to convince the leadership at PSA that a volunteer’s ability to convey accurate information is an essential skill in risk reduction efforts for others; however, information alone is insufficient to result in behavior change. By examining very basic behavioral theories, including the health belief and transtheoretical models, PSA staff realized that people needed to perceive they were at risk for HIV or an unintended pregnancy, and that there was a perceived benefit to adopting the desired behavior, and that they were able to effect a change in their behavior. The most effective was to address the concerns of HBC clients and their family members and tailor an individual message to their needs. Basic communication skills could enhance the work of the PSA volunteers. Thus, basic communication skills became the main thrust of the training manual which would highlight:

- Interpersonal dynamics
- Family dynamics
• Risk taking and risk reduction
• Sexual decision making
• Gender roles and norms (what it means to be a man or woman in the community’s eyes)
• Trans-generational communication (the HBC volunteers discuss sexuality with any younger or older people who live in the household)

See the addendum to this paper for a copy of the training manual.

The qualitative data pointed to the family as the unit of intervention, rather than focusing exclusively on the person receiving HBC services. "Family" might be modified or expanded to "social and sexual network" in the event that a single mother lives with her children, yet has sexual partners who do not live in the same household. With this broader emphasis, the training manual would emphasize the following:
• Expanding current PSA efforts from client only, to reach the clients’ family members and sexual partner(s)
• Combining care and support with more comprehensive prevention
• Reinforcing age- and developmentally-appropriate prevention messages that offer dual protection against STIs, including HIV, and unintended pregnancy
• Referring clients and family members to other services, as appropriate and necessary
• Promoting being faithful to one’s personal values in sexual decision making

Thus, the program was designed to build on existing PSA infrastructure (trainers, nurse coordinators, volunteer coordinators, HBC supporters, and home-based caregivers) with volunteers being provided additional client-centered communication skills. The program’s goal it to improve reproductive health

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4 The dual protection messages include abstinence or delay for those who are not yet sexually active, increasing the time between sexual partners, decreasing coital frequency, using condoms, and/or a contraceptive method to address pregnancy and a barrier method to reduce the risk of acquiring or transmitting an STI.
(family planning and STIs) knowledge and health-seeking behavior among HBC clients and their family members.

The program used a cascading approach, applying a training of trainers (TOT) methodology, see Figure 1. PSA staff and volunteer coordinators were the first to be trained; they in turn were responsible for training HBC supporters. Finally the HBC supporters would incorporate the new communication skills in their routine contact with clients and family members. As a result of the training sessions, PSA volunteers should be able to 1) engage HBC clients, caregivers, and family members in discussions about their perceived and actual risk for STI/HIV and unintended pregnancy; and 2) appropriately assess sexual risk-taking behaviors and refer HBC clients, caregivers, and family members to appropriate services when necessary.

Basic communication, active listening, and tailoring appropriate risk assessment and risk reduction messages to the needs of the individual can be invaluable skills that cut across all health issues. They can be learned by community members, thus supplementing prevention services offered through governmental or other health service systems.
Figure 1. Pilot Intervention in Ekangala and Kwamhlanga

Training WEEK 1: I facilitated a training of trainers on integrating FP/RH into PSA's HBC program through client-centered risk reduction communication.

Training WEEK 2: PSA will train zone leaders and PSA volunteers on integrating FP/RH into PSA’s program in two pilot sites through client-centered risk reduction communication.

WEEK 3 and ongoing: PSA supporter home visits to provide care and support and appropriately integrate client-centered risk reduction communication skills learned.
Client-centered communication and basic counseling

The intervention consisted of a training manual designed for use by PSA trainers and by volunteer coordinators working in HBC programs in Mpumalanga. Rather than present new technical content areas, the training was designed to build on the information provided in the original training sessions for the volunteers providing HBC services in Kwamhlanga and Ekangala. The overall goal of this training manual was to strengthen communication skills among volunteers to promote risk assessment, risk reduction, and referrals among PLWHA and their family members. Although the emphasis is on communication, the manual provided participatory exercises in three content areas:

- Sexuality
- Sexually transmitted infections
- Family planning

The goals of the four-day training were to:

- Increase HBC supporters’ skills on risk assessment and reduction techniques
- Increase knowledge on appropriate referrals for family planning and STI services
- Increase health-seeking behavior of the training participants and their contacts (HBC caregivers and their family members)

The overall content was guided by the situation analysis, which highlighted the volunteers’ expressed desire to learn more about basic counseling and communication skills. This emphasis was a subtle yet significant departure from the information-based training and subsequent work that the volunteers had been used to. Previous training sessions (those implemented by PSA trainers) were conceived with a narrow focus of imparting correct and consistent information, with little regard to a person’s existing knowledge, or their immediate needs. Participants in the training were taught active listening skills, and then applied those skills through structured role plays on sexuality-related themes.
The pilot training program provided risk assessment and reduction communication skills to all PSA volunteers, who will ultimately integrate the prevention of unintended pregnancy and STIs, including HIV, into their interactions with HBC clients, caregivers, and family members. The training sessions reviewed reproductive health information and pregnancy and STI prevention, so that volunteers were able to identify and address any myths and misconceptions. Through client-centered communication and with the appropriate knowledge, the PSA volunteers will be able to work with others to assess their individual risks, and then refer to the appropriate services.

Monitoring and evaluation for the program

The monitoring and evaluation will consist of two independent activities. The first set of activities is related to the training itself and consists of written post-training evaluation. The second is ongoing supervision of the volunteers as they incorporate the communication skills into their routine contact with HBC clients and family members.

