

ON APPROVAL

FAMILY PLANNING COUNSELING: A CURRICULUM PROTOTYPE

TRAINER'S MANUAL

INCLUDES INFORMATION ON

- AIDS and other STDs
- Sexuality
- Counseling men, adolescents, postabortion women, pregnant and postpartum women

Family Planning Counseling

A Curriculum Prototype

• Trainer's Manual

AVSC International

New York

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Foreword

AVSC International has worked for years with family planning organizations, funding agencies, and other population and family planning organizations to help family planning services to establish and to improve counseling. This curriculum, as the acknowledgments suggest, grows out of the work and experience of many of these organizations. Why have so many organizations invested so much effort in counseling?

We think it is because successful family planning programs are those whose clients are contraceptive users rather than contraceptive acceptors, and that counseling is crucial to achieving this result. Counseling helps ensure that clients make free and informed decisions about fertility. In that context, it also helps clients choose the method of family planning best suited for them and their circumstances, and gives them the information they need to use the method successfully and to cope with side effects. When counseling works this way, it supports long-term use of contraception by giving clients confidence in the family planning service.

Although well-trained and supervised counselors are essential, counseling cannot simply be left to counselors. Everyone in a health facility, from receptionists to clinic managers, must be able to supplement the work of the counselors, so that the whole service reinforces counseling.

Counseling is most effective when policies and services support free and informed choices about reproductive health. This requires, among other things, a well-informed clientele; the availability of a broad array of safe and affordable contraceptive services that include follow-up care; and continuous attention to the needs and concerns of clients.

While this curriculum is focused primarily on counseling about contraception, it also incorporates information about other reproductive health factors that clients consider when deciding about family planning. Many of the principles and skills of effective counseling about family planning are relevant to helping clients make other choices about their reproductive health.

Hugo Hoogenboom
President, AVSC International

Acknowledgments

In 1988 and 1991, AVSC International¹ held two meetings of counseling trainers from Anglophone Africa in Mombasa, Kenya. This training curriculum grew out of the experiences and contributions of participants at those two meetings.

Cynthia Steele Verme, director of special programs, oversaw the conceptual development of the curriculum, and Pamela Beyer Harper, director of communications, managed the development process. Dr. Amy Pollack, vice president and medical director, and Sally Girvin, medical advisor, reviewed all medical content in the curriculum. Joseph Dwyer, director of AVSC's regional office in Nairobi, provided the impetus for the regional training events and has been a motivational force for this project. Ruth Mullen edited the curriculum and produced the copy using a desktop publishing system; Renée Santhouse, publications manager, supervised the production process.

Several individuals and organizations made special contributions in the formative stages of this curriculum. They include AVSC staff members Jeanne Haws and Grace Wambwa, AVSC consultants Paulette Chapionniere and Rosemary Kamunya, and free-lance editor and writer Andrew Kaplan. While she was an AVSC staff member, Jill Tabbutt further developed and refined the curriculum through numerous counseling trainings and throughout Sub-Saharan Africa.

The curriculum was field tested at the University College Hospital in Ibadan, Nigeria, in 1992 by Foluke Shobowale (AVSC), Juliana Thompson (AVSC), Rosemary Kamunya (AVSC consultant), Bola Lana (Pathfinder), Mini Soyoola (Population Communication Services), and Bunmi Dosunmi (Family Health Services Project). The curriculum was informally field tested through many other counseling training workshops.

We are grateful to the following individuals who contributed ideas to the development or review of parts of the curriculum: Deborah Bossemeyer, Ellen Eiseman, Pape Gaye, Jim Griffin, Alicia Hernandez, Flor Alicia Huezo, Jan Neamatalla, Lourdes Quintanilla, Florencia Roitstein, and Mutombo Yatshita.

This curriculum uses the GATHER acronym to help training participants remember the major counseling steps. This acronym was first described in 1987 in "Counseling makes a difference" by Moira Gallen and Cheryl Lettenmaier, *Population Reports*, series J, number 35.

We would also like to acknowledge two resources that were helpful in developing Module 5 on effective communication skills: *Interpersonal Communication and*

¹ On October 1, 1994, the Association for Voluntary Surgical Contraception changed its name to AVSC International.

Counseling for Family Planning: Nigeria Three-Day Curriculum, published in 1991 by the Planned Parenthood Federation of Nigeria, with technical assistance from Population Communication Services, Johns Hopkins University, and PATH, and *Counseling Skills in Family Planning: Trainer's Handbook* by Deborah Bender and Cydne Bean, published in 1982 by the Carolina Population Center.

INSTRUCTIONS FOR THE TRAINER

Purpose

This curriculum is designed to develop or improve counseling skills among health and family planning workers who interact with clients. The curriculum also includes a basic review of family planning methods, common sexually transmitted diseases, including HIV infection, and reproductive anatomy and physiology.

The term *counselor* refers to a health care worker who is responsible for family planning counseling and usually other duties. Family planning counselors do not have to be professional psychologists or social workers. Many health professionals who have the appropriate knowledge and interest in working with clients can be effective counselors with practice and with training such as this.

While this curriculum is intended to help health workers in counseling about family planning, many of the concepts, skills, and principles apply to counseling clients with other reproductive health concerns.

Audience for the training

This curriculum is intended for people who are already familiar with family planning methods, but need or want to develop or improve interpersonal communication skills used in counseling clients. The curriculum is *not* designed for people who need an introduction to family planning methods; these methods are reviewed, rather than explained in detail.

Curriculum structure

The curriculum is divided into 14 modules, each of which focuses on an aspect of family planning counseling. Appendixes include evaluation instruments, guidelines for how to conduct a counseling practicum, and instructions on how to arrange observations of clinical procedures.

The curriculum begins with general topics, then progresses to the specific. Modules 1-11 apply to counseling clients about all types of family planning methods. Module 12 concerns the particular counseling needs of clients who are interested in tubal ligation or vasectomy. Module 13 discusses client populations with special needs, including pregnant and postpartum women, men, postabortion women, and unmarried adolescents. The final module helps participants manage the transition from training

back to the worksite; they leave the workshop with a plan for implementing their newly acquired skills and knowledge.

Each module begins with the critical information you, the trainer, will need to conduct the module: objectives for the participants, estimated time required, and advance preparation needed. An instructional grid summarizes the content of each training step, the time estimated for the step, the training techniques, and any special aids that are needed. Before using this curriculum, you should familiarize yourself with the content of each module.

This curriculum includes two fold-out posters: one of the female reproductive system and one of the male reproductive system. These posters are intended for use in Module 8 and should be traced or copied onto blank newsprint.

In addition to this trainer's guide and the posters, the curriculum includes two books to be given to each participant: a participant's handbook and *Talking with Clients about Family Planning: A Guide for Health Care Providers*. The handbook contains worksheets and other background information that reinforce the content of each module and that participants use throughout the training. Materials in the handbook are called *handouts* and are numbered according to the module numbers within the curriculum. For instance, Handout 3-1 is the first handout for Module 3. Some modules do not have handouts. This trainer's manual specifies when each handout is needed. The *Participant's Handbook* is listed as a special aid only in Module 1, when it is first introduced. Participants should bring the handbook with them to every session.

Talking with Clients about Family Planning: A Guide for Health Care Providers presents basic information about commonly available contraceptive methods. It provides information clients need to *choose* a method (for instance, how the method works and its characteristics and effectiveness) as well as instructions about how to *use* each method. The booklet is used as resource material during training and can also be used as a reference when participants counsel at their worksites. The booklet does not contain comprehensive clinical information about contraceptive methods and is not intended to be a clinical reference.

The complete list of materials needed for this curriculum appears later in this introduction.

Time allocation

The times assigned to each module are estimates and should be used as a guide for planning the training. The training can also be done in short sessions over a period of time, rather than in a single workshop.

The training is estimated to last five or six days, if the curriculum is followed without major modifications.

Following are three sample schedules.

SAMPLE SCHEDULE A: 6 DAYS

Time	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
M O R N I N G	Introduction to the Workshop (1)	Values and Attitudes (3) (cont.)	The GATHER Technique: Greet (6)	Mid-course Evaluation	Permanent Contraception (12)	Counseling Needs of Special Populations (13)
	Introduction to Counseling (2)	Factors in Client Decisions (4)	The GATHER Technique: Ask/Assess (7)	The GATHER Technique: Help (9)		
A F T E R N O O N	Introduction to Counseling (2) (cont.)	Factors in Client Decisions (4) (cont.)	The GATHER Technique: Tell (8)	The GATHER Technique: Explain (10)	Permanent Contraception (12) (cont.)	Application of Skills (14)
		Effective Communication Skills (5)				Posttest
	Values and Attitudes (3)			The GATHER Technique: Return Visits (11)		Feedback
						Closing Ceremony

SAMPLE SCHEDULE B: 5½ DAYS

Time	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
M O R N I N G	Introduction to the Workshop (1)	Values and Attitudes (3) (cont.)	The GATHER Technique: Greet (6)	The GATHER Technique: Help (9)	Permanent Contraception (Sections 4-6, 12)	Application of Skills (14)
				The GATHER Technique: Explain (10)		Posttest
	Introduction to Counseling (2)	Factors in Client Decisions (4)	The GATHER Technique: Ask/Assess (7)	The GATHER Technique: Return Visits (11)		Feedback
						Closing Ceremony
A F T E R N O O N	Introduction to Counseling (2) (cont.)	Factors in Client Decisions (4) (cont.)	The GATHER Technique: Tell (8)	Permanent Contraception (Sections 1-3, 12)	Counseling Needs of Special Populations (13)	
	Values and Attitudes (3)	Effective Communication Skills (5)				

SAMPLE SCHEDULE C: 6 DAYS
(includes observation of clinical procedures)

Time	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
M O R N I N G	Introduction to the Workshop (1)	Values and Attitudes (3) (cont.)	The GATHER Technique: Greet (6)	The GATHER Technique: Help (9) The GATHER Technique: Explain (10)	Observation of Clinical Procedures (Appendix C)	Counseling Needs of Special Populations (13)
	Introduction to Counseling (2)	Factors in Client Decisions (4)	The GATHER Technique: Ask/Assess (7)	The GATHER Technique: Return Visits (11)		
A F T E R N O O N	Introduction to Counseling (2) (cont.)	Factors in Client Decisions (4) (cont.)	The GATHER Technique: Tell (8)	Permanent Contraception (Sections 1-3, 12)	Permanent Contraception (Sections 4-6, 12)	Application of Skills (14)
	Values and Attitudes (3)	Effective Communication Skills (5)				Posttest
					Feedback	
					Closing Ceremony	

How to use this curriculum

This curriculum is intended as guide. While it provides detailed information for you, the trainer, it is not meant to be a script or a “cookbook.” You will need to adapt the curriculum to suit your own style and experience, as well as to meet the needs of each particular training group, family planning program, or culture in which it is being used. Each module contains spaces for writing notes. Feel free to write in this trainer’s guide, to add to it, or to substitute activities—in other words, to make it your own.

- **Adapt the curriculum to the culture.** Refer to customs and practices in the local community. If any of the examples provided are unsuitable, change them or ask participants to offer relevant examples. Consider replacing the names used in the activities with names that are common in your area. The videos *Counseling: Helping People Make Family Planning Choices*, *Minilaparotomy for Voluntary Surgical Contraception*, and *Education and Counseling: Helping Clients Make Family Planning Choices* were developed for use in Sub-Saharan Africa. Review their suitability for use in your training setting, and substitute other videos as appropriate and available. For instance, you may want to substitute the video *GATHER* in place of *Counseling: Helping People Make Family Planning Choices*.
- **Adapt the curriculum to the needs of the participants’ family planning programs.** Include reports or discussions about the way information and counseling services are provided at the participants’ worksites.
- **Adapt the curriculum to reflect the participants’ expectations.** Either send participants a questionnaire before the training, or use the results of the small group exercise about participants’ expectations (Module 1, Step 2, page 1-4). Although you may not always be able to meet all of the participants’ needs, knowing what they want and expect will help you tailor the training and add relevant information and examples to the training sessions.
- **Choose the training techniques that work best for you.** You may already have counseling training techniques that work well for you and that fit into the curriculum. Feel free to substitute your activities for corresponding ones in the curriculum, particularly “standard” kinds of exercises, such as icebreakers and daily feedback. The training will go more

smoothly and be more interesting if you use techniques that you feel comfortable with and like.

- **Incorporate modules into other family planning training courses or orientations.** The training does not need to be done in a sequential, six-day workshop format. It may be appropriate to present it in other ways—for example, covering several modules per week for select health staff at a clinic or hospital. Such training may be conducted at a health site, rather than in an off-site workshop. This approach helps to ensure that all staff who may counsel family planning clients receive training. Also, integration of the content of this curriculum into other training programs is encouraged.

Language

The language used in this curriculum is, as much as possible, intentionally nontechnical, so that participants are exposed to and can gain practice with simple terminology that can be used with clients.

In the case of clinical vocabulary, the curriculum, whenever possible, uses terms that will be most easily understood. For example, the term *tubal ligation* is used instead of the more general clinical term *female sterilization* since, in many settings, clients and providers customarily use the phrase *tubal ligation*.

The two terms *HIV infection* and *AIDS* have important distinctions in meaning. *HIV infection* is used when a person has been exposed to and infected with the human immunodeficiency virus; the person may have no symptoms and may not know that he or she has the virus. People who are infected with HIV can transmit the virus to others. People who have AIDS carry the human immunodeficiency virus and also have symptoms. For accuracy, the curriculum usually uses the less well-known phrase *HIV infection*, rather than *AIDS*, since the term encompasses individuals with and without symptoms.

Because the language used at particular sites varies, you should work with participants to use terms that are both accurate and easily understood.

Materials for the trainer

In addition to this trainer's manual and the two posters that accompany this curriculum, you will need the items listed below to conduct a training. The reference list at the end of this book provides source information for the books and videotapes.

- blank newsprint and markers
- writing paper and pens for participants
- drawings of the male and female reproductive system, traced from posters provided with this curriculum (see Module 8)
- samples of informational materials counselors use with clients: brochures, posters, illustrated flipcharts, and videos (see Modules 8 and 10)
- boxes containing samples of commonly available contraceptives (see Modules 8 and 10)
- flipcharts or brochures depicting the male and female reproductive systems (see Module 12)
- video cassette player and monitor
- *Counseling: Helping People Make Family Planning Choices* (videotape; see Module 2)
- *Minilaparotomy for Voluntary Surgical Contraception* (videotape; see Module 12)
- *No-scalpel Vasectomy* (videotape; see Module 12)
- *Education and Counseling: Helping Clients Make Family Planning Choices* (videotape; see Module 12)

If any of the listed videos are unavailable or inappropriate, or if a video cassette player is unavailable, substitute discussions or, in the case of videos on clinical subjects, observations of procedures, illustrations, or slides.

Materials for the participants

As mentioned earlier, each participant will need a copy of the participant's handbook and *Talking with Clients about Family Planning: A Guide for Health Care Providers*. If copies of the participant's handbook are not available or if you are presenting only some of the modules, give each client copies of the appropriate handouts at the beginning of each module. Participants will also need copies of the workshop schedule, which is distributed in Module 1.

You are responsible for obtaining information about any laws and policies in your area regarding tubal ligation and vasectomy, and explaining them to participants in Module 12.

Each participant may also have one copy of the following optional reference materials:

- *Family Planning Counseling and Voluntary Sterilization: A Guide for Managers*
- *Informed Consent and Voluntary Sterilization: An Implementation Guide for Program Managers*
- *Family Planning Counseling and Voluntary Sterilization: A Reference Guide for Counselors*
- *Population Reports: “Counseling Makes a Difference”*
- *Population Reports: “Why Counseling Counts”*

The reference list at the end of this book provides source information for these printed materials.

Participants can use these materials as references, both during the training and when they return to their service sites.

Evaluation

Evaluation is a fundamental part of training that donors, host organizations, and trainers should plan and budget for in advance of each training. Proper evaluation helps ensure that the counseling training is not merely a one-time intervention, but part of a broader strategy to develop participants’ skills and to help them apply those skills upon return to their worksites. Evaluation can also help to improve future counseling training activities. Evaluation of counseling training can include the following:

- an assessment of participants’ needs and abilities, before training
- a pre- and posttest of participants’ knowledge and attitudes
- continuous assessment of the training
- an assessment of the training course by the trainer
- an assessment of the training course by the participants
- a follow-up assessment of the application of skills and attitudes acquired during training
- an evaluation of the impact the training has had on participants, their worksites, and their clients (variables that can be studied include changes in quality of services, number

of clients served, client satisfaction, clients' rates of contraceptive continuation, and numbers of referrals)

Evaluation should be seen as part of a cycle of training, in which the training itself is only one step. This cycle begins with program managers, who should provide trainers with information (such as curriculum vitae and needs assessments of participants) that will help them tailor the training to the needs of the participants. After the training is completed, program managers are once again involved as trainers should tell them what additional support the participants may need. Program managers are also vital sources of information about the impact of the training on participants and on services.

This curriculum does not comprehensively cover either counseling evaluation or training evaluation. It does provide prototype evaluation instruments for the period of the training itself. Pre- and posttests, sample daily feedback exercises, a continuous assessment form, a participants' course evaluation, and discussions of these instruments are provided in Appendix A.

Practicum

If it can be arranged, it is desirable to give participants a chance to practice their counseling skills with real clients. Guidelines for the practicum are given in Appendix B.

Observation of clinical procedures

If participants are unfamiliar with tubal ligation, vasectomy, or insertion of IUDs or Norplant implants, and if observation of these procedures can be arranged at a nearby facility without unduly disturbing service delivery or clients, you may wish to arrange such observation. Guidelines for observation of clinical procedures are given in Appendix C.

MODULE 1: INTRODUCTION TO THE WORKSHOP

Objectives

By the end of this module, participants should be able to:

- describe the general objectives for the workshop.
- describe their expectations for the workshop.
- explain the norms for the workshop.

Estimated time

2 hours

Advance preparation

- Decide which of the exercises to use in Step 1, page 1-3.
- Write the general objectives of the workshop on newsprint (see Step 2, page 1-4).
- Write the three sentence fragments from the small group activity about participants' expectations (see Step 2, page 1-4).
- Prepare and duplicate a schedule that shows the starting time and location of each session. Include the names of the modules to be covered (see Step 3, page 1-6).
- Have enough copies of the *Participant's Handbook* to give one to each participant (see Step 6, page 1-8).

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
30 minutes	Introduction of trainers and participants (page 1-3)	Partners exercise (or alternative exercise)	None
40 minutes	Objectives (page 1-4)	Small groups Discussion	None
15 minutes	Organization and schedule (page 1-5)	Lecture	Workshop schedule (1 copy for each participant)
15 minutes	Workshop logistics (page 1-6)	Lecture	None
15 minutes	Workshop norms (page 1-7)	Discussion	None
5 minutes	<i>Participant's Handbook</i> (page 1-8)	Presentation	<i>Participant's Handbook</i> (1 copy for each participant)

Step 1

Introduction of trainers and participants

Welcome the group to the workshop. Introduce yourself and any key facilitators to the group. Lead a warm-up activity, such as one of those listed below.

PARTNERS EXERCISE

Introduction of pairs

Pair each person in the workshop, including trainers, with a person to his or her right or left. Have partners spend five minutes sharing information with each other, including:

- where they are from
- where they work and what their job is
- what their professional training is
- how they use or will use counseling in their work

After the five-minute period, each participant should briefly introduce his or her partner to the other participants.

ALTERNATIVE EXERCISE

The name game

1. The first person introduces herself by the name she wishes the group to use: "I am Grace."
2. The next person introduces the first person and himself: "This is Grace and I am John."
3. The third person introduces the first two and herself, and so on, until the last person introduces everyone in the group.

If someone is stuck on a name, encourage the group to help that person by giving a hint so things move quickly and easily.

Following the exercise

Outline the objectives for the remainder of the module. Tell participants:

- You will now:
 - » Become familiar with the workshop logistics, objectives, and schedule.
 - » Work together to develop norms for the workshop.
 - » Have an opportunity to express your expectations for the workshop.

Notes: _____

Step 2

Objectives

Explain the general objectives of the workshop, which are written on newsprint (see the Advance Preparation section, page 1-1).

- In this workshop, we plan to:
 - » Discuss counseling in the context of quality family planning services.
 - » Build skills in family planning counseling.
 - » Look at attitudes and knowledge that have an impact on or are related to counseling skills.
 - » Review information about family planning methods.
 - » Relate family planning to clients' other reproductive health and personal needs.

Explain:

- These are broad objectives, and it is important that the training meet your needs.

Find out what the participants expect from the workshop, through the activity below, or your own. If a questionnaire was sent to participants before the training, briefly discuss the findings before doing the activity below.

SMALL GROUPS

Participants' expectations

Ask each participant to take a sheet of paper and write responses to the following statements, which are written on newsprint (see the Advance Preparation section, page 1-1):

- In this workshop, I expect to develop the following skills about family planning counseling:
- The most important benefit I hope to get from this workshop is:

- This workshop will help me in my job because . . .

Divide participants into small groups. Group members should share their answers and compile a common list.

DISCUSSION

Participants' expectations

As each group reports back to the class, record each new response on newsprint, without repeating those that have been stated already, and discuss whether the workshop will meet participants' expectations. Indicate how the workshop can be adapted to meet participants' needs.

Advise participants:

- We will look at these expectations at the end of the workshop, and they will be a useful checkpoint during training.

If the workshop cannot cover all of the information and skills requested, tell participants that you will let them know how and where they can get further information in those skills and topics that are not covered. Keep the newsprint for later use in Module 14.

Explain:

- Through exercises and role plays, you will have many opportunities to try out and improve skills.
- Participation is the key to the workshop's success.
- You should consider each other, as well as trainers, as resources.

Notes: _____

Step 3

Organization and schedule

LECTURE

Workshop organization

Explain the general organization of the workshop:

- The training begins with key counseling concepts, such as free and informed choice.
- Information about different contraceptive methods is reviewed throughout the training, rather than in one session alone (such as in a contraceptive technology update).
- Skills are introduced in approximately the same sequence as they are used in counseling sessions. For example, building rapport and creating a good climate for counseling are presented early in the workshop, because these skills are needed the moment the client walks in the door; skills related to client follow-up are presented near the end of the training. Thus the development of skills follows a natural sequence, while skills that were learned earlier are continually reinforced.
- The workshop progresses from the general to the specific. Early modules are relevant to counseling for all family planning methods. Later modules focus on considerations for permanent methods and on clients who have special concerns or needs. At the end of the training, you will explore how to best use your skills upon return to your service sites.

Distribute and post copies of the workshop schedule (see the Advance Preparation section, page 1-1).

Notes: _____

Step 4

Workshop logistics

LECTURE

Workshop logistics

Discuss logistical details such as the following:

- starting and ending times for each day
- lunch and break arrangements
- per diem and other financial matters (including how and where to change currency, if applicable)

- expectations regarding homework, evening sessions, and weekends
- time off, holidays, special excursions, and shopping
- whom to see about logistical problems or needs
- reconfirmation of flights and other transportation arrangements

Answer any questions participants may have about logistics.

