CHARISMA
Agency in Relationships + Safer Microbicide Adherence

CHARISMA
Counselor Training Curriculum

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Acknowledgments

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 This work was made possible by the generous support of the American people through the United States Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The contents are the responsibility of the CHARISMA project and do not necessarily reflect the views of USAID, PEPFAR, or the United States Government. CHARISMA is led by RTI International with core partners FHI 360, Wits RHI, and the University of Washington.

Suggested Citation: RTI international, FHI 360, Wits RHI. CHARISMA counseling manual: empowering counseling to improve women's ability to use PrEP safely and effectively. Durham (NC): FHI 360; 2020.

Table of contents

Overview

INTRODUCTION

This curriculum is for facilitators who are conducting training to implement the Community Health Clinic Model for Agency in Relationships and Safer Microbicide Adherence (CHARISMA) intervention. It covers a range of topics, skills, and practice opportunities to ensure counselors are well prepared.

FACILITATORS

Facilitators will ideally be experienced in HIV prevention and intimate partner violence (IPV). Facilitators should be good listeners who elicit active participation from training participants and establish a safe and respectful training environment. A clinic leader or supervisor would be an appropriate person to facilitate this training.

The training should be led by two co-facilitators, when possible. Facilitators will need to read through this curriculum, as well as the counseling manual, prior to the training to familiarize themselves with the content and determine how best to prepare printouts, handouts, and presentations. Co-facilitators should discuss how they will divide responsibilities.

PARTICIPANTS

Three groups should participate in this training:

1. Staff members who will provide CHARISMA counseling and will need to understand and address relationship dynamics, gender-based violence, and HIV; have the ability to empathize with clients, and demonstrate strong communication skills.
2. Staff members who will supervise and mentor CHARISMA counselors.
3. Site administrators and others involved in pre-exposure prophylaxis (PrEP) delivery should attend at least the first day of the four-day training or the first half-day of the two-and-a-half-day training to ensure they are aware of the content and scope of the intervention and its broad applicability to be responsive to the appropriate clients.

TRAINING

If possible, counselors should complete the World Health Organization (WHO) training *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-Care Providers*, with a particular focus on sessions 1–8.[1] For participants who recently completed this training, the CHARISMA training can be shortened from four to two-and-a-half days (see sample agendas in next section). The shorter version eliminates activities that overlap with the WHO training. For participants who have not completed the WHO training, the full CHARISMA training will be needed to successfully and ethically implement CHARISMA counseling.

Note that those who facilitate or participate in the training may themselves be experiencing or may have experienced gender-based violence. They may need to step out of the training if any of the content retriggers trauma.

- Acknowledge that this content may be difficult for participants and that they may step out of the training at any time, if needed.
- Identify a facilitator or counselor with whom they can speak if needed.
- Have a list of referral services for participants to use if needed.

[1] WHO. Caring for women subjected to violence: a WHO curriculum for training health-care providers. Geneva: WHO; 2019. Available from: https://www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en/.

Orientation	
OBJECTIVES	Shows the main goals of the session.
TIME	Provides estimate for total activity time.
MATERIALS	Summarizes all preparations you should do prior to the activity.
STEPS	Outlines each step of the activity.
FACILITATOR NOTE	Provide the overarching ideas of the session.
WHO LIVES OVERLAP	Individuals who have recently completed WHO training on Listen, Inquire, Validate, Enhance safety and Support (LIVES) may be able to skip some CHARISMA training sessions that cover similar content.
CITATION	Lists the original citations for activities, and adaptations are noted.

Preparing Materials	
PRINTOUTS	Print printouts in advance, with one single copy for the facilitator.
HANDOUTS	Print handouts in advance, with enough copies for all participants. Provide a folder for each participant so they can save handouts in one location.
PRESENTATION	Presentation slides are included in related files. Copies may be printed for participants if they would like to take notes about each presentation.

SAMPLE FOUR-DAY AGENDA (FULL TRAINING)

Prior to training ask counselors to review the Counseling Manual and Counseling Job Aid

Section	Time required	Activity	Activity name
DAY ONE			
Welcome	8:30–8:40 a.m. (10 min)		
A. CHARISMA and Why We Need It	8:40–9:10 (30 min)	A.1	What Is CHARISMA
	9:10–9:40 (30 min)	A.2	Why We Need CHARISMA
	9:40–10:40 (60 min)	A.3	Relationships and PrEP
Break	*10:40–10:55 (15 min)*		
B. Counselor Skills	10:55–11:35 (40 min)	B.4	The Counselor Role
	11:35 a.m.–12:20 p.m. (45 min)	B.5	Counselor Challenges
Lunch	*12:20–1:10 (50 min)*		
B. Counselor Skills	1:50–2:00 (10 min)	B.6	Active Listening
	2:00–2:40 (40 min)	B.7	Listening Skills
Break	*2:40–2:55 (15 min)*		
C. Gender Exercises	2:55–3:25 (30 min)	C.8	Who Has Power
	3:25–3:55 (30 min)	C.9	Sex and Gender
	3:55–4:25 (30 min)	C.10	Where Do You Stand?
Wrap-Up	4:25–4:40 (15 min)		
DAY TWO			
Welcome Day Two	8:30–8:40 a.m. (10 min)		
D. Counseling: Healthy and Unhealthy Relationships	8:40–9:40 (60 min)	D.11	Happy and Unhappy Relationships
	9:40–10:10 (30 min)	D.12	What Makes a Good Relationship
	10:10–10:40 (30 min)	D.13	Tree Activity
Break	*10:40–10:55 (15 min)*		
D. Counseling: Healthy and Unhealthy Relationships	10:55–11:25 (30 min)	D.14	Types of Abuse
E. Counseling: Partner Communication	11:25–11:55 (30 min)	E.15	Relationship "I" Statements
Lunch	*11:55–12:45 (50 min)*		
E. Counseling: Partner Communication	12:45–1:15 (30 min)	E.16	Conflict De-Escalation
F. Counseling: Discussing PrEP Use with Your Partner	1:15–2:30 (75 min)	F.17	Discussing PrEP Use with Partners

Section	Time required	Activity	Activity name
Break	*2:30–2:45 (15 min)*		
G. Counseling: Responding to IPV	2:45–3:45 (60 min)	G.18	Guiding Principles for Provider Response to IPV
Wrap-Up	3:45–4:00 (15 min)		
DAY THREE			
Welcome Day Three	8:30–8:40 a.m. (10 min)		
G. Counseling: Responding to IPV	8:40–9:40 (60 min)	G.19	Cycle of Violence
	9:40–10:40 (60 min)	G.20	Safety Planning
Break	*10:40–10:55 (15 min)*		
G. Counseling: Responding to IPV	10:55–11:25 (30 min)	G.21	Legal Actions
	11:25–11:40 (15 min)	G.22	Referrals
	11:40 a.m.–12:40 p.m. (60 min)	G.23	Alinah's Web
Lunch	*12:40–1:30 (50 min)*		
H. Implementation Practice	1:30–2:45 (75 min)	H.24	Practice: HEART Relationship Assessment
Break	*2:45–3:00 (15 min)*		
H. Implementation Practice	3:00–4:00 (60 min)	H.25	Practice Module A: Healthy and Unhealthy Relationships
Wrap-Up	4:00–4:15 (15 min)		
DAY FOUR			
Welcome Day Four	8:30–8:40 a.m. (10 min)		
H. Implementation Practice	8:40–9:40 (60 min)	H.25	Practice Module B: Partner Communication
Break	*9:40–9:55 (15 min)*		
H. Implementation Practice	9:55–10:55 (60 min)	H.25	Practice Module C: Revealing PrEP Use
Break	10:55–11:10 (15 min)		
H. Implementation Practice	11:10 a.m.–12:40 p.m. (90 min)	H.26	Practice Module D: Responding to IPV
Lunch	*12:40–1:40 (60 min)*		
H. Implementation Practice	1:40–3:10 (90 min)	H.27	Practice: Mock Session and Observation
Wrap-Up	3:10–3:30 (20 min)		

SAMPLE TWO-AND-A-HALF-DAY AGENDA (SHORT TRAINING FOR THOSE WHO HAVE COMPLETED WHO LIVES)

Prior to training: ask counselors to review the Counseling Manual and Counseling Job Aid

Section	Time required	Activity	Activity name
DAY ONE			
Welcome	8:30–8:40 a.m. (10 min)		
A. CHARISMA and Why We Need It	8:40–9:10 (30 min)	A.1	What Is CHARISMA
	9:10–9:40 (30 min)	A.2	Why We Need CHARISMA
	9:40–10:40 (60 min)	A.3	Relationships and PrEP
Break	*10:40–10:55 (15 min)*		
C. Gender Exercises	10:45–11:25 (30 min)	C.8	Who Has Power
	11:25–11:55 (30 min)	C.9	Sex and Gender
D. Counseling: Healthy and Unhealthy Relationships	11:55 a.m.–12:55 p.m. (60 min)	D.11	Happy and Unhappy Relationships
Lunch	*12:20–1:10 (50 min)*		
D. Counseling: Healthy and Unhealthy Relationships	1:45–2:15 (30 min)	D.12	What Makes a Good Relationship
	2:15–2:45 (30 min)	D.13	Tree Activity
E. Counseling: Partner Communication	2:45–3:15 (30 min)	E.15	Relationship "I" Statements
	3:15–3:45 (30 min)	E.16	Conflict De-Escalation
Break	*2:40–2:55 (15 min)*		
F. Counseling: Discussing PrEP Use with Your Partner	4:00–5:15 (75 min)	F.17	Discussing PrEP Use With Partners
Wrap-Up	5:15–5:30 (15 min)		
DAY TWO			
Welcome Day Two	8:30–8:40 a.m. (10 min)		
G. Counseling Responding to IPV	8:40–9:40 (60 min)	G.19	Cycle of Violence
Break	*9:40–9:55 (15 min)*		
G. Counseling: Responding to IPV	9:55–10:25 (30 min)	G.22	Referrals
H. Implementation Practice	10:25–11:40 (75 min)	H.24	Practice: HEART Relationship Assessment
Lunch	*11:40–12:30 (50 min)*		

Section	Time required	Activity	Activity name
H. Implementation Practice	12:30–1:30 (60 min)	H.25	Practice Module A: Healthy and Unhealthy Relationships
Break	*1:30–1:45 (15 min)*		
H. Implementation Practice	1:45–2:45 (60 min)	H.25	Practice Module B: Partner Communication
	2:45–3:45 (60 min)	H.25	Practice Module C: Revealing PrEP Use
Wrap-Up	3:45–4:00 (15 min)		
DAY THREE			
Welcome Day Three	8:30–8:40 a.m. (10 min)		
H. Implementation Practice	8:40–10:10 (90 min)	H.26	Practice Module D: Responding to IPV
Break	*10:10–10:30 (20 min)*		
H. Implementation Practice	10:30–12:00 (90 min)	H.27	Practice: Mock Session and Observation
Wrap-Up	4:00–4:15 (15 min)		

A CHARISMA and Why We Need It

This section introduces the CHARISMA intervention and why relationships are an important part of understanding PrEP use. Through participatory and didactic activities, participants will learn in different ways using visual, physical, verbal, and written tools.

ACTIVITY A.1 - WHAT IS CHARISMA

OBJECTIVES

Introduce the CHARISMA intervention and explain how it works.

TIME

30 minutes

MATERIALS

Presentation A.1

STEPS

Walk the group through the presentation, answering any questions that arise

Developed by Miriam Hartmann, RTI International, Research Triangle Park (NC); 2016.

ACTIVITY A.2 - WHY WE NEED CHARISMA

OBJECTIVES

Explore why relationships are a key part of taking PrEP.

TIME

30 minutes

MATERIALS

- Flip chart paper
- Sticky notes
- Markers
- Printout A.2 (can be printed or drawn on flip chart)

Facilitator Note

As the teams work, see if there are any discussions or arguments about where along the continuum a certain action should be placed. Start to group the sticky notes so they are near similar cards. Help the teams decide where on the continuum a certain action might fit.

Be sure to have extra sticky notes in case new ideas emerge during discussion.

STEPS

1. Draw a picture of Zethu and Sipho on the flip chart, or use Printout A.2.
2. Introduce the activity: Zethu and Sipho have been together for a number of years. They live in a nearby neighborhood.
3. Split the group into two – four teams (depending on the size of the group) and give each team a pile of sticky notes. Ask some teams to imagine that Sipho is supportive of Zethu's use of PrEP. Ask the other team(s) to imagine that Sipho is unsupportive.
4. Ask the groups to reflect on a question: What are the actions that Sipho might take in each scenario? Ask them to write ideas on the sticky notes, one idea per note, so that they create a large pile of sticky notes by the end. Give each team 8-10 minutes to come up with ideas, walking around to make sure the group understands the activity.
5. Bring everyone together and draw a line underneath the drawing of Zethu and Sipho. Explain that this line represents a "continuum of male partner support" with some men falling on the supportive side and others on the nonsupportive side.
6. Ask one group to start by sending a representative to the front of the room to put one sticky note on the continuum and explaining what they mean. Follow with the other group sharing a sticky note. Ask the groups to share ideas until all the notes are on the chart.

Developed by Abigail Hatcher, Wits Reproductive Health and HIV Institute, Johannesburg (South Africa); 2016.

PRINTOUT A.2 - WHY WE NEED CHARISMA

Not Supportive

Very Supportive

ACTIVITY A.3 - RELATIONSHIPS AND PREP

OBJECTIVES

Explore why relationships are a key part of taking PrEP.

TIME

60 minutes

MATERIALS

Presentation A.3

STEPS

1. Ask the group: *"What does PrEP stand for?"* [Write down the full name on the flip chart: "Pre-Exposure Prophylaxis"]
2. Ask the group: *"What is oral PrEP?"* [Answer: A daily, oral pill that prevents HIV transmission.]
3. Ask the group: *"Who should take PrEP?"* [Answer: anyone at risk of HIV transmission]
4. Walk the group through the presentation, answering questions as they come up.

Developed by Danielle Wagner, RTI International, Research Triangle Park (NC); 2016.

B Counselor Skills

This section introduces the role of a counselor working in areas of violence, helps improve active listening skills, and equips counselors to recognize and develop support systems for burnout.

ACTIVITY B.4 - THE COUNSELOR ROLE – LISTENING, INQUIRING, AND VALIDATING

WHO LIVES OVERLAP

This section overlaps with the WHO LIVES training (Session 6). If participants have recently completed that training, they can skip this section, although it can be a valuable refresher.

OBJECTIVES

Understand the roles of a counselor who is asking about violence.

TIME

40 minutes

MATERIALS

Handout B.4 (Part 1 and 2, two pages)

Facilitator Note

You can adapt Khomotso's name and story to be relevant to your setting.

The role of a CHARISMA counselor is to understand more about the participant's life and use that knowledge to provide counseling and support her decision-making. The role of a counselor is NOT to fix the problem or make sure participants feel better.