Participants’ comments from their written evaluations are presented below.

In response to the item, “What you liked best about the workshop” the participants indicated that the participatory nature of the sessions, including the role plays, group discussions, and sharing one’s thoughts and opinions, was one of the most positive aspects of the four-day training session. The emphasis on listening and communication skills was the second most frequently cited favorable element. The following statement summarizes the sentiments of most participants, “It was a good serious workshop with a lot of skills learned but in a way which had fun.”
When asked what they would change in future trainings, most participants reported being satisfied with the workshop, although some felt they would like additional training on counseling and more role plays, so that everyone could talk and participate more actively.

Participants were also asked to share three things they learned during the workshop. The majority mentioned communication and counseling skills, including how to approach others and introduce potentially sensitive topics. There were also comments suggesting that actively involving participants can be a valid training technique: “It is important to have fun in workshops without diluting the content of the workshop.”

While these comments reflect the mood of the participants immediately following the workshop, I do not have any reports from the PSA staff on if and how the skills have been applied in the routine interactions between volunteers and HBC clients and family members. One of the requirements of the broader project is that PSA submit periodic reports intended to guide future refresher training sessions.

A post-intervention assessment of the project has been approved by FHI’s PHSC. In addition to assessing impact of the training intervention, it will also examine 1) the capacity of HBC volunteers to effectively integrate family planning into their care and support responsibilities, 2) their comfort in discussing sexuality issues with clients and family members who are much younger or older than the volunteer, and 3) their interest in focusing on risk reduction communication and their ability to do so. This study is a complement to a similar one to be conducted in Kenya. The findings from the rigorous study design and data collection will contribute to the evolving body of integration knowledge.
Limitations of the Program

As to be expected, this program, like all others, has limitations. The overview of the limitations presented in this paper is not intended to be exhaustive. Rather it is intended to inform future planning and implementation of similar projects.

Perhaps the greatest limitation to the approach described is the narrow focus of training—limited to HBC volunteers in PSA’s program—as determined by the funding stream. A more comprehensive intervention needs to be considered, taking into account the following:

- Quality of care through existing Department of Health services, making sure health care providers were prepared and equipped to deal with a potential increase in demand for services
- Apartheid era associations to family planning as a way to control the black population, and the need to link community-driven and community-based efforts to broader comprehensive health promotion efforts
- Logistics and supply to ensure family planning commodities are available in the target communities
- Work with traditional healers, who are often a point of first contact for many South Africans and are not generally considered part of the formal health care structure

An additional limitation is the short timeframe for the broader research effort. The initial training was conducted in July 2004 and was replicated through early August, reaching all HBC volunteers in the two pilot sites. The

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5 Female condoms, for example, are said to be readily available in South Africa; however, the volunteers and select community members stated that female condoms were not affordable or accessible in the rural communities.

6 This, in spite of the information presented in “Traditional Healing and HIV-AIDS in KwaZulu-Natal, South Africa: To curb the epidemic, South African nurses, physicians, and traditional healers are learning to collaborate.” by Giarelli, Ellen EdD, CRNP, RN, CS; and Jacobs, Linda A. PhD, CRNP, AOCN, BC, from the October 2003, Volume 103(10) of the American Journal of Nursing
relatively short period of time between training and the three-month research follow-up is unlikely to demonstrate a significant change in the content and quality of the HBC volunteers’ interactions with clients and family members.

**Expected Outcomes and Implications**

Although there are limitations to the project, there are two main desired outcomes:

- **PSA volunteers are engaging HBC clients, caregivers, and family members in discussions about their perceived and actual risk for STI/HIV and unintended pregnancy**
- **PSA volunteers are appropriately assessing sexual risk-taking behaviors and referring HBC clients, caregivers, and family members to FP/RH services when necessary**

If there are positive outcomes from the integrated training approach, the program might be expanded beyond the two-site pilot effort into all 58 communities in Mpumalanga where PSA currently has peer-mediated prevention and community-based mitigation programs.

Based on the results of the an intermediate scaling up within the province of Mpumalanga, the PSA’s experiences in integrating reproductive health into HBC programs might serve as a model program for replication and scale up throughout South Africa.

**Expected Lessons to be Learned**

Although there is little literature to guide the integration efforts, my experience in other training-based programs provides a framework to project expected lessons learned:

- **One-shot training alone is insufficient to result in desired outcomes**
• Ongoing supervision is necessary to ensure the quality of the volunteer/client or volunteer/family member interaction
• Ongoing skills building in more advanced communication and counseling skills are essential
• There may be differences, based on demographics of the PSA volunteers, in their comfort level in discussing sexual risk reduction among clients and family members
• The meaning of “family” is complex, reflecting a constellation of relationships including those who may or may not live together

Future Implications

The focus on basic communication skills for HBC workers who have traditionally been trained in infection control might prove to supplement clinic-based family planning/HIV integration efforts. As demonstrated through community-based distribution programs, community members can play a vital role, linking those at greatest need for health care services into informal or alternative service delivery models.

Although not the explicit focus of this paper, the complementary research study is designed to answer key questions on the feasibility of training HBC volunteers to move beyond universal precautions and HIV infection prevention. An HBC volunteer with this enhance training would be able to capitalize on the inherent trust to discuss broader, behaviorally-based, prevention of HIV.

If the research results in favorable outcomes, the cadre of trained people to support a country's HIV prevention goals can be increased significantly, without necessarily increasing limited health care finances. Positive results open the door to increasing the number and type of community-based programs, including faith-based organizations that have traditionally played a significant role in care and
support for HIV-positive people, capable of delivering expanded HIV prevention messages, or referring to appropriate services.