Notes: _____

Step 5

Workshop norms

DISCUSSION

Developing workshop norms

Ask participants to develop norms or ground rules for the workshop. Write their responses on newsprint. Give one or more of the following examples to get the group started:

- punctuality at sessions
- smoking or not smoking in the meeting rooms
- raising one's hand to speak instead of speaking up
- following the schedule so that sessions do not run late
- respecting confidentiality

Ask the group for comments on the norms. Add, delete, or change the norms until the whole group agrees.

Suggest any appropriate norms that you feel have not been brought up, including norms for trainers (for example, keeping within time limits).

Notes: _____

Step 6 ***Participant's Handbook***

Give each participant one copy of the *Participant's Handbook* (see the Advance Preparation section, page 1-1).

PRESENTATION **Using the *Participant's Handbook***

Explain:

- This handbook will be used throughout the training, both for reference and for some of the activities.
- You should bring your handbooks with you each day of the training.
- You may keep your handbooks and take them with you at the end of training.
- Much of the material covered in the training course is summarized in the handbook and in other reference materials that you will receive. You do not need to take notes during the course. But feel free to write in your handbooks, to note any points you consider important.

Notes: _____

MODULE 2: INTRODUCTION TO COUNSELING

- Objectives** By the end of this module, participants should be able to:
- describe the basic rights of clients.
 - define free and informed choice.
 - describe three kinds of communication used in family planning: motivation, information-giving, and counseling.
 - describe the purpose of counseling.
 - describe the counselor's role in ensuring free and informed choice.
 - list personal qualities, skills, and knowledge needed to be a good counselor.
 - list six steps in counseling, as described by the GATHER¹ acronym.
 - describe the counselor's role in assuring clients' rights and contributing to quality of care.
- Estimated time** 3 hours, 30 minutes
- Advance preparation**
- Write the four points about the meaning of free and informed choice on newsprint (see Step 3, page 2-5).
 - Turn a piece of newsprint so the widest part is at the top, and copy the boldface headings from the grid about three types of family planning communication (see Step 4, page 2-6). Omit the answers, which are in parentheses.
 - If appropriate, substitute another video that describes counseling for *Counseling: Helping People Make Family Planning Choices* (see Step 8, page 2-13).
 - Write the GATHER acronym on newsprint (see Step 8, page 2-13).

¹ The GATHER acronym was first described in "Counseling makes a difference" by M. Gallen and C. Lettenmaier, *Population Reports* series J, no. 35 (1987).

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
25 minutes	Quality of care and clients' rights (page 2-3)	Visualization Partners exercise Discussion	None
10 minutes	Free and informed choice (page 2-5)	Discussion	None
50 minutes	Three kinds of family planning communication (page 2-5)	Exercise Exercise with worksheet	None
15 minutes	The purpose of counseling (page 2-8)	Discussion	None
30 minutes	The counselor's role in ensuring free and informed choice (page 2-9)	Discussion Case studies	None
30 minutes	Attributes of family planning counselors (page 2-11)	Brainstorming Discussion	None
40 minutes	The basic steps of counseling (page 2-13)	Viewing of videotape Lecture	Video cassette player, monitor, videotape: <i>Counseling: Helping People Make Family Planning Choices</i> or an appropriate substitute
10 minutes	Assuring clients' rights and contributing to quality of care (page 2-14)	Discussion	None

Step 1

Introduction

Review the objectives with participants.

Explain:

- This module will introduce some of the terms and concepts that will be used throughout the remainder of the workshop, since it is important for the group to have common definitions. A clear understanding of these terms and concepts will lay the groundwork for succeeding modules.

Step 2

Quality of care and clients' rights

VISUALIZATION

Positive experiences

Ask participants to close their eyes for a few moments. Speaking in a slow and pleasant voice and, pausing between each question, say to participants:

- Remember the last time that you went to visit the doctor, or to a health clinic.
 - » What was your experience like?
 - » Did you have to wait a long time, or were you seen right away?
 - » Were the doctors and nurses courteous, or did you find them to be rushed or rude?
 - » Were all your concerns taken care of, or did you leave with some questions or worries?
- Now, reflect on this experience, or another one you had or imagined in the past.
 - » What is it that makes a visit for health care a positive experience for you?
 - » How would you like to be treated?

PARTNERS EXERCISE

Feeling well cared for

Tell participants:

- You can open your eyes now. Pair up with the person sitting next to you. Each of you take about five minutes to describe to

the other the two most important factors that make you feel well cared for when you are a health care client.

After the partners have completed their discussions, ask participants to volunteer their responses. Write them on newsprint, avoiding duplication of responses.

Point out:

- Each of us has different opinions or priorities about what matters to us in getting quality care. This list on newsprint reminds us of aspects of quality care that clients who come to us might also appreciate.
- Being able to empathize with clients by putting ourselves in their situations, as we have just done, is a useful way to check whether we are treating others as we ourselves would like to be treated.

Post the newsprint, and ask participants to look at it from time to time throughout the training—to see how the group measures up in delivering the kind of counseling they themselves would like to receive.

DISCUSSION

Rights of the client

Refer participants to Handout 2-1: Rights of the Client. Ask:

- Is there anything on this list that you disagree with? Is there anything missing from the list?

Through discussion, modify the handout (participants can write on their copies). After making the modification, ask participants:

- Raise your hands if you feel you can adopt the client's bill of rights as a basic set of principles.

Notes: _____

Step 3

Free and informed choice

DISCUSSION

Definitions

Ask participants:

- What does *free and informed choice* mean?

The discussion should cover the following four points, which are written on newsprint (see the Advance Preparation section, page 2-1):

- *Free and informed choice* means that men and women are making free and informed choices about their fertility. The three words *free*, *informed*, and *choice* are all key to understanding the concept.
- *Free* refers to a decision made without coercion, constraints, or other forms of pressure. The word *voluntary* is sometimes used to express this concept.
- *Informed choice* requires full information about the nature, risks, and benefits of the available family planning options.
- *Choice* means that the client can decide whether or not to use contraception, and can choose among different methods.

Emphasize:

- Ensuring free and informed choice is one of the goals of counseling.

Notes: _____

Step 4

Three kinds of family planning communication

Explain:

- There are typically three different types of communication activities in family planning programs: *motivation* (also known as promotion), *information-giving*, and *counseling*. To have a clear understanding of counseling, it is important to

differentiate it from other kinds of family planning communication, and to see how each type of communication can affect clients' choices.

Display a newsprint copy of the grid below (see the Advance Preparation section, page 2-1). Omit the answers, which are in parentheses.

TYPE OF COMMUNICATION	GOAL	CONTENT	DIRECTION	BIAS	LOCATION
Motivation or promotion	(Influencing behavior in a particular direction)	(Propaganda or persuasion)	(One-way)	(Biased)	(Anywhere)
Information-giving	(Providing facts and raising awareness)	(Facts—complete or incomplete)	(One- or two-way)	(Biased or objective)	(Anywhere)
Counseling	(The client's free and informed choice; a satisfied client)	(Facts; client's feelings, needs, concerns)	(Two-way)	(Objective)	(Private atmosphere)

EXERCISE

Completing the grid

Ask participants to suggest responses to complete the grid by filling in one column at a time, starting with *Goal* and moving through to *Location*. Encourage discussion. When the group has reached consensus, fill in the responses. If necessary, provide the appropriate responses.

Summarize the results of the grid discussion by emphasizing the following points:

- **Motivational or promotional** activities encourage the use of family planning. These activities may be conducted in person or through the media. While they can convey useful information, these activities are usually biased. They often attempt to influence an individual or group to adopt family planning and to use particular methods.
- **Information-giving** activities provide facts about methods and can be done in person (either individually or in groups), or through print materials or other media. The information presented may be complete or limited, and may be accurate or incorrect.

- **Counseling** activities focus on helping individuals make choices about fertility. Counseling goes beyond just giving facts; it enables clients to apply information about family planning to their particular circumstances and to make informed choices. It includes a discussion of the client's feelings and concerns since they are relevant to the client's choices regarding fertility. Counseling always involves two-way communication between the client and counselor, in which each spends time talking, listening, and asking questions.
- While motivation and information-giving can be done anywhere, it is important for counseling to be done in a private atmosphere since personal information is shared.

**EXERCISE WITH
WORKSHEET**

Identifying kinds of communication

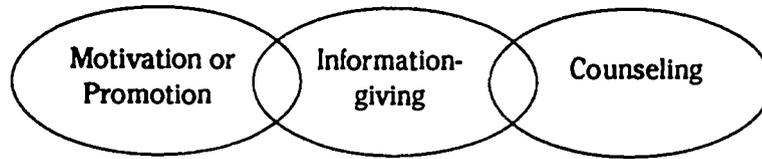
Ask participants to complete Handout 2-2 by deciding whether the described activities are examples of motivational, information-giving, or counseling activities.

ANSWERS:	6. C
1. C	7. I
2. M	8. C
3. I	9. I
4. M	10. M
5. C	11. M

Review the answers by calling on volunteers. Ask them to tell what kind of activity they believe each item is and why. Participants may have different answers to the worksheet according to their interpretation of the situation. Emphasize that the different forms of communication overlap considerably, and more than one answer may be right.

Summarize the main points of motivational, information-giving, and counseling activities. Draw the following diagram² on newsprint.

² Source: G.S. Neamatalla and P.B. Harper. *Family planning counseling and voluntary sterilization: A guide for managers*. New York: Association for Voluntary Surgical Contraception, 1990.



Explain to participants:

- As you can see on the diagram, there are overlaps between motivation and information-giving, and between counseling and information-giving, but there is no overlap between counseling and motivational activities. While both counseling and motivational activities involve information-giving, counseling does not attempt to promote a particular outcome.
- Each of these types of communication has a place in family planning. For example, it may be acceptable to motivate people in general to use family planning since contraception offers health and other advantages. It is not acceptable to motivate people to use one particular method since that violates the individual's right to make a decision and to choose the best option for himself or herself.

Notes: _____

Step 5 The purpose of counseling

Explain to participants:

- Although *family planning counseling* is a term that means different things to different people, we will work as a group towards a common understanding of its purpose.

DISCUSSION The purpose of counseling

Ask each participant to write the purpose of family planning counseling on a sheet of paper. Have volunteers list their responses, and write them on newsprint. The list should include these points:

Counseling:

- helps clients weigh the benefits and risks of available contraceptive methods.
- helps clients consider their own needs and feelings.
- helps clients make informed and voluntary decisions about fertility and contraception.
- involves two-way communication between the counselor and the client.
- provides information and helps the client apply that information to his or her needs and circumstances.
- helps clients use contraceptive methods correctly.

Point out:

- Family planning counseling differs from medical advice since it involves healthy individuals and does not recommend a particular course of action. The client makes the choice rather than the health care provider. Counseling helps ensure that the client's choice is free and informed.

Notes: _____

Step 6

The counselor's role in ensuring free and informed choice

DISCUSSION

Ensuring free and informed choice

Discuss the counselor's role in ensuring free and informed choice. Cover the following points:

- The counselor can help ensure free and informed choice by:
 - » providing balanced and accurate information.
 - » ensuring that clients make their own decisions about their fertility.

- » helping clients gain access to the methods that they desire.
- Often, the counselor must help the client negotiate the health care system or complete the steps needed to obtain the desired method (particularly for permanent or long-term methods that require a clinical procedure).

CASE STUDIES

When free and informed choice is jeopardized

Read each of the following cases out loud. Have participants describe how free and informed choice is jeopardized in each case. Encourage participants to discuss each situation. Ask volunteers to describe what actions they would take if they were the counselor in this situation. Possible responses are given for each situation.

CASE: A client seems very unsure about a decision about contraception, although the partner (or someone else) is urging the client to go ahead with it.

POSSIBLE RESPONSE: The client may feel pressured. Make sure that the client has a chance to speak to you alone. Let the client know that she or he has the right to make decisions and that it is important that she or he feels comfortable with choices about reproduction.

CASE: You are counseling a couple. The husband does all the talking. You are not sure what the wife is thinking.

POSSIBLE RESPONSE: Although counseling couples is encouraged, always try to have at least a brief period in which you speak alone with the client who plans to use contraception. At that time, check whether the client's decision is his or her own.

Explain:

- Free and informed choice can be affected by many factors and people. For example:
 - » A woman's husband or mother-in-law may encourage her to adopt or dissuade her from using a particular method.
 - » Doctors' recommendations often influence clients' family planning choices.
 - » Promoters or community health care workers may provide information about some contraceptive methods but not others.

- » A government may have policies that restrict or promote certain contraceptive methods or certain reproductive health services.

Ask participants to discuss situations in which they have encountered factors jeopardizing free and informed choice.

Discuss the potential hazards, for both the client and the service site, of not having a program that ensures free and informed choice:

- Clients are more likely to discontinue methods that they do not choose for themselves.
- Clients who do not choose tubal ligation or vasectomy voluntarily are more likely to experience postoperative regret and dissatisfaction. They may also want to reverse the procedure.
- Clinics in which free and informed choice is not ensured may lose credibility and prestige, and as a result, experience declines in attendance and referrals.

Notes: _____

Step 7

Attributes of family planning counselors

Tell the participants:

- Most health care workers need a number of personal qualities, skills, and knowledge to do their jobs.
- The term *counselor* refers to a health care worker who is responsible for family planning counseling and usually other duties. Health care workers responsible for counseling need certain skills and knowledge to counsel well.

BRAINSTORMING **Personal qualities**

On a piece of newsprint, write the heading *Personal qualities*. Ask the participants to name some of the personal qualities needed by an effective family planning counselor. Write participants' responses on the newsprint. Turn to Handout 2-3, and review any items that were not mentioned. Explain:

- Personal qualities and attitudes, such as empathy for clients, a supportive attitude, and tolerance for different values, are an important part of who a person is. It may not be easy to change these qualities and attitudes, but it can be done if the person is motivated.

DISCUSSION **Skills and knowledge**

Review with participants the skills and knowledge counselors need, which are listed on Handouts 2-4 and 2-5. Ask if there is anything they would add to the lists or that they disagree with.

Ask participants to raise their hands if they themselves have all the qualities mentioned (none should). Point out:

- No one has every personal quality, skill, or area of knowledge that we have discussed.
- This training will help develop these attributes. Being aware of our own individual strengths and limitations will help us become better counselors.
- Communication skills such as listening, asking questions effectively, and presenting information, are sometimes innate. However, these skills can be developed and enhanced through training and practice.
- Knowledge related to contraception, clients, family planning counseling and programs, and a country's policies and laws regarding family planning, can be learned.
- This workshop is intended to develop and reinforce the communication skills and knowledge listed on Handouts 2-4 and 2-5. Acquiring these skills and knowledge takes time and practice that extend beyond this workshop.

Notes: _____

Step 8 The basic steps of counseling

VIEWING OF VIDEOTAPE

Counseling

Show the videotape *Counseling: Helping People Make Family Planning Choices* or an appropriate substitute.

Ask participants what they liked and did not like about the video. Answer any questions they have.

LECTURE

The GATHER concept

Display a sheet of newsprint (see the Advance Preparation section, page 2-1) that lists the following:

G — GREET client

A — ASK client about self; **ASSESS** client's knowledge and needs

T — TELL client about family planning methods

H — HELP client choose a method

E — EXPLAIN how to use a method

R — RETURN visits

Explain:

- The GATHER acronym is a way to remember the essential steps of counseling.
- The video *Counseling: Helping People Make Family Planning Choices* demonstrates most counseling steps, but it does not show a clear example of assessing.
- A large part of the workshop will use the GATHER approach as its organizing principle. After learning about how attitudes, values, and experience affect counseling, and about building good relationships with clients, you will learn and practice

each step of GATHER, and review the knowledge needed for the implementation of each step.

Place the newsprint discussing the GATHER acronym where it is clearly visible for reference during the training.

Notes: _____

Step 9

Assuring clients' rights and contributing to quality of care

DISCUSSION

Counseling and quality

Summarize this introductory module by reiterating the importance of counseling in providing quality services.

Tell participants to look once again at Handout 2-1: Rights of the Client. Going down the list, ask participants:

- Which of these 10 rights can be influenced by counseling or by the counselor?

Point out:

- Counselors can affect each of the rights of the client. This shows the vital role that the counselor plays in contributing to the quality of care that the client receives.
- Other health care providers also have a part to play in assuring clients' rights and in providing good quality of care. These responsibilities do not rest only with the counselor, but counselors can be an important model for others.

Notes: _____

MODULE 3: VALUES AND ATTITUDES

Objectives

By the end of this module, participants should be able to:

- explain the terms *value* and *attitude*.
- describe how values and attitudes can affect counseling.
- describe the relationship between sexuality, family planning, and counseling.

Estimated time

2 hours, 15 minutes

Advance preparation

- Make three signs labeled *Agree*, *Disagree*, and *Undecided*, and post each of them in a different corner of the room (see Step 3, page 3-3).
- Decide whether to use the role play or the alternative discussion in Step 3, page 3-5. The role play is more active, and is better for holding participants' attention, but it takes more time and preparation.

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
5 minutes	Definition of <i>value</i> and <i>attitude</i> (page 3-3)	Discussion	None
1 hour, 10 minutes	Counselors' values and their effects on counseling (page 3-3)	Exercise with worksheet Role play (or alternative discussion)	None
1 hour	Sexuality, family planning, and counseling (page 3-7)	Visualization Partners exercise Discussion	None

Step 1 Introduction

Review the objectives with participants.

Step 2 Definition of *value* and *attitude*

DISCUSSION Definitions

Ask participants what is meant by the terms *value* and *attitude*. Responses should include:

- A *value* is a belief that is important to an individual. Values can be influenced by religious, educational, or cultural factors, or by other personal experiences.
- An *attitude* is a view or opinion that is formed by values and beliefs.

Point out:

- There is substantial overlap between terms.
- During this course, you may discover that some of your personal attitudes or opinions are based on values that you hold and may not share in common with your clients.

Notes: _____

Step 3 Counselors' values and their effects on counseling

Tell participants that they will now complete an exercise in which they examine their values. Before they begin, emphasize that in this exercise there are no "right" or "wrong" values.

EXERCISE WITH WORKSHEET

Values clarification

To complete this exercise, follow these steps:

1. Have participants read Handout 3-1: Values Clarification Worksheet. Give them five minutes to complete the worksheet.

2. Point out the three areas of the room that have signs: *Agree*, *Disagree*, and *Undecided* (see the Advance Preparation section, page 3-1).
3. Read a statement from the handout and ask participants to move to the area with the sign that reflects their opinion.
4. Ask volunteers to explain the reasons behind their choices.
5. Repeat steps 3 and 4 of this exercise for as many statements as time permits.
6. Wrap up the exercise by asking the following questions and encouraging discussion about each:
 - Were you surprised by the responses of your peers?
 - How did you feel when you disagreed with other participants? How did you feel when others disagreed with you?
 - What can happen if a counselor disagrees with a client's values or imposes her or his values on a client?
 - Why is it necessary for a counselor to be aware of her or his own values?
7. Stress these additional points:
 - Even in this group of participants who have much in common (job functions and educational levels), the exercise showed differences in values.
 - No two individuals hold identical values. Each person's values and attitudes are shaped by her or his own culture, upbringing, and life experiences.
 - The point of the exercise was not to persuade others or to prove the validity of any one view. Rather, the exercise was designed to make you aware of the values behind your opinions, so that you can avoid imposing those values on clients.
 - You may have found yourselves trying to convince your colleagues of your viewpoint. It is important to recognize this natural tendency and to avoid doing this with clients.

- Information and alternatives must be presented in a neutral, objective manner so that clients can make their *own* decisions.
- The client has a right to a different choice than the counselor would make.

Explain the following to participants:

- The next activity is designed to demonstrate the difficulty of keeping personal values out of the service provider's role, and the potential danger when the service provider's beliefs influence a client's choice.

Complete either the role play *or* the discussion by following the directions below.

ROLE PLAY

Who is responsible?

1. Ask six volunteers to play the parts in this role play. If they wish, the volunteers can choose names for the parts they will play. Use Handout 3-2: Who Is Responsible? to brief each player on her or his role.
2. Set up chairs or positions around the room to allow for movements between "scenes" in the role play.
3. Mrs. X goes to each player in the sequence described on the handout. The players perform their roles, as the rest of the group watches.
4. Following the role play, have the group discuss who is most responsible for the death of Mrs. X, and why. In conducting this discussion, follow these guidelines:
 - Remain neutral.
 - Ask participants how the characters' personal beliefs influenced their interactions with Mrs. X.
 - Ask participants which of their own personal beliefs support the opinions of the characters. Point out that each participant is entitled to his or her own perspective.
 - Encourage participants to express all of their opinions, even if they differ from those held by others. The differences among participants' opinions are important in illustrating

the danger of assuming that the service provider's values are the same as the client's.

5. Summarize the discussion by asking how the counselor's beliefs can affect her or his ability to meet clients' needs. Note that:
 - The choices the counselor makes for someone else may be harmful rather than helpful.
 - The service provider's personal ideas about what is "right" or "wrong" can be barriers to a client's using family planning services or may even represent a threat to the client's health.

ALTERNATIVE DISCUSSION

Who is responsible?

Use this activity as an alternative to the role play.

1. Ask participants to read Handout 3-2: Who Is Responsible?, and choose the character who they feel is most responsible for the outcome.
2. Ask participants which character they chose as most responsible and why. Tally the responses on newsprint. Ask participants the reasons behind their choices. In conducting this discussion, follow the guidelines described in step 4 of the role play.
3. As described in step 5 of the role play, summarize the discussion.

Following the role play or discussion

After either the role play or discussion, summarize by asking participants:

- Why do you think we spent time talking about values in this training?

The following points should emerge:

- Understanding our own values can help us better understand and respect the values of clients.
- Reflecting on our own values can help us draw limits so we don't influence clients by expressing our personal views.

Notes: _____

Step 4

Sexuality, family planning, and counseling

Explain the following to participants:

- We need to realize how our own attitudes and inhibitions may affect how we counsel clients.
- Since individuals use contraception so they can have sexual intercourse without getting pregnant or getting sexually transmitted diseases (STDs), we need to be able to talk comfortably with clients about their sexual practices and those of their partners.
- Frank discussion of sexual practices, particularly those that put clients at risk of STDs, including HIV infection, is necessary to help clients choose the contraceptive methods that will work best for them, and be most desirable to them.
- Often clients will bring up sexual matters themselves.

Tell participants that they will explore how attitudes towards sexuality can affect counseling.

VISUALIZATION

The counselor and sexuality

Ask participants to close their eyes and relax. Ask participants the following questions in a slow, pleasant voice, pausing after each sentence to give participants a moment to think.

- Think back to your childhood experiences with sexuality. How did you learn about sex? Did your parents explain it to you, or did you learn some other way? Did you understand what you were told?
- Did you ever play “house” or “doctor” with a friend or relative when you were small? What do you remember about discovering your own body or someone else’s?