Using the Counselor Tips helps ensure that the counseling session experience is helpful and does not cause additional distress for the respondent.

STEPS

1. Ask the room to read Handout B.4 (Khomotso's Story). You can ask them to read silently or to take turns reading aloud.
2. Give the group a moment to think about the story silently. Ask them to imagine that Khomotso is the next person they speak to as a counselor.
3. Ask the group some reflective questions:
   - Imagine how Khomotso might act when we ask questions about her relationship and violence, how might Khomotso respond? Would she be shy or confident?
   - How might she react when she is receiving CHARISMA counseling. How would her body language be? How would she talk?
   - How would you respond when she says "Yes" to physical and sexual violence? What does it feel like to hear about such severe forms of violence as a counselor?
4. Explain that your job as a counselor is not to fix the problem, but to listen attentively and with empathy, inquire about her needs, and validate what she is telling you. Sometimes, just talking about experiences with violence can be helpful for clients.
5. Give participants Handout B.4 (Counselor Tips). Slowly go through each tip and ask if participants have any questions.

Developed by Abigail Hatcher, Wits Reproductive Health and HIV Institute, Johannesburg (South Africa); 2016.

PRINTOUT B.4 (1) - THE COUNSELOR ROLE – LISTENING, INQUIRING, AND VALIDATING

Khomotso's Story

Khomotso is 36 years old and the mother of three children. She grew up in a village 400 kilometers away from Johannesburg. She stopped schooling after grade 9. 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."

At 16, she was married to a man twice her age. Her family received a substantial bride price. Together, Khomotso and her husband moved to a nearby city to find work. The very next year, she gave birth at home to a baby boy. The baby was stillborn. Khomotso 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.

Khomotso struggled to keep body and soul together through her several pregnancies and raising her children. She approached her pastor several times for help. He always advised her to have faith in God and keep her sacraments.

Khomotso's husband considered it his right to have sex with her, and regularly forced himself on her. She was nervous about his risk for HIV, because she knew that he slept with other women. When a neighbor told her about taking steps to prevent HIV, she was very interested. She visited the clinic with her neighbor and learned that taking a daily pill could prevent HIV. Although she was afraid to tell her husband about it, she decided to use PrEP.

One day not long after Khomotso started using PrEP, her husband accused her of 'carrying on' with a man living nearby. He had seen Khomotso laughing and chatting with the man, he claimed. When she answered back, he hit her with a stick repeatedly on her knees saying "you whore! I will break your legs." Khomotso was badly injured; she thought she had a fracture. For weeks, she could not move out of the house, and she had to miss her scheduled clinic visits for fear of angering her husband further.

Adapted from World Health Organization (WHO) (Ravindran TKS, editor). Transforming health systems: Gender and rights in reproductive health. Geneva: WHO; 2001.

PRINTOUT B.4 (2) - THE COUNSELOR ROLE – LISTENING, INQUIRING, AND VALIDATING

Listening is the most important part of good communication and the basis of first-line support. It involves more than just hearing the woman's words. It means:

- being aware of the feelings behind her words
- hearing both what she says and what she does not say
- paying attention to body language – both hers and yours – including facial expressions, eye contact, gestures
- sitting or standing at the same level and close enough to the woman to show concern and attention but not so close as to intrude
- through empathy, showing understanding of how the woman feels

Active listening dos and don'ts

Dos	Don'ts
HOW YOU ACT	
Be patient and calm.	Don't pressure her to tell her story.
Let her know you are listening; for example, nod your head or say "hmm…."	Don't look at your watch or speak too rapidly. Don't answer the telephone, look at a computer, or write.
YOUR ATTITUDE	
Acknowledge how she is feeling.	Don't judge what she has or has not done, or how she is feeling. Don't say: "You shouldn't feel that way," or "You should feel lucky you survived," or "Poor you."
YOUR ATTITUDE	
Give her the opportunity to say what she wants. Ask, "How can we help you?"	Don't assume that you know what is best for her.
Encourage her to keep talking if she wishes. Ask, "Would you like to tell me more?"	Don't interrupt. Wait until she has finished before asking questions.
Allow for silence. Give her time to think.	Don't try to finish her thoughts for her.
Stay focused on her experience and on offering her support.	Don't tell her someone else's story or talk about your own troubles.
Acknowledge what she wants and respect her wishes.	Don't think and act as if you must solve her problems for her.

Source: World Health Organization (WHO). Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook (No. WHO/RHR/14.26). Geneva: WHO; 2014.

ACTIVITY B.5 - COUNSELOR CHALLENGES

WHO LIVES OVERLAP

This section overlaps with the WHO LIVES training (Session 12). If participants have recently completed that training, they can skip this section, although it can be a valuable refresher.

Facilitator Note

Working with conflicted relationships creates a work environment that is conducive to signs and symptoms of burnout, compassion fatigue, and vicarious trauma. Being alert to these can help us intervene early to give care, time, and space to team members.

OBJECTIVES

Increase self-awareness and understanding of the challenges that face counselors, including burnout, vicarious trauma, and compassion fatigue.

TIME

25 minutes

MATERIALS

Handout B.5 (Part 1, 2, and 3, three pages)

STEPS

1. Give each participant Handout B.5. Explain that work environments can be challenging in different ways. Ask participants to raise their hands if they have heard of "burnout."

2. Explain that burnout is just one type of work challenge. Other important causes of stress include "compassion fatigue" and "vicarious trauma." These conditions are more serious. Although some signs and symptoms may overlap across all three types of stress (see handout), they are different and sometimes add to one another for counselors.

3. Ask for volunteers to read each scenario and decide as a group whether their scenario represents burnout, compassion fatigue, or vicarious trauma.

    - In Scenario One, counselors are experiencing burnout. In burnout, emotional exhaustion, cynicism, and a low sense of personal accomplishment are key elements.

    - In Scenario Two, the counselors are experiencing compassion fatigue. They exhibit an intensified level of emotional distress leading to

interpersonal withdrawal and changes in their beliefs, expectations, and assumptions. The counselors experience 'witness guilt': taking personal blame for the inability to resolve a situation, such as easing the suffering of a patient.

- In Scenario Three, counselors are experiencing symptoms associated with vicarious trauma. Hallmark signs are intrusive imagery; changes in values, beliefs, and assumptions (cognitive shift); anxiety; and loss of trust. The counselor in Scenario Three could have come from a healthy work environment and yet still experience vicarious trauma.

Adapted from Sabo B. Reflecting on the concept of compassion fatigue. Online J Issues Nurs. 2011;16(1): Manuscript 1. doi: 10.3912/OJIN.Vol16No01Man01.

PRINTOUT B.5 (1) - NAMING THE PROBLEM

Scenario One

You have been working as a counselor at a clinic for three years. Since you started working, the clinic has experienced numerous changes because of financial restructuring. The clinic eliminated dedicated lay counselor positions and all counselors on the floor now rotate through the position for six-month periods. Further, you no longer have a supervisor for your team. Instead, several units have been consolidated under one manager who has had no prior experience in intimate partner violence and who does not hold a professional degree in a health-related discipline. Rather, the manager holds a master's in business administration degree. Over the past 10 months the counselors have had their workload doubled, found themselves working more overtime shifts, and seen the complexity of patients increase. Counselors rarely hear they have done a good job. Nor do they have appreciable input in the ongoing changes. They are feeling increasingly disenfranchised and stressed. Sick time has increased, more counselors are leaving, and the unit has had difficulty recruiting new counselors to the unit because of increasing interpersonal conflicts. The most likely outcome in this scenario is burnout if the situation is not resolved.

Scenario Two

Scenario One is allowed to continue without remediation. Over the next year the complexity of patients increases and favorable prognoses decline. There have been several difficult deaths in recent weeks, particularly among younger patients. With little time to connect with families in crisis because of time and resource issues, the counselors are finding it increasingly difficult to continue working on the unit. The level of emotional distress has increased. Counselors who had been friendly and outgoing are now more reserved and withdrawn. Some counselors have identified feeling guilty over poor patient outcomes while others have begun to perceive that all patients with a specific diagnosis will die. Management perceives the problem to be related to burnout. Strategies to address the problem have proven unsuccessful.

Scenario Three

A counselor working in the unit described in Scenarios One and Two makes the decision to change practice areas and shifts to working in a new community health clinic in the belief that a change of work environment will support the return of physical, psychological, and emotional well-being. The community health clinic provides health services for a local shelter for abused women and children. Initially the counselor notes an improvement in overall health and well-being; however, this improvement is not sustained. During the course of working with clients, the counselor hears ongoing stories of abuse. Over time, the counselor begins to experience intrusive images of clients' stories of abuse. As time continues, the counselor's relationship with her spouse deteriorates. A once loving, intimate relationship no longer exists, and touch, in particular, evokes hostility. On occasion, the counselor has noted feelings of panic when in the presence of unknown males (e.g., while waiting for the bus). Further, the counselor's sense of trust in the compassion and caring of others has changed. Trust is no longer present. What is happening here? Is this vicarious traumatization? Can this occur without the presence of burnout or compassion fatigue?

PRINTOUT B.5 (2) - NAMING THE PROBLEM

	Burnout	Compassion Fatigue	Vicarious Traumatization
HALLMARK SIGNS	• Anger and frustration • Fatigue • Negative reactions toward others • Cynicism • Negativity • Withdrawal	• Sadness and grief • Nightmares • Avoidance • Addiction • Somatic complaints • Increased psychological arousal • Changes in beliefs, expectations, assumptions • 'Witness guilt' • Detachment • Decreased intimacy	• Anxiety, sadness, confusion, apathy • Intrusive imagery • Somatic complaints • Loss of control, trust, and independence • Decreased capacity for intimacy • Relational disturbances (crossover to personal life)
SYMPTOMS	• Physical • Psychological distress • Cognitive shifts • Relational disturbances	• Physical • Psychological distress • Cognitive shifts • Relational disturbances	• Physical • Psychological distress • Cognitive shifts • Relational disturbances • Permanent alteration in individual's cognitive schema
KEY TRIGGERS	• Personal characteristics • Work-related attributes • Work/ organizational characteristics	• Personal characteristics • Previous exposure to trauma • Empathy and emotional energy • Prolonged exposure to trauma material of participants • Response to stressor • Work environment • Work-related attitudes	• Personal characteristics • Previous exposure to trauma • Type of therapy • Organizational context • Health care structure • Resources • Re-enactment

PRINTOUT B.5 (3) - STRESS REDUCTION EXERCISE

Learning objective

Practice stress reduction exercises that providers can offer as part of basic psychosocial support and mental health care and, also, use themselves.

Instructions for the facilitator

- Inform participants that we will practice one stress reduction technique
- Explain that the technique can help people to feel calm and relaxed. Survivors can do this and other stress reduction exercises whenever they are stressed or anxious, or cannot sleep.
- Lead participants through the instructions.

Slow breathing technique (10 minutes)

- Try to keep your eyes closed. Sit with feet flat on the floor.
- First, relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
- Put your hands on your belly. Think about your breath.
- Slowly breathe out all the air through your mouth, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon.
- Breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out.
- Keep breathing like this for about two minutes. As you breathe, feel the tension leave your body.

Discussion: (5 minutes)

- Discuss how this exercise felt for the group (for example, any positive effects, challenges), and ask if there are any questions.
- Emphasize that this exercise can take some time to learn and encourage participants to practice at home.
- Remind participants that this same exercise can be helpful to them as well in their daily lives and when they themselves need to remain calm and reduce the stress from caring for patients.

Source: World Health Organization (WHO). Caring for women subjected to violence: a WHO curriculum for training health-care providers. Geneva: WHO; 2019.

ACTIVITY B.6 - ACTIVE LISTENING VISUALIZATION

WHO LIVES OVERLAP

This section overlaps with the WHO LIVES training (Sessions 4 and 6). If participants have recently completed that training, they can skip this section, although it can be a valuable refresher.

OBJECTIVES

Understand what active listening feels like.

TIME

10 minutes

MATERIALS

None

STEPS

1. Ask participants to settle in their chairs, both feet on the ground and arms comfortably on their laps. Ask them to take a deep breath and let it out. Explain that you are going to read them a short exercise and you would like them to gently close their eyes while you read.
2. Read the following in a slow, soothing voice:
   - Think of a time when you really felt listened to.
   - What was going on for you at the time that made you decide to talk to someone? It may have been a problem, difficulty, concern, or something you wanted to share with someone else.
   - How did you feel about talking to this person? What were your fears, anxieties, and thoughts about how it might be received?
   - Think of the person you spoke to. What qualities did this person have that made you decide that it would be safe to talk to them? What were some of the things that they said to you?
   - How did you know that the person really listened?

Facilitator Note

The person leading the visualization should talk slowly and clearly, pausing between each question in the visualization. Remind all participants that they do not have to do the visualization if they do not feel comfortable, and they should only visualize things which they wish to remember. For those who do the visualization, make sure they are seated comfortably and have their eyes closed before beginning.

- What was it about them that made you feel comfortable?
- How would you describe the experience of having really been listened to?

3. Wait until a count of 10 to ask the participants to open their eyes. There is no need to have a discussion, just ask them to feel how their body is doing. Ask them to take one more deep breath and let it out in a nice, big exhale.

Developed by Abigail Hatcher, Wits Reproductive Health and HIV Institute, Johannesburg (South Africa); 2016.

ACTIVITY B.7 - LISTENING SKILLS

WHO LIVES OVERLAP

This section overlaps with the WHO LIVES training (Sessions 4 and 6). If participants have recently completed that training, they can skip this section, although it can be a valuable refresher.

OBJECTIVES

Practice active listening skills and consider how these skills influence conversations with CHARISMA clients.

TIME

40 minutes

MATERIALS

Handout B.7 | Active listening principles

Facilitator Note

Key messages to emphasize about active listening and its importance:

- Allows survivors to be heard–an important step towards healing
- Empathic and effective communication takes place throughout the meeting.
- Use both verbal and non-verbal skills
- Start with open-ended questions

STEPS

1. Ask the participants to divide into pairs, finding someone to work with – one of them should start with describing a challenging situation in any area of life and to tell their partner a story about it for about 5 minutes. NOTE: Do not use an example related to violence, as this time is too short for dealing with a disclosure of violence.
2. Ask the listener to practice active listening, including open-ended questions, nonverbal communication, and nonjudgmental responses. Refer them to the handout Active listening principles for reminders of active listening practices.
3. After 5 minutes, ask the participants to switch roles so that the person who first listened now tells his or her story for about 5 minutes and the other partner becomes the active listener.
4. Ask participants the following discussion questions (20 minutes):
   - What did your partner do to show she/he was listening attentively to you?

- What did your partner say that showed active listening?
- What did your partner NOT do or say – both good and bad?
- How did you feel afterwards?
- How do listening and communication play a role when we see patients in the clinic?

Adapted from World Health Organization (WHO). Caring for women subjected to violence: a WHO curriculum for training health-care providers. Geneva: WHO; 2019.