If successful, national guidelines on community-driven home-based care and support in South Africa may be revised to incorporate the prevention of sexual transmission of HIV. This proactive stance by the government of South Africa might influence international donor support, thus increasing the financial resources dedicated to addressing one of the worst HIV/AIDS pandemics.

Conclusions

HIV/AIDS continues to exact a toll on countless people around the world. I have worked in HIV/AIDS prevention since 1986, in both international and U.S.-based programs. While it is true that government systems and structures must play a central role in any response, they alone are insufficient to deal with the overwhelming needs in resource-constrained settings. Any significant response must include community-based and community-driven efforts. It is with the union rather than the intersection of these two enormous systems, the governmental or public sector and the nongovernmental or private, that we can achieve the greatest impact.

It is my sincere hope that the results of the research project will indicate that future investment in home-based care programs, and others, merits greater attention. This is a potential area where additional operations and health services research must be done. The approach presented in this paper is one of possibly dozens that exist. The processes and successes must be rigorously studied and documented, thus contributing to the evidence base for future interventions.
Addendum 1

Introduction to the Training Manual

This manual is designed for use by PSA trainers and by volunteer coordinators working in home-based care (HBC) programs in Mpumalanga. Rather than present new content areas, the workshop is designed to build on the information provided in the original training sessions for the volunteers providing HBC services in Kwamhlanga and Ekangala. The overall goal of this training manual is to strengthen communication skills among volunteers to promote risk assessment, risk reduction and referrals among persons living with HIV/AIDS and their family members. Although the emphasis is on communication, the manual provides participatory exercises in three key areas:

- Sexuality
- Sexually Transmitted Infections
- Family Planning

The goals of the four-day training are to:

- Increase HBC supporters’ knowledge and skills on risk reduction techniques.
- Increase the number of referrals for family planning and STI services.
- Increase health-seeking behavior of the training participants and their contacts (HBC caregivers and their family members).

The training manual has an introduction section for the trainer and step-by-step instructions for the activities. It is important for the trainer to read through all the materials before the start of each session and to have a thorough understanding of every activity. This will allow the trainer to be familiar with the content and increase his/her ability to deliver the training in a more confident manner.

To conduct a program tailored to the needs of the HBC supporters and caregivers, consider the following suggestions:
• **Familiarize yourself** with the entire manual. Please read through and be familiar with the suggestions for increasing the participants’ involvement in the training activities.

• **Prepare** all the material that may be needed before the session begins.

• **Present the objectives** of each session so that the participants know the content or theme of the session. This can be done by writing the session’s objectives on newsprint and reviewing it at the beginning of each session. Alternatively, the trainers can state the objectives verbally.

Most of the activities presented in the manual can be done with materials that are generally on hand during a training session, such as flip chart paper, markers, etc. It is recommended that you read through each exercise to make sure that other materials are on hand as you need them. Examples of other materials might include manila cards (index cards), masking tape, extra paper, drawings, scissors, a basket or a container of some sort.

You may want to prepare a box with “questions and suggestions” and make it available throughout the training session. If you do, please encourage the participants to write down any questions, or share comments that they did not make during the sessions. Make sure they understand that there are no silly questions and that others may have the same question. By allowing the HBC supporters and caregivers to ask questions anonymously, you increase the likelihood that all concerns and questions can be addressed. You will need to check the box regularly, either at the end of every day, or the beginning of each day.

**Notes on how to run a training session**
Before the beginning of each training session, as part of your preparation, here are some suggestions:

- Arrange the room, making sure there are enough tables and chairs for the trainees or make sure they have a comfortable place to sit.
- Prepare the flip charts or chalkboard with the session title and objectives.
- Make sure the ground rules are clearly displayed.
- Introduce the module and session, and link it with the session you are going to cover.
- Remind the group what was covered in the previous session.

Daily evaluations

This manual provides an overview of the evaluation used in the general training, the "Mood Meter." The mood meter will be more useful in determining the participant's perception on the quality of the training sessions and can be filled out at the beginning of each day, before lunch and at the end of the day.

Mood Meter

At the beginning of each day, prepare a flip chart called 'The Mood Meter'. The 'mood meter' is a way to measure the mood of the group. It is not directly related to the content of the workshop. See the following page for a sample. You may recall that an additional line, for angry, was added. If the participants in your training session would like to add another line, please, do so.

Ask the trainees to place an 'X' or a dot in line with the emotion they are feeling at the end of the day or the session. You can draw a line through the dots or 'Xs'
which reflects the group feeling or the 'ups' and 'downs' of the group. This could be used to discuss the energy level of the group or possible success or dissatisfaction.

Please remember to prepare a “Mood Meter” for each day of the workshop. Also remind the participants to fill in the “Mood Meter” every day.

**MOOD METER**

<table>
<thead>
<tr>
<th>Morning</th>
<th>Before Lunch</th>
<th>End of the Day</th>
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<tbody>
<tr>
<td>![Happy Face]</td>
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Suggested facilitation tips during the course

The following is a list of facilitation tips that the trainer can use in order to improve trainee’s learning and participation.