Ask participants to open their eyes. Tell them:

- On a piece of paper, write several words that describe how you felt about sexuality when you were a child. Your responses will remain anonymous. Take no more than a minute to do this.

If participants need help, give several examples of words, such as *excitement*, *forbidden*, *shame*, and *curiosity*.

Tell participants to fold their papers in half. Collect the responses and shuffle the papers. Then read the words aloud. Lead a discussion:

- Do you think these feelings also describe how many adults feel about sexuality?
- Almost all of us learn when we are very small that sex is something people often don't feel comfortable talking about. Our parents may not have told us anything, or they may have felt uncomfortable answering our questions. Our friends may have given us misinformation. It was probably important to us not to let others know that we didn't understand everything about sex.
- These feelings carry over into our adult life. Sexuality is of interest to all of us, yet we may become uncomfortable when discussions come close to us. We wonder if we're normal. We wonder if other people think the things we think or do the things we do. We want to be private about our concerns or questions about our sexuality.
- We'll now talk with a partner about how we each view sexuality.

PARTNERS EXERCISE

Sexuality and counseling

To complete this activity, follow these steps:

1. Write the following questions on newsprint:
 - What does the word *sexuality* mean to you personally?
 - When clients begin to discuss sexuality, how do you feel?
2. Pair each participant with a person next to her or him. Tell partners to spend 10 minutes thinking about these two questions and discussing their responses with each other.
3. Ask participants:

- How did you feel when I said we were going to talk about sexuality with a partner?

State:

- You may have felt nervous, worried, or maybe excited. This is how clients may feel when you bring up sexual topics with them.

4. For each question listed in step 1 of this exercise, have volunteers share their responses with the group. In concluding the discussion of each question, make the corresponding point below.

- **QUESTION 1:** People have different definitions of sexuality, ranging from narrower interpretations (for example, sexuality refers only to the act of sexual intercourse) to broader concepts (what it means to be male or female). As with values, there are different ways of viewing the concept.
- **QUESTION 2:** People have different levels of comfort in talking about sexuality. Some counselors may feel very comfortable. Others may have had no training or professional experience in dealing with sexuality, and may feel shy or uncomfortable talking about it. Since counselors are human, they may have the same difficulties or feelings of awkwardness as other people when talking about sexuality. They have their own questions or concerns about sexuality. However, counselors often find it easier to talk about sexuality in a professional context than they do when talking about it with people that they know personally.

5. Ask the group:

- What might happen if a counselor is uncomfortable discussing topics related to sexuality?

Possible responses include the following:

- If counselors show discomfort when talking about sexuality with clients, it may inhibit clients.
- A counselor who does not feel comfortable talking about these issues may avoid asking or answering certain questions.

- A counselor may have difficulty helping a client think about which method to use if the counselor feels uncomfortable talking about sexuality and the client's personal needs.
- Although we may not always feel comfortable talking about sexuality, practice can help, as can the realization that this is a difficult but vital topic for counselors.

DISCUSSION

Summary

Summarize by asking participants:

- Why did we spend time discussing sexuality?

Possible responses include the following:

- Being sexually active (or planning to be) is a major reason clients seek contraception.
- Understanding our own values and feelings about sexuality can help us to be more effective counselors and to empathize with clients when they bring up sensitive subjects.

Notes: _____

MODULE 4: FACTORS IN CLIENT DECISIONS

Objectives

By the end of this module, participants should be able to:

- describe individual and community factors that influence family planning decisions, and how those factors affect counseling.
- describe different reproductive goals that clients may have at different stages in life.
- describe basic facts about STDs, including HIV infection.
- list possible effects that different contraceptive methods can have on sexuality.

Estimated time

3 hours, 15 minutes

Advance preparation

- On newsprint, write the questions from the first exercise (see Step 2, page 4-3).
- Choose four examples of family planning decisions from the small group activity (see Step 2, page 4-5), and write them on newsprint. If the training group is large, you may want to use additional examples.
- On newsprint, write the bulleted items about the client Mary (see Step 3, page 4-7).
- If possible, arrange for a doctor or another health care worker knowledgeable about STDs, including HIV infection, to lead the discussion described in Step 4 (see page 4-10). Review the material from Step 4 in advance with the person.
- On newsprint, write the column headings and the names of the methods for the chart described in Handout 4-3 (see Step 5, page 4-11). Turn several sheets of newsprint sideways; divide each sheet into two vertical columns. Write the heading *Contraceptive method* over the left column and the heading *Possible relationship to sexuality* over the right column. In the left column, write the names of different contraceptive methods: pills, injectables, and implants; IUD; diaphragm with spermicide; condoms; spermicides; fertility awareness methods; withdrawal; tubal ligation; and vasectomy. Leave space below each item named in the left column.

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
45 minutes	Factors that influence clients' choices (page 4-3)	Exercise Small groups	None
45 minutes	How family planning needs change and differ (page 4-6)	Case study Discussion	None
45 minutes	HIV infection and other STDs as factors for clients (page 4-9)	Lecture Reading Discussion	Doctor or other health care worker knowledgeable about STDs, <i>Talking with Clients about Family Planning: A Guide for Health Care Providers</i> (1 copy for each participant)
1 hour	Effects of contraceptive methods on sexuality (page 4-11)	Exercise	None

Step 1 **Introduction**

Review the objectives with participants.

Step 2 **Factors that influence clients' choices**

Explain:

- One of the counselor's main responsibilities is helping clients to reflect on their experiences, attitudes, and values, in order to make choices that are consistent with their values and priorities.

EXERCISE **Personal choices about family planning**

1. Tell participants:

- We will now examine personal experiences and reproductive choices, in order to learn more about the factors that influence clients' family planning choices.

Show the participants the questions that you have written in advance on newsprint (see the Advance Preparation section, page 4-1):

- Are you currently using a method of family planning? If you are, what is the method and why did you choose it? If not, why not?
- For those not currently using a method: Have you ever used a method?
- For those currently using a method: Have you ever used a different method? Why did you stop using that method?
- What factors or people influenced your decisions to use family planning or particular methods?

2. Tell participants:

- When answering these questions, you can draw on your own experience or on that of someone you know (a friend, relative, or client).

Read each question out loud to the group, and pause a minute to allow time for the participants to write their responses on sheets of paper.

3. Collect the responses, shuffle them, and then hand them out to the group (so that each participant will have a paper that is not her or his own).
4. Have participants volunteer responses from the sheets about factors that influence the choice to use family planning or a particular method. Ask participants to brainstorm other factors that influence clients' choice of a method. Write their responses on newsprint under two headings: *Individual characteristics* and *Community influences*. Responses should include the following:

Individual characteristics

- Age
- Number and gender of children
- Health status of the client
- Risk of contracting or transmitting HIV infection or other sexually transmitted diseases
- Health status of the family
- Economic status
- Educational level of both partners
- Previous contraceptive use and experiences
- The nature of the relationship(s) with the partner(s)
- Sexuality
- Religious beliefs
- Personal beliefs

Community influences

- *Word of mouth*: the influence of relatives and satisfied or dissatisfied clients
- *Culture*: the cultural expectations concerning family size
- *Religion*: the pronouncements of religious leaders on family planning
- *Politics*: governmental population policies

- *Gender roles*: the status and roles of women and men in the society. A woman's role may be tied to maternity status; a man may associate manhood with the number of children he has.
- *Health providers*: their willingness to provide family planning services, their knowledge and skills
- *Information*: educational messages and promotional efforts concerning family planning
- *Misconceptions*: common misconceptions about contraceptive methods

SMALL GROUPS

Examples of family planning decisions

Tell participants that they will now complete an activity that illustrates how different factors affect family planning decisions. Follow these steps:

1. Divide participants into small groups of four to six people. Assign each group one of the following descriptions of family planning decisions, which you have written in advance on newsprint (see the Advance Preparation section, page 4-1):
 - A woman is afraid of using contraception because her mother-in-law and sisters say she should have the children God gives her.
 - A woman uses the injectable because she can get it without her husband's knowledge.
 - A husband and wife have three girls and feel they cannot afford more children, but are reluctant to give up the idea of having a boy.
 - An adolescent's boyfriend will not use condoms, because he thinks they reduce sensation.
 - A man chooses vasectomy after a health care worker convinces him it is the best way to prevent pregnancy.
 - A woman will not consider the IUD because her sister did not like her IUD.
2. Have each small group discuss how their client's decision may have been influenced by the individual characteristics and community influences listed earlier in this training step.

3. Ask each group to report its results to the larger group, and to highlight the different factors influencing each client's situation.
4. Conclude by making the following points:
 - Counseling requires focusing on the circumstances, values, and needs that affect the client's decisions about fertility. The factors that determine what family planning method a person uses are more complex than just the various characteristics of that method.
 - If individuals make their own choices for contraception, they are more likely to use and be satisfied with a method they have chosen. As this activity has shown, however, clients are part of marriages, families, and communities that may influence their choices.
 - If the client wishes, it is usually desirable to include the partner in the decision about contraception and, if possible, in part of the counseling session, since the use of contraception affects them both. Partners may be more supportive of contraceptive use if they are informed and involved in discussions early on. But in every case, each client should have some time alone with the counselor.

Notes: _____

Step 3

How family planning needs change and differ

Explain:

- Now we will examine how a client's physical and life situation changes with time, and how those changes affect a client's priorities, reproductive intentions, and contraceptive needs.

Have participants consider the following case study.

CASE STUDY

Family planning needs throughout life

Follow these steps:

1. Have each participant take out a blank sheet of paper.
2. Tell participants that Mary is a 24-year-old woman with three young children who has come to them for counseling. Have participants draw on their own experience with clients to invent other details about Mary, and write a paragraph that gives a fuller portrait of her. Participants' paragraphs should include the following points, which you have written in advance on newsprint (see the Advance Preparation section, page 4-1):
 - Mary's reason for coming for family planning counseling
 - Mary's marital status
 - Mary's economic status
 - Mary's past experience with family planning methods
 - Mary's plans for having or not having more children
3. Ask 3-4 volunteers to read their descriptions. Point out that participants have created various scenarios and goals for this client, illustrating how even individuals of the same age and parity differ.
4. Tell participants:
 - Imagine that Mary is now 38 years old and has five children. Describe the changes you think might have occurred in Mary's life.
 - » Has her marital status changed?
 - » Has her economic situation changed?
 - » What are her reproductive goals now?

DISCUSSION

Different reproductive goals

Using the responses, lead a discussion on:

- the ways in which reproductive goals change (postponing or spacing pregnancy; ending childbearing)
- how changes in marital status can affect reproductive goals

- how changes in economic status can affect reproductive goals

Explain:

- Clients of the same age may have different reproductive goals.

Illustrate this point by describing three different 19-year-old women. Write these descriptions on newsprint:

- One already has three children and does not want any more.
- One is about to have sex for the first time and is worried about AIDS.
- One has just been married and wants to have her first baby right away.

Discuss with the participants how the reproductive goals of these young women differ. Conclude by explaining:

- Each client has different reproductive goals at different times in her or his life.
- There is no typical path of reproductive goals. These goals depend on each client and may be influenced by cultural patterns.
- As with other personal values, there is no “right” or “wrong” sequence of reproductive goals.
- What *is* important is for the counselor to learn about the client’s current and planned reproductive intentions, since certain methods may be more appropriate to help the client meet those goals.

Notes: _____

Step 4

HIV infection and other STDs as factors for clients

LECTURE

Basic information about HIV infection and other STDS

Explain:

- The world as we know it has changed a lot in recent years. Not so long ago, few of us knew the words *HIV infection* and *AIDS*, yet HIV infection and AIDS are now facts of life for those of us involved in health care and for the clients we serve.
- Clients have concerns, and need to know, about their risk of getting HIV infection and other sexually transmitted diseases or of passing these diseases to others, if they are already infected.
- HIV infection and other STDs are factors that can influence clients' choice of contraception. Some clients need protection not only against pregnancy but also against these diseases.
- Information about HIV infection and other STDs is woven throughout this training program.

Introduce the book *Talking with Clients about Family Planning: A Guide for Health Care Providers*. Explain:

- The book provides the key information clients need to choose and use contraception. It also provides basic facts about sexually transmitted diseases, including HIV infection.
- The book will be used throughout the training and can also be a reference once you return to work.
- The appendixes provide information about sexually transmitted diseases. (This information also appears on Handouts 4-1 and 4-2.)

Tell participants:

- In order to counsel clients about prevention of HIV infection, you need to understand the following:
 - » What HIV is
 - » What AIDS is
 - » How HIV is transmitted
 - » What are some of the common symptoms of AIDS

- » Who is at risk
- » How to prevent HIV infection
- » How to assess risk

READING

Differences between HIV infection and AIDS

Give participants 10 minutes to read either Handout 4-2 or the appendix about AIDS from *Talking with Clients about Family Planning: A Guide for Health Care Providers*. Then explain the difference between HIV infection and AIDS:

- *HIV* stands for *human immunodeficiency virus*. *AIDS* stands for *acquired immunodeficiency syndrome*, a condition caused by HIV.
- *HIV infection* means that the person has been exposed to and has gotten the human immunodeficiency virus. The person may have no symptoms and may not know that he or she has the virus. However, people who are infected with HIV can transmit the disease to others.
- People who have AIDS have the human immunodeficiency virus and also have symptoms.
- Throughout this training, we will primarily use the term *HIV infection* since clients need protection against the virus in order to be protected against getting AIDS. Counselors will need to decide which terms to use when they speak with clients, depending upon the customary language used in the community.

DISCUSSION

Questions about STDs

If a doctor or other health care worker knowledgeable about STDs is present (see the Advance Preparation section, page 4-1), open the floor for questions and discussion. If this person is not available, answer as many questions as possible. If questions arise that you cannot answer, explain that you will check with a doctor and obtain the answer.

Notes: _____

Step 5 Effects of contraceptive methods on sexuality

EXERCISE Completing a chart

Explain:

- As we discussed earlier, people use contraception because they are sexually active or plan to be.
- Clients' use of and satisfaction with contraception is often related to the real or perceived effect of contraceptives on their sexual practices and enjoyment.

Using the chart you prepared earlier (see the Advance Preparation section, page 4-1), ask the group what relationship each of the methods listed on the newsprint might have to a client's sexuality. (The chart appears as Handout 4-3; you may want to tell participants about the handout, but encourage them to complete the newsprint chart on their own without consulting the handout.) Examples can be either factual or widely perceived as factual by clients.

Give an example to start, and write it in the *Possible relationship to sexuality* column. For instance, write *condom* in the left-hand column under the heading *Contraceptive method*; then state that some believe the condom reduces sensation and interrupts lovemaking. Write these two points in the right-hand column.

Then ask the group for other examples of possible relationships between the condom and a client's sexuality, and write them in the right-hand column. Encourage participants to think of examples of how methods might be seen to either enhance or limit sexuality. Continue until the group has no more examples. Point out:

- What one person may see as a disadvantage may not be a problem, or may even be an advantage, for another person. For example, while some people may claim that a condom

interrupts lovemaking, others may incorporate putting the condom on into lovemaking, or involve their partner in this activity. Sometimes condoms may enhance lovemaking by helping men avoid premature ejaculation.

Handout 4-3 provides illustrative examples.

Ask how the issues that you have just discussed relate to family planning counseling. Point out:

- In order for clients to use contraception consistently, and to be reasonably satisfied with the methods chosen, the methods need to fit into their lifestyles, including their sexual practices and preferences.
- Clients need to think about which methods will meet their needs, and which ones will cause problems for them (including not using the method). For example:
 - » If spontaneity is important, methods that are directly related to intercourse may not work well.
 - » Women considering hormonal methods or the IUD need to think about whether menstrual changes, including spotting between periods, will cause problems for them or their partners.
 - » More effective methods give some people a greater sense of security; without the fear of pregnancy, these people may enjoy sex more.
 - » For some, frequency of sexual relations will be a factor in choosing contraceptives. Individuals who have sex occasionally or infrequently may prefer a method that can be used as needed, such as condoms, the diaphragm, or spermicides, rather than a method like the pill that requires doing something every day.
 - » Whether a client is at risk of, or has, a sexually transmitted disease affects the type of contraception he or she uses. This is discussed later in the training (Modules 8 and 9).
 - » Clients who strongly associate fertility with their sexuality or self-esteem may not be comfortable with permanent methods.

- » Clients who need to conceal their sexual activities (for instance, unmarried adolescents) or their use of contraception (for instance, clients whose partners do not approve) may want to consider methods that do not require continuing supplies.

Summarize by asking participants:

- Tell me one thing that you learned or that surprised you in our discussion of factors that influence clients' choices about family planning.

Notes: _____

MODULE 5: EFFECTIVE COMMUNICATION SKILLS

Objectives

By the end of this module, participants should be able to:

- describe nonverbal behaviors, and explain how they can affect the counseling relationship.
- demonstrate effective listening skills, verbal encouragement, and tone of voice.
- give examples of using nontechnical language in counseling and explain why this is important.
- demonstrate paraphrasing and clarifying skills.
- apply the principles of giving effective and constructive feedback.

Estimated time

3 hours, 30 minutes

Advance preparation

- On separate pieces of paper, write the names of emotions and feelings, such as *anger, boredom, sadness, happiness, impatience, disapproval, nervousness, shame, respect, understanding, kindness* (see Step 5, page 5-7).
- Write the following words on newsprint: *uterus, contraceptive, testicles, vagina, semen, sperm, fallopian tubes, ovary, menstruation, intercourse, penis, procedure* (see Step 6, page 5-8).
- Write examples of medical terminology from the second exercise in Step 6 on newsprint (see page 5-9).
- Write the information on feedback on newsprint (see Step 8, page 5-15).

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
20 minutes	Nonverbal communication (page 5-3)	Discussion	None
20 minutes	Active listening (page 5-4)	Discussion Partners exercise	None
15 minutes	Verbal encouragement (page 5-6)	Demonstration Role play Discussion	None
20 minutes	Tone of voice (page 5-7)	Exercise	None
40 minutes	Using simple language (page 5-8)	Exercise Role play Demonstration Exercise	None
1 hour, 10 minutes	Paraphrasing and clarifying (page 5-11)	Lecture Demonstrations Role play Discussion	None
25 minutes	Feedback skills (page 5-15)	Discussion Role play	None

Step 1

Introduction

Review the objectives with participants. Explain:

- This module introduces the key concepts of interpersonal communication, which are the foundation for effective counseling. These skills will be used throughout the remainder of the training.

Step 2

Nonverbal communication

Explain:

- When we hear the word *communication*, we usually think of words or what is said. Yet much of our communication with others is done without words.

Ask participants:

QUESTION: Think for a moment about how babies and young children communicate. How do they get their messages across before they learn to talk?

POSSIBLE RESPONSES: Smiling, crying, pointing, frowning

Explain:

- Nonverbal signals can communicate interest, attention, warmth, and understanding to clients.

DISCUSSION

Positive and negative nonverbal communication

Write *Positive* on the left side of a sheet of newsprint and *Negative* on the right.

Ask participants to draw upon their own experience for instances of positive and negative nonverbal communication. Write each response in the appropriate column on newsprint. Examples may include the following:

Positive nonverbal cues

- leaning towards the client
- smiling, not showing tension
- avoiding nervous or inappropriate mannerisms
- presenting facial expressions that inspire trust
- maintaining eye contact with the client

- making encouraging gestures, such as nodding one's head

Negative nonverbal cues

- reading from a chart
- glancing at one's watch
- yawning or looking at papers or out the window
- frowning
- fidgeting
- not maintaining eye contact

Summarize the discussion by explaining:

- A good relationship with a client is based not only on what the client hears, but also on what she or he observes and senses about the counselor.
- Remember that nonverbal cues vary from culture to culture, and sometimes among different groups within a culture (for example, men and women, adolescents and adults, may show different nonverbal patterns).

Notes: _____

Step 3

Active listening

Tell participants:

- One of the keys to establishing a good counselor-client relationship is *active listening*.

DISCUSSION

Defining active listening

Ask participants:

QUESTION: How do you know when someone is really listening to you?

POSSIBLE RESPONSES: Good listeners sustain eye contact, avoid fidgeting, and give the speaker their full attention.

QUESTION: How do you know when someone is a poor listener?

POSSIBLE RESPONSES: Poor listeners avoid eye contact, glance at papers or out the window, and give an impression of impatience, boredom, or distraction.

QUESTION: What is *active listening*?

POSSIBLE RESPONSE: *Active listening* is more than just hearing what a client says. It involves listening in a way that communicates empathy, understanding, and interest.

Tell participants that they will do an exercise to sensitize them to active listening.

**PARTNERS
EXERCISE**

Listening to a partner

1. Pair the participants. One member of each pair will be the listener and the other will be the speaker.
2. The speaker talks for three minutes about any subject, such as how she or he feels about this training session or how to handle a particular client. The listener tries to communicate interest but is not allowed to speak.
3. The two switch roles and repeat the exercise.
4. Lead a discussion with the whole group, using the following questions:
 - How did it feel to talk without interruption?
 - How did it feel not to be allowed to speak?
 - When you were the speaker, did you feel as if you were understood? If so, how was that feeling conveyed to you? Which nonverbal behaviors expressed understanding? Which did not?

Notes: _____

Step 4

Verbal encouragement

Tell participants:

- You will now have the chance to practice six verbal communication skills: giving verbal encouragement, using an appropriate tone of voice, using simple language, paraphrasing, clarifying, and giving feedback.
- These skills communicate to clients that they have been heard, understood, and accepted, and help clients understand themselves and their own needs.

DEMONSTRATION How to provide verbal encouragement

Explain:

- Counselors can express interest and understanding by giving brief verbal responses such as “I see,” or “Right.” This type of response is the verbal equivalent of nodding one’s head.

Demonstrate verbal encouragement. You play counselor. Ask another person to play a client who says her religion opposes the use of contraception. As the client discusses her concern, do the following:

- Lean forward slightly, listening sympathetically.
- Give various verbal cues, such as “Yes,” “I see,” “Mm-mm,” “Right,” or “OK.”
- Nod your head sympathetically.

ROLE PLAY

Lack of verbal encouragement

Now illustrate the difference between verbal encouragement and making no response by doing a role play in which you simply stare at the client and say nothing at all.

DISCUSSION

Advantages of verbal encouragement

Have the group discuss the differences between the demonstration and the role play. Emphasize that:

- Verbal encouragement demonstrates that the counselor is listening, and encourages the client to continue talking.
- Verbal encouragement is especially useful with shy clients.

Notes: _____

Step 5

Tone of voice

Explain:

- Tone of voice is an important component in building rapport.
- We will now do an exercise to observe how a person's tone of voice communicates different emotions.