PRINTOUT B.7 - ACTIVE LISTENING PRINCIPLES

Listening is an interactive, engaging process whereby the listener focuses attention on the person to whom he/she is speaking.

- The listener attempts to understand and interpret the nonverbal and verbal messages.
- The listener uses verbal and nonverbal techniques to convey support and communicate that he/she has heard and understood the message.
- Active listening is central to communication.

TYPES OF QUESTIONS

These are appropriate for eliciting relevant information:

Open-ended questions. An open-ended question is broad in scope and does not limit the area of inquiry. For example: *"What difficulties are you having?"*

- Open-ended questions elicit more information than the other types of questions.
- It is helpful to start interactions with open-ended questions and then, depending on the answers, move to focused and closed questions.

Focused questions. The listener defines the area of inquiry but allows considerable latitude in answering. For example: "Can you tell me about your visit to the doctor?"

Closed questions. These questions require a "yes" or "no" or a numerical answer. For example: *"How long have you been experiencing trouble sleeping?"*

These are to be avoided, as they usually elicit insufficient or inaccurate information:

Leading questions. The listener leads the speaker into a particular, acceptable answer. For example: *"You agree that getting some professional help is the only way you're going to start feeling better, don't you?"*

Compound questions. Two or more questions are asked without time given for the speaker to respond to the previous question in the series. For example: "*Tell me, have you decided on the model of care you want and whether you want to breastfeed?"*

Nonverbal communication

Nonverbal communication norms vary across settings and cultures. These guidelines may be helpful for you to begin thinking about what is appropriate in your setting.

Sitting posture

- Sitting at the same level as the speaker can open the conversation.
- Crossed arms and legs can signal less involvement. An open posture shows an openness to the speaker and to what she or he has to say.
- A slight inclination toward a person can convey, "I am with you. I am interested in what you have to say."

Eye contact

- Norms about eye contact vary across contexts. Let your context be your guide on eye contact.
- Frequent and soft eye contact makes the client feel that the provider is being attentive.
- The provider should not make as frequent eye contact during the initial session, but the level of eye contact can be increased and maintained with rapport and the progression of discussion.

Additional support

- Nodding can convey encouragement and compassion, and conveys understanding.
- Conveying confidence and understanding helps patients know that the topic of violence is not new or unusual for the listener.
- An unrushed, relaxed approach waits for the conversation to unfold and does not rush the speaker.

C Gender Exercises

This section introduces participants to important topics on gender bias and inequality. The exploratory exercises are intended to help participants better empathize with women, particularly those in vulnerable situations.

ACTIVITY C.8 - WHO HAS POWER

OBJECTIVES

Experience the feeling of being powerless, and explore which individuals in communities are typically encouraged to use more power.

TIME

30 minutes

MATERIALS

Flip chart paper

STEPS

1. Hang flip chart paper on the wall.

Explain: At some point in our lives, we all have had an experience in which someone had power over us. We are going to do an exercise that will help each of us remember how it feels when someone uses her or his power over us. You will be asked to remember an experience from

Facilitator Note

Suggested comments for summarizing:

- Using one's power over another person creates negative feelings, such as resentment, hopelessness, and anger. Using one's power over another person is abusive. It is a violation of that person's rights.
- Men are usually allowed to use their power over women in our families and community.

your past. You will later be asked to share that experience with others, so choose a memory that you feel comfortable sharing.

2. Ask participants to get comfortable, close their eyes, and listen carefully to what you will read to them. Ask them to picture their personal experiences in their minds as you read.

3. Once everyone's eyes are closed, read the following guided imagery. Read it very slowly so that participants have time to imagine many details. When you see the word "pause" take a deep breath and silently count to five to let a few seconds pass. Do not rush.

   Think of a time when you were in a situation in which you felt you had no power (pause). It could be a time when you were younger or an adolescent, or maybe you were an adult (pause). Maybe it was years ago or maybe it happened quite recently (pause). It is a time when you felt powerless (pause). Someone else was using her or his power over you (pause). It could have been a friend, a parent, a sibling, another community member, a boss. She or he could have been older or younger, female or male, or even a group of people. Think about what she, he, or they were doing to use power over you (pause). What happened? (pause) What was the situation? (pause)

   Try to picture yourself in that situation. Where were you? (pause) Try to imagine the person or people who were using their power over you (pause). Remember the details of that interaction. Remember what happened. What words were said? (pause) What were the expressions on people's faces? (pause) On your face? (pause) How did it feel to have someone use power over you? (pause) Try to remember your feelings specifically. What were your emotions? Did you feel angry, sad, ashamed, not able to react, something else? (pause) Now, when you are ready, open your eyes.

4. Ask participants: Please turn to your neighbor and share this experience in which you felt a lack of power. Describe your experience briefly. Explain how it made you feel when someone had power over you. I will notify you when 3 minutes have passed, at which time you can switch roles and have the other person talk about her or his experience.

5. Ensure there are no questions, then tell the participants to begin.

6. After 3 minutes ask the pairs to switch roles of teller and listener.

7. After another 3 minutes have passed, ask participants to turn back to the large circle.

8. Debrief: Read the following questions. Write responses to the first two on the flip chart.

   - You have just remembered what it's like to have someone use her or his power over you. How did it make you feel to be in that situation?

C

- Think about our community. Is there one group of people who is typically allowed to use their power over another group? Who?
- Are men as a group typically allowed to use more power than women?
- Do you think women in our community feel the same emotions you had in the situation you have imagined?

Adapted from Raising Voices. SASA! start training module. Kampala, Uganda: Raising Voices; 2008. Available from: http://raisingvoices.org/wp-content/uploads/2013/03/downloads/Sasa/SASA_Activist_Kit/START/Training/Start.Training.DeepKnowModule.pdf.

ACTIVITY C.9 - SEX AND GENDER

OBJECTIVES

Deepen understanding of "sex" and "gender" and be able to differentiate between the two concepts.

TIME

30 minutes

MATERIALS

Handout C.9

STEPS

1. Explain that men and women´s social and cultural characteristics are largely driven by social and not biological dynamics. Use the example of how people react when a boy is born, the type of clothes and toys he is given, and the attitudes, values, and behavior he is taught in his family, at school, in the community, making comparisons to the way a girl is brought up and what is expected of her.
2. Explain that men and women are different on a natural, biological, and anatomical level but unequal on a cultural, social, economic level and that the inequalities are a result of the way society assigns characteristics, values, roles, and identities to male and female children.
3. Ask the group to give some examples of the inequalities that exist between men and women that they have seen in their friends, families, or communities.
4. Emphasize that "sex" is a biological, anatomical term that refers to men's and women´s sexual organs (outer and inner) while "gender" is a social term that refers to the different process that men and women experience in society as they are taught (and learn) to be men and women. Our sex makes us different as men and women, but our gender makes us unequal, and those inequalities are socially constructed on the basis of biological, anatomical differences.

Facilitator Note

Society attributes different characteristics, attitudes, and behavior to men and women and places values on them. Often, male characteristics are given a greater value.

"Sex" is a biological, anatomical category that makes men and women different. "Gender" is a social, cultural category that leads to inequalities between women and men (attitude, values, feelings, roles, opportunities, rights, access to resources).

5. Distribute the "Sex and Gender" handout and ask the participants to indicate if the statements are referring to sex or gender (by putting an "X" in the corresponding column). After giving the participants a chance to read and answer the statements on their own, discuss each of the answers with the entire group.

6. Explain that there are other terms related to the word "gender" that also need to be explored. Ask the group if they have ever heard the term "gender equality." Ask them what they think it means. Allow plenty of time for discussion.

Adapted from Sonke Gender Justice Network. Adolescent sexual and reproductive health and rights: facilitator's manual. Johannesburg, South Africa: National Department of Social Development/National Population Unit; 2012.

HANDOUT C.9 - SEX AND GENDER

Identify if the statement refers to gender or sex...		
	Gender	Sex
1. Women give birth to babies, men don't.		
2. Girls should be gentle, boys should be tough.		
3. Women or girls are the primary caregivers for those who are sick in most households.		
4. Women can breastfeed babies.		
5. Many women do not make decisions with freedom, especially regarding sexuality and couple relationships.		
6. Men's voices change with puberty, women's voices do not.		
7. Four-fifths of all the world's injection drug users are men.		
8. Women get paid less than men for doing the same work.		
9. A woman should obey her husband in all things.		
10. To be a man, you need to be tough.		
11. A real man produces a male child.		
12. Men need sex more than women do.		

ACTIVITY C.10 - WHERE DO YOU STAND?

WHO LIVES OVERLAP

This section overlaps with the WHO LIVES training (Session 2). If participants have recently completed that training, they can skip this section, although it can be a valuable refresher.

OBJECTIVES

Explore values and attitudes about gender and violence.

TIME

30 minutes

MATERIALS

Printout C.10 (signs only)

STEPS

1. Tape the two signs (Agree/ Disagree) to the wall before the activity begins. Leave space between them, so that a group of participants can stand near each one.
2. Choose five or six statements that you think will lead to the most discussion.
3. Explain that this activity will give participants a general understanding of their own and each other's values and attitudes about gender. Remind the participants that we all have a right to our own opinions, and no response is right or wrong.
4. Read the first statement aloud. Ask participants to stand near the sign that says what they think about the statement. After they do this, ask one or two people beside each sign to explain why they are standing there, and why they feel this way about the statement.
5. After a few participants have talked about their attitudes toward the statement, ask if anyone wants to change their mind and move to another sign.
6. Then bring everyone back together. Read the next statement and repeat steps 3 and 4. Continue for each of the statements that you chose.

Facilitator Note

The main role of the facilitator is to get people sharing their ideas without being judgmental. Try to allow as many different views to be voiced as possible.

If some participants don't know whether they agree or disagree and don't want to stand beside either of the signs, ask them to say more about their reactions to the statement. Then encourage them to choose a sign to stand next to. If they still don't want to, let these participants stand in the middle of the room as a "don't know" group.

Adapted from World Health Organization (WHO). Caring for women subjected to violence: a WHO curriculum for training health-care providers. Geneva: WHO; 2019.

PRINTOUT C.10 - WHERE DO YOU STAND ?

Printout signs on A4 paper

ACTIVITY C.10 STATEMENTS - WHERE DO YOU STAND? (1 of 2)

12 STATEMENTS FOR VALUES CLARIFICATION

(Pick no more than four or five, depending on time)

1. Women are just as violent as men in relationships.

Points for the facilitator to emphasize: The few population-based studies that have examined women's perpetration of violence have found that the level of violence experienced by men at the hands of their female partners is much lower than violence experienced by women at the hands of their male partners. The violence perpetrated by women is less likely to result in physical injuries, and often the violence is in response to violence perpetrated by the men. Violence by men against women is also more likely to include sexual violence.

2. Most women are abused by strangers. Women are safe when they are at home.

Points for the facilitator to emphasize: Studies show that in most settings, the majority of the perpetrators of sexual abuse are known to the survivors. Moreover, intimate partner violence—that is, physical and/or sexual violence—is the most common form of violence experienced by women. Therefore, unfortunately for many women, home is not necessarily a safe space.

3. Women who wear revealing clothing are asking to be raped OR Survivors of intimate partner or sexual violence provoke the abuse through their inappropriate behavior.

Points for the facilitator to emphasize: There is never any excuse or justification for rape or any type of violence. Women who are abused should never be blamed or told that it is their fault.

4. A woman can say "no" if she does not want to have sex with her husband.

Points for the facilitator to emphasize: Every woman has the right to bodily integrity and the right to refuse sex. In many settings, however, gender norms socialize women and men into believing that once you are married, the man is entitled to have sex with his wife whenever he wants. In fact, in many countries, forced sex with your spouse is not considered to be rape. However, women always have the right to control their own bodies and sexuality, and this means that they can say "no" to sex with their husbands.

5. Men cannot control themselves. Violence is simply a part of their nature.

Points for the facilitator to emphasize: Perpetrating violence is always a choice for the perpetrators. It is not part of their nature or inevitable. Violence is often a learned behavior. Data show that children who are either subjected to violence themselves or witness violence in their homes are more likely to perpetrate or experience intimate partner violence when they grow up.

6. Violence against women is a private matter and should not be discussed publicly OR Intimate partner violence/domestic violence is a private matter, and outsiders should not interfere.

Points for the facilitator to emphasize: Violence against women is a public health issue with grave effects on the health of women and families. The need to treat and respond to the harm done to women's health has an economic impact, as does the negative effect on survivors' productivity. There are also compounding effects on children/witnesses of violence who may become violent themselves, drop out of school, or otherwise be unable to lead productive lives as a result of the violence to which they were exposed.

7. Men sometimes have a good reason to use violence against their partners.

Points for the facilitator to emphasize: There is never any excuse or justification for any type of violence. Any conflict can be resolved without resorting to violence. It should never be used as a form of power or control.

ACTIVITY C.10 STATEMENTS - WHERE DO YOU STAND? (2 of 2)

8. As a health care worker, how I respond to a woman who has suffered violence from a partner or sexual abuse is not very important.

Points for the facilitator to emphasize: Women subjected to violence often do not disclose their experience of violence to anyone because of fear of being blamed or stigmatized or that no one will believe them. As a health care provider, even if a woman does not disclose violence to you, studies show that such women are more likely to seek health care for a range of related conditions. Hence, you are likely to come into contact with survivors of violence. Women also indicate that an empathic response from a health-care provider can gain their trust for disclosing their experience. Therefore, an empathetic, validating, and nonjudgmental response to a survivor is very important to the survivor and to putting her on a path to healing.

9. A sex worker cannot be raped.

Points for the facilitator to emphasize: The fact that a person sells sex for a living does not mean that she/he is always ready and willing to have sex. Rape is the act of forcing someone to have sex without their consent. Sex workers are often forced to have sex because of the stigma that they are always available for sex. Even clients and potential clients can force sex workers to have sex. If someone has sex with you once, even when you paid for it, she/he does not necessarily have the right to have sex with you again without your consent.

10. If a woman stays with a violent partner, it is her fault.

Points for the facilitator to emphasize: There are many reasons why a woman might stay with a violent partner. It is not our place to judge these women. In fact, leaving a violent relationship can result in increased risk of violence from a controlling, violent partner. Other reasons, such as economic dependence and social pressures not to break up the family, can prevent a woman from leaving her violent partner.

11. Men who have sex with men do not experience gender-based violence.

Points for the facilitator to emphasize: Gender-based violence is defined as "An umbrella term for any act, omission, or conduct that is perpetuated against a person's will and that is based on socially ascribed differences (gender) between males and females." Men who have sex with men defy the socially ascribed roles for males and females and, as a result, may experience abuse and violence. This is considered a form of gender-based violence, although it is more precisely described as violence on the basis of sexual orientation.

12. If a drunk person is raped, it is partially their fault because they chose to drink.

Points for the facilitator to emphasize: There is never any excuse or justification for rape or any type of violence. Although we may encourage people to stay aware of their surroundings and potential risks for being in vulnerable or potentially abusive situations, not doing so does not mean that a person is at fault for experiencing violence.