- **Prepare nametags** for participants.
- **Arrange seating** so that all participants have a place to sit and you can walk around during your presentation, so that you can interact with your participants.
- **Practice your presentations** to make sure you understand each of the steps and are prepared to respond to additional questions of the participants.
- **Arrive early** to set up the room and organize all the materials that you will need.
- **Call people by their names** as often as possible to make them feel important.
- **Be aware of time** limits to make sure you are able to cover all the materials. Although the time limits in the manual are suggestions, you will want to make sure that you pace the training session accordingly.
- **Greet** participants when they arrive and establish rapport.
- **Start each new session by sharing the objectives** so that participants know what to expect. You may want to write these on newsprint.
- **Explain** in clear, simple, and concise ways.
- **Know your subject matter.** Prepare in advance.
- **Speak clearly and loudly** to make sure the participants can understand you.
- **Summarize** the main points covered at the end of each session.
- **Answer questions** as they are asked, giving clear and concise answers. Also, be sure to check the “questions and suggestions” box and respond to those questions daily. It is important to recognize that participants may ask questions that you do not know the answer to. If that happens, please tell the participants you will have to get back to them at a future time to share the information.
• **Give examples** that help clarify information and increase understanding.
• **Use illustrations** to facilitate learning since some people learn better by seeing pictures.
• **Paraphrase** statement and questions to model active listening skills.
• **Be confident** in making presentations.
• **Maintain eye contact** with participants, if this is appropriate, to check the mood of the class and individual attention.
• **Encourage** everyone to participate fully. Give them compliments when they do well, allow all participants to ask or answer questions.

This training workshop seeks to enhance HBC supporters’ communication skills to reduce the risk of sexually transmitted infections and unintended pregnancies among HBC caregivers and their family members.

**Day One**

Singing and Opening Prayer
Greeting
Introduction of Trainers
Participant Introductions
“Why Are We here?” ..... Our Purpose
Ice Breaker/ Introduction of Trainees
Communication Skills, introduction

Opening: The workshop will follow PSA’s regular training protocol. It will begin with the participants singing a song. Once the song is completed, an opening prayer will be said.
Greeting: The first session of the workshop is designed for the lead trainer, or the most senior person from PSA, to welcome the participants to the training event. The greeting should cover:

- Welcome participants and introduce the facilitators.
- Thank the participants for agreeing to attend the training sessions.
- Tell the participants that the course has been developed in collaboration with PSA and FHI.
- Provide a brief overview of the reason to integrate reproductive health into PSA’s ongoing home-based care program.
- Share any necessary logistics information (what time tea will be, for example).
- Inform participants that the training is designed to be participatory, that they will be learning and practicing new skills.
- The content of the training will focus on communication skills, rather than on new HIV, STI, or family planning content, per se. Emphasize why each of the volunteers has been invited to participate in the training session (review the objectives, as necessary).

Introduction of trainers: Allow a couple minutes for each member of the training team to say his/her name, the specific area or program in which s/he works, and a comment or two on one of the themes to be presented during the workshop.

Participant Introductions: Before the training session begins, make sure that there is at least one nametag for each participant. The introductions session will set the tone for the rest of the workshop by having each person do something active and say something at the outset.

Distribute the nametags telling the participant that they will each fill one out with the following information:
• Their name in the center of the nametag.
• Number 1., 2., 3. in upper right corner and write three personal characteristics they are most proud of, or three of best personal attributes.
• Number 1., 2., 3. in the lower left corner and write the names of the three people who they value the most, or those who are most important to them.)

In addition to the nametags, the participants will play, “Sonja’s shoe exercise” in which:

• Trainees remove one shoe and place in center of the circle.
• Each then picks up a shoe that is not their own and match it to the person to whom it belongs.

When the participants have identified the owner of the shoe, have them negotiate with others so that they end up in pairs. Tell the participants to use the information on their nametags to begin a short discussion with their partner, exploring an attribute (or characteristic) and some information as to why a particular person on the nametag is important to them.

Once the small groups have finished their discussions, have the participants return to their seats. Ask for a volunteer to start the reporting back to the larger group by introducing the owner of the shoe and sharing the highlights of the discussion. After the first participant has introduced his/her partner, that person then introduces the other person.

Repeat this process until all participants have been introduced.

*Note to trainers: you may decide not to participate in this activity, depending on how familiar you are with the volunteers.*
Please remember to allow time for a tea break, as well as the singing and prayer before tea and the singing to call participants back to the workshop.

Expectations: Using the flip chart, use the brainstorm technique to elicit from trainees what their expectations are for the training. Ask them what they want to ‘take away’ with them at the end of the week.

As you review the stated expectations, review how these expectations compare with the training content, and if they can be met? You may find it necessary to clarify the purpose of the training workshop, informing the participants of what they can realistically expect to gain at the end of the week. For example, if someone mentions being trained in taking blood pressure or inserting/removing a catheter, it is important to tell the whole group that those topics will not be covered in this workshop.

Ground Rules: Using the brainstorming technique once again, ask the participants to list the “rules” for the week. You may need to encourage participants to call out specific rules. Some suggestions might include:

- **Confidentiality** – please don’t share what others say in the training.
- **Respect** – everyone’s opinions matter, it’s okay to disagree.
- **Non-judgmental approach** – it is okay to disagree, but not to put down another person.
- **Anonymity** – please use the “question or suggestion” box to pose questions if you can’t ask them.
- **Timeliness** – please be on time for all sessions and return from breaks promptly.
- **Noise level** – make sure to turn cell phones shut off during the training sessions.
- **HAVE FUN.**
This might be an appropriate time for the lunch break. If so, please allow sufficient time for singing and the pre-meal prayer.

Introduction to Communication: Before the start of the session, prepare three drawings on a blank piece of paper. In preparing the drawings, remember to make them a little complicated, yet familiar enough to the participants.