EXERCISE

Practicing tone of voice

To complete this exercise, follow these steps:

1. Distribute pieces of paper with the names of emotions and feelings written on them to volunteers (see the Advance Preparation section, page 5-1).
2. Ask each volunteer to say a few sentences in a neutral tone, and then repeat them using the emotion on the slip of paper. Sample sentences include "The nurse will see you in a few minutes," "So, you have three sexual partners," and "Please fill out this form." Volunteers can invent other sentences.
3. Have the rest of the group guess which emotion is being displayed and discuss how the feeling is shown.
4. Summarize by asking:
 - Which tone of voice would you prefer to be used when you go to someone for help?
 - Which tones of voice are inappropriate in a family planning setting?

Notes: _____

Step 6

Using simple language

Explain:

- Another way to make clients feel comfortable is to use appropriate language.
- Unfortunately, because they are so familiar with medical terms, health care professionals often use words that clients may not understand and may find intimidating.
- Technical information needs to be geared to the level of education and language of each client, without talking down to her or him.

EXERCISE

Simplifying language

Display the following words written on newsprint (see the Advance Preparation section, page 5-1). Point to each word and ask volunteers for simpler words or phrases with the same meanings. Explain that in this exercise, as in counseling, counselors should try to use language that clients will not find embarrassing or vulgar.

Words:

uterus

contraceptive

testicles

vagina

semen

sperm

fallopian tubes

ovary

menstruation

intercourse

penis

procedure

Explain:

- Many items related to sex may be known by slang rather than medical terms. Some items may also be expressed by profanity.
- Counseling provides an opportunity to acquaint clients with medical terms. However, counselors should acknowledge and not ridicule the use of more commonly understood terms.

The role play and demonstration below illustrate how language can affect a client.

**ROLE PLAY,
DEMONSTRATION**

Medical language versus simple language

You play a counselor. Ask a participant to play a client. Take the participant aside and explain that he or she should appear confused and intimidated by the medical information you give in the role play.

First present information in medical terminology, then repeat the activity using simpler language. Use words from the list in the previous exercise as examples of difficult medical terminology.

Ask the participant who played the client:

- How did it feel to have the counselor use language you did not understand?
- How did it feel when the counselor switched to simpler language?

Ask the group:

- How can using simpler language improve the quality of counseling?

EXERCISE

Rephrasing medical language in simple language

1. Refer to the following examples of medical terminology written on newsprint (see the Advance Preparation section, page 5-1). Ask each participant to rewrite the information in simple language on a sheet of paper. Examples of simple language are given below. There are several acceptable ways to rephrase medical terminology.

MEDICAL TERMINOLOGY: "Tubal ligation is a surgical procedure for permanent contraception. In women the operation involves occluding both fallopian tubes to prevent the passage of both ova and sperm."

SAMPLE SIMPLE LANGUAGE: "People can choose to have an operation that prevents them from having any more babies. In women the tubes are blocked so that the eggs and sperm cannot meet."

MEDICAL TERMINOLOGY: "The IUD can cause menstrual irregularities such as dysmenorrhea or intermittent bleeding."

SAMPLE SIMPLE LANGUAGE: “The IUD can cause changes in your monthly periods, such as cramping, heavier bleeding than usual, longer periods than usual, or spotting between periods.”

MEDICAL TERMINOLOGY: “The most serious side effects of combined oral contraceptives are cardiovascular (high blood pressure, blood clots, heart attack, and stroke). These occur primarily in women who are older than 35 years and smoke or women who have an underlying disease contraindicating the use of the pill.”

SAMPLE SIMPLE LANGUAGE: “The pill can cause heart and blood problems. These are more likely to occur in women older than 35 who smoke or in women who have certain other health problems.”

2. Ask participants to volunteer examples that they have written. Discuss other examples or questions the participants have.
3. Summarize by emphasizing:
 - Clients may become confused, angered, or intimidated by language that they do not understand.
 - Using appropriate, simple language helps prevent misunderstandings, encourages clients to ask questions, and helps clients make informed decisions.
 - Using simple language does not apply only to medical words. Many of the words that counselors use frequently, such as *counseling*, *family planning*, *follow-up*, and *referral*, may not be understood by or may have different meanings for clients. Always explain terms, or double-check with clients, to ensure clients' understanding.

Notes: _____

Step 7 **Paraphrasing and clarifying¹**

Explain to participants that they will now learn about two more communication skills: *paraphrasing* and *clarifying*. Although there is some overlap between these techniques, each has a different purpose.

LECTURE **Paraphrasing**

Introduce participants to the key concepts of paraphrasing (Handout 5-1):

Definition: *Paraphrasing* is restating the client's message simply.

Use: Counselors use paraphrasing to make sure that they have understood what the client has said and to let clients know that they are trying to understand clients' basic messages.

Paraphrasing supports the client and encourages her or him to continue speaking.

Example:

Client: "I want to use the IUD, but my sister said that it can travel around your body, and stick in the baby's head."

Counselor: "You have some questions because of what you have heard about the IUD, and you want to find out what is true."

DEMONSTRATION **How to paraphrase**

You play a counselor. Ask another person to play a client. The client chooses a lead line from Handout 5-2, or creates a situation based on her or his own counseling experience. The client states the situation to you in her or his own words. You respond by paraphrasing. The client gives feedback on the accuracy of your paraphrase. If you have not captured the situation clearly, continue trying until the client says the paraphrase is accurate.

Ask participants:

QUESTION: How did paraphrasing contribute to communication?

POSSIBLE RESPONSE: It helped the counselor understand what the client was saying, and it made the client feel that she or he had been understood.

¹ Adapted from: D. E. Bender and C. Bean. *Counseling skills in family planning: Trainer's handbook*. Chapel Hill, N.C.: Carolina Population Center, University of North Carolina, 1982.

Review the following guidelines for paraphrasing:

- Listen for the client's basic message.
- Restate to the client a simple summary of what you believe is his or her basic message. Do not add any new ideas.
- Observe a cue or ask for a response from the client that confirms or denies the accuracy of the paraphrase.
- Do not restate negative images clients may have made about themselves in a way that confirms this perception. For example, if the client says "I feel stupid asking this," it is not appropriate to say "You feel ignorant."

DISCUSSION

Clarifying

Tell participants:

- Sometimes a client's message is so vague that it is difficult to understand. At those times, it is useful for counselors to help clients *clarify* their message.

Introduce participants to the key concepts of clarifying (Handout 5-3):

Definition: *Clarifying* is making an educated guess about the client's message for the client to confirm or deny.

Use: Like paraphrasing, clarifying is a way of making sure the client's message is understood. The counselor uses clarifying to clear up confusion if a client's responses are vague or not understandable.

Example:

Client: "I am using the pill and I like it, but my sister says that with Norplant, I do not need to remember to take anything."

Counselor: "Let me see if I understand you. You are thinking about switching from the pill to Norplant because Norplant would be more convenient for you?"

DEMONSTRATION

How to clarify

You play counselor. Ask another person to play a client. The client chooses a lead line from Handout 5-4, or creates a situation based on her or his own counseling experience. Tell the client to state the situation to you in a vague or confusing way. You

respond by clarifying, and the client confirms or denies your clarification. Continue until the client confirms that your clarifying statement reflects her or his situation.

Explain these guidelines for clarifying:

- Admit that you do not have a clear understanding of what the client is telling you.
- Restate the client's message as you understand it, asking the client if your interpretation is correct. Ask questions beginning with phrases such as "Do you mean that . . . ?" or "Are you saying . . . ?"
- Clients should not be made to feel as if they have been cut off or have failed to communicate. Therefore, do not use clarifying excessively.

Tell participants:

- You will now enact a role play to practice paraphrasing and clarifying skills. You will take turns playing counselor and client, and acting as observer. The observer is as important as the other two roles, since this person provides feedback on the session.

ROLE PLAY

Paraphrasing and clarifying

Divide participants into groups of three. Have each of them choose a role as counselor, client, or observer.

The client can choose a lead line from Handout 5-2 or 5-4, or create a situation. The client states the situation to the counselor in her or his own words. If the counselor understands the client's message, she or he responds by paraphrasing what the client has said. If the counselor is unsure what the client is trying to say, she or he should clarify. The observer gives constructive feedback about the paraphrasing or clarifying skills of the person playing the role of the counselor.

Repeat the role play two more times, so that everyone gets a chance to play each part.

DISCUSSION

Paraphrasing and clarifying

Ask participants the following questions:

QUESTION: What was difficult about playing the counselor?

POSSIBLE RESPONSES: It required full attention; it was difficult to listen at times when you wanted to prepare your next comment; it was not always easy to know what the underlying message was; it was not always easy to rephrase what clients said into simple messages.

QUESTION: How can paraphrasing and clarifying improve the quality of a counseling session?

POSSIBLE RESPONSES: They let the client know that she or he has been understood; they help the counselor understand the client's statements and the feelings or concerns behind the client's words.

Conclude by making the following points:

- These skills illustrate what makes counseling different from information-giving: counselors must have two-way conversations with clients. Counselors must listen, speak, try to understand clients' situations, and pay attention to the feelings behind clients' words.
- Paraphrasing and clarifying become easier with practice.
- These skills will be useful throughout the rest of the training.

Encourage participants to practice paraphrasing and clarifying throughout the training, even in their informal conversations with other participants.

Notes: _____

Step 8 Feedback skills²

DISCUSSION Definition

Ask participants:

- What does *feedback* mean?
- How can feedback help you in counseling?

Summarize the responses by covering the following points, which you have written in advance on newsprint (see the Advance Preparation section, page 5-1):

Feedback is a way of:

- helping another person to consider changing her or his behavior.
- communicating to another person about how she or he affects others.
- helping people learn how well their behavior matches their intentions.
- helping people keep their behavior close to their intentions.

Explain that:

- Giving effective feedback requires other skills that are necessary to counseling: objectivity, respect for the listener's feelings, and positive verbal and nonverbal communication. Both paraphrasing and clarifying involve giving feedback.
- Giving effective feedback to clients can help make each client feel she or he is being treated as an individual.
- Giving constructive feedback in a client interaction can help build a good client-counselor relationship.
- Feedback is also an essential skill for any participants who are or will be trainers or supervisors.

Have participants look at Handout 5-5: Criteria for Useful Feedback, and answer any questions.

Stress that giving feedback:

² Adapted from: D. E. Bender and C. Bean. *Counseling skills in family planning: Trainer's handbook*. Chapel Hill, N.C.: Carolina Population Center, University of North Carolina, 1982.

- means describing what was seen, *not* interpreting it.
- requires paying attention to details.

ROLE PLAY

The effects of poor feedback

Illustrate the effects of poor feedback by giving another person negative feedback on her or his performance as counselor in the role plays done in Step 7, page 5-13. Focus on that person's flaws. (Note: If possible, choose a cotrainer to receive feedback; if you must choose a participant, select someone who will not be sensitive to being singled out and criticized.)

Ask the person who received the feedback how she or he felt. Ask participants the following questions:

- How do you think a person receiving this type of feedback might feel?
- How might this feedback affect a person's willingness to change?

Invite participants to give more constructive feedback to the person who just received feedback. Suggest that participants start each sentence with a phrase such as "I saw" or "I observed." Guide the process as needed, asking if participants' responses follow the guidelines for giving effective feedback.

Conclude by stating:

- In the role plays, each of you had the opportunity to give feedback in your role as observer, and to receive feedback after playing the role of counselor.
- Throughout the rest of the training, you will provide feedback to colleagues when you observe role plays, using the guidelines for effective feedback.

Go around the room, asking each participant to comment about the role plays in one sentence, using effective feedback techniques.

Notes: _____

MODULE 6: THE GATHER TECHNIQUE: GREET

- Objective** By the end of this module, participants should be able to:
- describe some norms for counseling.
 - explain how adhering to these norms helps to build good relationships with clients.
 - greet clients in a manner that puts them at ease.
- Estimated time** 1 hour, 30 minutes
- Advance preparation**
- Ask two participants (or a participant and a cotrainer) if they would act as clients in a role play and demonstration (see Step 2, page 6-3). Tell them that in each situation, the clients they will portray are women who feel uncomfortable coming to the clinic. The women want information about temporary contraceptive methods they can use to postpone pregnancy, but know little about the different methods.
 - Post the newsprint list from Step 2 of Module 2 (page 2-4) in a visible place, such as on a wall (see Step 2, page 6-3).
 - Post the GATHER acronym written on newsprint for Module 2 (page 2-13) in a visible place, such as on a wall (see Step 3, page 6-5).

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
1 hour	Norms for counseling (page 6-3)	Discussion Role play Demonstration	None
30 minutes	Greeting practice (page 6-5)	Role play	None

Step 1

Introduction

Review the objectives with participants. Explain:

- This module focuses on how the counselor builds a relationship with a client, starting with the initial contact between the counselor and client when they greet.
- A good relationship develops when counselor and client share common goals, are open and communicative, and respect and trust each other. This module introduces norms for counseling, which set the stage for a positive relationship.
- Because a relationship is built on verbal and nonverbal interactions, you will have a chance to practice these skills.

Step 2

Norms for counseling

DISCUSSION

What do clients want?

Ask participants to imagine that they are family planning clients. Have them list behaviors that they would want their counselor to exhibit. Write participants' responses on newsprint. Responses should include the following:

- Conduct counseling in a comfortable setting that ensures privacy and confidentiality.
- Give the client full attention.
- Always place the client's needs first.
- Respect the client regardless of socioeconomic, ethnic, or marital status, age, gender, educational level, religion, or language.
- Never make judgmental remarks to the client.

Give participants the opportunity to add to or modify these norms.

Have the participants look at the newsprint list from Module 2 that describes factors of quality health care (see the Advance Preparation section, page 6-1).

ROLE PLAY

An insensitive counselor

Ask one of the participants (or cotrainers) who agreed to help with this role play to join you at the front of the room (see the

Advance Preparation section, page 6-1). (You may wish to have a third person play your colleague, who enters the counseling area, interrupts the session, and distracts you. You pay attention to the colleague, rather than the client.)

Tell participants to imagine that the setting is a crowded family planning clinic. Role play a counselor who violates the norms for counseling. Your manner is brusque. You are insensitive to the client's unease. You speak in a loud voice and are unconcerned about anyone overhearing you. You do not listen to what the client has to say, and interrupt before determining her needs. You urge the client to adopt a particular method.

End the role play after about five minutes, and explain that real-life counseling would continue but that the participants have seen enough to discuss the role play.

Ask the person who played the client:

- How do you feel about the family planning clinic and the counselor?

Lead a discussion by asking the group:

- Do you think the client is likely to be a satisfied user of the method recommended by the family planning counselor?
- If you had been the counselor, what would you have done differently?

DEMONSTRATION A sensitive counselor

Invite the second person who agreed to portray a client to come forward (see the Advance Preparation section, page 6-1).

Now portray a counselor who respects the norms for counseling. You are sensitive to the client's unease and respectful of the client's feelings and need for privacy. You begin the session by shutting an imaginary door. You smile and are courteous. You listen to what the client has to say and are empathetic. You ask about the client's reasons for visiting the clinic and what she needs. You assess what the client knows about contraception and provide brief information about different temporary methods that she could use for spacing.

End the demonstration after 5-10 minutes, and explain that real-life counseling would continue but that the participants have seen enough to discuss the demonstration.

Ask the person who played the client:

- How do you feel about the family planning clinic and the counselor?

Lead a discussion by asking the group:

- Do you think the client is likely to be a satisfied user of the method that the family planning counselor helped her choose?
- If you had been the counselor, what would you have done differently?

Summarize:

- Family planning is a sensitive subject, dealing with private issues. Clients may be uncomfortable talking to someone they do not know, someone they perceive as being in a different social class, or someone in a position of authority, such as a doctor or nurse.
- It is the job of the counselor to treat the client with respect and to gain the client's confidence so she or he can reach a decision consistent with her or his own needs and values.

Notes: _____

Step 3

Greeting practice

Refer to the word GATHER written on newsprint (see the Advance Preparation section, page 6-1). Explain to participants:

- This module covers the step of greeting the client, the "G" in GATHER.
- While the greeting step in counseling is very brief, it is important because it is the first contact between the counselor

and the client. Establishing a positive rapport with the client at the outset facilitates two-way communication.

Direct the group to Handout 6-1: Counseling Steps: GATHER. Go over each point listed in the "G" section. Answer any questions.

Have participants practice greeting by completing the role play described below. Each role play should take only one or two minutes, as it is only intended to cover the initial part of the counseling session.

ROLE PLAY

Greeting a partner

Pair the participants. Partners take turns playing counselor and client. Clients can choose different reasons for coming to the clinic.

The client comes in and is greeted by the counselor. After the greeting, the client gives the counselor feedback on how she or he felt about the greeting. The client can refer to the criteria in the "G" section of Handout 6-1.

Notes: _____

MODULE 7: THE GATHER TECHNIQUE: ASK/ASSESS

Objectives

By the end of this module, participants should be able to:

- demonstrate the appropriate use of closed, open, and probing questions.
- assess clients' needs.
- help clients assess their risk of contracting or transmitting STDs, including HIV infection.
- assess clients' knowledge of family planning.

Estimated time

2 hours, 45 minutes

Advance preparation

- Write the two case studies on newsprint (see Step 4, page 7-7).
- Write the descriptions of the two clients on small pieces of paper (see Step 6, page 7-13). Have enough copies for the participants who will play the client roles.

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
5 minutes	The importance of assessing (page 7-3)	Lecture	None
25 minutes	Asking questions (page 7-3)	Discussion Lecture	None
45 minutes	Assessing the client's needs (page 7-5)	Demonstration Case studies Lecture	None
40 minutes	Assessing the risk of HIV infection and other STDs (page 7-8)	Lecture Discussion	None
40 minutes	Assessing the client's knowledge of family planning methods (page 7-11)	Brainstorming Role play Discussion	None
10 minutes	Summary (page 7-15)	Discussion	None

Step 1 Introduction

Review the objectives with participants. Explain:

- This module covers the second counseling step in GATHER, in which a counselor *asks* clients questions about themselves and *assesses* their family planning knowledge and needs.

Step 2 The importance of assessing

LECTURE Individual needs

Point out to participants:

- As we saw when we examined factors influencing clients' decisions (Module 4), each client's situation is different. Assessing each client's individual needs is what makes counseling different from information-giving.
- Assessing the client's needs, especially her or his reproductive intentions, may be the key step in counseling, since it allows you to tailor the session to the particular needs of the client.

Notes: _____

Step 3 Asking questions

DISCUSSION How to use questions

Ask participants:

- What reasons can you give for asking clients family planning questions?

Write the responses on newsprint. Responses should include the following:

- to assess the needs of the client
- to find out what the client already knows about family planning
- to learn how the client feels

- to help the client anticipate how she or he might feel if she or he takes a certain action
- to help the client reach or act on a decision

Ask participants for examples of questions that counselors commonly ask clients in family planning sessions. Write participants' responses on newsprint.

LECTURE

Types of questions

Explain that there are three types of questions that have a role in discussions with clients:

- **Closed questions** are questions that can be answered by *yes*, *no*, a number, or a few words. They can be used at the beginning of a counseling session to break the ice, since they usually do not require the client to reveal sensitive information or to share feelings. They can be used to get *information*, such as a medical history. Examples of closed questions are "How many children do you have?" or "Are you using a family planning method now?"
- **Open questions** have many possible answers. They can be used to learn about the client's *feelings*, *thoughts*, *knowledge*, and *beliefs*. Examples of open questions are "What do you know about the pill?" or "How does your partner feel about your decision?" Although open questions may address "Why?," asking questions that begin with *why* may be intimidating or seem judgmental. It is preferable to use phrases such as "What are your reasons for . . . ?"
- **Probing questions** help the counselor clarify the client's responses to open questions. An example of a probing question is "Can you tell me how your friend's experience has made you feel about using injectables?"

Note:

- There may be some overlap between open and probing questions. The difference between these types of questions is clearer in actual discussions with clients, when they appear in context. Probing questions usually follow open questions.

Give participants five minutes to read Handout 7-1: Family Planning Questions. Answer any questions they have about the handout.

Return to the list of questions that participants volunteered. For each example on the newsprint, ask participants to classify the question as closed, open, or probing, and explain the reasons for the classification.

Notes: _____

Step 4

Assessing the client's needs

Explain:

- Now that we have identified the different kinds of questions for family planning counseling, we will use them to assess the client's needs and understanding of family planning methods.
- You will now watch a demonstration of assessing clients' needs. The demonstration will cover only the greet and assess steps of GATHER.

DEMONSTRATION Using questions to assess needs

Ask for two volunteers. Have each play a client who has come to the family planning clinic. Tell the volunteers that they can make up details for the clients they will portray (reason for the visit, past contraceptive use, age, number of children). Ask for two other volunteers to write down the questions you ask during the counseling session (not the responses).

You play counselor. Your purpose is to discover and clarify the client's needs by asking key questions. Begin with the first volunteer. Continue until you have a clear understanding of the reason for that client's visit and the help she or he needs. Then end the assessment and tell the group what you believe are the client's needs. Verify your assessment by asking the client if the assessment is accurate. Repeat the process with the second volunteer.

After each assessment, have the whole group discuss the questions you asked. The note-takers can prompt the group by reading questions from their notes. Determine:

- Which questions were closed, open, or probing?
- Were the questions pertinent?
- Were any questions unnecessary?
- Are there other questions that the group would have used to assess the clients' needs?

Conclude by pointing out:

- In these demonstrations, as in real life, the counselor did not know in advance the needs of the clients. The only way to find out about clients and their needs is by assessment.

Emphasize:

- Each client has different reproductive plans and reasons for seeking contraception. By finding out about those needs, the counselor can help the client choose an appropriate method. For example:

- » A client plans to have a baby in a year or so and is very certain she does not want to get pregnant any sooner. This client may especially want to learn how the various short-term methods compare in effectiveness.
- » A client wants to delay childbearing for an extended period of time and has been using condoms, but not consistently. She needs to know that other temporary methods are available and that some of them (the IUD and Norplant implants) are effective for several years and require little ongoing attention.
- » A client has decided to have no more children. The client should be informed about both tubal ligation and vasectomy as well as about the other available choices.

CASE STUDIES

Two different clients

Refer to the case studies written on newsprint (see the Advance Preparation section, page 7-1):

- **CASE:** A client wants no more children but has chosen not to have a tubal ligation. She uses either condoms or spermicides because she does not want to undergo surgery, is uncomfortable about ending her fertility, and does not like the side effects of other methods. She knows that her chosen methods might fail and has decided to use them anyway.
- **CASE:** A client wants to delay childbearing for several years. Although she may seem to be an “ideal” candidate for Norplant implants or an IUD, she has chosen the pill for her contraceptive method. She likes its high rate of effectiveness, and she can stop using it any time, without having to return to the clinic.

Read the first case out loud and discuss it, using the following questions.

- Are each client’s goals being met?
- Should you, as the counselor, try to persuade the client to use another method that might better meet her needs?

Use the same two questions to discuss the second case study.

LECTURE

Two helpful questions

Stress:

- These clients have made appropriate choices for their circumstances, even though other methods might appear to be a better “fit.”

Ask participants if they can think of other examples of client choices in this category.