Miscellaneous statements (This exercise can be very personal and uncomfortable for some participants. If you hear discomfort or if group members become upset with one another, use these neutral statements in between the other statements to create a nonthreatening atmosphere.)

1. *I would rather ride a bike a mile than walk a mile.*

2. *I love to cook.*

3. *I am a good dancer.*

4. *It makes me feel proud when someone thinks I have done a good job.*

5. *Babies are cute.*

D Counseling Healthy and Unhealthy Relationships

The next four sections introduce the counseling topics of the CHARISMA intervention, starting with the Healthy and Unhealthy Relationships Counseling module that is offered to all CHARISMA clients. The following activities will introduce counselors to intervention strategies and skills and will prompt counselors to reflect on their own relationships to understand how clients will experience counseling.

ACTIVITY D.11 - HAPPY AND UNHAPPY RELATIONSHIPS

OBJECTIVES

Explore further how sexual relationships can be unhealthy and how this impacts the ability of women to safely use PrEP.

TIME

60 minutes

MATERIALS

Computer to show videos online; Printout D.11 in case a computer and internet are not available

Facilitator Note

The main role of the facilitator is to get people to share their ideas without being judgmental and to emphasize the dynamic nature of relationships and the fact that all relationships can make adjustments to move toward healthier dynamics. Try to allow as many different views to be voiced as possible.

STEPS

1. Divide participants into two groups. Ask one group to prepare a role-play that shows a healthy relationship between sexual partners (they can choose from one of the Situation Cards).

2. Two individuals will be the actors and the rest of the group should discuss and guide them on how they should behave toward each other to demonstrate healthy relationships. Other participants may play supporting roles (e.g., as a woman trying to seduce the boyfriend or husband, a health worker trying to understand why PrEP is challenging).

3. Ask the other group to prepare a role-play that shows an unhealthy relationship based on the Situation Cards.

4. Show the CHARISMA healthy relationship video (https://www.youtube.com/watch?v=JnxzZWaJB_E&list=PL8dxTeql1PSPdnAz3dOjFE2_mVYars1xf&index=4&t=0s) to the whole group and discuss [note that role-plays in Printout D.11 can be used if access to a computer and internet is not available]:

   - What makes the two scenes healthy and unhealthy?
   - What advice would they like to give to the women and men shown in each scene to improve their relationships from unhealthy to healthy or healthy to healthier?
   - If it is not possible to make the unhealthy relationships healthy, what advice would you give the unhappy partner?
   - Consider the ways in which the woman was unhappy, what would she lose by leaving that relationship? What would she gain?
   - Consider the ways in which the man was unhappy. What would he lose by leaving the relationship? What would he gain?

Adapted from Jewkes R, Nduna M, Jama, N. Stepping stones: a training manual for sexual and reproductive health communication and relationship skills. 3rd ed. Pretoria (South Africa): Medical Research Council; 2010.

PRINTOUT D.11 - HAPPY AND UNHAPPY RELATIONSHIPS

Lesedi and her boyfriend Junior have known each other since they were children and began dating four months ago when Lesedi broke up with her ex-boyfriend Paul. Lesedi is extremely happy with Junior because he is the complete opposite of Paul. He treats her well, supports her emotionally and financially, and she also feels comfortable expressing her opinions to him. When she was dating Paul, she could never disagree with him, and he forced her to drink alcohol with him.

Iminathi and John have been married for six years and have a 5-year-old daughter. Iminathi is happy in her marriage but wishes John had been more supportive of her decision to take PrEP. He did not ask her to stop, but he did say that he was uncomfortable with her taking an unknown pill every day. She struggled to help him understand why it was important for her to take PrEP but she appreciates that he respected her decision to do so.

Alice, 23 years old, and her boyfriend David, 29 years old, have been dating for seven years. Alice has been living with David since she finished secondary school. Alice does not have paid work outside the home because David does not want her to. He gets angry with her when she is too tired for sex after working all day. However, she receives very little financial support from him and frequently has to ask her parents for money to buy necessities for herself and her daughter. Alice feels humiliated relying on her parents for support.

Khoghelo is 34 years old and his girlfriend of three years is his first serious relationship. He loves that she has a good relationship with his family, he can share his dreams with her and that she does not expect him to financially support her. He was very supportive of her decision to start taking PrEP because he liked that she was being health conscious and taking care of herself. He wishes that she would not nag him so much about his partying. He knows that she is worried that he will propose to other women.

Amahle and her boyfriend Jacob have been dating for two years. She is happy in her relationship but hates that Jacob is very controlling and jealous. He does not like her spending time with her friends and gets angry when she does not inform him about her whereabouts. Amahle did not tell Jacob that she has started to take PrEP because she thought that he would start to mistrust her and would ask her to stop.

Bandile and his wife Ester have been married for one year. The one thing that Bandile and Ester argue about is finances. Bandile brings home his paycheck and makes a budget with Ester, but she rarely follows their budget. She recently decided that she wanted to go back to college, and Bandile gave her money to take two courses. Instead of using the money for school fees, Ester bought clothes and make-up. Bandile did not confront his wife but is angry that she continues to misuse their money.

ACTIVITY D.12 - WHAT MAKES A GOOD RELATIONSHIP?

OBJECTIVES

Reflect on relationships and how to contribute to healthy, happy partnerships.

TIME

30 minutes

MATERIALS

Handout D.12

STEPS

1. Give participants the handout.
2. Explain that the list includes conditions necessary for a healthy, happy relationship. For a relationship to be strong, each partner must be committed to these conditions.
3. Ask participants to consider how well they are doing with these conditions.
4. Invite the group to fill out Section A. Then, ask them to consider the question in Section B: What are some of the ways they can better meet these conditions?

Facilitator Note

Many of the relationship problems faced by clients align with those we face in our own lives. When client stories align with our own experience, it can make us empathize more intently. However, it can also "trigger" difficult memories from our own lives.

It is important to think of relationships as dynamic. The dynamic can change slowly over time, with dedicated work. At times of stress, most relationships will fall into an old pattern.

Counselors will discuss relationships with women, including behaviors that women may not initially identify as unhealthy (e.g., tracking partners' whereabouts). Counselors will need to understand what is/is not unhealthy to effectively deliver the counseling.

Adapted from Hamel J. Gender-inclusive treatment of intimate partner abuse: evidence-based approaches. 2nd ed. New York: Springer, 2013.

HANDOUT D.12 - WHAT MAKES A GOOD RELATIONSHIP?

A. The following is a list of conditions necessary for a healthy, happy relationship, that each partner must be committed to. How good of a job are you doing with these?

	Doing a great job	Doing a fair job	Doing a bad job
1 WILLING TO TAKE RESPONSIBILITY FOR MY OWN HAPPINESS: Taking care of myself when I need to, instead of expecting my partner to make me feel better.			
2 RESPECTING MY PARTNER'S IDENTITY/ INDEPENDENCE: Allowing my partner to be who he or she is, including faults, without having to criticize or control him or her. Letting my partner make own decisions and trusting that he or she knows what is best for him or her.			
3 ROLE FLEXIBILITY: Willing to change roles when necessary, such as helping out with tasks I don't normally do.			
4 MAINTAINING GOOD COMMUNICATION: Being a good listener, expressing myself with respect, and generally trying to maintain an open, two-way flow of communication.			
5 WILLING TO NEGOTIATE AND OPEN TO BEING INFLUENCED: Open to finding compromise rather than always trying to "win" an argument. Committed to finding a solution that works for everyone. Being part of a "team."			
6 STRIVING FOR RELATIONSHIP INTIMACY: Knowing my partner, his or her habits, friends, likes and dislikes. Having them in my thoughts. Wanting to maintain an emotional, intellectual, spiritual, and sexual connection to my partner, and willing to do the hard work of making this happen.			

B. What are some of the ways you can better meet these conditions?

_____

_____

_____

_____

Adapted from Hamel J. Gender-inclusive treatment of intimate partner abuse: evidence-based approaches. 2nd ed. New York: Springer, 2013.

ACTIVITY D.13 - TREE ACTIVITY

OBJECTIVES

Encourage participants to think about different kinds of violence, and to recognize the root causes and outcomes of intimate partner violence.

TIME

30 minutes

MATERIALS

- Printout D.13 (can be printed or drawn on flip chart)
- Sticky notes or cards
- Flip chart
- Pens or markers

Facilitator Note

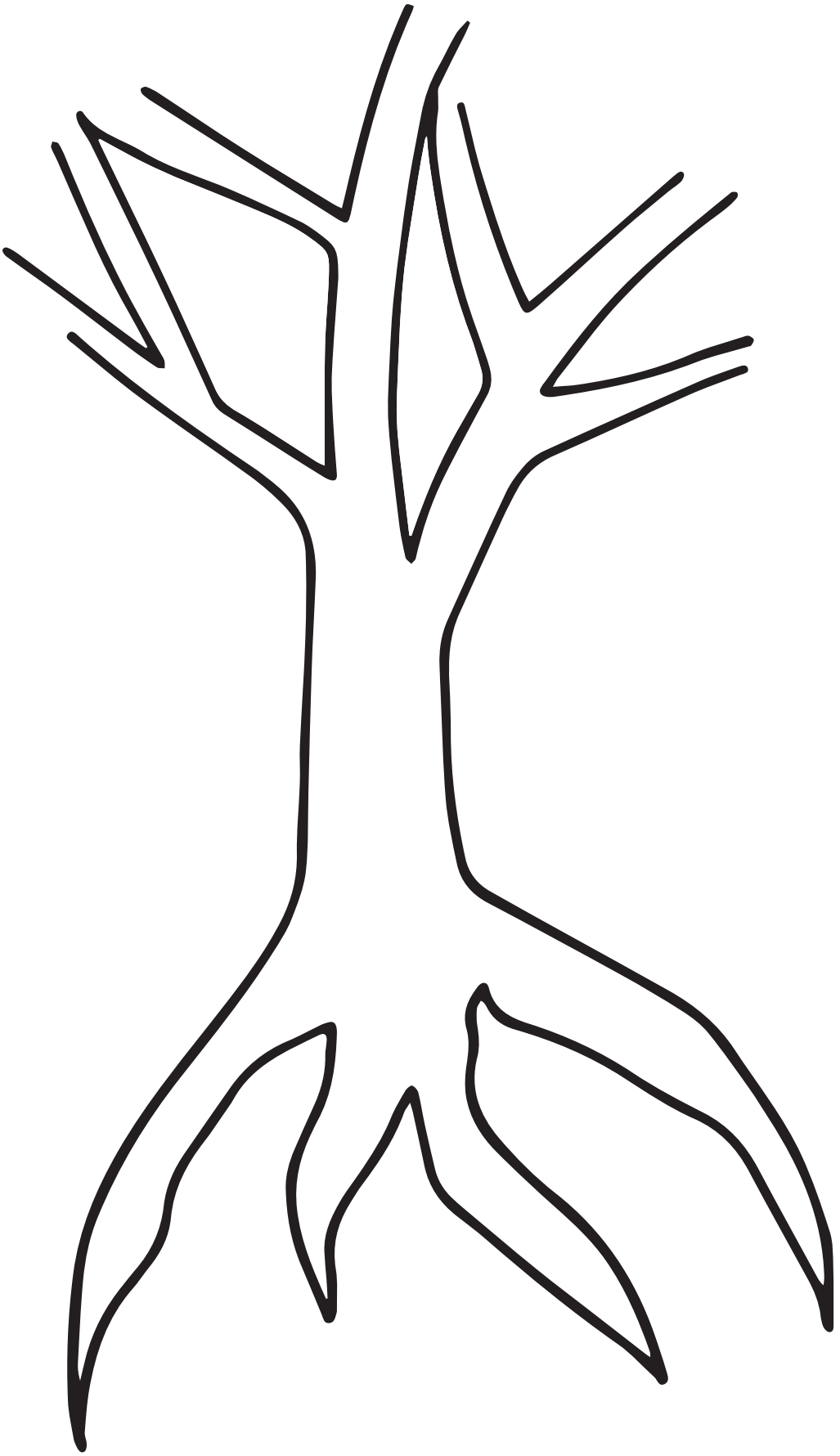
There are no wrong answers, but the important part of this activity is to get participants thinking broadly about the various forms of violence, the causes and effects. This also helps us become familiar with the different forms of violence that we'll be talking through with participants.

STEPS

1. Draw a tree on the flip chart, similar to the one in the printout.
2. Divide the room into three groups:
   - The first group is the "roots" of the tree: they will think about the causes of violence against women.
   - The second group is the "trunk" of the tree: they will think about the forms that violence against women takes.
   - The third group is the "branches" of the tree: they will think about outcomes of violence for women and communities.
3. Hand out cards and markers. Ask pairs to write individual points on the forms, effects, and causes of violence (one point per card), taking 4-5 minutes.
4. Starting with one team, ask them to choose one card and stick it to the correct part of the tree. The next team goes, sticking a new card to the tree. Go back and forth until all of the cards are on the tree.
5. Debrief: Review one level at a time. Cluster common points and eliminate repetition. Give each set of common points a category title, e.g., "PERSONAL," "FAMILY," "COMMUNITY."
6. When reviewing "effects," help participants see two levels of effects – immediate impact on women (e.g., injuries, fear), and spin-off effects (e.g., reduced productivity, inability to protect herself from HIV or, more broadly, promote her own health).

Adapted from Ellsberg M, Heise L. Researching violence against women: a practical guide for researchers and activists. Washington (DC): World Health Organization, PATH; 2005.

PRINTOUT D.13 - TREE ACTIVITY



ACTIVITY D.14 - TYPES OF ABUSE

OBJECTIVES

Understand how partners can use power and control in relationships, and the effect it has on our clients and our own lives.

TIME

30 minutes

MATERIALS

- Handout D.14
- Stickers

Facilitator Note

The handout is a helpful way to understand the types of behaviors used by abusers to establish and maintain control over their partners. Other types of abuse often accompany violent incidents. While they can be more difficult to identify, they contribute to a pattern of intimidation and control in relationships.

STEPS

1. Distribute handout to participants. Ask them to read it carefully.
2. Explain that physical and sexual assaults, or threats to commit them, are the most well-known and easily recognized forms of IPV. These acts are usually the ones that cause others—outside of the relationship—to become aware of an IPV problem. However, other abusive behaviors contribute to a larger system of abuse. Although physical and sexual assaults may occur only once or occasionally, they instill the threat of future violent attacks and allow the abuser to take control of the woman's life and circumstances. Some abusers never use physical or sexual violence, but still exert power and control over their partner through emotional and economic violence. In fact, emotional abuse is the most common form of abuse and often leads to violence. It is important not to ignore emotional and economic abuse.
3. Give each participant 10 stickers. Ask them to reflect on their own lives and other women's lives—for example, friends, family members, or even scenarios they've seen in movies or on television—and think about times they've noticed abusive or controlling behaviors. Invite them to come up to the poster and place a sticker representing this abuse. Remind participants that they do not have to share personal stories and that counseling resources are available to them, if needed.
4. Ask the group to look at the stickers on the poster. Is this surprising? Is there any area where we might have expected more stickers? Fewer stickers?