Divide the participants into groups with equal numbers of individuals, no fewer than ten per group. Tell the participants to line up in a single queue, all facing the same direction. Make sure there are newsprint and a marker at the front of each line.

Walk to the back of the line, so that you are facing the same directions as the participants. Tell them that you have two drawings, which you are going to give to the last person in each line. That person will, with his/her finger, draw the picture on the back of the person in front of him/her, who will subsequently draw it on the back of the person in front of him/her. Tell them that they are NOT allowed to ask any questions, cannot ask that the picture be drawn more than once.

The person at the front of each line will, once the picture has been drawn on his/her back, use a marker (or pen) to draw the picture on the newsprint at the front of the line.

Ask the person at the back to bring the picture up and tape it to the newsprint. Allow each of the participants to look at the original picture and the class drawing.

Have them return to their seats so that the trainer can facilitate a discussion on communication. Some sample questions you might like to ask include:
• How close are the two drawings? What’s different about them?
• Was this exercise easy? Or difficult?
• What made this exercise challenging?
• What would have made it easier for each of you to correctly draw the picture on another person’s back?
• What lessons do you think this exercise can teach us about communication?
• If you have to do it over again, what would you do differently?

Some of the observations the trainer might want to share include:

• It’s easier to talk with someone when you are looking at them.
• If you are looking at someone’s face you might be able to tell if they understand you.
• It’s hard to get the meaning of things if you aren’t allowed to ask questions.
• I didn’t like it because I couldn’t understand what she was doing.
• I couldn’t see what was happening and that was very confusing.
• Sometimes it is easier to talk with someone than to write something down for them.

Operator/Telephone Game: One person begins by thinking of a short story, any story they would like, preferably a made up one. The story might be something that happened to them on the way to the training workshop, it might be about a recent trip they took, or it might have to do with something funny that happened to them recently. He or she then whispers it into the ear of the person next to them. That person then relays what they heard to the next person, and so on, until the final person has had the message whispered in their ear. That person then tells the whole group what they were told. Most likely, the message is very different from what the first person said.

The trainer asks the group what lessons can be drawn from this exercise. Some of the issues raised might include:
• It’s easier to communicate with someone when you can look at them in the face.
• I didn’t understand because the story was too complex.
• Some people were very good and could transfer the message very easily, and others got confused.
• Some people forgot because it was too long.
• Some people need to see and hear the message to understand.
• Not everyone communicates the same thing in the same way, some times they change it based on what they can remember.

Ask the participants to think about what can happen when we are communicating with people about STIs and family planning, as well as any other information.

It might be appropriate to have a tea break about now. Please allow time for singing and praying. Also allow time for singing to call the group back together following the break.

Small Group Exercise: “So, What Have We Got to Lose?” The training team will:

• Divide the participants into small groups of five or six people in each group.
• Give each group markers and newsprint/flip chart.
• Ask the participants to brainstorm what the losses might be if communication is not clear and accurate when they are working with the HBC clients, and in turn, with their families and others on issues of sexuality and risk reduction.
• Tell the participants to identify one person to report back to the larger group, and one person to be the note taker.
• Allow the participants to think about and list as many issues as they can think of, which may take some time.
After the groups have finished preparing their lists, and the note takers have written all the information on the newsprint, ask them to take their seats. Have one person per group report to larger group on their discussion and findings. When all the small groups have reported back, the training team then synthesizes information.

Before closing the day, ask for questions from the day. Any concerns?

Remind trainees to check the Mood Meter.

Allow time at the end of the day for Singing, Closing Prayer and Farewell

DAY TWO

Singing and Opening Prayer
Mood Meter Reminder
Check-in

First things first: At the start of each day, please remember to do the following:

Allow time for singing and an opening prayer to start each day.
Remind the participants to fill in the "Mood Meter."
Ask the volunteers if they have any questions from the day before. Be sure to respond to questions and address any of the issues that might be raised.
Review the questions and concerns that might have been placed in the suggestions box.
Ask one or two participants to share what they learned during the previous day.

Note to trainer: You may need to prompt the volunteers by asking, "What happens when you don't have clear communication between two people?" Be sure to review your notes from Day One to make sure that the responses are
You may need to remind them of some of the discussion points from the “Eyes on your back” or the “Operator/telephone” exercises.

The emphasis for the day is practicing communication skills through role plays. What you as trainers are striving for, is to get the trainees to move from the classroom style of learning that they are used to, that is listening to information and then taking notes to be studied later, to an experiential style of learning. Through the use of participatory exercises, the participants will learn through doing…in this case speaking/communicating what they already know to another person. The skills to be practiced include:

- Listening.
- Reflecting what we see and hear to be certain our assumptions are correct.
- Expressing empathy, when appropriate.
- Always expressing ourselves in a culturally appropriate manner.
- Building trust with a client.
- Understanding when the time is right to communicate information or when we know the client can “hear” what we have to say.
- Using appropriate body language and eye contact.
- Using minimal encouragers, as appropriate. Minimal encouragers may include nodding your head; saying, “mmm;” leaning forward; using facial expressions that allow a person to keep talking; and others.

Throughout the workshop you will want to create the role plays from discussions that have taken place during the training. This is usually the best approach as it lets the participants know you have heard what their concerns are and what is important to them. Remember, you are always modelling the communication skills that you are teaching. One of the primary purposes of the role play is to allow the volunteers to rehearse what they are going to say if face with the same or a similar situation.
Note to trainers: In your training session we used a role play in which there were 4 sisters, ages 16, 15, 14 and 10. The parents had passed. The 16 year old had a baby and the 14 year old was pregnant. The worker was making their first visit to the home.