Emphasize:

- The counselor must avoid directing or steering a client toward a particular choice even if the client’s reproductive goals appear to “match” a particular method.

Tell participants that two specific questions will help them assess the contraceptive needs of clients:

- **Do you want to have (more) children at some point?** If the client says no, she or he may be especially interested in learning about long-term or permanent methods. But the client

should also have the opportunity to learn about and use other methods.

- **How long were you thinking of waiting before having a child?** If the answer is two or three years, the client is a short-term user. Although she or he may want to learn about long-term or permanent methods, the focus of the discussion should be on methods that can be readily discontinued.

Notes: _____

Step 5

Assessing the risk of HIV infection and other STDs

LECTURE

Helping the client assess personal risk

Tell participants:

- This part of the training deals with *how* clients can assess their risk of contracting or transmitting sexually transmitted diseases, including HIV infection.
- Later we will cover *what* to tell clients about HIV infection and how to address common misconceptions clients may have (Module 8).

Point out that talking about STDs, including HIV infection, is difficult because:

- Clients and counselors have attitudes, fears, and prejudices about STDs, especially HIV infection.
- To discuss these issues, counselors must ask clients about matters that are very personal and can be threatening, including the client's sexual practices and the faithfulness of his or her partner(s).
- Clients who face the possibility of being HIV-positive also face possible losses of health and life, of employment, of personal relationships, and perhaps of acceptance in the community.

DISCUSSION

Talking with clients

Lead a discussion with participants by asking the following questions:

- Do you normally discuss HIV infection, other STDs, and STD prevention with your clients?
- Is it difficult to talk about HIV infection and other STDs? Why?
- How do you decide whether to talk about HIV infection and other STDs with a client?
- How do you decide what information about HIV infection and other STDs to give to a client?

Introducing the topic

Explain:

- As with any counseling topic, it is important to tailor discussions of HIV infection and other STDs to the client's situation, needs, and knowledge. Although most counselors will probably want to introduce the topic to most clients, the approach to take and the information to give will differ.
- Although some clients will ask about HIV infection and other STDs, others will not raise the topic.

Ask participants if and how they would raise the topic with the following clients:

- a woman who wants the IUD
- an unmarried 25-year-old woman
- a 40-year-old woman who has been married for 20 years and who believes her relationship is monogamous
- a man who has had many sexual partners
- an adolescent

Give some examples of nonthreatening ways to introduce the topic to these clients and to others, such as:

- "We're talking to everyone about safe sex so that they can protect themselves from infection."
- "You've probably heard a lot about AIDS and HIV infection. Do you have any questions you'd like to ask me?"

- “I’d like to tell you a few facts about how you can protect yourself and your partner(s) from HIV infection.”

Assessing risk

Explain that an important part of counseling for STD prevention is helping clients assess their own risk. Write the following question on newsprint:

- What questions could clients answer for themselves to help them assess their risk of contracting or transmitting HIV infection or other STDs?

Ask participants for examples of such questions, and write them on newsprint. Questions could include the following:

- Have I had more than one sexual partner?
- Have I had a sexual partner who has had more than one partner?
- Have I had a sexually transmitted disease?
- Have I had sex (vaginal, oral, or anal) with someone who has a sexually transmitted disease?
- Have I ever had sex (vaginal, oral, or anal) with someone who may be infected with the virus that causes AIDS (HIV)?
- Have I gotten injections from dirty needles?

Tell participants:

- Handout 7-2 lists questions that clients can answer to assess STD risk.

Ask participants how they might introduce questions about risk to clients in a sensitive and respectful manner. Here is an example:

- “I’m going to read a list of questions. Think about them as I say them. You don’t need to answer out loud. You can keep your answers to yourself, if you wish.”

After the client has thought about the questions, the counselor might say something like this:

- “If you answered yes to any of the questions, then you may be at risk of getting HIV infection or another sexually transmitted disease. It’s important for you to protect your health, and I’d

like to help you do that. Would you like to know more about how to protect yourself?"

Ask participants to discuss how they might introduce the terms *vaginal*, *anal*, and *oral intercourse* with clients. Emphasize:

- You may need to use simpler language, without being vulgar, or you may need to define the terms for clients.
- Some clients may have difficulty discussing anal and oral intercourse because of the stigma sometimes attached to these sexual activities.

Summarize by pointing out:

- It is important for clients to feel that they are in control when discussing intimate matters and that their privacy is respected. If they do not wish to talk about these issues, counselors should not force the discussion.
- Clients who see themselves as being at risk of contracting or transmitting a sexually transmitted disease, including HIV infection, will need to take this into account when they choose a contraceptive method. This will be discussed further in the session on helping clients to make a decision about contraception (Module 9).

Notes: _____

Step 6

Assessing the client's knowledge of family planning methods

Write the sentence fragment below on newsprint:

- By assessing the client's knowledge of family planning methods, the counselor:

BRAINSTORMING **Why knowledge assessment is important**

Ask the group to brainstorm why assessing the client's knowledge of family planning methods can be helpful. Possible responses include:

- shows respect for the client's knowledge
- can save time for both counselor and client by not repeating information that the client already knows
- can identify gaps in knowledge or areas of misunderstanding
- can determine what level of terminology or language to use in talking with the client

Ask the group what specific questions the counselor can ask to assess the client's understanding of and experience with family planning methods. Note that most of these questions will be open. Examples include:

- What family planning methods have you used?
- What was it like for you to use this method?
- What have you heard about other family planning methods?

Point out:

- Having *heard* of a method is not always the same as having accurate information about it. The counselor needs to get a sense of whether the client has an adequate understanding of available methods.

Explain:

- Now we are going to do a role play about two different client situations. To save time, the role play focuses only on the assessing step of counseling.

ROLE PLAY

Assessing different clients

1. Divide the participants into pairs. Have each pair choose who will play the role of the counselor and who will play the role of the client. Give each participant who will play a client one of the following descriptions written on small pieces of paper (see the Advance Preparation section, page 7-1).

- **A client who is reluctant to speak about her desires and needs (Catherine):**
 - » sits quietly, looking down at her lap
 - » answers the counselor's questions using the fewest words possible
 - » is embarrassed to be talking about sex
 - » knows very little about family planning methods
- **A client who asks for a particular method (Mary):**
 - » says she wants to use an IUD
 - » has a friend who has had an IUD for two years and reports "no problems"
 - » is tired of having to remember to take a pill every day
 - » thinks the injectable causes cancer
 - » has never heard of Norplant implants

Tell participants who are playing the client roles:

- Feel free to make up other characteristics about the client you are playing.
- As you play the role of the client, be sure not to reveal everything about the person too early in the discussion. Remember, the counselor must use questioning skills to assess the client's needs, desires, and knowledge.

Tell the pairs:

- You will have about five minutes for the role play.
2. After the role play, ask participants who counseled Catherine how they conducted the assessment with this client, who was reluctant to talk. The following points should emerge:
- Began by discussing topics that might be less threatening to Catherine than contraception. Closed questions are ideal for this purpose. Examples are: How many children do you have? How old are they? How far did you have to travel to the clinic?
 - Put Catherine at ease by saying something like this: "I know it's hard to talk about such personal matters. But if you and

I talk a little about you and your family planning needs, it will help you choose a method that is good for you and that you will be happy with.”

- **Relied on open questions to encourage Catherine to speak and provided support for her answers. Assessing is an ideal time to practice effective communication skills, such as verbal encouragement.**
- **Avoided asking a lengthy series of questions, which might have increased Catherine’s apprehension.**

Ask participants who played Catherine if they have any suggestions that would have helped them to open up to the counselor.

- 3. Ask counselors who had Mary as a client how they assessed her needs and knowledge. What questions did they ask? The following points should emerge:**
 - **Acknowledged that the IUD, the method in which Mary was interested, is a good choice for many people, and explained that they would discuss whether the IUD is a good choice for Mary.**
 - **Asked Mary about her reproductive situation. Did she want to have children in the future? If so, when?**
 - **Verified that Mary was well informed about the IUD. One way to do this is to ask “Tell me what you already know about the method.” In Mary’s case, the counselor would want to explain that, while the IUD is safe and effective, some women who use it have cramping, spotting, or bleeding between periods, or heavier or longer periods. This explanation is an example of how the counselor uses telling after assessing the client’s individual needs.**
 - **Checked that Mary was not misinformed about other choices. The counselor might say something like this: “I’d like to spend just a few moments talking to you about other methods. What other methods have you tried or heard of? Have you heard anything about them that bothers you or frightens you?” In Mary’s case, the counselor would want to correct her misconception about the injectable causing cancer and to tell her about Norplant implants. This is**

another example of how the counselor uses telling in response to something revealed during assessment.

- Avoided asking many questions or prolonging the discussion if Mary's initial choice seemed to meet her needs, if she had accurate information about it, and if she knew there were alternatives.

DISCUSSION

Improving client assessment

Ask participants who played Mary if they have any suggestions on how to improve the assessment step.

Notes: _____

Step 7

Summary

DISCUSSION

Questions about assessment

Have the group summarize the asking/assessing step of GATHER by asking the following questions:

QUESTION: How is asking/assessing different from information-giving?

POSSIBLE RESPONSES: In information-giving, clients simply receive factual information about family planning methods. The information is not necessarily tailored to their needs, nor to what they already know. In the asking/assessing step, the counselor assesses the client's needs and knowledge. The counselor fills in gaps in the client's knowledge, and presents only the information that is relevant to the client.

QUESTION: Why is the asking/assessing step important?

POSSIBLE RESPONSES: This step:

- helps to establish the relationship between the counselor and the client.
- enables the counselor to focus on each client's individual needs.

- determines what the client already knows.
- lets the client assess her or his risk for contracting or transmitting HIV infection and other sexually transmitted diseases.
- determines how the counselor will carry out the remaining counseling steps.
- can save time, which is useful for the client as well as the counselor.

Give participants a few minutes to review the “A” section of Handout 6-1: Counseling Steps: GATHER, and answer any questions they may have.

Notes: _____

MODULE 8: THE GATHER TECHNIQUE: TELL

Objectives

- By the end of this module, participants should be able to:
- describe the anatomy and physiology of the female reproductive system in relation to sexuality and family planning.
- describe the anatomy and physiology of the male reproductive system in relation to sexuality and family planning.
- demonstrate appropriate use of informational materials.
- tell clients about temporary family planning methods.
- tell clients about HIV infection.
- address common misconceptions about temporary family planning methods and about HIV infection.

The information about contraceptive methods covered in this module is intended for use when providing clients with basic facts about methods. If participants are not already knowledgeable about contraceptive methods, you will need to provide them with a comprehensive update.

Estimated time

3 hours, 25 minutes

Advance preparation

- Decide which of the exercises to use in Step 2, page 8-4, and Step 6, page 8-12.
- Using the poster provided with this curriculum as a model, trace or draw the female reproductive system on a page of newsprint. Leave blank lines where the labels should be. Tape the paper with the traced drawing to a wall (see Step 2, page 8-4).
- Using the poster provided with this curriculum as a model, trace or draw the male reproductive system on a page of newsprint. Leave blank lines where the labels should be. Tape the paper with the traced drawing to a wall (see Step 3, page 8-5).
- Gather samples of materials that are available at participants' work sites for use in counseling clients. If possible, include at

least one of each of the following: sample contraceptive methods (either loose or pasted to a display board), brochures, posters, illustrated flipcharts, and videos (see Step 4, page 8-7).

- Fill several boxes with samples of temporary contraceptives. Include condoms, the pill, the IUD, and a spermicide (the most commonly used spermicide where the counseling is done). Also include Norplant implants, the diaphragm, and the injectable, if available. Fertility awareness methods can be represented by a thermometer or a small calendar. If supplies are unavailable, write the names of the methods on pieces of paper (see Step 5, page 8-8).
- Before teaching this module, review the information on telling for temporary methods in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers* (see Step 5, page 8-8).
- Write the two case studies about Grace and Elizabeth on newsprint (see Step 5, page 8-10).

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
30 minutes	Review of the female reproductive system (page 8-4)	Exercise (or alternative exercise)	Drawing of the female reproductive system
20 minutes	Review of the male reproductive system (page 8-5)	Exercise	Drawing of the male reproductive system
35 minutes	Using informational materials (page 8-6)	Lecture Discussion Role play Discussion	Client informational materials available at participants' work sites
30 minutes	Telling clients about temporary contraceptive methods (page 8-8)	Role play Case studies	Boxes of sample temporary contraceptives, client informational materials available at participants' work sites, <i>Talking with Clients about Family Planning: A Guide for Health Care Providers</i> (1 copy for each participant)
30 minutes	Addressing common misconceptions about temporary family planning methods (page 8-11)	Discussion Exercise (or alternative exercise)	None
30 minutes	Telling clients about HIV infection (page 8-12)	Lecture Discussion	None
30 minutes	Addressing common misconceptions about HIV infection (page 8-15)	Discussion	None

Step 1

Introduction

Review the objectives with participants. Explain:

- This module covers the third counseling step in GATHER, in which a counselor *tells* clients about family planning methods. This module focuses on temporary methods. Permanent methods are discussed later in the training (Module 12).

Step 2

Review of the female reproductive system

Explain:

- In order for counselors to tell clients about family planning methods, clients need to understand basic information about the female and male reproductive systems.
- We will review these reproductive systems and how they work, using nontechnical language that clients can understand.

To begin the review, complete the exercise below, or use the alternative exercise.

EXERCISE

Labeling a diagram

Point to each line on the female reproductive system diagram where a label should be (see the Advance Preparation section, page 8-1). Have volunteers name each part. Write the name on the line. Have volunteers explain the function of each part, using simple language that clients can understand.

In completing the activity, you may wish to use the questions on Handout 8-1 to lead participants through their explanations of how the female reproductive system works. Encourage them to answer the questions on their own without consulting the handout.

ALTERNATIVE EXERCISE

Labeling a diagram

Write the names of the female reproductive organs on small pieces of paper. Ask for volunteers to discuss the function and position of the organs. Give a piece of paper to each volunteer.

Have volunteers come forward and tape their labels onto the female reproductive system diagram (see the Advance Preparation section, page 8-1). The volunteers then explain to the group the function of the organ, using nontechnical language

as they would with clients. You may wish to use the questions on Handout 8-1 to lead participants through their explanations. Encourage them to answer the questions on their own, without consulting the handout. If necessary, the group and you, the trainer, correct the explanations.

Following the exercise

Tell participants:

- The drawing of the female reproductive system appears as Handout 8-2 and also as an appendix in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers*. You can use this drawing to explain the female reproductive system to clients.

Notes: _____

Step 3

Review of the male reproductive system

Tell participants that they will now review how the male reproductive system works.

Point to each line on the male reproductive system diagram where a label should be (see the Advance Preparation section, page 8-1). Have volunteers name each part. Write the name on the line.

EXERCISE

Labeling a diagram

After each part has been labeled, lead participants in a discussion of how the male reproductive system works. Have participants use simple language that clients can understand. In completing the activity, you may wish to use the questions on Handout 8-3.

Tell participants:

- The drawing of the male reproductive system appears as Handout 8-4, and also in the appendix of the book *Talking with Clients about Family Planning: A Guide for Health Care*

Providers. You can use this drawing to explain the male reproductive system to clients.

Notes: _____

Step 4 Using informational materials

LECTURE Introduction to materials

Tell participants:

- In order to explain reproductive physiology and how various contraceptive methods are used and work, it is helpful to use informational materials, such as brochures, posters, illustrated flipcharts, videos, and samples of the contraceptive methods.
- Visual materials reinforce what is said, keep client interest, and help explain concepts, especially those involving anatomy. This is particularly important for women, since most of their reproductive organs cannot be seen.
- Materials that the clients take with them, such as brochures, can help clients use methods correctly and cope with minor problems and side effects.

DISCUSSION Characteristics of effective materials

Ask participants to describe characteristics of effective informational materials. Responses should include:

- Materials must contain accurate information.
- Materials must be available.
- Materials must use language that clients can easily understand.
- Materials should be used in conjunction with (not in place of) interpersonal communication.
- Drawings and language should not be overly technical.

ROLE PLAY

How not to use materials

Ask a participant to play the role of a client. Explain that you will role play the telling segment of a counseling session. Each time participants see you do something incorrectly, or in a way that could be improved upon, they should raise their hands. Call on participants to point out the error, and, if the group is in agreement, correct the mistake.

Using the anatomical drawings from Steps 2 and 3 or an illustrated flipchart, commit the following “mistakes”:

- Stand in front of or block the view of a picture.
- Discuss parts of the anatomy, such as the fallopian tubes or the testicles, without pointing them out on the picture.
- Assume the client knows nothing about the reproductive system. Make a statement such as: “You might not know this, but every woman has a tube attached to each ovary.”
- Flip through pages of the flipchart without allowing enough time to go over each one.

You may also improvise your own “mistakes.”

DISCUSSION

Using materials effectively

Handout 8-5 provides information for this discussion. Encourage participants to respond on their own without consulting the handout. Tell participants:

- I have just shown you some “don’ts” about using informational materials. What should the counselor do to use materials effectively?

List responses on newsprint.

Ask participants which informational materials are available at their sites. Hold up examples of each of these materials (see the Advance Preparation section, page 8-1), and ask participants for suggestions about the effective use of each one.

Notes: _____

Step 5

Telling clients about temporary contraceptive methods

ROLE PLAY

Practicing telling

Have participants look at the telling section of Handout 6-1.

Explain:

- In the following role play, you will practice telling clients about temporary methods.

Divide participants into groups of four or five. Give each group a box of temporary contraceptives and some client informational materials (see the Advance Preparation section, page 8-2).

- Each person will take a turn playing counselor. The counselor picks a method, without looking, from the box and describes that method to the person at his or her left, who plays a client interested in that particular method. Counselors can use brochures or illustrated flipcharts depicting male and female anatomy for this role play.
- Counselors should practice the skills of using materials effectively and using nontechnical language.
- Each counselor has one or two minutes to explain the method. This time limit is important because counselors give only basic information about methods during the telling step and because it simulates real-life situations in which counselors have limited time.

After each role play, the rest of the group should practice their feedback skills, touching on the following points:

- information that they were unsure about
- information that was omitted
- observations about the way the information was presented
- instances in which the counselor provided more information than the client needed at this stage in decision making

Refer to the book *Talking with Clients about Family Planning: A Guide for Health Care Providers* (see the Advance Preparation section, page 8-2). Explain:

- This book presents information about each contraceptive method that may be needed during three steps of counseling:

telling, helping, and explaining. We will use the book as we practice these three steps. You can also use the book as a reference after you return to work.

Give participants a few moments to look through the book, especially the section about telling.

Answer any questions that participants have about methods or about the telling step. Explain:

- Telling is closely linked to assessing, since the counselor concentrates on giving information that fills knowledge gaps identified when assessing the client. Telling is also linked to helping, since clients apply this knowledge to decision making.
- At this stage, the counselor provides information that the client needs to *choose* a method, such as the mode of action, effectiveness, and other characteristics of the method. Later, in the explain step of GATHER, the counselor gives the client instructions about how to use the particular method she or he has chosen.
- The focus of telling is on *key* information, rather than highly detailed information. In actual counseling situations, time is always a constraint. Therefore, counselors should provide basic information and focus on those methods that most interest the client. This is especially true if the client already has a method in mind. In this case, counselors often simply remind the client that there are other methods, and provide detailed information about them only if the client wants it.
- The chart in the introduction of the book *Talking with Clients about Family Planning: A Guide for Health Care Providers* highlights information of special importance about each method.

CASE STUDIES

Grace and Elizabeth

1. Explain:

- Now that you have reviewed the knowledge and techniques for telling clients about family planning methods, we will consider two hypothetical case studies.

Display the following two scenarios written on two separate sheets of newsprint (see the Advance Preparation section, page 8-2):

- Grace has never used a method before, knows very little about family planning, and wants to wait two years for her next pregnancy.
- Elizabeth uses the pill, but keeps forgetting to take it. She is interested in switching to a temporary method that she does not have to remember to use every day.

Explain:

- The information about these clients would have been gathered during the asking/assessing step of counseling.

2. Ask participants the following questions:

QUESTION: Which methods could Grace use to help her achieve her goal of waiting two years before her next pregnancy?

POSSIBLE RESPONSE: Condoms, the pill, injectables, the diaphragm, spermicides, fertility awareness methods, and withdrawal. The IUD and Norplant implants are also options, although they are usually used for longer than two years.

QUESTION: Which methods would satisfy Elizabeth's desire to not need to remember to do something every day?

POSSIBLE RESPONSE: Norplant implants, the IUD, injectables, and methods that are linked to sexual intercourse, such as condoms, spermicides, and the diaphragm.

3. Stress the following:

- Telling the client about contraceptive methods should be directly linked to what was learned during assessment of the client's needs. When describing methods to Grace and Elizabeth, the counselor should devote the most time to the methods most likely to meet the client's individual needs.

Have the group volunteer information they would give each of the two clients. For each client, do the following:

- List participants' points on newsprint.
- Ask if any of the points seem irrelevant or unnecessary, considering the client's situation as it was assessed. If necessary, strike items from the list.

- Add any important points that were omitted. Explain why these points are important.

Notes: _____

Step 6

Addressing common misconceptions about temporary family planning methods

Explain:

- Addressing misinformation is often part of telling clients about family planning and other health issues.
- When addressing misinformation, it is particularly important not to make the client feel ignorant.

DISCUSSION

How to respond to common misconceptions

Begin a discussion by mentioning one or two common but untrue beliefs about temporary contraceptives and having volunteers correct them. You may wish to use one or both of these examples:

COMMON MISCONCEPTION: The IUD can travel through a woman's body.

POSSIBLE RESPONSE: The IUD almost always stays in the womb until a health care worker removes it. If it does come out by itself, which is uncommon, it usually comes out through the vagina. The woman can check the strings of the IUD to reassure herself that the IUD is still in place.

COMMON MISCONCEPTION: Since they are taken every day, pills build up in a woman's body.

POSSIBLE RESPONSE: Pills dissolve in a woman's stomach, just like other medicines. They do not build up in the woman's body.

Tell participants that they will now draw on their own experience to describe and correct common misconceptions about different temporary methods. Tubal ligation and vasectomy will be

covered later (Module 12). Complete one of the following exercises.

EXERCISE

Two facing lines

Participants form two lines that face each other. One member of the first line mentions a misconception that she or he has heard about any temporary contraceptive; the person facing her or him corrects it. If that person cannot correct the misinformation, the turn bounces to the next person in line.

Participants continue the activity until they have no more examples. For additional reference, participants can look at Handout 8-6: Temporary Contraceptives: How to Correct Common Misconceptions.

ALTERNATIVE EXERCISE

Hot potato

Participants form two lines that face each other. Give a person in one line something small and light to toss: a ball, a small pillow, a crumpled piece of paper. The person names a misconception about a temporary method and tosses the "hot potato" to a person in the second line. This person must catch the "hot potato," respond to the misconception, name another misconception, and then toss the "hot potato" to a person in the first line. The game continues until the group has no more examples or until all participants have had a chance to catch the "hot potato" and respond to a misconception.