D

5. Invite participants to reflect quietly about what this means for our communities and our workplaces, since so much power and control is enacted every day.

6. Ask the following reflection questions:

   - *How will you explain this to women participating in CHARISMA?*
   - *What will be difficult?*
   - *What will be surprising/new?*

Adapted from the National Center on Domestic and Sexual Violence, Austin, TX. Originally developed by the Domestic Abuse Intervention Project, Duluth, MN .

HANDOUT D.14 - TYPES OF INTIMATE PARTNER VIOLENCE AND ABUSE

Emotional and Psychological Abuse

- Verbal abuse
- Humiliation
- Threats of physical or sexual violence or any other harm to an individual or those they care about, including threatening to take custody of an individual's children
- Coercion or controlling behaviors
- Calling names or verbal insults
- Being confined to or isolated from friends/family
- Repeated shouting
- Intimidating words/gestures
- Destroying possessions
- Blaming
- Isolating
- Bullying
- Attempts to impregnate a partner against their will
- Interfering with contraceptive methods

Economic Abuse

- Use of money or resources to control an Individual
- Blackmailing
- Refusing right to work
- Taking earnings
- Refusing to pay money that is earned/due
- Withholding resources as punishment

Sexual Abuse

- Rape
- Being physically forced, coerced, psychologically intimidated, or socially or economically pressured to engage in any sexual activity against one's will (undesired touching, oral, anal, or vaginal penetration with penis or with an object)
- Being forced to perform sexual acts that one finds humiliating or degrading
- Refusal to wear a condom
- Coercing a partner to have unprotected sex

Physical Abuse

- Hitting, pushing, kicking, choking, spitting, pinching, punching, poking, slapping, biting, shaking, pulling hair
- Throwing objects at, dragging, or burning someone
- Threatening use of a weapon
- Kidnapping or holding someone against their will
- Depriving someone of sleep by force
- Forcing someone to consume drugs or alcohol
- Poisoning
- Killing

Adapted from Dayton R, Morales GJ, Dixon KS. LINKAGES: a guide to comprehensive violence prevention and response in key population programs. Durham (NC): FHI 360; 2019.

E Counseling Partner Communication

This section introduces participants to healthy communication strategies a person can use when experiencing verbal conflict within a relationship. Through participatory and didactic activities, participants will be able to recognize and navigate different types of conflict within partner communication.

ACTIVITY E.15 - RELATIONSHIP "I" STATEMENTS

OBJECTIVES

Demonstrate how to communicate with someone about a challenging topic in a productive way.

TIME

30 minutes

MATERIALS

- Handout E.15 (print, fold in thirds lengthwise before sharing with participants)
- Flip chart

Facilitator Note

Using ***"I"*** statements is just one way to improve the way you deal with conflict.

If this exercise is taking some time for the participants to understand, ask one participant in the group to come up with a harsh "You" statement and write it on the flip chart. Then ask the group to try to brainstorm a good ***"I"*** statement in reflection.

- This is a useful way of separating feelings and facts in order to clarify what a problem really is.
- The formula may seem strange and unfamiliar, but with practice it can become more natural. It is a tough discipline and needs practice!

STEPS

1. Following the discussion on how positive or negative communication and behaviors can influence relationship health, we will shift to the practice of using "I" statements to communicate needs in a healthy way.

2. Ask participants to look ONLY at the page that says "Start here" at the top. Ask them to read the first statement. Explain that this is a "You" statement because it is about placing blame on the other person. Ask them to reflect on how this statement might make a partner feel. What will happen after it is stated?

3. Now explain that an "I" statement is a way of expressing clearly your point of view about a situation. It includes an expression of how it is affecting you, and how you would like to see it change. The best "I" statement is free of specific demands and blame. It opens up the area for discussion and leaves the next move for the other person. We should aim for our "I" statements to be clear (to the point) and clean (free of blame and judgment). Beware of "You" statements that place blame on someone else, hold him or her responsible, demand change from them, or hold a threat.

4. Ask the group to brainstorm out loud what a possible "I" statement could be to replace the first "You" statement. Write these in the blank box next to the statement. Then, ask the group to do the same exercise for the second "You" statement. Discuss what statements people brainstormed and encourage the group to think about being clear, expressing how it is affecting you, and not laying blame.

5. Flip the page over to the last third and ask them to compare their brainstormed "I" statement to the example given. What can they learn from the example?

6. Ask the group the following questions:

   - What do you think about this approach? What is useful or not useful?

   - Can you commit to using at least one "I" statement with your partner or family members or housemates before tomorrow's session?

Adapted from Hamel J. Gender-inclusive treatment of intimate partner abuse: evidence-based approaches. 2nd ed. New York: Springer; 2013.

START HERE

Examples of a ***"YOU"*** statement:	Examples of an ***"I"*** statement:	Examples of an ***"I"*** statement:
These statements are very judgmental and make the listener feel hemmed-in and thus defensive.		These statements carry no blame and are phrased not to annoy the listener. The expectations within them are presented in a non-judgmental manner (there is no "you must...") and are not accusing the listener. They state the speaker's expectations or hopes, but they do not demand that they be met.
"You are such a disgrace to me, you are always getting drunk and flirting with other men. I don't want to go to social events with you any more even if you are my wife. You must control yourself."		"I felt very embarrassed last night as you were so drunk and you were letting that Bafana kiss you and letting her dance with you in a very sexy way. If you are unhappy about our marriage and your mind is straying to thoughts of other women I would like us to discuss it rather than you showing everyone that we have problems."
"You are always so drunk when you crash into the house at night. And you never give me any money to buy any food. I don't know why I ever married you. You must stop going to that bar from now on!"		"When you come home at night after the bar, I feel disappointed, because I would like to see more of you, and I would like some money for food for the children. I would like us to discuss how we can arrange things better together."

ACTIVITY E.16 - CONFLICT DE-ESCALATION SKILLS

OBJECTIVES

Help participants develop a clear understanding of the nature and causes of conflict and means of resolution.

TIME

30 minutes

MATERIALS

Handout E.16

Facilitator Note

Happy couples still have disagreements, but they do not use dirty fighting and apologize quickly when they do.

STEPS

1. Conflict is an inevitable part of our daily lives whether at home, in the workplace, in community groups, or elsewhere. The word conflict generally means struggle and disagreement. It takes various forms such as physical fights, resistance, quarrels, and acute silence. But abusive behavior is an unacceptable way of handling conflict. This makes it necessary to understand how best to deal with conflict.
2. Conflict management experts tell us that conflict is normal and natural. We should not avoid conflict because, when handled well, it can be managed and resolved. Conflict has the potential to lead to stronger relationships when managed well.
3. Conflict can happen at three levels:
   - Issue level: Respectfully talking about an issue and seeking compromise
   - Personality level: Shifting to focus on personal characteristics (e.g., "You're a drunk.")
   - Relationship level: Question the relationship (e.g., "If you don't like it, leave me!")
4. Explain the importance of focusing on the issue level during a conflict rather than the personality level or relationship level.
5. It is also important to recognize how you fight. Explain that conflicts escalate when we use five types of "dirty fighting." Ask the group to read the five types of dirty fighting in the handout. Invite them to think about when they have used these types of fighting.
6. Finally, review the key principles of conflict de-escalation. Ask participants to think about how they may apply these principles to conflicts in their own relationships. Note to the group that we are all involved in conflict escalation at times, and we can all use practice to communicate in ways that are supportive and healthy.

Adapted from Hamel J. Gender-inclusive treatment of intimate partner abuse: evidence-based approaches. 2nd ed. New York: Springer; 2013.

HANDOUT E.16 - CONFLICT DE-ESCALATION SKILLS

Five Types of Dirty Fighting

1. **Criticism** (when you point out your partner's weaknesses)
2. **Defensiveness** (tendency to react, quick to take offense)
3. **Belittling** (making your partner feel "small," name calling, e.g. telling your partner they're stupid)
4. **Humiliation** (embarrassing your partner, often in front of others)
5. **Withdrawing** (refusing to talk, silent treatment)

Key Principles of Conflict De-Escalation

1. **Use a "softened start-up" and be respectful**—Bring up your issue respectfully, starting with easier (soft) topics before raising more difficult ones, and use "I" statements.
2. **Stay on the issue level**—Discuss one problem at a time.
3. **Use effective communication skills**—These include listening carefully and speaking with respect.
4. **Identify the real issue**—Determine what's really going on (e.g., an argument over what movie to see may be about who makes decisions in the family).
5. **Make decisions together and look for areas of agreement**—Be willing to compromise and allow the other person to have some influence.
6. **Seek areas of agreement**—Be willing to compromise and allow the other person to have some influence over you.

F Counseling
Discussing PrEP Use with Your Partner

This section introduces participants to different ways and tips for a woman to discuss her PrEP use with a partner.

ACTIVITY F.17 - DISCUSSING PREP USE WITH PARTNERS

NOTE

Male partner packet materials should be adapted to your context in advance of the training.

OBJECTIVES

Explore how women can safely tell their male partner they are using oral PrEP.

TIME

1 hour and 15 minutes

MATERIALS

- Handout F.17
- Flip chart
- Sticky notes
- Male partner packet materials

STEPS

1. Put up three pieces of flip chart paper. Label one "Positive Methods," another "Negative Methods," and the third "Secret Use." Give everyone about 10 sticky notes and a marker.

Facilitator Note

There are many reasons why women do tell their partners about taking PrEP. For example, some women tell their partners because:

- They like to make decisions with their partner, they 'share everything.'
- They worry their partner would be more upset if he found out without her telling him.
- They don't want their partner to have misconceptions about PrEP.

Other women do not tell their partners because:

- They worry their partner may not be supportive, and will think they don't trust them.
- They worry their partner may start sleeping around.
- They worry their partner may ask or force them to stop using PrEP.
- They worry their partner may be violent.
- They don't feel the need to share the decision with their partner; it is a woman's body and a woman's decision to make

It is a woman's choice to use PrEP and a woman's choice whether or not to tell her partner she is using PrEP. Our job as CHARISMA counselors is to support women in whatever they choose and to answer any questions. If violence is a concern, you as a counselor should ask more questions to understand if the woman's partner has been violent before (e.g., what leads to her concern), and try to understand if she would prefer to be supported by talking through how to take PrEP without discussing it with her partner or if she would benefit from the IPV counseling to create a safe strategy.

Note: "Disclosure to partners" is a commonly used term for conversations between partners about HIV prevention or treatment use. We recommend using "discussing" or "sharing" as a more relatable term.

2. Explain that the group will brainstorm ways that women can tell their partners they are using PrEP. Assign a couple of people to brainstorm the "positive" methods of discussing this topic, a couple to the "negative" methods, and a couple to the "secret use." If the group needs clarity, explain that "secret use" is when women purposefully keep their PrEP use a secret in order to stay safe.
3. Give everyone 5 minutes to write down ideas—one idea per sticky note. Once everyone has used up their sticky notes, ask one person to start. They will explain what is on a single sticky note and you, as facilitator,

can help them place it on one of the flip chart pages. If anyone has a similar idea, ask them to stick it underneath so that popular ideas build a "pile" of sticky notes.

4. Keep going around the room sharing each sticky note until all the ideas have been shared. Review the three pages. Are there more positive ways to tell a partner about PrEP use or more negative ways? Or, more ways to hide use?

5. Choose one of the following stories to read to participants.

   - Anneke said that she told her partner she was using PrEP because she wanted him to know that she cares about her health. Her partner was supportive of her PrEP use because he thought it was good for women to protect themselves from HIV. Anneke's partner also showed his support by agreeing to get tested for HIV with her.

   - Ammaarah's boyfriend initially forbade her from taking PrEP because he thought that she would have sex with other men. After reassuring him that was not the case, Ammaarah was able to begin using PrEP.

   - Claudia was afraid that her partner would not allow her to take PrEP because he would be suspicious and think it would cause him harm. After a while, she decided to tell him that she was taking PrEP.

6. After reading the story aloud, ask the group:

   - What challenges do women face when deciding whether to tell their male partners they are using PrEP?

   - How do you know, as a CHARISMA counselor, whether it will be safe for them to tell their partner they are using PrEP?

   - How would you advise a woman who thinks her partner will be supportive, but does not want to tell him about her PrEP use?

7. Introduce male partner packet materials. Explain how each can be used including how they can be used by clients to start a conversation about PrEP and/or for a couple to educate themselves together on PrEP. Counselors should always offer clients male partner packets, regardless of module. Materials may include information on HIV, PrEP and PrEP use, and/or an invitation for the partner to visit the clinic for counseling.

Developed by Miriam Hartmann, RTI International, Research Triangle Park (NC), and Abigail Hatcher, Wits Reproductive Health and HIV Institute, Johannesburg (South Africa); 2016.

HANDOUT F.17 - DISCUSSING PrEP USE WITH PARTNERS

Tips for discussing PrEP with your partner or for using PrEP without telling your partner

If she would like to disclose: "Great, I'm glad to hear you feel comfortable telling your partner about your PrEP use. Let's talk about some tips for doing so."

How to tell your partner

- Use clear and simple language.
- Maintain eye contact; remain confident and calm.
- Have prepared answers for anticipated questions.
- Listen objectively to your partner's concerns.
- Avoid blaming others for why you decided to use PrEP.
- Observe his body language.
- Be sensitive to his emotions and feelings.

When to tell him

- When you will have enough time to say everything you need to say
- When you will have enough time for him to respond and ask questions
- When both of you are in a good mood and have a settled mind

Where to tell him

- Tell him in a comfortable and private place where no one else will hear you or interrupt you.
- Don't be too far away from others so that you can get help if you need it.

Issues to consider

- *Why did you decide to use oral PrEP?*
- *What does PrEP use mean for your sexual relationship?*
- *What are the benefits of your use of PrEP for the relationship?*

Additional tips from women with experience telling their partners about PrEP:

- Talk about PrEP generally to see what he says before telling him you are using it.
- Give a little information at a time.
- Only tell him what he needs to know.
- If he is resistant at first, continue bringing it up over time until he becomes more supportive.

If she does not want to tell her partner: "It's okay if you still don't want to tell your partner. That is your choice. I want to say that many women who do share often find that their partners can be supportive and that this support helps them feel more comfortable using PrEP. If you change your mind in the future, we would be happy to provide you with other support to make it easier. For now, let's talk about ways for you to use PrEP safely without your partner's knowledge."

Key points

- Many women successfully use PrEP without telling their partners
- If you're anxious (or scared) about keeping oral PrEP in your house, store it in an unmarked container, in your handbag, or at a friend's house.
- On a rare occasion, women have experienced male partners discovering oral PrEP. If this happens, you could say the pills are for period pains or contraception.