Whatever scenario you choose to use, be clear with the group as to what the roles are. At first, the trainees will probably want to ask for many clarifications and will want to take notes.

After you have divided the participants into smaller groups for the role plays (groups of 4, 5 or 6 depending on how many there are in the training) you can have all the groups do the same role play.

For the first role plays give the groups at least 20 minutes to get themselves ready and to actually act out the role play. You will have to judge the timing by what you observe happening in the room. Also give the groups time to process what happened in their role plays among themselves.

After the small groups have finished with the first round, please remember to:

- Process what happened during the role plays.
- Remember to reflect back to them what you hear them saying.
- Remark on your observations of body language, the kinds of information that is being shared, the amount of time each person in the role play spends talking, and others.
- Use communication terminology (listening, reflecting, and mirroring) to get them familiar with it from the beginning.
- Model summarizing skills by synthesizing what has been discussed.
It might be appropriate to have a tea break about now. Please allow time for singing and praying. Also allow time for singing to call the group back together following the break.

Immediately after the tea break, ask the participants:

- To close their eyes.
- To think about a time when they were having a problem, or when they wanted some help from someone.
- To share any of the details, only to think about the situation.

Now tell them, that a couple of the trainers will perform two distinct role plays. To prepare for the role play, set two chairs in front of the group. Have a trainer sit in each one.

Tell the participants that you are going to show them a couple different ways to communicate. Tell them only that one of the trainers is a 15 year-old young man who is living with his grandmother, and that his grandfather recently died after a long illness. The other trainer is a volunteer with PSA who visited the house regularly when the grandfather was alive.

In the first, the two trainers would demonstrate poor communication skills, for example, interrupting one another, not paying attention to what the other is saying, providing too much information, ignoring what the other is asking and starting to tell the other how to correctly use a condom to prevent STIs, HIV and pregnancy, for example.

In the second, the two trainers would model more effective communication skills, for example, listening, reflecting what s/he sees, hears and understands based on what is said, and others.
After each of the model role plays has been performed for approximately ten minutes, process the interactions by asking the training group the following questions:

- What’s the difference between the first and the second role play?
- Which do you think was more helpful? Why?
- If you were the young man, which would you prefer?
- If you have been faced with a similar situation in the past, which more closely resembles your old communication style?
- How do you think the volunteer could have been more helpful?
- Do you think that the volunteer rushed in too quickly to give information?
- Do you think the volunteer was able to respond to the issues of the young man?
- Was non-verbal communication used effectively?
- Is it appropriate for an older woman to talk with a younger man about sex and sexuality? About STIs? About family planning and pregnancy prevention?

Allow plenty of time to talk about some of the differences between effective and ineffective communication skills.

This might be an appropriate time for lunch. Please remember to allow time for singing and a pre-mail prayer before lunch.

Immediately following lunch, allow time for singing to call the group back to the workshop.

After the participants have settled back into their seats, tell them that the rest of the afternoon will be dedicated to sex and sexuality.

Introduction to Sexuality: “Boy/Girl Drawing Exercise”
• Ask the participants to open their notebooks to a clean page, with noting on the front or back.
• Tell them to draw a line down the middle of the page from top to bottom, dividing it into two equal parts.
• Have them draw a line across the center of the page, from left to right, so that there are four equal sections.
• Tell them they will now have the opportunity to demonstrate their artistic abilities.
• Ask them to draw the following:
  o In the upper left section, a picture of an eight year-old girl
  o In the upper right section, a picture of an 18 year-old young woman
  o In the bottom left, a picture of an eight year-old boy
  o In the bottom right, a picture of an 18 year-old young man
• Remind them that since the session deals with sex and sexuality, the pictures must be drawn of naked people, with no clothes on.
• Allow plenty of time for each of the participants to finish his/her drawing.

When all the drawings are done, divide the group into dyads. Using their drawings as reference, have them discuss what the changes are in every person as we all move through puberty and sexual maturation.

As the participants discuss their drawings, have the trainers circulate around the room. The trainers will be observing the communication styles of the participants. After a short conversation, have the whole group discuss what it was like to talk about sex, what it was like to talk about sex with fellow volunteers, and other questions to promote more discussion.

*Note to trainers: Be on the look out for verbal and non-verbal communication including laughter. Be prepared to talk with them about how they felt during the discussion. You might also need to talk with them about empathy, the fact that the home-based caregivers and their family members might also feel uncomfortable,*
or they might feel embarrassed and want to laugh if the conversation turns to issues related to sex and sexuality.

Following the discussion, have them each put their pictures on the wall for the “art gallery.” Invite all the participants to take a walk through the art gallery during the next break.

What are the words we use? Exercise:

Write the word “penis” on a piece of newsprint in the front of the room. Using the brainstorm technique, have the participants call out as many different names for penis, writing them on the newsprint as the words are called out.

Repeat the process with the word “vagina” written on a separate piece of newsprint.

Repeat once more with the word “sex” written on a separate piece of newsprint.

After all the options for penis, vagina, and sex have been written on newsprint, explain to the participants that the idea is not necessarily for them to use these words. It is, rather, for them to practice hearing them, because sometimes people we talk to use different words to explain the same thing.

*Note to the trainers: You may recall that Michael asked for volunteers from the group to write the words on the newsprint. You will need to assess the literacy level of your participants and then decide if it is appropriate for one of them to volunteer.*

It is also important to talk about what is going on in the room as the words are called out, and then again as they are read aloud. Usually there is laughter and, occasionally there is embarrassment. Remind the participants that it is highly
likely their clients may feel the same when talking about their body parts or about sex.