Notes: _____

Step 7

Telling clients about HIV infection

LECTURE

Basic information

Tell participants:

- As we discussed earlier (Module 4), counselors need to be able to talk to clients about HIV infection, since it may affect their

choice of contraception. Also, clients may have many questions and common misconceptions about HIV infection.

- Information about HIV infection should be tailored to the client. However, every client should understand the following:
 - » HIV is the virus that causes AIDS.
 - » People get HIV through sexual contact (vaginal, anal, or oral), through skin-piercing instruments (such as needles), or through contaminated blood. Women sometimes pass on HIV to their babies before or during birth, or through breast milk.
 - » HIV is not transmitted through ordinary social contact, tears, saliva, sweat, or insect bites.
 - » A person can be infected with HIV without knowing it. Symptoms may not show up for eight years or more.
 - » AIDS is almost always fatal.
 - » There are tests that tell people if they have been exposed to HIV. They do not tell people if or when they will get AIDS.
 - » Latex condoms offer protection against HIV infection.
- A convenient method to summarize different ways to protect oneself against HIV infection is ABC.
 - » A means *abstinence*.
 - » B means *be faithful*. A couple should have sex only with each other.
 - » C means *condoms*.

DISCUSSION

Responding to questions

Ask participants how they would respond to the following questions from clients. Handout 8-7 presents these questions and answers; encourage participants to respond on their own without consulting the handout.

QUESTION: "My partner is HIV-positive. Will I get AIDS?"

POSSIBLE RESPONSE: "We don't know for sure, but the risk is very serious for you." The client needs to understand that HIV can be transmitted through vaginal, oral, and anal intercourse.

QUESTION: “I got a blood transfusion a year ago. Could I have gotten HIV?”

POSSIBLE RESPONSE: The answer to this question depends upon whether the blood supply was screened for HIV at the time the transfusion was obtained. If it was, the counselor might respond, “Probably not, because blood used for transfusions is tested to be sure it does not contain HIV.”

If blood was not routinely screened during this period or at this site, the counselor might say, “We don’t know for sure,” and explain why.

QUESTION: “A few years ago, I had sex with someone who now has AIDS. Will I get AIDS?”

POSSIBLE RESPONSE: “We don’t know for sure. What’s important is for you to protect yourself and your partner now.”

The following points should also emerge from the discussion:

- In these three cases, in addition to answering the client’s immediate question, the counselor should:
 - » Let the client know if testing for HIV infection is available and, if so, where.
 - » If testing is unavailable, help the client to deal with the uncertainty of not knowing and to consider seriously the need for protection.
 - » Ensure that the client understands that, if infected, she or he needs to avoid transmitting the virus to others.
 - » Review the use of condoms, as explained in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers*.
 - » Review the contraceptive effectiveness of condoms. Some clients choose to use an additional family planning method to gain more effective protection against pregnancy.

Ask participants for examples of other questions clients have asked them about HIV infection. Ask how they responded to the questions and solicit suggestions for responses from other participants.

Explain to participants:

- One difficulty in dealing with HIV infection is that many things are not known about the disease. As a result, clients may ask for information that is not available anywhere. Tell clients what facts are known and acknowledge that further information is unavailable.
- There are many phrases that can be used to respond to questions that have no clear or simple answer, such as:
 - » “This is still being studied. We don’t know yet.”
 - » “I’ll give you the facts that we do have.”
 - » “It differs according to the person. We aren’t sure why.”
 - » “That’s a good question. Unfortunately, all I know to tell you is . . .”
 - » “I’m sorry, we just don’t know yet.”

Tell participants:

- Handout 8-7 summarizes questions frequently asked by clients about HIV infection and proposes answers.
- More information on assessing clients’ risk of HIV infection and on negotiating condom use is included later in the training in the section on helping clients make decisions (Module 9).

Notes: _____

Step 8 Addressing common misconceptions about HIV infection

DISCUSSION How to respond to common misconceptions

Begin the discussion by mentioning one or two common but untrue beliefs about HIV infection. Ask participants to volunteer accurate responses to correct the common misconceptions below.

COMMON MISCONCEPTION: A person can become infected with HIV from kissing, mosquito bites, or drinking from the same glass as someone who has AIDS.

POSSIBLE RESPONSE: None of these are true. People are infected with HIV by having sex with an infected person, by using infected instruments that pierce the skin (like needles), or by getting a transfusion of infected blood. Babies are sometimes infected with HIV by their mothers before birth, at the time of delivery, or from breast milk.

COMMON MISCONCEPTION: AIDS is curable.

POSSIBLE RESPONSE: This is not true. Some treatments help people who are infected with HIV or who have AIDS, but AIDS cannot be cured at the present time.

COMMON MISCONCEPTION: There is a vaccine that prevents HIV infection.

POSSIBLE RESPONSE: This is not true. Scientists are working to develop a vaccine, but there is no vaccine that prevents HIV infection at this time.

COMMON MISCONCEPTION: Only prostitutes or men who go to prostitutes become infected with HIV.

POSSIBLE RESPONSE: This is not true. Anyone can become infected with HIV by having sex with an infected person, by using infected instruments that pierce the skin (like needles), or by getting a transfusion of infected blood.

Ask participants to draw on their own experience to describe and correct common misconceptions about HIV infection.

Notes: _____

MODULE 9: THE GATHER TECHNIQUE: HELP

Objectives

By the end of this module, participants should be able to:

- help clients make decisions about family planning methods.
- help clients who may be at risk of contracting or transmitting STDs, especially HIV infection, consider or negotiate condom use.

The information about contraceptive methods covered in this module is intended for use when helping clients make decisions. If participants are not already knowledgeable about contraceptive methods, you will need to provide them with a comprehensive update.

Estimated time

1 hour, 30 minutes

Advance preparation

- Before teaching this module, review the information on the helping step of counseling for temporary methods in the booklet *Talking with Clients about Family Planning: A Guide for Health Care Providers* (see Step 3, page 9-4).

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
10 minutes	The counselor's role in the decision-making process (page 9-3)	Discussion	None
50 minutes	Helping clients make decisions (page 9-3)	Demonstration Role play	<i>Talking with Clients about Family Planning: A Guide for Health Care Providers</i> (1 copy for each participant)
30 minutes	Condoms and STD prevention (page 9-6)	Discussion Case studies Role play	None

Step 1 Introduction

Explain:

- This module covers the “H” step in GATHER, in which the counselor *helps* the client choose a family planning method. This module focuses on temporary methods. Tubal ligation and vasectomy are discussed later in the training (Module 12).

Review the objectives with participants.

Step 2 The counselor’s role in the decision-making process

DISCUSSION

Assisting the decision-making process

Ask participants to list ways in which counselors can help clients make well-informed, carefully considered decisions. Record responses on newsprint. Points mentioned should include the following.

- Counselors can help the decision-making process by:
 - » assessing clients’ needs and knowledge
 - » telling clients about the characteristics and effects of available contraceptive methods, focusing on information that clients do not know and are interested in
 - » helping clients clarify their thoughts and feelings
 - » helping clients apply this knowledge to their circumstances

Notes: _____

Step 3 Helping clients make decisions

Explain:

- We will now observe and practice communication skills used in helping clients choose family planning methods.

DEMONSTRATION Helping Grace make a decision

Begin by reintroducing participants to Grace, whose case was examined in Step 5 of Module 8, page 8-10. Remind participants that Grace:

- has never used a method before.
- knew very little about family planning before coming to the clinic.
- wants to wait two years for her next pregnancy.
- has been informed about short-term method options.

You play counselor. Ask another person to play Grace. As needed, you may refer to the booklet *Talking with Clients about Family Planning: A Guide for Health Care Providers*, but do not read lengthy sections aloud to the client (see the Advance Preparation section, page 9-1). As counselor, you do the following:

- Ask if Grace has discussed her family planning plans with her partner. If she has, ask the outcome of the discussion.
- Ask her which of the methods she has learned about most appeals to her.
- Determine if there are any medical reasons why Grace should not use the method she is interested in. If there are, help her choose another method. If necessary, refer her to another health care provider for medical evaluation.
- Ask her if there is anything she does not understand about her chosen method.
- Ask her whether she thinks she can tolerate the predictable side effects of this method (for example, changes in menstrual bleeding, if Grace chooses the injectable).
- Help her to consider the need for protection against HIV infection and other STDs, as appropriate.
- Check whether she wants to proceed with this choice.

Answer any questions that participants have about the demonstration. Then stress the following points:

- If clients do not express a preference for a particular method, the counselor can ask what information would help them decide, and provide it.
- For clients who remain undecided or who ask counselors what method they recommend, counselors might suggest one or two short-term methods for the client to consider (such as condoms, spermicides, pills, or the diaphragm with spermicide). Counselors can tell clients that if they are unhappy with their first choice, they can try another method.
- In the helping step, effective questioning is very important. Counselors should concentrate on asking a few probing questions, to get a clear view of the client's preferences and feelings.
- During this step, counselors should make use of paraphrasing and clarifying skills they have learned.

Have participants look at the "H" section of Handout 6-1. Answer any questions.

ROLE PLAY

Helping clients choose a family planning method

Divide participants into groups of three. Explain:

- Now you are going to practice the helping step in GATHER. Each of you will take a turn playing counselor, client, and observer.
- While many clients already know which method they are most interested in, these role plays concern clients who do not have a particular method in mind. They will give you practice helping clients choose a method that may work well for them.

Have each participant read Handout 9-1 and choose a role. As a reference, the counselor can use the booklet *Talking with Clients about Family Planning: A Guide for Health Care Providers*. After each role play is completed, the observer gives constructive feedback. Give participants about 25 minutes for all the role plays, including feedback.

After the role plays, ask participants:

- What did you find easy to do?
- What was hard for you?

Spend a few moments reviewing clients 2 and 3 with the group.
For client 2, ask:

- How did you help the woman who disagreed with her husband about when to have their next child?

For client 3, ask:

- How did you help the woman who wanted the counselor to select a family planning method for her?

Summarize:

- The counselor's role is to help clients make decisions, not to make decisions for them.

Notes: _____

Step 4

Condoms and STD prevention

Explain:

- Since the latex condom is an excellent way to prevent the transmission of HIV infection and other STDs, counselors have a special responsibility to help clients overcome objections they or their partners have about this method. This is especially important for clients who are at risk of HIV infection or other STDs.
- It is not enough to simply tell clients to use condoms. Counselors may need to determine how clients and their partners feel about condoms, to address common misconceptions, to help clients negotiate condom use, and to demonstrate and explain how to use condoms.

DISCUSSION

Objections to condoms

Ask participants:

- What objections do your clients mention when talking about the condom?

List these objections on the left-hand side of newsprint. Then ask participants to suggest responses they could make to each of these objections. Write these responses on the right-hand side, across from the corresponding objection. Some sample objections and responses are listed below:

OBJECTION: I can't feel as much when we use a condom.

POSSIBLE RESPONSE: Some condoms are made extra thin to increase sensation. (Having clients put a condom over their fingers to show how much they can feel may help.)

OBJECTION: It doesn't feel natural to wear a condom.

POSSIBLE RESPONSE: Wearing a condom may feel different the first few times, but many men get used to it over time. Many people would rather use condoms than risk getting a deadly disease.

OBJECTION: Condoms are only for use with prostitutes.

POSSIBLE RESPONSE: Many married people and others use condoms to make sure they don't get pregnant or get a disease.

OBJECTION: Condoms break too easily.

POSSIBLE RESPONSE: Condoms do break sometimes, but today condoms are made stronger than ever. If a condom looks old or is dried out, it shouldn't be used. (The counselor can demonstrate how strong a condom is by filling it with water and showing clients that it doesn't break.)

Review positive aspects of condom use that counselors can present to clients.

- Many couples find that condoms can become a pleasurable part of the sex act, rather than a burden or an interruption.
- Using condoms is a sign that the partners care about each other.
- Using condoms can prolong erection and delay ejaculation. This can extend sexual intercourse.
- Using condoms of different textures and colors can add variety and fun to sex.

Explain:

- We sometimes assume all men know how to use the condom. Some men may not know how to put a condom on, or may do so incorrectly.

- A man may be more interested in using a condom if his partner helps him put it on. Women may need help learning how to do this, since they may not know how or may initially feel uncomfortable or embarrassed.
- It can be helpful to both men and women clients to demonstrate putting a condom on a realistic model of a penis. If no model is available, use two fingers or another substitute, but be sure the client understands that the fingers or substitute represent the penis. (See the instructions under the heading *Helping* in the condom section of *Talking with Clients about Family Planning: A Guide for Health Care Providers*.)
- After the demonstration, the client can practice putting a condom on the model, if desired.

CASE STUDIES

Condoms and STD prevention

Describe the two cases below to participants:

- Catherine is 28 years old. Her husband is away from home a lot. She thinks he is having sex with other women while he is away. Her husband refuses to use condoms with her.
- Margaret is about to be married. She has never had sex with her future husband, but she knows that he has had many lovers.

Ask participants:

- How would you help these women understand that they might be at risk of being infected with HIV?
- How would you help these women talk to their partners about using condoms?

ROLE PLAY

Condoms and STD prevention

If time allows, ask volunteers to role play what they would say to Catherine and Margaret. Other participants can enact the roles of Catherine and Margaret.

Summarize:

- Condoms are worn by men, so men ultimately decide about their use.

- Counselors can promote positive attitudes among men about condoms and about male responsibility for family planning and prevention of STDs, including HIV infection.
- Counselors can also give women suggestions and support for influencing their partners.

Notes: _____

MODULE 10: THE GATHER TECHNIQUE: EXPLAIN

Objectives

By the end of this module, participants should be able to:

- describe common side effects and warning signs associated with temporary contraceptives and what the client should do if they occur.
- explain why it is important to discuss side effects and warning signs with clients.
- explain how to use temporary family planning methods.

The information about contraceptive methods covered in this module is intended for use when explaining to clients how to use temporary methods. If participants are not already knowledgeable about contraceptive methods, you will need to provide them with a comprehensive update.

Estimated time

1 hour, 45 minutes

Advance preparation

- Before teaching this module, review the information on the explaining step of counseling for temporary methods in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers* (see Step 2, page 10-3, and Step 3, page 10-6).
- Write the list explaining the reasons for counseling clients about side effects on newsprint (see Step 2, page 10-5).
- Collect printed client informational materials (such as method-specific instructions or brochures) to use in the demonstration and role play (see Step 3, pages 10-6 and 10-7).
- As you did in Module 8, fill several boxes with samples of temporary contraceptives (see Step 3, page 10-7). See Module 8, page 8-2, for instructions.

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
30 minutes	Common side effects and their impact on clients (page 10-3)	Exercise Lecture	None
1 hour, 15 minutes	Explaining how to use temporary family planning methods (page 10-5)	Demonstration Role play	<i>Talking with Clients about Family Planning: A Guide for Health Care Providers</i> (1 copy for each participant), client informational materials, boxes of sample temporary contraceptives

Step 1

Introduction

Review the objectives with participants.

Explain:

- This module covers the “E” step in GATHER, in which the counselor *explains* how to use the particular family planning method chosen by the client.
- The focus of this module is temporary methods. Tubal ligation and vasectomy are discussed later in the training (Module 12).
- The explaining step covers the following about the client’s chosen contraceptive method:
 - » explaining how to get it
 - » explaining how to use it
 - » describing possible side effects and warning signs
 - » explaining what to do if side effects or warning signs occur
 - » making sure that the client understands instructions
 - » giving the client printed informational material, when available
- The explaining step is important because it helps ensure that clients can obtain the methods they have chosen, and that they know how to use the methods correctly and safely.

Step 2

Common side effects and their impact on clients

Explain:

- We will now review some side effects of temporary contraceptives. This review is not comprehensive, but will briefly cover the most common side effects. The sections on explaining in *Talking with Clients about Family Planning: A Guide for Health Care Providers* cover side effects in more detail.

EXERCISE

Completing a grid

Turn a sheet or two of newsprint lengthwise and write the following grid. Copy the boldface headings, but not the answers, which are in parentheses.

Common Side Effects ¹					
Weight gain	Spotting	Amenorrhea (missing periods)	Nausea	Cramping	Heavier periods
(COCs Injectables)	(COCs POPs Injectables Norplant implants IUD)	(POPs Injectables Norplant implants)	(COCs)	(IUD)	(IUD POPs Injectables Norplant implants)

Ask participants to tell you which method or methods may be associated with each side effect listed. Write the correct answers in the appropriate columns on the grid. If necessary, provide the appropriate responses or correct misinformation.¹

Ask participants:

QUESTION: Are any of these side effects serious from a medical point of view?

POSSIBLE RESPONSE: Not usually, but some occasionally are. For instance, amenorrhea may be a sign of pregnancy that could be ectopic.

QUESTION: Why be concerned about these side effects if they pose little medical risk?

POSSIBLE RESPONSES:

- Although side effects may not pose a health risk, clients may find them uncomfortable or worrisome. For example, the woman who no longer has periods when she is using the injectable may wonder if she will still be fertile after she discontinues this method.
- Tolerance of side effects (including pain and discomfort) is an individual matter. For example, weight gain may be desirable to one client and discouraging to another. Menstrual changes, which are common with some methods, are taken in stride by some women but can be very inconvenient for others, particularly if bleeding interrupts their sex life or some aspect of their daily routine.

¹ The abbreviation *COC* stands for *combined oral contraceptive*; the abbreviation *POP*, for *progestin-only pill*.

Ask participants to raise their hands if they have known clients to stop using a method because of one of these common side effects.

LECTURE

Why counsel about side effects?

Explain:

- Side effects are a major reason clients stop using a method. Yet research studies have shown that clients who have been prepared for common side effects are less likely to stop using the method because of them.

Display the following list written on newsprint (see the Advance Preparation section, page 10-1):

- Counseling for side effects:
 - » prepares the client for what may occur.
 - » tells the client about symptoms that may diminish over time.
 - » does not dismiss the client's concerns about side effects.
 - » provides reassurance and suggestions for coping.
 - » assists the client to choose another method if desired.

Review these points with participants and answer any questions.

Notes: _____

Step 3

Explaining how to use temporary family planning methods

Demonstrate explaining to a client how to use a temporary family planning method.

DEMONSTRATION

Explaining temporary family planning methods

You play counselor. Ask another person to play Grace, the client whose case was reviewed earlier (Module 8, Step 5, page 8-9, and

Module 9, Step 3, page 9-3). Remind participants of the method Grace chose (Module 9).

Using the method chosen by Grace, complete this counseling step by following the instructions below. As needed, refer to the booklet *Talking with Clients about Family Planning: A Guide for Health Care Providers*, but do not read lengthy sections aloud to the client (see the Advance Preparation section, page 10-1). The demonstration should last 5-10 minutes.

- Provide the method, or tell Grace how, when, and where it can be provided.
- If fees are involved, go over them with Grace.
- Explain how to use the method.
- If there is printed client informational material, such as a brochure or instruction sheet, give it to Grace (see the Advance Preparation section, page 10-1).
- Ask Grace to repeat the instructions. Listen carefully to make sure she remembers and understands.
- Describe any common side effects associated with this method. Differentiate between side effects that are normal and those that may be a sign of a problem. Clearly tell Grace what to do if warning signs occur.
- Ask Grace to repeat the information about warning signs. Listen carefully to make sure she remembers and understands.
- Arrange a follow-up visit or explain to Grace when she should return.
- Tell Grace to come back sooner if she has any questions, or is experiencing problems.

Answer any questions that participants have about the demonstration.

Point out:

- Asking Grace to repeat the instructions is an example in which the *client* uses paraphrasing, and the counselor checks to make sure she or he understands correctly.

Have participants look at the explaining section of Handout 6-1, and answer any questions.

ROLE PLAY

Explaining temporary family planning methods

Remind participants:

- A common mistake is to give clients information they have already received in the telling step. In the explaining step, clients only need information about how to use the method they have chosen.

Divide participants into groups of four or five. Give each group a box of temporary contraceptives (see the Advance Preparation section, page 10-1).

Have each group member take a turn playing the counselor. Without looking, he or she picks a method from the box and explains the method to the person at his or her left, who plays a client who has chosen that method. The counselor follows the steps for explaining outlined on Handout 6-1. The counselor may use printed informational materials to help explain the method, or may refer to the book *Talking with Clients about Family Planning: A Guide for Health Care Providers*. Tell participants each role play should take 5-10 minutes, since in real life the counselor is unlikely to have more time than this.

After each role play, the group practices giving effective feedback (see Handout 5-5). Participants should touch on points such as the following:

- information that they were unsure about
- information that was omitted
- information that was not needed at this stage in counseling
- observations about the way the information was presented

Conclude by asking:

QUESTION: How is explaining different from telling?

POSSIBLE RESPONSE: Telling is giving information that helps a client select a method. Explaining is concerned with how to use a method that has already been chosen.

Notes: _____

MODULE 11: THE GATHER TECHNIQUE: RETURN VISITS

Objectives	By the end of this module, participants should be able to: <ul style="list-style-type: none">• counsel clients during routine return visits.• explain what to do if clients come to the clinic reporting warning signs of complications.
Estimated time	1 hour, 15 minutes

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
1 hour, 10 minutes	Return visits (page 11-3)	Role play	<i>Talking with Clients about Family Planning: A Guide for Health Care Providers</i> (1 copy for each participant)
5 minutes	Summary of the GATHER steps (page 11-5)	Lecture	None

Step 1

Introduction

Review the objectives with participants. Explain:

- This module covers the last counseling step in GATHER, the step in which the client *returns* for a follow-up visit. The focus of this module is on temporary methods; tubal ligation and vasectomy will be discussed later in the training (Module 12).
- Clients make return visits for a variety of reasons.

Write the following reasons on newsprint:

- to obtain more supplies
- to complete a routine follow-up
- to ask questions
- to switch to another method
- to stop using a method that must be removed (Norplant implants, IUD)
- to report side effects or complications

Emphasize:

- Although most return visits are made for routine reasons, such as the first five items on the list, clients will occasionally present symptoms of serious problems (such as those noted as “warning signs” in the booklet *Talking with Clients about Family Planning: A Guide for Health Care Providers*).
- The counselor needs to know how to identify these signs, so that clients exhibiting them can be referred to health care personnel.
- If you feel unsure about side effects or warning signs, please review the booklet *Talking with Clients about Family Planning: A Guide for Health Care Providers* after today’s session.

Step 2

Return visits

Have participants look at the “R” section of Handout 6-1, and answer any questions.

Explain:

- We will now role play counseling clients during return visits.

ROLE PLAY

Counseling clients during return visits

Divide participants into groups of three. Participants take turns role playing counselor, client, and observer. The client chooses one of the first four reasons for returning from the list that you wrote on newsprint in Step 1. The counselor follows the steps for return visits outlined in Handout 6-1. After each role play, the observer gives feedback. Suggest 10 minutes for each role play, including feedback.

Continue the role plays so that each group member gets a chance to play each part.