G Counseling
Responding to Intimate Partner Violence

This section introduces how lay counselors can ask about relationships in safe and confidential ways. It deepens the understanding of relationship conflict, such as partner violence, to help participants predict how clients might respond. The most important aspect of facilitating this section is to allow CHARISMA counselors to openly voice their concerns and fears. By openly discussing fears, the facilitator can provide tips and guidance to help lay counselors feel confident to take on the counselor role.

ACTIVITY G.18 - GUIDING PRINCIPLES FOR PROVIDER RESPONSE TO IPV

OBJECTIVE

Demonstrate behaviors and understand values contributing to a safe and supportive service culture.

TIME

30 minutes

MATERIALS

Slides from WHO clinical handbook

Facilitator Note

Re-state the key messages that the health system response should be based on respect for human rights and promotion of gender equality.

Note that these principles should underlie our approach to responding to women who experience violence. The next sessions will cover our specific counseling approach and tools.

STEPS

1. Introduce the session by explaining that a woman-centered care approach is the basis of an appropriate and supportive response to violence against women. In this session we will better understand and learn how to apply these principles in practice.

2. Review the guiding principles (see slides 3–8 from WHO clinical handbook)

   - The two fundamental principles for woman-centered care are respect for human rights and promotion of gender equality (slides 4–6).

   - Privacy, safety, and confidentiality are essential for providing care to women subjected to violence (slide 7).

3. Ask the group to discuss what respect for human rights means. Explain the definitions from the WHO, which includes autonomy, freedom from fear and violence, highest attainable standard of health, and nondiscrimination. Were there any missing from our discussion?

4. Now ask the group to consider what it means to promote gender equality in our work. After discussion ask them to report back. Finally, review the WHO considerations: (1) be aware of power differentials and (2) avoid reinforcing unequal power dynamics. Discuss how these can be accomplished. Avoiding reinforcing unequal power dynamics may include: reinforcing the woman's value as a person; respecting her autonomy and dignity; providing information and counseling that helps her to make her own decisions; listen, believe, and take what she says seriously; and do not blame or judge her.

5. Finally, reinforce the idea that privacy, safety, and confidentiality must drive when and where violence is discussed, the documentation, and the referral process. Ask the group what confidentiality and privacy might entail in practice in their clinic?

6. Ask if there are any questions or concerns.

Source: World Health Organization (WHO). Caring for women subjected to violence: a WHO curriculum for training health-care providers. Geneva: WHO; 2019.

ACTIVITY G.19 - CYCLE OF VIOLENCE

OBJECTIVE

Inform participants of the dynamics of violence in a couple using the Cycle of Violence handout.

TIME

60 minutes

MATERIALS

- Handout G.19
- Flip chart

STEPS

1. Begin the activity by asking participants to think of someone that they know or have heard of who is experiencing intimate partner violence. Ask participants to think about the pattern of that relationship. Has it changed over a period of time? Does it go through identifiable stages? Ask participants to write these down silently on a piece of paper.
2. Give an initial overview of the cycle and include the following points:
   - During the 'Violence' stage, many women seek assistance.
   - During the 'Calm' stage, many women 'forgive' the abuser and may return to the relationship. During the calm stage, the abuser may apologize, buy gifts, or make special efforts to create an atmosphere of love and peace in the family. This is the stage when women may hope that the abuser loves them and will change. They may believe the promises that the abuser makes, and the abuser may be sincere about his promises.
   - Over a period of time, tension begins to build again and the woman and others in the family feel anxious and fearful that violence will occur again. During this time, the woman usually tries hard to pacify the man and maintain normalcy in the family. During the 'Tension' stage, the woman may think about how to stay safe and may consider taking action.
   - Eventually, the tension is broken with a violent episode. This pattern keeps repeating unless it is broken.
3. Explain that most abusive relationships settle into this circular pattern.

Developed by Nataly Woollett, Wits Reproductive Health and HIV Institute, University of the Witwatersrand, Johannesburg (South Africa); 2013; with input from Raising Voices. Mobilizing communities to prevent domestic violence: a resource guide for organizations in East and Southern Africa. Kampala (Uganda); 2007.

Facilitator Note

The participants may often ask why women 'choose' to remain in abusive relationships. Even those who are sympathetic to women may often struggle with why many women, despite apparent offers of help, remain in violent relationships for years. Research shows that women who leave violent partners take about six tries before they actually leave. It's important to understand that deciding to leave an abusive relationship puts a woman at risk of severe violence. Most intimate partner homicides occur when a woman leaves the relationship.

Some counselors may feel 'betrayed' when they go out of their way to assist a woman experiencing intimate partner violence and yet the woman returns to the abusive partner once the crisis has subsided. This can be demoralizing to counselors who don't understand the pattern of an abusive relationship.

Understanding this cycle will enable advocates to be more effective and help women and men break the pattern. This cycle can take a long time:

One woman was in the tension building phase for 14 years until the first physical act of violence. She had experienced a great deal of verbal, emotional, and sexual violence, but did not recognize it as abuse at the time. After the first violent outburst there were eight months of honeymoon which included going on a second honeymoon, promises to renew their commitment, etc. Then the tension-building phase started again, and she was brutalized after four months. The cycle kept speeding up with the tension-building phase becoming shorter and shorter; it would take less for her husband to 'snap' every time and he was becoming increasingly lethal during his outbursts. The honeymoon phase went from apologetic and lots of gifts and promises to change, to nearly nonexistent. Instead he blamed her for each and everything that went wrong not only in his life, but in the world. After a particularly scary outburst in front of her children she decided to leave and received help from the local police and shelter. She and her children are now safe but still deal with the aftereffects of living in a violent home for so long.

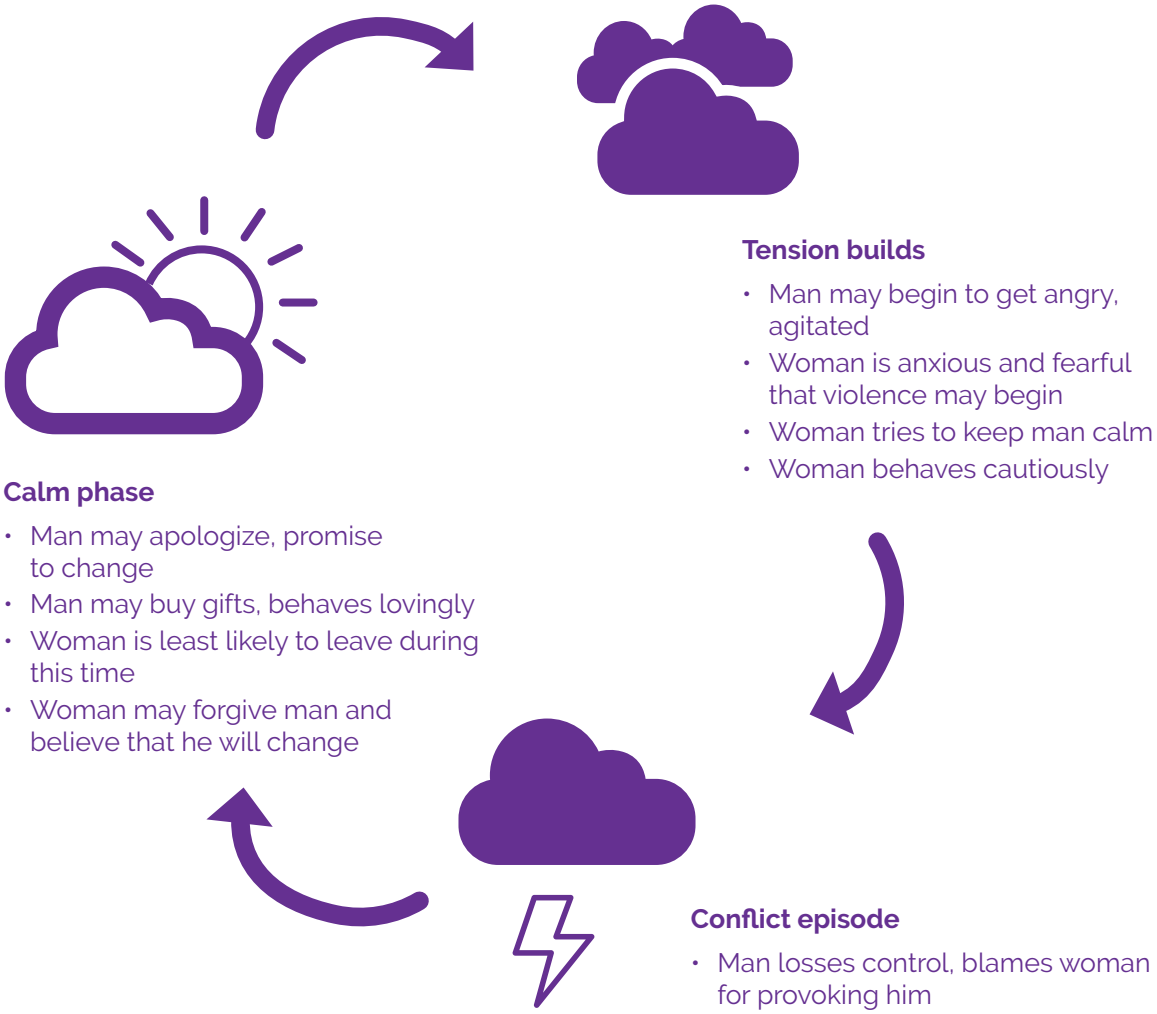
Sometimes a victim may use violence against their abusive partner. It is possible that if a woman recognizes she is in the tension-building phase she may want to get it over with and may 'push the abuser's buttons' or find a way to instigate the violence so the incident will be over more quickly.

- Many feel guilty about using this tactic or resistive violence to defend themselves.
- It is important to support them and help them understand why they resort to this method and how they have been conditioned to use violence to deal with their own feelings of anger and frustration.

When working with women, it can be helpful to understand the cycle of violence:

- It is important to avoid blaming a woman for staying in the relationship.
- It is also important to be careful not to pressure women to take actions they are not ready to take.
- Remember that women are the experts in their own relationships.
- Leaving an abusive partner can be very dangerous. Some women avoid leaving an abusive relationship because they fear their partner will resort to even more violent actions against herself or her children when she leaves.
- Whatever support you choose to offer the woman living with the abuse, bear in mind where she is in the cycle of violence and whether she is ready to break the cycle or not.

HANDOUT G.19 - CYCLE OF VIOLENCE



Tension builds

- Man may begin to get angry, agitated
- Woman is anxious and fearful that violence may begin
- Woman tries to keep man calm
- Woman behaves cautiously

Conflict episode

- Man losses control, blames woman for provoking him
- Man may deny or minimize abuse
- Woman may be very frightened or emotionally numb
- Woman may flee and decide to leave

Calm phase

- Man may apologize, promise to change
- Man may buy gifts, behaves lovingly
- Woman is least likely to leave during this time
- Woman may forgive man and believe that he will change

Adapted from Walker, Lenore. The battered woman. New York: Harper and Row; 1979.

ACTIVITY G.20 - ENHANCING SAFETY AND SAFETY PLANNING

WHO LIVES OVERLAP

This section overlaps with the WHO LIVES training (Session 8). If participants have recently completed that training, they can skip this section, although it can be a valuable refresher.

OBJECTIVES

Help counselors learn how to work with clients to develop safety plans.

TIME

60 minutes

MATERIALS

- Handout G.20 (Part of Counseling Job Aid)
- Printout G.20 (Situation cards, printed and cut, 1 set for each group)

STEPS

1. Start by reviewing the Safety Planning handout, explaining that this tool will be used to help women make a plan for her future safety. Evidence suggests that even if women don't think they need a safety plan, the cycle of violence often does not stop on its own and having a safety plan can be critical to protecting her and her children, if she has any, should violence occur again.
2. Divide participants into pairs and give each pair the pile of Situation Cards. Ask them to choose one situation that captures their imagination.

Facilitator Note

After the role-play, invite participants to talk about their experiences and ask any questions. Counselor frustrations may arise during this activity, since it highlights the fact that counselors can try to protect clients, but ultimately, we are unable to ensure our clients' safety. Give participants a safe space to vent these fears, as they are important to acknowledge openly.

Our job as counselors is not to "save" clients or make promises, but rather to assist women in making as safe of decisions as possible. No intervention can guarantee safety, but CHARISMA aims to improve women's sense of support and ability to keep herself and her children safer.

Safety planning is based on the client's specific needs and strategies. Women who live in situations of violence are often highly skillful at navigating dangerous and challenges situations. Let the client take the lead on the types of safety strategies that are most helpful.

3. Ask pairs to decide what their Situation Card is illustrating, and to make up a story about the woman's experience. After creating a story, ask pairs to develop a role-play between a CHARISMA counselor and client around safety planning. Give pairs 10 minutes to practice their role-play.

4. Ask each pair to present their role-play in 4-5 minutes. Invite participants to share all concerns or questions until all the role-plays are finished. After- wards, ask the group which aspects of safety planning were well done.

Developed by Abigail Hatcher, Wits Reproductive Health and HIV Institute, University of the Witwatersrand, Johannesburg (South Africa); 2013.

Adapted from Hatcher, A.M., Woollett, N., Pallitto, C.C., GarciaMoreno, C. Safe & Sound Nurse-led counseling for empowerment and wellbeing: Facilitators Manual. Johannesburg: Wits Reproductive Health and HIV Institute; 2014. Available at: https://www.researchgate.net/project/Safe-Sound-Addressing-IPV-in-Pregnancy.

Adapted from World Health Organization (WHO). Caring for women subjected to violence: a WHO curriculum for training health-care providers. Geneva: WHO; 2019.

HANDOUT G.20 - SAFETY PLANNING

Making a safety plan

- Identify a safe place to go.
- Plan how to get there.
- Consider whether to take children or go alone.
- Agree with family/friends on a safe word or SOS code so they can come help you or call police.**
- Remove weapons.
- Keep phone charged.

Staging an easy exit

- Keep a bag packed with necessities (money, keys, clothing and medicines, including PrEP) for yourself and children.
- Prepare copies of important documents (deeds, birth certificates, insurance policies, photographs, phone numbers).
- If leaving a partner, do not tell partner until after leaving and arriving at a safe place.