Sex Soap Opera: One person begins a sexy story drawing from the words that have been listed. Going around in a circle, each person adds one or two sentences to the story. Encourage them to be as crazy, funny and outrageous as they can.

You may have time for one role play before the suggested tea break. However, if you need to take a tea break at this point, please be sure and allow sufficient time for singing and a prayer.

If there is enough time to start another role play exercise, please introduce it by placing two chairs in front of the room. Ask for two volunteers to come to the front of the room and sit, one each, in the chairs. The main topics for these role plays should include sex and sexuality. The trainers can create any role play situation, preferably drawing from the discussions that have taken place previously during the workshop. Some suggested role plays might include:

- A 14-year old girl is home taking care of her younger brothers and sisters while her mother is working. A PSA volunteer has stopped by the house and notices that the young girl is turning into a young woman. One of the training participants will play the role of the young woman and the other will play the PSA volunteer.

- A woman in her 50s is suffering from heat flashes associated with menopause. She has been seeing a traditional healer, someone she has gone to visit in the past to help with medical conditions. She has been offered and is taking a herbal remedy, following the healer’s instructions. A PSA volunteer has come to the house and notices that the woman is behaving in an odd manor.
A young girl has just started her period (menstruation) and is scared because she does not know what is happening to her. The only person for her to talk with is her father. He is the only one home and must deal with the crisis.

Note to trainers: You are encouraged to create other role plays, based on the issues you have heard throughout the workshop, or based on a particular topic or theme you would like to develop further.

As you process the role plays, follow the same structure of giving enough time for the role play to develop. Make sure you allow some time following each role play for discussion and feedback. It is often helpful to start the processing by asking the two people who did the role play how it felt while they were playing the roles. Get their feedback and then open the discussion to the larger group.

Note to trainers: As you process each of the role plays, encourage the participants to practice their summarizing skills. The goal of the process is NOT to discuss everything that happened. You want to avoid “she said...” and then “I said.” You are not necessarily interested in whether they give information. You are more interested in hearing the words that people say, the techniques that are used to raise issues of sex and sexuality.

Please remember to create some tension, pairing younger with older participants, having some participants pretend to be a different gender. Remember, too, that during the conversations following the role plays, you can also discuss non-verbal communication, or body language.

If you have not yet had a tea break, this might be an appropriate time. If you do stop for tea, please allow sufficient time for singing and a prayer. Also allow time for singing to call the group back together for the rest of the afternoon session.
Debates:

- Create small groups of three or four participants.
- Tell the participants that you are going to be reading a statement, which they are to discuss in the small group.
- Ask them to decide in the small group which person will be for the statement and which will be against it. The other people in the small groups will be observers.
- Once they have identified the person for and the one against the statement, select one from below (or create your own).
- Allow five minutes for the small groups to argue, discuss, or debate the issue freely.
- Let them know when they have one minute left.
- Call time after the five minutes have passed.
- Each participant is then given two minutes to summarize his or her main points and to make one final plea.

Some suggested statements include:

- Everyone knows who has HIV. It’s obvious. Anyone can tell just by looking at someone.

- The very best health advice I’ve heard is that any man can be cured of STIs if he has sex with a virgin. All the men at work know this.

- I take pride in my cultural heritage. We all should. That’s why we should all know our traditional healers are all that we need to be cured of STIs.

- If we are to be honest, STIs are all caused by men and their habits. There is simply no argument here. We’ve known it always.
• All STIs are caused by women and this has always been the case. Men are superior in all ways and God would not have us, the stronger and most powerful of his creations be the cause of such sicknesses.

• A woman should never have an abortion. She should always have the baby and then she can find someone to take care of it.

After each of the debates, ask the participants to share their thoughts and feelings in what happened. Some suggested questions for the trainers to start the discussion might be:

• How did that feel for you?
• Were you arguing a position that you truly believe in?
• If so, did you feel you presented an argument that reflects your true values and passion for your position? In looking back, would you have changed your approach, (added or left some things unsaid)? Do you feel stronger in your convictions for this issue having done this role play?
• For those trainees who argued a position that does not reflect their true values and beliefs, how did that feel for them? Did they gain some insight on why some people do take that position on the subject? How might this new insight change how they will approach communication in the future on this issue?

Final check-in for the day

Reminder to check the Mood Meter

Singing and Closing Prayer

Farewell
DAY Three

Singing and Opening Prayer
Reminder to check Mood Meter
Morning Greeting
Check-In

Please see the first session for Day Two for an overview of the early morning process and possible discussion points.

The main focus for this training day is to continue practicing communication skills mostly through role plays. You might choose to continue using the suggested roles plays from the previous days, or you are free to create your own based on the issues that you have identified during the discussions.

Note to trainers: During your training, we realized we needed to help you develop specific skills in how to open a conversation with someone. We had you brainstorm this in small groups. If you have the same experience with your trainees, you might want to get the group to give you several situations in which they might find themselves when meeting with a client. Put these situations on the flipchart. Have them get into small groups and discuss the possibilities for how they could begin conversations with their clients in these situations.

The idea is to have them practice opening a conversation using listening skills, appropriate body language, eye contact, reflection, etc. After they have had the time to practice this in small groups, have them discuss within their groups how they felt they did this and what improvements they could make. Then process this with the whole group.
If this is an appropriate time for a tea break, please allow enough time for singing and a pre-tea prayer. Also remember to allow enough time following the tea break for singing to call the group back together.