After the role plays are completed, summarize the purposes of return visits. Stress the following:

- If clients present warning signs of complications or other symptoms of poor health, refer them to a doctor or nurse in the clinic.
- If clients report side effects that are unfamiliar to you, or if you are not sure if a side effect may be serious, check with a qualified health care worker.
- Clients often complain of side effects that you know are normal. While not medically serious, these side effects may be bothersome to the client (for instance, spotting between periods). It is important not to dismiss the client's concerns. Listen to the client. Provide reassurance and support.
- If clients are having trouble tolerating normal side effects, ask them to consider switching methods.
- In return visits, even clients who have no side effects or complications may wish to change methods. This is normal. Experience with a method may cause a client to change her or his mind. A client's needs may change. The counselor's goal is client satisfaction, not the promotion of a particular method.
- As appropriate, review with clients how to protect themselves and their partners against HIV infection and other sexually transmitted diseases.
- Clients who wish to discontinue contraception in order to have a child should be told about prenatal care and where it is available.

- Return visits play an important role in providing continuing care to clients who desire or need it. It is important to make clients feel that they are welcome to return to the clinic.

Notes: _____

Step 3

Summary of the GATHER steps

LECTURE

Counseling steps

Explain:

- We have now practiced all six of the GATHER steps: greeting, asking/assessing, telling, helping, explaining, and return visits.
- The order of the steps, and the content of the counseling, may change to fit each client's needs. The full six-step process may only be necessary for the first visit. Subsequent visits are usually much shorter, based on the client's needs.
- Even for first-time clients, counseling may not be lengthy, since many clients already have some information and preferences. This is one reason why individual assessment is important.

Notes: _____

MODULE 12: PERMANENT CONTRACEPTION

SECTION 1: INTRODUCTION TO COUNSELING CONSIDERATIONS (page 12-2; 45 minutes)

SECTION 2: TELLING CLIENTS INTERESTED IN TUBAL LIGATION ABOUT THE PROCEDURE (page 12-7; 1 hour, 30 minutes)

SECTION 3: TELLING CLIENTS INTERESTED IN VASECTOMY ABOUT THE PROCEDURE (page 12-12; 1 hour, 15 minutes)

SECTION 4: HELPING CLIENTS INTERESTED IN PERMANENT CONTRACEPTION MAKE A DECISION (page 12-17; 2 hours)

SECTION 5: EXPLAINING PERMANENT CONTRACEPTION TO CLIENTS WHO HAVE CHOSEN THIS METHOD (page 12-26; 1 hour, 30 minutes)

SECTION 6: POSTOPERATIVE INSTRUCTIONS AND RETURN VISITS (page 12-34; 45 minutes)

The information about tubal ligation and vasectomy covered in this module is intended for use when counseling clients about these methods. If participants are not already knowledgeable about these procedures, you will need to provide them with a comprehensive update.

SECTION I: INTRODUCTION TO COUNSELING CONSIDERATIONS

Objectives

By the end of this section, participants should be able to:

- list two ways in which counseling clients interested in tubal ligation or vasectomy differs from counseling clients interested in temporary methods.
- give three or more reasons why reversal surgery is not a reliable option for many clients who have had tubal ligation or vasectomy.
- describe the legal status and eligibility criteria for tubal ligation or vasectomy in participants' localities.

Estimated time

45 minutes

Advance preparation

- If possible, arrange for a service provider or health official to discuss laws and policies that affect the delivery of permanent contraception (see Step 3, page 12-5). If this is not possible, talk to a service provider or health official and find out about the following laws and policies in your setting:
 - » any laws that govern the availability of tubal ligation and vasectomy
 - » any program policies about tubal ligation and vasectomy, such as eligibility criteria (for example, age or parity requirements) and spousal consent requirements
- If possible, prepare copies of policies or laws regarding tubal ligation and vasectomy to hand out to participants (see Step 3, page 12-6).

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
25 minutes	What's different about counseling clients interested in permanent contraception? (page 12-4)	Discussion	None
20 minutes	Legal status and eligibility criteria (page 12-5)	Discussion	Service provider or health official, copies of laws and policies regarding tubal ligation and vasectomy

Step 1

Introduction

Review the objectives with participants. Explain:

- This module focuses on clients who tell the counselor that they are interested in permanent contraception or that they do not want any more children. It covers the knowledge counselors need about the surgical procedures and counseling steps for permanent contraception.

Step 2

What's different about counseling clients interested in permanent contraception?

DISCUSSION

Unique features of permanent contraception

Ask participants the following questions. Propose responses if participants do not answer.

QUESTION: Counseling clients who are interested in permanent contraception differs from counseling about temporary methods. Why?

POSSIBLE RESPONSE: Because tubal ligation and vasectomy (1) are surgical and (2) should be considered permanent. Clients choosing temporary contraceptive methods can discontinue or switch methods if they wish.

QUESTION: Why is it important to inform the client about possible risks associated with tubal ligation and vasectomy? How should it be done?

POSSIBLE RESPONSE: Clients should be informed about risks associated with any method, including tubal ligation and vasectomy. However, this should be done without scaring the client, and by putting the risk factors in perspective. Although there are health risks associated with these operations and while complications are possible, these problems rarely occur. It is helpful to compare the risks of permanent contraception with other risks the client faces. For instance, tubal ligation is safer than pregnancy.

QUESTION: Since reversal surgery is possible, why should you tell clients that tubal ligation and vasectomy are meant to be permanent? How would you handle this contradiction when clients bring it up?

POSSIBLE RESPONSE: For most clients, reversal is not a realistic alternative. Many factors make reversal of tubal ligation and

vasectomy difficult or impossible. For example, reversal procedures:

- may be unavailable.
- are costly.
- often fail.
- require that the doctor have special skills.
- usually take about four hours to perform.
- may not be appropriate for some individuals because of medical reasons.

For further information on reversal, review Handout 12-1, and answer any questions.

Notes: _____

Step 3

Legal status and eligibility criteria

DISCUSSION

Special considerations

Tell participants:

- Because tubal ligation and vasectomy are considered permanent, they often involve unique legal considerations, which may have a bearing on counseling.

Have a local service provider or health official lead a discussion about client eligibility for tubal ligation and vasectomy (see the Advance Preparation section, page 12-2). The discussion should cover the following:

- What is the legal status of tubal ligation and vasectomy in the country? Are there legal restrictions for men and women? Are there policies that encourage or discourage clients of certain age or parity to have a tubal ligation or vasectomy?
- What are the policies and practices for spousal consent?

Allow time for discussion of eligibility requirements, covering such issues as whether the requirements are well known, uniformly applied, or overly restrictive. Solicit participants' opinions about these requirements.

Point out that:

- In many countries, the laws may be ambiguous, or interpreted differently by policymakers and providers. Often, there are no laws about eligibility criteria or spousal consent requirements; rather, these are determined by the program. Wherever possible, programs should opt for flexible criteria and consent requirements so access to services is not inappropriately restricted.

Distribute copies of laws and policies regarding tubal ligation and vasectomy, if available (see the Advance Preparation section, page 12-2).

Notes: _____

SECTION 2: TELLING CLIENTS INTERESTED IN TUBAL LIGATION ABOUT THE PROCEDURE

Objectives	By the end of this section, participants should be able to: <ul style="list-style-type: none">• correct common misconceptions about tubal ligation.• tell clients who are interested in tubal ligation about the procedure.
Estimated time	1 hour, 30 minutes
Advance preparation	<ul style="list-style-type: none">• If appropriate, substitute another video or a slide set for <i>Minilaparotomy for Voluntary Surgical Contraception</i> (see Step 2, page 12-9)• If possible, arrange for a doctor or another clinician familiar with minilaparotomy (or laparoscopy, if that technique is used) to discuss and answer questions about the technique (see Step 2, page 12-9). For minilaparotomy, ask the clinician to be prepared to briefly describe both postpartum and interval techniques.• Gather flipcharts or brochures depicting the female reproductive system (see Step 4, page 12-11).• Before teaching this module, review the information on the telling step of counseling for tubal ligation in the booklet <i>Talking with Clients about Family Planning: A Guide for Health Care Providers</i> (see Step 4, page 12-11)

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
40 minutes	The surgical procedure (page 12-9)	Viewing of videotape Discussion	Video cassette player, monitor, videotape: <i>Minilaparotomy for Voluntary Surgical Contraception</i> or an appropriate substitute, doctor or other clinician
20 minutes	Tubal ligation: Addressing common misconceptions (page 12-10)	Discussion	None
30 minutes	Telling clients interested in tubal ligation about the procedure (page 12-10)	Role play	Flipcharts or brochures depicting the female reproductive system, <i>Talking with Clients about Family Planning: A Guide for Health Care Providers</i> (1 copy for each participant)

Step 1

Introduction

Review the objectives with participants.

Step 2

The surgical procedure

**VIEWING OF
VIDEOTAPE**

Surgery

If minilaparotomy is the standard technique for tubal ligation, explain that participants will now watch a videotape about minilaparotomy. The video features local anesthesia. If tubal ligation is performed under general anesthesia at participants' facilities, explain that the video does not discuss general anesthesia, but that the surgical technique is similar, regardless of which type of anesthesia is used.

Show the videotape *Minilaparotomy for Voluntary Surgical Contraception* or an appropriate substitute.

DISCUSSION

Learning more about surgery

After presenting the video, encourage participants to ask questions. If a doctor or other clinician familiar with tubal ligation is present, ask him or her to briefly discuss commonly used techniques and to answer participants' questions (see the Advance Preparation section, page 12-7). The clinician should provide basic information about interval and postpartum procedures and should show participants the incision site for each technique. If a clinician is not available, answer as many questions as possible. If questions arise that you cannot answer, explain that you will check with a doctor and obtain the answer.

Tell participants to consult the telling section about tubal ligation in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers* for further information.

Notes: _____

Step 3

Tubal ligation: Addressing common misconceptions

DISCUSSION

How to respond to common misconceptions

Remind participants that gently correcting common misconceptions is an important part of telling clients about family planning methods. Ask participants how they would correct this statement:

COMMON MISCONCEPTION: Tubal ligation is a painful, difficult procedure.

POSSIBLE RESPONSE: Tubal ligation is a simple procedure often performed under local anesthesia. It can be done as an outpatient procedure (the client leaves the same day) or after the birth of a baby. Women may have some pain after the procedure, but this discomfort usually is minor and lasts only a few days.

Ask participants for other examples of common misconceptions about tubal ligation, and have volunteers correct them. If participants do not have sufficient examples of common misconceptions, read some from Handout 12-2.

Notes: _____

Step 4

Telling clients interested in tubal ligation about the procedure

Explain that participants will now practice telling clients who are interested in tubal ligation about the procedure.

Remind participants:

- It is important not to overwhelm clients by giving them information that they do not need. As you learned earlier, counselors should fill in the gaps in clients' knowledge.
- At this stage, a woman who is trying to decide whether she wants tubal ligation needs information about the procedure, how it works, and its effectiveness.

- The telling step is an appropriate time to discuss any fees, since this may be a factor in the client's decision.
- Later, during the explaining step, a client who has chosen tubal ligation will be given more details about what happens during surgery, possible risks, and the possibility of failure.

Have participants complete the role play described below.

ROLE PLAY

Telling clients about the procedure

Pair each participant with a person sitting next to him or her. Have them take turns playing counselor and client. Ask them to portray different client roles: one plays a client who is interested in having an interval procedure and the other plays a pregnant woman who is thinking about having a tubal ligation after delivery.

Using a flipchart or a brochure that depicts the female reproductive system, the counselor briefly explains the procedure and how it works. The information about the procedure will vary slightly, depending upon the surgical technique used and whether the surgery is postpartum or interval. The counselor also briefly explains effectiveness and characteristics of the method, and answers any questions that the client has. The counselor can use the book *Talking with Clients about Family Planning: A Guide for Health Care Providers* as a resource.

The client gives feedback on the counselor's performance, focusing on the counselor's ability to give information that is appropriate and necessary at this stage of decision making.

Notes: _____

SECTION 3: TELLING CLIENTS INTERESTED IN VASECTOMY ABOUT THE PROCEDURE

- Objectives** By the end of this section, participants should be able to:
- correct common misconceptions about vasectomy.
 - tell clients who are interested in vasectomy about the procedure.
- Estimated time** 1 hour, 15 minutes
- Advance preparation**
- You may want to cover the material on counseling men that appears in Module 13 in the introduction to this module (see Steps 3 and 4 of Module 13, pages 13-5 and 13-9).
 - If appropriate, substitute another video or a slide set for *No-scalpel Vasectomy* (see Step 2, page 12-14)
 - If possible, arrange for a doctor or another clinician familiar with vasectomy to discuss and answer questions about this procedure (see Step 2, page 12-14).
 - Gather flipcharts or brochures depicting the male reproductive anatomy (see Step 4, page 12-16).
 - Before teaching this module, review the information on the telling step of counseling for vasectomy in the booklet *Talking with Clients about Family Planning: A Guide for Health Care Providers* (see Step 4, page 12-16).

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
30 minutes	The vasectomy procedure (page 12-14)	Viewing of videotape Discussion	Video cassette player, monitor, videotape: <i>No-scalpel Vasectomy</i> or an appropriate substitute, doctor or other clinician
20 minutes	Vasectomy: Addressing common misconceptions (page 12-14)	Discussion	None
25 minutes	Telling clients interested in vasectomy about the procedure (page 12-15)	Role play	Flipcharts or brochures depicting the male reproductive anatomy, <i>Talking with Clients about Family Planning: A Guide for Health Care Providers</i> (1 copy for each participant)

Step 1 Introduction

Review the objectives with participants.

Step 2 The vasectomy procedure

VIEWING OF VIDEOTAPE

Surgery

Explain that participants will now watch a videotape about vasectomy.

Show the videotape or an appropriate substitute.

DISCUSSION

Learning more about surgery

If a doctor or other clinician familiar with vasectomy is present, ask her or him to answer participants' questions (see the Advance Preparation section, page 12-12). If a clinician is not available, answer as many questions as possible. If questions arise that you cannot answer, explain that you will check with a doctor and obtain the answer.

Tell participants to consult the telling section about vasectomy in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers* for further information.

Notes: _____

Step 3 Vasectomy: Addressing common misconceptions

DISCUSSION

How to respond to common misconceptions

Discuss common misconceptions about vasectomy:

- There are perhaps more common misconceptions about vasectomy than about any other method.
- Since vasectomy is often misunderstood or little known, both women and men should be given correct information about vasectomy.

Begin the discussion by mentioning a common misconception and having a volunteer correct it. Use the following example:

COMMON MISCONCEPTION: Vasectomy is the same as castration.
POSSIBLE RESPONSE: Vasectomy is not castration. Castration is the removal of the testicles. This is not done in vasectomy. Only one or two tiny incisions (or punctures, in the case of no-scalpel vasectomy) are made and two tiny tubes are cut or tied off.

Ask participants for other examples of common misconceptions about vasectomy, and have volunteers correct them. If participants do not have sufficient examples of common misconceptions, read some from Handout 12-3.

Stress that men are often most concerned about the effect of vasectomy on their sexuality. Review the questions men usually ask about vasectomy:

QUESTION: Will I still have the same sex drive, potency, and enjoyment?

POSSIBLE RESPONSE: Yes. Vasectomy stops the man's sperm from becoming part of the semen. It leaves the rest of his body, desire, and ability unchanged.

QUESTION: Will I still ejaculate?

POSSIBLE RESPONSE: Yes. The sperm are only a small part of the fluid men ejaculate, so you will not notice a difference. (To help clients understand this concept, it may help to use images familiar to men, such as "Even when fish are taken out of the river, the water still flows.")

Notes: _____

Step 4

Telling clients interested in vasectomy about the procedure

Explain that participants will now practice telling clients who are interested in vasectomy about the procedure.

Remind participants:

- It is important not to overwhelm clients by giving them too much information. If the client already has some information, the counselor need only complete it.
- At this stage, a man who is trying to decide whether he wants a vasectomy needs information about what vasectomy is, how it works, and its effectiveness.
- This is also the time to tell the client about any fees for vasectomy, since this may be a factor in the decision.
- Later, a client who has chosen vasectomy will be given more details about what happens during surgery, possible risks, and the possibility of failure.

Have participants complete the role play described below.

ROLE PLAY

Telling clients about the procedure

Divide participants into groups of three. Have them take turns playing counselor, client, and observer.

The client is a man who is trying to decide whether he is interested in vasectomy. Using a flipchart or a brochure that depicts the male reproductive system, the counselor tells the client about vasectomy and answers any questions that he has. The counselor can use the book *Talking with Clients about Family Planning: A Guide for Health Care Providers* as a resource.

The observer gives feedback on the role play.

Notes: _____

SECTION 4: HELPING CLIENTS INTERESTED IN PERMANENT CONTRACEPTION MAKE A DECISION

- Objectives** By the end of this section, participants should be able to:
- list factors usually associated with a sound decision.
 - list factors often associated with regret after surgery.
 - assess the soundness of a client's decision for permanent contraception.
- Estimated time** 2 hours
- Advance preparation**
- If appropriate, substitute another video or a slide set for *Education and Counseling: Helping Clients Make Family Planning Choices* (see Step 2, page 12-19).
 - Write the four client profiles on four separate sheets of newsprint (see Step 4, page 12-23).

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
45 minutes	Helping clients make decisions (page 12-19)	Viewing of videotape	Video cassette player, monitor, videotape: <i>Education and Counseling: Helping Clients Make Family Planning Choices</i> or an appropriate substitute
45 minutes	Identifying signs of a sound decision (page 12-20)	Discussion Lecture	None
30 minutes	Assessing the client's decision for permanent contraception (page 12-23)	Case studies	None

Step 1

Introduction

Review the objectives with participants.

Step 2

Helping clients make decisions

Explain:

- In this section, you will learn how to assess the soundness of a client’s decision to have tubal ligation or vasectomy. Skilled counseling at this point is crucial, since it helps screen people who may be likely to regret their decision later.
- This section focuses primarily on the clients’ decision to end fertility. As with temporary methods, counselors also need to help clients assess their risk of contracting or transmitting diseases, including HIV infection.
- Some clients who seek permanent contraception may need ongoing protection against STDs and will require special counseling. Clients may believe that they will be “finished with contraception” once they have had a tubal ligation or vasectomy. For instance, a client named John chooses vasectomy in part because he and his partner are tired of using temporary methods. He may be reluctant to use condoms to prevent disease transmission once he has had his vasectomy.

Direct participants to Handout 12-4: Family Planning Counseling and Voluntary Sterilization: A Reference Guide for Counselors. Review the questions listed under the heading “If the client expresses an interest in voluntary sterilization.” Tell participants to keep these questions in mind as they watch the video.

VIEWING OF VIDEOTAPE

Helping clients make family planning choices

Play the videotape *Education and Counseling: Helping Clients Make Family Planning Choices* or an appropriate substitute. Ask participants to comment on the two cases presented and to identify counseling skills demonstrated in the video.

Notes: _____

Step 3

Identifying signs of a sound decision

DISCUSSION

Characteristics of a sound decision

Label two columns on newsprint: *Signs of a sound decision* and *Signs additional counseling may be needed*. Ask participants:

- What did you see in the video that made you think the clients are making a sound decision?
- Did you see any signs that the clients may later regret the decision to end fertility and that should be further explored during counseling?

Write responses in the two columns. Ask participants to draw on their experiences and to give additional signs of a sound decision or possible signs for regret. Add these to the two lists on newsprint.

When the group has no more responses, refer to “Some signs of a sound decision” and “Some warning signs” in Handout 12-4. Point out any items that were not mentioned.

Ask participants to explain how the following characteristics increase the chances that a client may regret the decision to end fertility.

CHARACTERISTIC: Young age and few or no children

POSSIBLE REASONS FOR REGRET: Clients who undergo tubal ligation or vasectomy when they are very young or who have few or no children are more likely than other clients to regret their decision later on. As their circumstances change, they may wish to have children. (The definitions of “young age” and “few children” vary from country to country, depending upon the typical age at marriage, the ages at which women normally bear children, and typical family size.)

CHARACTERISTIC: Pressure from partner, relatives, or providers

POSSIBLE REASONS FOR REGRET: Pressure from family members to undergo tubal ligation or vasectomy can lead to a decision that does not reflect the client’s wishes. Health providers can also exert pressure on clients, especially since they often have higher status and influence and are perceived as being more knowledgeable. When the decision has been forced upon the client, later regret is likely.

CHARACTERISTIC: Marital instability (including instability among couples in union)

POSSIBLE REASONS FOR REGRET: Periods of marital difficulty are times of great stress. Decisions made under stress may be regretted if and when the situation causing the stress is resolved. If a relationship does break up, partners may remarry (or form new relationships) and wish to have children.

CHARACTERISTIC: Unrealistic expectations

POSSIBLE REASONS FOR REGRET: Tubal ligation and vasectomy end fertility; they do not solve all of clients' problems. Unrealistic expectations may be related to misinformation about the procedure.

CHARACTERISTIC: Unresolved conflict or doubt

POSSIBLE REASONS FOR REGRET: The existence of unresolved doubts indicates that clients are not entirely sure of their decisions, and, therefore, could experience regret in the future. Examples include unresolved religious or cultural conflicts; unresolved feelings about ending fertility; unresolved feelings about wanting more children if a child were to die or if the client were to remarry.

CHARACTERISTIC: Excessive interest in reversal

POSSIBLE REASONS FOR REGRET: Reversal is a difficult, expensive, and often unavailable procedure, for which some clients do not medically qualify. Because clients who assume that tubal ligation and vasectomy are reversible are likely to be disappointed and to regret the choice, the counselor needs to carefully review the decision, stressing the intended permanence of these procedures.

CHARACTERISTIC: Decision pressured by a fertility-related event (birth or abortion)

POSSIBLE REASONS FOR REGRET: In general, delivery and abortion are poor times to make a decision to end fertility. Stress, pain, sedatives, or pressure from others may lead a woman to make a choice she otherwise would not make. Sometimes, however, clients have already carefully considered the decision for tubal ligation, and delivery or abortion may be an appropriate time for the procedure. Providers need to carefully weigh the individual circumstances in each case before deciding to offer the surgery. The special needs of postpartum and postabortion clients will be covered later in the training (Module 13).

LECTURE

Regret

Conclude the discussion by making the following points:

- Regret is often triggered by a major change in circumstance, such as the loss of a child or partner, or remarriage.
- Regret is sometimes strong enough to lead clients to seek reversal. Because reversal is usually not a realistic option, it is important to help clients avoid regret.
- Clients who show warning signs of future regret require careful counseling.

Ask participants if they have encountered situations where they felt the client might later regret his or her decision. Ask how they handled these situations.

Review the information listed on Handout 12-4 under “If you believe the client is at risk of dissatisfaction or regret after sterilization.”

Emphasize:

- Clients who show warning signs of regret should not necessarily be denied permanent contraception.
- Rather, these characteristics should signal the counselor to devote special time and care to ensuring the client carefully weighs the choice of permanent contraception and its alternatives.