Preparing your children

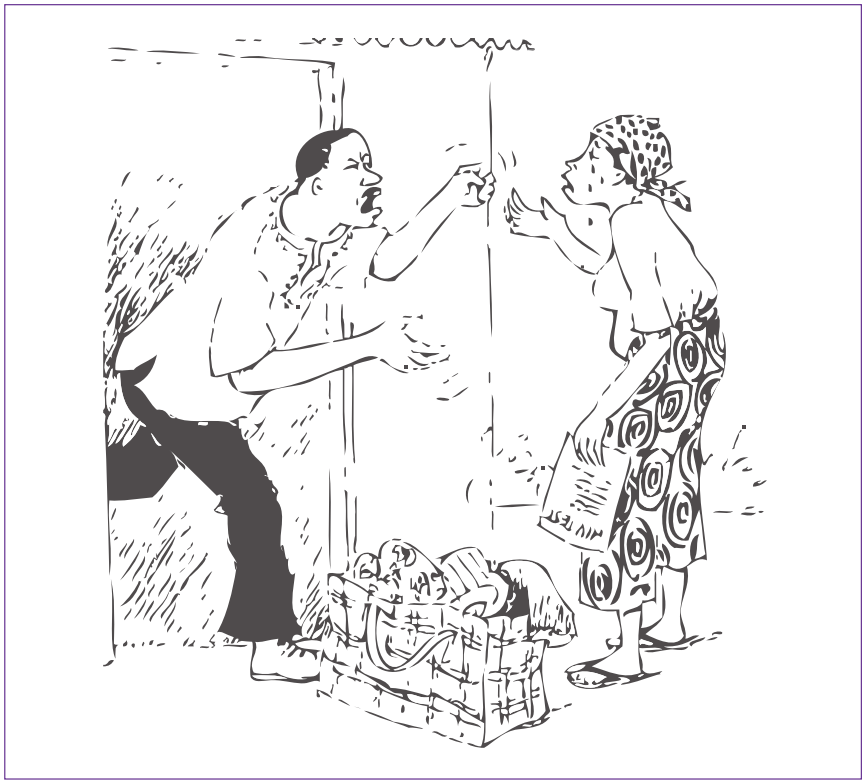
- Teach them to use a phone to call the police.**
- Teach them their full names, your full name, address, and phone number.
- Teach them what to do if separated from you, including when and where to escape to a safe space (family, neighbors, or shelter) if needed.

Surviving a violent incident

- Get to a room with an outside door.
- Avoid rooms where abuser can access weapons (kitchen).
- Call police when violence occurs.**
- Document your abuse; take photographs and keep copies of medical records.

*Icons created by Adrien Coquet, Gina Rafaella Furnari, and b a r z i n from Noun Project
**Calling the police is not a safe or helpful option in all settings. Only consider this if it is safe in your setting.

PRINTOUT G.20 - SAFETY PLANNING (1 of 3)



PRINTOUT G.20 - SAFETY PLANNING (2 of 3)

PRINTOUT G.20 - SAFETY PLANNING (3 of 3)

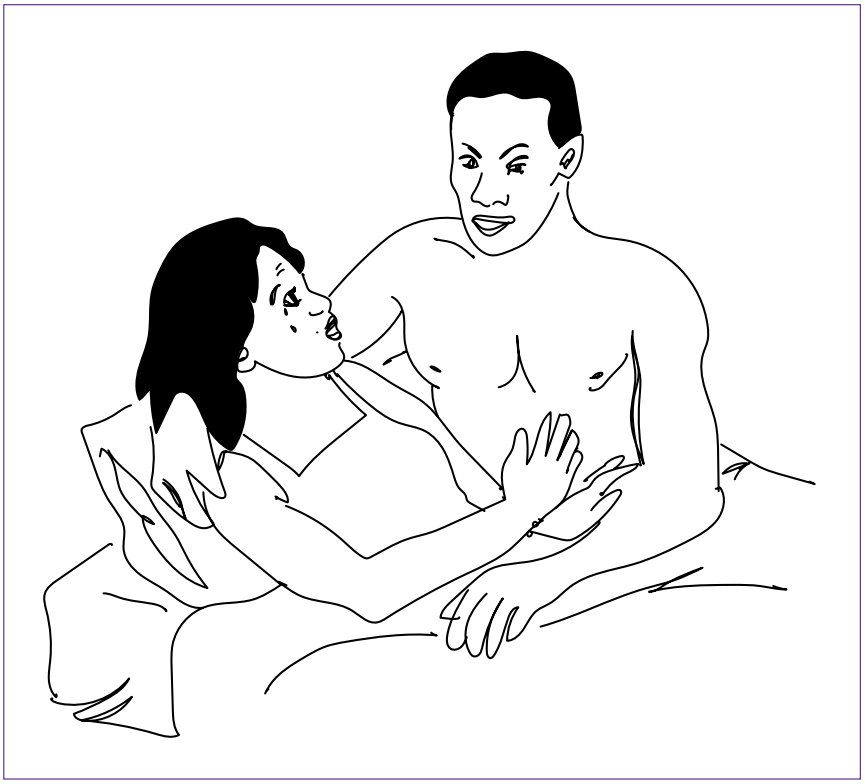


Illustration sources:

Kidd R, Clay S. Understanding and challenging HIV stigma: toolkit for action. Washington (DC): International Center for Research on Women; 2003; WHO.

Flip chart for patient education: HIV prevention, treatment and care. Geneva: WHO; 2009,

ACTIVITY G.21 - LEGAL ACTIONS

NOTE

This section of the training is optional and should only be used if legal actions and protection orders are relevant and effective in your context. Note that in some contexts, taking legal action may not be a preferred or viable course of action for women experiencing intimate partner violence. If you are using these materials, they will need to be adapted to reflect processes in your context. For example, Protection Orders place different kinds of restrictions on the abuser, depending on the local law.

OBJECTIVES

Help counselors understand how to assist clients with protection orders.

TIME

30 minutes

MATERIALS

Handout G.21 (Note: Adapt this handout for your setting.)

STEPS

1. Hand out the Legal Action handout . Ask participants to carefully read through the steps of obtaining a protection order.
2. Invite two participants to role-play getting a protection order. Ask the group to assist by pretending to be police officers, magistrate court staff, and others.
3. After the role-play, invite participants to talk about their experiences and ask questions.

Facilitator Note

In some settings, protection orders can be an important tool for women. A protection order allows women to protect themselves legally against violence without actually separating from a partner. This may be particularly helpful for pregnant women, when women may want to live with their partners but be free from violence.

Clients often have questions about how protection orders work. Prior to the training, adapt Handout G.21 to reflect the way protection orders work in your setting. The following handout is specific to South Africa.

Client questions may include:

- Does the protection order still work if the partner tears it up?
- How long does it take to get a protection order?
- What happens if the partner does not obey the order? What are next steps?
- What does this mean for my children?

Source: Hatcher , A.M., Woollett, N., Pallitto, C.C., Garcia-Moreno, C. (2014). *Safe & Sound Nurse-led counseling for empowerment and wellbeing: Facilitators Manual.* Johannesburg: Wits Reproductive Health and HIV Institute. Available at: https://www.researchgate.net/project/Safe-Sound-Addressing-IPV-in-Pregnancy

HANDOUT G.21 - LEGAL ACTION

APPLYING FOR PROTECTION ORDER

A **protection order** is issued by a court and says actions that a person cannot take. For example, it will say:

- the perpetrator cannot hit the victim
- he cannot be within certain distance of her.

A protection order can make the perpetrator pay for victim's temporary living costs. If the perpetrator violates protection order, he can be arrested and either fined or put in prison.

STEP 1

Fill Form 2 (or appropriate form for your setting) and specify whether for domestic violence or harassment. Once form is filled out, take to Magistrate's Court for clerk of the court to certify the form.

STEP 2

Take application and any additional affidavits and evidence to South African Police Services (SAPS).

Deliver application to police office Take down name, badge number and telephone number of officer who takes your application. The police will now serve the papers on the perpetrator.

Follow up with police to find out when they have served the papers.

STEP 3

Pick up "return of service" from SAPS. Once the perpetrator has been informed of the application, you can pick up a "return of service" from the police station.

STEP 4

Return to Magistrate's Court and take return of service to clerk of the court. You will be given a warrant of arrest and return date, which is the date of the hearing.

Now you have a warrant of arrest which is your interim protection order and lasts for 2 months. If the perpetrator tries to do anything on the protection order, you can take warrant of arrest to SAPS to have him arrested.

STEP 5

On the return date, you go back to the Magistrate's Court for the hearing. At the hearing both you and the perpetrator will be given the opportunity to testify, and the Court will decide whether to grant a permanent protection order.

South African Legislation (ACTS). There are three pieces of legislation (or Acts) that help survivors of violence:

- Sexual Offences Act 32 of 2007
- Domestic Violence Act 116 OF 1998
- Protection from Harassment Act 17 of 2011

ACTIVITY G.22 - FACILITATING SOCIAL SUPPORT AND PROVIDING REFERRALS

NOTE

These materials will need to be adapted to your context in advance of the training.

OBJECTIVES

Help counselors consider how to refer CHARISMA clients to other services.

TIME

15 minutes

MATERIALS

Copies of CHARISMA Referral List created for your setting; Tips on Giving Referrals

STEPS

1. Remind participants that as CHARISMA counselors, we cannot deal with every problem a client presents. Therefore, it is essential to use other local services for ongoing or persistent problems.
2. Hand out the Referral List developed for your clinic. Explain that these referrals were developed through a series of meetings by the clinic administrative team. Now, it is time for the CHARISMA counselors to get to know each referral organization.
3. Review the referral list and go into detail about each type of referral.

Facilitator Note

The Referral List is incredibly important for an intervention that aims to help women. The most important thing for a client will be the ability to easily access services they are referred to. Clients want referrals to services that:

- Answer the phone the first time
- Can make an appointment quickly
- Will greet them with warmth and care

Establishing this type of referral network takes some time but makes it much easier for CHARISMA counselors to feel confident about referring clients elsewhere. Ethically, it is an imperative for any project, like CHARISMA, that asks women to disclose their experience of violence or relationship harms.

Note that often women do not follow up on referrals from health-care providers. You can help make it more likely that she gets the help you have recommended, however do not expect her to make decisions immediately. It may seem frustrating if she does not seem to be taking steps to change her situation. She will need to take her time and do what she thinks is right for her. Always respect her wishes and decisions.

4. Review the process of providing referrals to participants. This includes:

   a. First assessing her immediate safety returning home

   b. Discussing what is most important to her and helping her identify and consider her options

   c. Offering her a 'warm referral,' which includes explaining how the referral service can meet her need, giving her specific contact details (location, how to get there, names of contacts), offering to make an appointment for her (call on her behalf or make the call with her or offer a private space where she can call), and helping her solve any practical problems that might interfere such as not having transport or child care, or fear that her partner may find out.

Adapted from Abigail Hatcher, Wits Reproductive Health and HIV Institute, University of the Witwatersrand, Johannesburg (South Africa); 2013.

Adapted from Hatcher, A.M., Woollett, N., Pallitto, C.C., Garcia-Moreno, C. Safe & Sound Nurse-led counseling for empowerment and wellbeing: Facilitators Manual. Johannesburg: Wits Reproductive Health and HIV Institute; 2014. Available at: https://www.researchgate.net/project/Safe-Sound-Addressing-IPV-in-Pregnancy.

Source: World Health organization (WHO). Caring for women subjected to violence: a WHO curriculum for training health-care providers. Geneva: WHO: 2019.

HANDOUT G.22 - TIPS ON GIVING REFERRALS

Tips on giving referrals

- Be sure that the referral addresses her most important needs or concerns.
- If she expresses problems with going to a referral for any reason, think creatively with her about solutions.
- Problems you might discuss:
  - No one to leave the children with
  - Her partner might find out and try to prevent it
  - She doesn't have transport

If she accepts a referral, here are some things you can do to make it easier for her:

- Tell her about the service (location, how to get there, who she will see).
- Offer to telephone to make an appointment for her if this would be of help (for example, she does not have a phone or a safe place to make a call).
- If she wants it, provide the written information that she needs—time, location, how to get there, name of person she will see. Ask her to think how she will make sure that no one else sees the paper.
- If possible, arrange for a trusted person to accompany her on the first appointment.
- Always check to see if she has questions or concerns and to be sure that she has understood.

ACTIVITY G.23 - ALINAH'S WEB

WHO LIVES OVERLAP

This section overlaps with the WHO LIVES training (Session 8). If participants have recently completed that training, they can skip this section, although it can be a valuable refresher.

OBJECTIVES

Understand why some referral systems are challenging to navigate.

TIME

60 minutes

MATERIALS

- Printout G.23, cut into separate pieces
- Ball of string

STEPS

1. Print the next page and cut on dotted lines. Prepare cardstock paper with the name tag on front, and corresponding story pasted on back.
2. Invite each person to choose a name tag. This will be their character for the exercise. If you have extra name tags, ask someone to play two characters.
3. Start by asking Alinah to read out her passage. She will then hold onto a piece of string and toss (or roll) the ball of string to the next person. In Alinah's case, the next person is Sister.
4. Carry on until the entire story has been read. A "web" of string should have formed across the group.
5. Ask participants to reflect on the exercise:
   - How do you think Alinah felt after being sent "from pillar to post"?
   - Does this story match real-life experiences?
   - How might Alinah's story have been different if someone were there to advise her about the best referral?

Adapted from Vann, B. Training manual facilitator's guide: multisectoral and interagency response to gender-based violence in populations affected by armed conflict. Washington (DC): JSI Research and Training Institute/RHRC Consortium; 2004.

PRINTOUT G.23 - ALINAH'S WEB (1 of 3)

STEP 1: PRINT AND CUT ALONG DOTTED LINES

ALINAH is 23 and pregnant. Her partner, Andre, is out of work and the couple has been yelling and fighting recently. Alinah is worried about times that Andre drinks because he becomes physically violent. She asks her SISTER for advice.

Alinah's SISTER has had similar conflict in her own relationships, but is not sure what the best step is. When the sister had relationship problems, she asked her in-laws for help. So, she advises Alinah to speak to ANDRE'S BROTHER.

ANDRE'S BROTHER is outraged at Alinah's accusations of physical violence. He shouts at her over the phone and suggests that she should repent for her own part in the conflict. He sends her to the PASTOR.

The PASTOR is calm and kind. But, he advises her to find ways to avoid arguments. "Are you being a good wife? Cooking food and showing love in the bedroom? Go and do these things, my sister, and your husband will be happy." Alinah wonders if the pastor and Andre's brother are right. Perhaps it is her fault that Andre is violent. She vows to try harder, and goes for her first booking at the ANC CLINIC.

The ANC CLINIC is busy, and Alinah waits the entire morning before seeing a sister. The sister notices bruising around Alinah's eye but looks towards the long queue and chooses to ignore it. On the way out, Alinah sees a sign for a SHELTER.

The SHELTER is across town, but Alinah is hopeful because the sign at the clinic says the shelter helps with GBV. The house mother kindly explains that the shelter only accepts clients with a judicial order from the POLICE.

The POLICE station is near her house, so Alinah decides to ask about a judicial order. The police on duty says that a "protection order" will prevent Andre from coming near to Alinah. But this is not what she wants at all! Alinah is not prepared to take care of an infant alone, and she still loves Andre. She leaves, and on her way out a NEIGHBOR sees her.

PRINTOUT G.23 - ALINAH'S WEB (2 of 3)

That night, the NEIGHBOR sees Andre at the bottle store and asks why Alinah was at the police. He says goodbye, and ANDRE heads home, furious.