Risk-assessment and risk reduction communication: During this session, the training participants will be divided into small groups of four and asked to develop a list of questions. You may need to remind them that the goal is to find out what kind of information or referral might be needed, based on the needs of each individual. The only way to make sure the information or referral really responds to another person’s needs is to let them tell you what those needs are. The follow the steps below:

- Allow ten minutes for the group to think about and write as many questions as they can think of to determine if someone is at risk for unintended pregnancy, sexually transmitted infections, or HIV.
- Let them know when they have two, then one minute left.
- Ask each of the groups to quickly read through the questions they have listed.

For the second part of this exercise, the participants will practice applying their risk assessment questions in role plays. You, as the trainers, can decide if you want to do this in small groups, or if you prefer to ask for two participants to volunteer to perform in front of the larger group. Depending on the size of the group, you may want to divide the group into two equal parts and then have two participants from each of the smaller groups perform. Those who are not participating in the role plays, will need to use their listening skills because they will be asked to provide specific details on what worked well, and what could be improved.

The small role plays, which you can select from previous days or create your own, in addition to the discussion after they are finished will more than likely take you to lunch.
Note to trainers: During the session the previous week, there were times when you were asked to perform one role play, provide feedback within your small groups, then asked to change roles (so, for example, the person who played the volunteer one time was asked to either be the PSA volunteer or an observer). Once the participants changed roles in their smaller groups, they were asked to perform the same role play. This was processed once more, then they were asked to switch roles. This can be a powerful technique, however one that requires you to be extremely aware of the communication skills that are and are not being practiced. If you notice there is no improvement as the participants practice the same role play a couple times, you will definitely need to address this in the discussion that follows these role plays.

Values Clarification:

You can choose to do this as described below, or as you did in your training; have a small group of women come to the front of the room and discuss among themselves one of the four topics.

Depending on the time, you can bring different groups to the front and give them different topics. Or, you might choose to move the trainees into four groups. Each group is given a topic to explore fully all the issues that impact the given topic.

A reminder that it is important for everyone to participate as:

“A tool in building self-awareness is self-disclosure: showing more about ourselves with others. By describing to others what we may think or feel we are forced to be clear about how we really think or feel for ourselves. By better understanding ourselves, we are better able to understand others. By doing some of these activities with our staff we are better able to understand why and how they operate the way they do.”
The four topics for discussion are (given to groups verbally as well as on index cards):

- What does it mean to be a woman in your community?

- What are the issues around HIV+ women and pregnancy?

- At what age is it appropriate for boys and girls (women and men? Youth?) to begin having sexual relations?

- When is it okay for a woman to say “No.” What is the ‘appropriate’ number of children a woman should have? What decides this?

Trainees are told to take complete freedom in exploring these issues. Express their personal viewpoints as well as those of different voices, for example, community leaders and elders, the media, and any other sources.

Trainees are brought back to the larger group and openly discuss the process that occurred within their groups. Possible points to be used for facilitation might include but are not necessarily limited to the following:

- Was the topic difficult to begin discussing?
- Did anyone have any fear or concern in voicing their personal opinion?
- Was there disagreement within the group?
- Did you experience listening to each other in a different way than you might have in the past?
- How was this different?
- Did you feel heard?
- Did you feel it was very important that you got your point of view across to the others in the group?
Did you not want to speak about the topic given to you? Why?

This might be an appropriate time for a lunch break. Please allow enough time for the participants to sing and have a pre-meal prayer.

Brainstorm Family Planning Methods: Remaining in the larger group, the discussion centers around what family planning methods are used within the community. What might be missing and what is hoped for, for the future? What are key impediments to successful family Planning in the community? What has improved over the past few years?

*Note to trainers: Use the rest of the afternoon to create role plays that center on family planning issues. When you process the role plays, you are looking for best ways to communicate these sensitive issues using the skills they have learned.*

You can create your own role plays or refer to the separate list of role play possibilities.

Plan time for tea and lunch according to how your trainees progress from the brainstorming into the role plays. When breaking for tea and lunch, please remember to allow time for singing and a prayer.

Remember to be sensitive to the group dynamics. You may want to stop and do an energizer exercise or play a game. The group may need to discuss an important topic that was brought up. You will know what to do!

*Note to trainers: We will debrief in the evening and plan for the last day of training depending on what your experience has been with the group and what you determine their needs to be.*
**Reminder! Day Four will be planned by YOU. This was our original plan for your training. Take whatever seems to be appropriate for your trainees.**

At the end of the day be sure to do a check-in with the group.

Remind group to check Mood Meter.

**DAY Four**

This day is about skills practice. Role plays and processing their effectiveness will be interspersed with brief energizer exercises as well as short stress-reducing meditations and the self-care exercise.

Topics for role plays will include, but may not be limited to, best practice in communicating about issues on family planning, STIs, risk assessment, making appropriate referrals and how best to follow-up, death, dying and the grief process, self-care, and issues of trans-generational communication on all the above. Role plays will be done in various configuration; dyads, triads, and small group.

When we feel there needs to be a break in the ‘practice process, we can take 20 minutes to do the ‘WHAT WOULD YOU LIKE TO SAY TO THE WORLD’ exercise. Each participant is given paper and picks crayons/markers to draw and write with. They are told;

Using the paper, you are to represent a free billboard your town council has just given to you. It is located on the main street or highway of your village or township. You are to use the billboard to display any message you want to give
to others. Compose the picture and wording any way you see fit in response to the question, “What I would like to say to the world is.......”

This is followed by a brief processing of the messages that have been developed. The question is posed to the group as to how they could actually get this message out in practical and meaningful ways.