ANDRE rushes into the house, screaming at Alinah and accusing her of "airing their dirty linens" to the entire neighborhood. He pushes her against the counter, and terrified, she tries to poor the boiling water on him. Andre goes crazy, running at Alinah at full force and tackling her to the ground. He hits her in the face and then starts crying. He can see that Alinah needs medical help, so he calls the AMBULANCE.

The AMBULANCE arrives two hours later. The driver cannot think of a good 24-hour hospital so he takes her to the HOSPITAL.

The HOSPITAL is quiet, as it is nearly midnight. The nurses are responsive and kind, but the doctor on duty never answers his page. The staff become annoyed – night doctors often avoid taking on new medical cases because they don't want to testify in court. Finally, after several hours, the NURSE arrives.

The NURSE attends to Alinah's wounds and examines the fetus, but she cannot ask questions about how the injuries occurred, since Andre is in the room. The nurse tells Alinah the fetus is fine and silently hands her a referral to the SOCIAL WORKER.

After a few days, Alinah gets up the courage to see the SOCIAL WORKER. She has to travel by matatu to the nearest city, which takes more than two hours. When she arrives, she is tired and nervous. When the Social Worker welcomes her into the small office, it is the first time ALINAH is able to share her feelings in a safe place. The Social Worker agrees to meet her each month to see how Alinah is coping.

PRINTOUT G.23 - ALINAH'S WEB (3 of 3)

STEP 2: ASK EVERYONE TO CHOOSE A NAME TAG (WITH CORRESPONDING STORY PASTED ON BACK)

NEIGHBOR	**POLICE**
SOCIAL WORKER	**SHELTER**
NURSE	**ANC CLINIC**
HOSPITAL	**PASTOR**
AMBULANCE	**ANDRE'S BROTHER**
ANDRE	**SISTER**
ALINAH	

H Implementation Practice

This section gives participants an opportunity to synthesize what they have learned throughout the training. It wraps up the lessons from previous sections so that participants have a chance to practice CHARISMA skills by role-playing with mock clients (i.e., other participants).

ACTIVITY H.24 - PRACTICE: HEART RELATIONSHIP ASSESSMENT

NOTE

Ensure counselors review the Counseling Manual and Job Aid in advance of this session.

Facilitator Note

After the role-play, invite participants to talk about their experiences and ask any questions.

OBJECTIVES

Try the questions of the HEAlthy Relationships Tool (HEART) using role-plays.

TIME

75 minutes

MATERIALS

- Presentation H.24
- Printout H.24
- Copies of HEART Assessment
- Flip chart

STEPS

1. Go through Presentation H.24 to introduce the HEART. Pause to ask participants if they have any questions or thoughts.
2. Give participants the HEART. Ask them to read through each statement. Take time to go through each item in turn, ensuring everyone understands what the item is asking.
3. Ask participants to read through the scoring system. Point out that everyone will have their own way of deciding how much they disagree or agree with a statement. Clients do not have to justify their responses, but should not be stopped from doing so if they choose to.
4. Then, ask participants to take one vignette and pair up to practice the HEART. One person will pretend to be the counselor, the other will pretend to be a client.
5. Ask the client to role-play the body language, emotions, and responses of the story.
6. Ask the counselor to read each statement without offering her own interpretations. She will place a check in the appropriate column for each statement and enter a score.
7. After 15 minutes, ask the partners to switch roles, using a different vignette. Once both partners have played the client role, ask the pair to work together to review and tally the scores for each HEART. The pair should compare scores with the recommended counseling modules presented at the end of the tool.
8. Bring everyone back together and ask about how it felt to ask these statements.
    - What statements were hard to ask?
    - Were any statements confusing or hard to understand?
    - How did the scoring go?
    - What counseling recommendations were made?
    - How did they feel about those recommendations?

Developed by Abigail Hatcher, Wits Reproductive Health and HIV Institute, University of the Witwatersrand, Johannesburg (South Africa); 2016. Vignettes developed by Asha Ayub, RTI International, Research Triangle Park (NC); 2016.

PRINTOUT H.24 - PRACTICE: HEART RELATIONSHIP ASSESSMENT

Julia and her partner, John, have been living together for three years. He does not work and instead gambles to earn money. John gets very angry when Julia suggests that he stop gambling and get a job so that he can have a steady income. He will usually disappear for a few days and ignore Julia's calls following an argument about his gambling.

Minenhle and her boyfriend Paul have a 2-year-old daughter together. Paul is Minenhle's first boyfriend. Minenhle feels like Paul is a good person and a good partner because he provides for her and their daughter. However, she is unhappy with how controlling he is, especially since they are not even married yet. He does not allow her to go out with her friends and will call her family members to confirm her whereabouts when she says she's going to visit with family. He once beat her because he saw her drinking alcohol after he told her that she was not allowed to drink.

When Aminata first met her boyfriend, she was impressed by his wealth and liked that he would spoil her. A few months into their relationship, he asked that she move into a flat he had rented for her. He paid for her expenses, provided her with an allowance, and asked that she fully obey him in return. When he discovered that she was using PrEP, he told her to stop and she did. In the last several months, she has become uncomfortable with the level of control he has over her and has begun to fear him. She realizes that she needs to move out of the flat and away from him but has no support to do so.

Zola and her husband Jacob have been married for eight years. They have two children together and she has a son from a previous relationship, Trevor. Jacob pays less attention to and spends less money on his stepson than he does with their other children, which upsets Zola. When Zola and Jacob argue, Jacob always says she should be grateful that he has accepted Trevor into his home.

Lethabo began taking drugs a few months ago and has become increasingly irritable and violent toward his girlfriend, Jane. Instead of leaving the house to cool off when they get into an argument, he has started beating Jane. Jane fears for her and their 5-year-old son's safety.

Sarah is a frontline/community health worker. She likes her job, although it doesn't pay much. Her husband is fairly supportive, even though it means she is often away from home during the day. Sarah does worry at times about her risk of contracting HIV because she gives injections and sometimes has to draw blood from people in the community. She has told her husband she is considering taking PrEP to stay safe.

Kamogelo and his girlfriend Mary have been dating for two years. Kamogelo likes to know where Mary is at all times. He asks her to call him every hour to tell him where she is. He follows her to her clinic visits and will sometimes ask her to send pictures of herself at the clinic. Kamogelo tells Mary that he likes to know where she is because he wants to know that she is safe. Mary suspects that Kamogelo thinks she will cheat on him in retaliation for him cheating on her and that is why he tracks her. He does not tell her where he is going or when he will return.

ACTIVITY H.25 - PRACTICE: COUNSELING MODULES A, B, AND C

NOTE

Ensure counselors review the Counseling Manual and Job Aid in advance of this session.

OBJECTIVES

Build counselor's familiarity with the counseling activities and improve their comfort with the content.

TIME

~1 hour for each module, with 15-minute breaks in between (total 3 hours and 45 minutes)

Facilitator Note

As participants are in the role-play, walk around the room to see if there are any challenges to practicing these modules.

MATERIALS

- CHARISMA Counseling Manual
- CHARISMA Counseling Job Aid

STEPS

1. Break into pairs.
2. Ask the pairs to conduct role-plays to practice Modules A, B, and C in the Counseling Manual and Job Aid. Include male partner packet material distribution as a final step. Each person should practice being the counselor for all three modules.
3. Pause after each practice module to ask (write answers down on a flip chart):
   - What did you find challenging in counseling your client?
   - What helped you be successful in counseling your client?

Developed by Abigail Hatcher, Wits Reproductive Health and HIV Institute, University of the Witwatersrand, Johannesburg (South Africa); 2016.

ACTIVITY H.26 - PRACTICE: COUNSELING MODULE D

NOTE

Ensure counselors review the Counseling Manual and Job Aid in advance of this session.

OBJECTIVES

Reflect on ways to tailor the CHARISMA intervention to client needs and practice Module D to support clients experiencing violence.

TIME

1 hour and 30 minutes

MATERIALS

- CHARISMA Counseling Manual
- CHARISMA Counseling Job Aid
- Printout H.26 (cut into separate cards)

STEPS

1. Divide participants into pairs and give each pair the pile of Situation Cards. Ask them to choose one situation that captures their imagination.
2. Ask pairs to decide what their Situation Card illustrates, and to make up a story about the woman experiencing violence. After creating a story, ask pairs to develop a role-play between a CHARISMA counselor and client around the intervention so that they will practice Module D: Responding to IPV.
3. This role-play should have all the elements of the intervention included. This means that the conversation should include the topics of the Counseling Manual, any additional topics or referrals, and proper documentation. Ask the group to fill out the documentation as they would for a real participant.
4. Give pairs 25 minutes to practice their role-play.

Facilitator Note

After the role-play, invite participants to talk about their experiences and ask any questions. Frustrations may arise during this activity, since it highlights the fact that counselors can try to protect participants but, ultimately, we are unable to ensure our client's safety. Give participants a safe space to vent these fears, as they are important to acknowledge openly.

Remember that the CHARISMA intervention is based on the client's specific needs and strategies. Women who live with conflicted relationships are often highly skillful at navigating dangerous and challenging situations. Let the client take the lead on the types of safety and PrEP disclosure strategies that are most helpful.

5. Choose three to four pairs to present their role-play to the rest of the group. Invite participants to share all concerns or questions until all the role-plays are finished. Afterward, ask the group which aspects of the intervention were well done. Which parts could be improved in the future?

6. Ask about any questions using the forms or the Counseling Manual. Which parts were easy and which parts were tricky?

Developed by Abigail Hatcher (2013), Wits Reproductive Health and HIV Institute, University of the Witwatersrand, Johannesburg (South Africa); 2013. Vignettes developed by Asha Ayub, RTI International, Research Triangle Park (NC); 2016.

PRINTOUT H.26 - PRACTICE: COUNSELING MODULE D (1 of 2)

A 25-year-old woman, Martha, is married with two children. Her husband has a child outside the marriage. Martha is not working, and she and her family are living in a single room within a house they share with two other families. Every month end, her husband Omondo spends the weekend with his other girlfriend. Although Martha worries about her sexual health, Omondo insists that he does not want to use condoms. Often, when he returns from seeing his girlfriend, he does not want to buy food. Martha has raised the situation, but is worried about pressing it further because her husband physically abuses her when she confronts him.

She learned about PrEP from a friend. Martha wants to tell Omondo about PrEP but is very nervous about what he will say. One of the reasons she feels strongly about using PrEP is because of his other girlfriend, and Martha wants to protect herself from HIV. Yet, talking about Omondo's infidelity is frightening.

- Adapted from Safe & Sound Nurse-led counseling for empowerment and well-being; 2014.

Buyisiwe did not disclose her PrEP use to her boyfriend, Ayanda. They have been together since they were in school and even though Ayanda is faithful to Buyisiwe, she knows that he is very controlling. For example, Ayanda told her that she should not use birth control because it might poison her and make it impossible to ever have children. Buyisiwe was worried that Ayanda would be opposed to the PrEP and demand that she stop taking it. Ayanda is very traditional and superstitious, and Buyisiwe thought that he would think that PrEP would bring him harm or bewitch him somehow.

Instead of telling Ayanda, Buyisiwe pretends to be going to the shops whenever she has a clinic appointment. This makes her very anxious each time she enters the clinic, because she wonders if somehow Ayanda will find out, or if a friend might see her and report to him. When she speaks with the clinic staff, Buyisiwe is guarded and on edge. It is difficult to get her to open up.

- Adapted from CHARISMA formative research

Alisa is 28 years old and pregnant. She has been experiencing violence but has received advice from her mother about trying not to irritate her husband: "Some women become more argumentative or 'stubborn' when pregnant. When my husband beats me, it's partly my fault. Because when I question his authority, he thinks it's because I am seeing other men. Then he becomes violent. What I know is that when a man is suspicious or insecure, violence is common. And because my husband is unemployed right now, I think maybe he is insecure. But I know this baby will bring us closer together, because after I had the first baby, our son, he calmed down. I think he felt like a real father once he had a child."

When you speak to Alisa about the violence in her marriage, she does not see it as a problem. She knows that this is a "normal" part of relationships and does not see any way of changing it. It is almost as if Alisa is afraid to realize how hurtful the violence can be – so, when you try to talk about it, her eyes glaze over and she becomes hardened.

- Adapted from Kaye DK, Mirembe F, Ekstrom, AM, et al. The social construction and context of domestic violence in Wakiso District, Uganda. Culture, Health & Sexuality. 2005;7(6); 625-35.

PRINTOUT H.26 - PRACTICE: COUNSELING MODULE D (2 of 2)

Anna did not tell her longtime partner, Dzingai, about her PrEP use. One year prior to starting to take PrEP, Anna had cheated on Dzingai. Although they decided to get back together, Dzingai did not fully trust Anna. When she started taking PrEP, she decided not to tell Dzingai about it because she was afraid he would think that she was using PrEP so that she could continue to cheat on him without the risk of HIV.

- Adapted from CHARISMA formative research

Mercy, 23 years old, is married and expecting her first child. She describes her husband as abusive and a jealous type of a person. The violence started before they were even married but Mercy ignored the signs. Her husband, Desmond, is controlling. Friends were not allowed to visit—not even family.

Every time Mercy tried to end the relationship, Desmond would stalk her. Yet afterward, he always promised he would change. He would make promises, take Mercy out, and buy things for her. Mercy started taking PrEP six months ago, but then stopped after several months because she could no longer handle the fear that her husband would follow her to clinic and beat her for not asking his permission before starting to take PrEP.

- Adapted from CHARISMA formative research

Judith is 33 years old and has two children. She explains how her marriage has been recently: "I am not working anymore, so my husband is the only one who is working at the big shop in the middle of town. I don't know whether it is the stress of working alone or the company of bad friends, but my husband has started drinking again. He is coming home late, wasting money. I tried to talk to him about his behavior but that did not help. He is always saying things to me like I am useless, I cannot even find money from selling at the market. One day he came late and found me sleeping. When he arrived at our bedroom, he wanted to sleep with me. I refused, then he started beating me up in the face till I got a blue eye. He beat me with his fists."

- From Nisaa Institute for Women's Development. Rising up moving on. Lenasia (South Africa); 2013.

ACTIVITY H.27 - MOCK COUNSELING SESSIONS AND OBSERVATION

OBJECTIVES

Practice implementing CHARISMA and learn how to document referrals and follow-up.

Facilitator Note

Counselors should have time to practice CHARISMA counseling before working with clients. We recommend counselors complete three mock counseling sessions, one during the training and two following the training.

TIME

1 hour and 30 minutes

MATERIALS

- CHARISMA Counseling Manual
- CHARISMA Counseling Job Aid
- CHARISMA Counseling Session Observation Form

STEPS

1. Explain that every CHARISMA counselor will have the opportunity to do mock sessions, during which they will be observed by a mentor trainer.
2. Show the participants the mock observation form and highlight the areas of the intervention that an observer will be interested in.
3. Answer any questions about what is expected of CHARISMA counselors during the mock session.

Developed by Danielle Wagner and Miriam Hartmann, RTI International, Research Triangle Park (NC); 2016.