Handout 12-5 provides information about regret after tubal ligation and vasectomy. Point out that the book *Talking with Clients about Family Planning: A Guide for Health Care Providers* has information on helping clients make decisions about permanent contraception.

Notes: _____

Step 4

Assessing the client's decision for permanent contraception

CASE STUDIES

Four clients

Display the four client profiles written on four separate sheets of newsprint (see the Advance Preparation section, page 12-17):

- **CLIENT 1**, a 30-year-old woman:
 - » has three children.
 - » does not want any more children.
 - » has a sister and cousin who have had tubal ligation, and has talked with them about the procedure.
 - » has a husband who agrees they should not have any more children.
- **CLIENT 2**, a 29-year-old man:
 - » does not want any more children.
 - » wants a vasectomy.
 - » does not want to tell his wife, since she wants more children.
- **CLIENT 3**, a 22-year-old woman:
 - » has two children under age three.
 - » feels overwhelmed with the responsibilities of her children.
 - » does not want any more children.
 - » is interested in tubal ligation.
- **CLIENT 4**, a 35-year-old woman:
 - » arrives at the hospital in early labor and asking for tubal ligation.
 - » did not receive prenatal care.
 - » has four healthy children.
 - » delivered all her children at home.
 - » says she came to the hospital to have her baby so she could get a tubal ligation.

- » says she and her husband have been discussing the decision for several months; neither of them want any more children.

Tell participants that they will consider these four clients who are interested in permanent contraception. Have them assess each client, listing signs of a sound decision or warning signs for regret. Write their responses on the newsprint. Possible responses are:

- **CLIENT 1:** The woman has the following signs of having made a sound decision: she is a mature individual, feels sure she has all the children she will ever want, and has support from her partner and information about the experiences of two relatives.
- **CLIENT 2:** The couple's difference in reproductive goals is a warning sign for regret.
- **CLIENT 3:** The woman has the following warning signs for regret: she is relatively young and under stress. One cause for her stress (the responsibilities of rearing young children) will change as the children get older.
- **CLIENT 4:** Although the woman is in labor, she appears to have considered the decision carefully.

Ask participants how they would handle each case in counseling. Start with Client 1, and proceed to discuss the remaining three cases. The following points should emerge:

- **CLIENT 1:** The counselor needs to check that the client has accurate information about tubal ligation.
- **CLIENT 2:** The counselor should explore whether the man has brought up the idea of vasectomy with his wife. Since the husband and wife differ in their desires for children in the future, it would be helpful if the wife came in for counseling. Until the couple resolve their differences, a temporary contraceptive method would be preferable to vasectomy.
- **CLIENT 3:** The counselor needs to determine the woman's marital status and learn about what her partner thinks. The counselor needs to talk with the woman about how her feelings may change over time.
- **CLIENT 4:** The counselor needs to be sure the woman is well informed about tubal ligation and its effects. Does she know

that it is meant to be permanent? Does she know she will not be able to have any more children if she has a tubal ligation? If the woman is well informed and clearly wants the procedure, it would be appropriate to perform the surgery. If the woman shows any signs of distress or uncertainty, the procedure should be delayed and the woman offered a temporary contraceptive method.

Summarize by making the following points:

- These four cases provide only a few details that suggest whether a decision is well considered or that the client may be at risk of regret.
- In a real situation, the counselor would be able to obtain additional information and explore the motives and concerns of clients in order to better assess the clients' decision.
- There are no recipes that can substitute for talking, listening, and, most importantly, helping the client to think through whether she or he would regret this decision if circumstances change.

Notes: _____

SECTION 5: EXPLAINING PERMANENT CONTRACEPTION TO CLIENTS WHO HAVE CHOSEN THIS METHOD

Objectives

By the end of this section, participants should be able to:

- define informed consent and list its six points.
- document informed consent.
- give preoperative instructions for tubal ligation and vasectomy.

Estimated time

1 hour, 30 minutes

Advance preparation

- Write the six boldface points of informed consent on newsprint (see Step 3, page 12-28).

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
5 minutes	Preparing the client for surgery (page 12-28)	Lecture	None
20 minutes	Informed consent (page 12-28)	Lecture Discussion	None
20 minutes	Using the informed consent form (page 12-30)	Lecture Discussion	None
45 minutes	Preoperative instructions (page 12-32)	Discussion Reading	<i>Talking with Clients about Family Planning: A Guide for Health Care Providers</i> (1 copy for each participant)

Step 1 Introduction

Review the objectives with participants.

Explain:

- We will now cover the explaining step in GATHER, in which the client learns how to use the method she or he has chosen.

Step 2 Preparing the client for surgery

LECTURE Resource material

Have participants look at Handout 12-4. Review each step under the heading "If you believe the client's decision for sterilization is informed, voluntary, and well considered."

Explain that participants have already learned the characteristics of tubal ligation and vasectomy (Sections 2 and 3 of this module), and can find this information in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers*.

Notes: _____

Step 3 Informed consent

LECTURE Six points

Tell participants:

- The next step in preparing clients for surgery is documenting informed consent.
- Informed consent is the client's voluntary decision to undergo a procedure, with full understanding of the relevant facts. Consent is voluntary when it is given of the client's own free will and not by means of special inducement (such as cash payment), force, fraud, bias, or other forms of coercion.

Refer to the six points written on newsprint (see the Advance Preparation section, page 12-26). Explain:

- In order to make an informed choice regarding permanent contraception, the client must be told and must understand the six elements of informed consent.
- These six points are listed on Handout 12-6:
 1. **Temporary methods of contraception are available to the client or the client's partner.** The client has a choice between temporary and permanent methods.
 2. **Tubal ligation/Vasectomy is a surgical procedure.** The client will undergo an operation.
 3. **There are risks and benefits associated with the procedure** (see the sections on explaining tubal ligation and vasectomy in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers*).
 4. **The client will no longer be able to have children.** Fertility will be ended.
 5. **The effect of this procedure is meant to be permanent.**
 6. **The client has the option to decide against the procedure without sacrificing the right to other services.** The client may change his or her mind at any time before the operation.

DISCUSSION

Importance of informed consent

Ask participants:

QUESTION: Why is informed consent important?

POSSIBLE RESPONSE: Making sure the client understands the procedure and his or her other options will help to:

1. Increase client satisfaction
2. Lessen the possibility of client's later regret
3. Protect the clinic and its staff against charges of involuntary tubal ligation or vasectomy and against possible legal action

Explain:

- Informed consent should be documented after the client requests the procedure and after the counselor verifies that the client's decision is voluntary, informed, and well considered.

- Usually the counselor is responsible for obtaining and documenting the client's informed consent. However, in some settings the surgeon does this. It is always the doctor's responsibility to verify informed consent by talking with the client just before the procedure. If possible, the doctor checks the informed consent form to be sure it is properly signed.

Notes: _____

Step 4

Using the informed consent form

LECTURE

Documenting informed consent

Have participants read Handout 12-7. Explain the ideal way to obtain and document informed consent:

- Even though the elements of informed consent have been discussed during counseling, the counselor should read the entire form with the client. Literate clients should have a form in order to read along.
- The counselor asks if the client understands the information on the form and voluntarily requests the procedure. This is a good time to use paraphrasing, by having the client explain the points of informed consent back to the counselor.
- After the client confirms that she or he understands the elements of informed consent, the counselor obtains the required signature or marks.

DISCUSSION

Special cases

Ask participants:

QUESTION: How would you suggest documenting informed consent of a client who cannot read?

POSSIBLE RESPONSE: If the client cannot read, the witness should have a form to read along with the counselor. If the witness also cannot read, he or she should be present when the form is read

aloud to the client. The client uses a thumbprint or mark if he or she cannot sign his or her name.

QUESTION: How would you suggest documenting informed consent with a client who speaks a language not spoken by the staff?

POSSIBLE RESPONSE: An interpreter should be available to ensure that the client understands the elements of informed consent. Interpreters should not be paid referral agents or persons who accompany the client to the facility because they may be biased towards the clients' choosing permanent contraception.

Explain:

- The informed consent form must be signed by the following:
 - » the client
 - » the attending doctor or his or her delegate (may be the counselor)
- For illiterate clients, the client signs by thumbprint or mark. The form must also be signed by a witness of the client's own choosing, preferably a person of the same sex who speaks the client's language.
- Each signature must be dated, and each date must be before or on the day of the operation. Clinic staff cannot sign forms before counseling has occurred or after the procedure has been performed.
- During counseling, providers should encourage clients to discuss the decisions with their partners. It is preferable for a couple to agree about the choice for permanent contraception. However, the consent of the spouse should not be required, except where expressly mandated by law or policy.

Notes: _____

Step 5 Preoperative instructions

DISCUSSION Purpose of instructions

Ask participants to explain the purpose of preoperative instructions for clients who choose tubal ligation or vasectomy. Make sure the following points are covered:

- Preoperative instructions are important to enhance the safety of tubal ligation and vasectomy.
- The instructions help clients prepare themselves physically and emotionally for the experience of surgery by telling clients what to expect *before*, *during*, and *after* the operation.

Ask participants how these instructions should be given to the client. The following points should emerge:

- All clients, even if they are illiterate, should receive both oral and written instructions. Illiterate clients usually have relatives or friends who can review the instructions with them. It is reassuring for clients to have written instructions to refer to if they cannot remember something.
- Instructions can be given either during counseling or at the medical screening, according to the practice at the service site.

READING Instructions before surgery

Tell participants:

- Oral instructions should contain essentially the same information as the instructions given in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers*.
- When giving preoperative instructions orally, the counselor should:
 - » use simple language that the client will understand.
 - » encourage the client to ask questions.
 - » check the client's understanding of the instructions by asking the client to repeat them.

For tubal ligation, have participants read the section "Explaining: Before Surgery" in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers*. Emphasize:

- The most important things to tell female clients before surgery are:
 - » No solid food or alcohol for eight hours before surgery
 - » No medication for 24 hours before surgery unless prescribed by the doctor who will do the surgery
- Failure to convey these instructions to clients in a manner they understand could result in serious complications.

For vasectomy, have participants read the section “Explaining: Before Surgery” in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers*.

Tell participants:

- The counselor should advise the client to use temporary contraception until the surgery and provide it, if necessary.
- Before surgery, counselors only briefly review the instructions about what clients will need to do when they return home after surgery (see “Explaining: After Surgery” in the sections on tubal ligation and vasectomy in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers*). They assure the client that she or he will receive detailed instructions after the operation.

Notes: _____

SECTION 6: POSTOPERATIVE INSTRUCTIONS AND RETURN VISITS

- Objectives** By the end of this section, participants should be able to:
- give postoperative instructions for tubal ligation and vasectomy.
 - counsel clients during return visits.
- Estimated time** 45 minutes

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
25 minutes	Postoperative instructions (page 12-36)	Lecture Reading	<i>Talking with Clients about Family Planning: A Guide for Health Care Providers</i> (1 copy for each participant)
20 minutes	Return visits (page 12-37)	Lecture Discussion	<i>Talking with Clients about Family Planning: A Guide for Health Care Providers</i> (1 copy for each participant)

Step 1

Introduction

Review the objectives with participants.

Explain:

- This section covers postoperative instructions and return visits for clients who have had tubal ligation or vasectomy.

Step 2

Postoperative instructions

LECTURE

Guidelines for postoperative instructions

Explain:

- Counselors are sometimes responsible for giving clients postoperative instructions after surgery.
- Remember, clients should receive both written and oral postoperative instructions. Written instructions help clients remember the oral instructions they receive. Illiterate clients can usually find someone to read the instructions if they forget what they were told.
- Clients should have recovered from the effects of sedation and anesthesia before receiving postoperative instructions.
- The counselor should use simple language that clients will understand.
- The counselor should encourage clients to ask questions.
- The counselor should check clients' understanding of the instructions by asking clients to repeat them.

READING

Explaining after surgery

Have participants read the section "Explaining: After Surgery" for both tubal ligation and vasectomy in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers*. Answer any questions they may have.

Notes: _____

Step 3

Return visits

LECTURE

Needs of clients who choose permanent contraception

Remind participants that return visits are the “R” step in GATHER.

State:

- Clients who have had tubal ligation or vasectomy:
 - » May not return to the family planning facility since they no longer have a need for contraceptive services. It is important to help clients feel welcome to return if they have questions. Clients must return if they need to have stitches removed.
 - » Should be encouraged to return for other reproductive health concerns (such as obtaining condoms to protect them against STDs, even if tubal ligation or vasectomy is providing protection against pregnancy).

Explain:

- Clients who have had tubal ligation or vasectomy make return visits for the following reasons:
 - » to complete a routine follow-up visit, including semen analysis for men who have had vasectomy
 - » to report side effects or complications
 - » to ask questions
 - » to say they regret having had tubal ligation or vasectomy

Emphasize:

- Although most return visits are made for routine reasons, clients will occasionally present symptoms of serious problems (such as those noted as warning signs in the book *Talking with Clients about Family Planning: A Guide for Health Care Providers*).
- The counselor needs to know how to identify these signs so that clients exhibiting them can be referred for medical evaluation.
- If you feel unsure about which side effects are warning signs, please review the book *Talking with Clients about Family*

Planning: A Guide for Health Care Providers after today's session.

DISCUSSION

Clients who regret

Ask participants:

- What should you do if a client returns saying that he or she regrets tubal ligation or vasectomy?

Possible responses include the following:

- If reversal is an option, explain the procedure to the client, taking special care to stress that not all reversal procedures are successful. If the client wants to pursue reversal, he or she will need further counseling and medical evaluation. Handout 12-1 provides information about reversal.
- If reversal is not an option, express empathy for the client's feelings of regret. Take the necessary time to help the client come to terms with the fact that he or she will never again be able to have children.
- Offer to speak to the client's partner.
- If appropriate, help the client consider the option of adoption.
- If appropriate, refer the client for psychological counseling.

Notes: _____

MODULE 13: COUNSELING NEEDS OF SPECIAL POPULATIONS

Objectives

By the end of this module, participants should be able to:

- describe common client concerns and counseling issues for:
 - » pregnant and postpartum women
 - » men
 - » postabortion women
 - » unmarried adolescents
 - » other special cases

Estimated time

3 hours, 20 minutes

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
10 minutes	Defining special populations (page 13-3)	Lecture	None
45 minutes	Special needs (page 13-4)	Small groups	None
1 hour	Counseling clients from special populations (page 13-8)	Discussion	None
25 minutes	Assessing individual needs (page 13-12)	Case studies	None
45 minutes	Other special cases in family planning counseling (page 13-14)	Discussion	None
15 minutes	Postpartum tubal ligation and the postpartum IUD (page 13-17)	Discussion	None

Step 1

Introduction

Review the objectives with participants.

Step 2

Defining special populations

LECTURE

Introduction to special populations

Explain:

- Special populations are those who:
 - » are likely to be overlooked by traditional family planning approaches.
 - » have special characteristics or needs.
- Members of certain client groups have something in common either because they are at a particular time in life (unmarried adolescents), they are of the same gender, or they are going through a particular life experience (having a baby, having an abortion). Understanding common experiences and needs of these different groups can lead to more sensitive and appropriate counseling.
- Specialized counselors are not needed to work with special populations. However, counselors at sites that offer particular services may be more likely to see certain clients than are other counselors. For example, facilities that serve pregnant and postpartum women need to consider how to counsel these clients, whereas sites that have no prenatal or maternity services will have little contact with these clients.
- The skills and attitudes needed for counseling clients from special populations are the same as those needed for other kinds of clients. All the skills learned in this training still apply, as do the basic principles and steps of counseling.
- The attitudes needed when counseling clients from special populations, such as empathy and openness, are the same as those needed for all clients. However, some counselors find that they may not feel comfortable working with certain populations. This is often a function of exposure and practice. Or they find that their own values come into play with certain client groups (for example, postabortion women or sexually active adolescents). It is important for counselors to be aware of any views they hold about different types of clients, so that

they do not let those views interfere with treating clients respectfully and nonjudgmentally.

- Counselors do need additional knowledge to counsel special populations. For example, they need to know which contraceptive methods are appropriate to use while breastfeeding, or they need to know the typical concerns of unmarried adolescents.

Notes: _____

Step 3

Special needs

SMALL GROUPS

Working with special populations

1. Divide participants into four groups, and assign each group one of these client populations: pregnant and postpartum women, men, postabortion women, and unmarried adolescents. Write the following assignment for the small groups on newsprint:
 - What are the special characteristics or needs to consider in counseling the population you have been given? List them on newsprint.

You may want to give a few examples from Handouts 13-1, 13-2, 13-3, or 13-4.

2. Give participants 15 minutes, and then ask the groups to rejoin. Have each group present its list, and discuss as needed. The points listed below should emerge, or you can introduce them, if necessary. (They are summarized on Handouts 13-1, 13-2, 13-3, and 13-4; you may want to tell participants about the handouts, but encourage them to come up with their own lists without consulting the handouts.)
 - **Pregnant and postpartum women:**
 - » A pregnant woman is likely to be most concerned about her own health and that of the baby.

- » The new mother is likely to be most concerned about her own recovery and the health and well-being of the baby; she also needs rest.
 - » Breastfeeding is a concern of pregnant and postpartum women. Clients often worry about the effects of contraception on breast milk.
 - » Pregnant and postpartum women may or may not be interested in discussing contraception, and their wishes should be respected.
 - » Some pregnant and postpartum women have multiple contacts with the health care system (for example, prenatal and well-baby visits) when they can learn about family planning. Other women may come to a facility just for the birth or may deliver their babies at home; they may have few opportunities to talk about family planning with a health care provider.
 - » Pregnant and postpartum women often experience psychological changes, physical discomfort, and other stress.
 - » Pregnant and postpartum women may be concerned about their sexuality and about meeting their partner's sexual needs. They may not know whether it is safe to have sexual intercourse during pregnancy. While they are pregnant, they may wonder if their spouses or partners are having sexual intercourse with someone else. Pregnant or postpartum women may worry that their partners will want to have sexual intercourse as soon as they return home after the delivery. Many women follow cultural or medical norms about postpartum sexual abstinence, but some do not. Pregnant and postpartum women may be reluctant to discuss sexual concerns with providers.
- **Men:**
 - » Men may need to be encouraged both to support women's use of contraception or to use contraception themselves. This may be especially true if male contraceptive use is uncommon in the community.

- » Men usually have less information than women about reproduction and family planning, and have fewer opportunities to talk to health care workers about their health.
- » Men tend to be more concerned about sexual desire and performance than women.
- » Compared to women, men may find it more difficult to talk about sexual problems or worries.
- » Some men find it easier to discuss sexuality and family planning with male counselors. Other men feel comfortable talking with a female counselor, provided she is knowledgeable, is unembarrassed, and treats them with respect.
- » The contraceptive method that offers the most protection against HIV infection and other sexually transmitted diseases is a male method—the condom.
- » Men may not be comfortable coming to a family planning clinic, particularly if it primarily serves women.
- **Postabortion women:**¹
 - » A woman who has just had an abortion is likely to be most concerned about her health and the abortion procedure. She may or may not be interested in discussing contraception, and her wishes must be respected.
 - » The woman may not be thinking about resuming sexual activity and needing contraceptive protection.
 - » The woman may be frightened, sedated, or in pain.
 - » Stress is likely to be greatest when a woman comes to the health facility for emergency treatment for an incomplete abortion.
 - » The woman may be feeling guilty, particularly if she induced the abortion herself.

¹ This section does not discuss clients who have had a spontaneous abortion (miscarriage).

- » The woman may be worried that her efforts to terminate her pregnancy will be discovered.
 - » Women who have just had an abortion may be especially concerned about confidentiality.
 - » A woman who became pregnant because her method failed may be distrustful of contraception.
 - » Women often do not realize that their fertility will return soon after abortion. A woman can ovulate within two weeks after an abortion.
- **Unmarried adolescents:**
 - » Adolescents undergo physical, emotional, and hormonal changes that influence their sexuality.
 - » Adolescents' sexual activity is often unplanned and infrequent.
 - » Adolescents are risk takers and often believe that unfortunate events happen to other people, not themselves. With respect to sexuality, adolescents often take emotional risks as well as risks related to pregnancy and STDs.
 - » Adolescents may deny that they are sexually active (especially girls, as this may not be acceptable in their culture or family). For this reason, they may not want to plan for sexual activity by acquiring contraception. They may find it easier to accept sexual activity if it "just happens."
 - » Adolescents' sexual activity is often based on needs outside of sex—for instance, their need for approval or affection.
 - » Adolescents are particularly susceptible to peer influences.
 - » Some adolescents want to get pregnant.
 - » Unmarried adolescents tend to be particularly concerned about privacy. They may be afraid to go to a family planning clinic for fear they will see someone they know there.

- » Adolescents worry that their parents or friends will find out that they are using contraception.
- » In many cultures, it is unacceptable for young unmarried men and women to go to family planning clinics.

Notes: _____

Step 4

Counseling clients from special populations

DISCUSSION

Special counseling concerns

Ask participants for suggestions for counseling these special populations. Refer to the newsprint lists that participants made earlier (Step 3). The points listed below should emerge. (They are also listed on Handouts 13-1, 13-2, 13-3, and 13-4; you may want to tell participants about the handouts, but encourage them to come up with their own ideas without consulting the handouts.)

- **Pregnant and postpartum women:**
 - » Pregnant women and women who have just delivered need clear and accurate information about breastfeeding, both for infant nutrition and for contraceptive purposes.
 - » Breastfeeding (the lactational amenorrhea method, or LAM) can be an effective contraceptive if certain conditions are met: The woman breastfeeds the baby on demand, she has not yet menstruated, the baby is receiving no other food or liquid besides breast milk, the baby is younger than six months old, there are no more than six hours between any two breastfeedings. If a woman does not want to use LAM, she can use other contraceptive methods while breastfeeding (see *Talking with Clients about Family Planning: A Guide for Health Care Providers*).
 - » Family planning counseling should be offered during the prenatal period. This allows the woman time to consider

and discuss her options well before delivery and to make any arrangements needed.

- » The period of labor and delivery is one of the few times that many women receive health care. Yet because of the pain and stress involved, it is not the best time for family planning counseling. Laboring women are preoccupied with their own pain and the birth outcome.
 - » Unless the pregnant woman has expressed an interest in getting an IUD or tubal ligation immediately after delivery, there is no reason to counsel during labor. Even for a woman interested in the IUD or tubal ligation immediately postpartum, providing counseling in early labor depends upon the receptivity of the woman and her ability to discuss contraceptive options.
 - » In the maternity setting, it is best if the person responsible for counseling is not part of the labor and delivery team, since these staff members have other responsibilities and an unpredictable workload.
 - » Providers may offer family planning counseling after delivery, while the woman is recovering and before she goes home with the new baby.
 - » In busy and crowded maternity wards, the counselor will need to make special efforts to provide privacy and confidentiality for the woman.
 - » If the woman is not interested in talking about contraception, the counselor can give her referral information so that she can seek out contraceptive services at a later time or return if she is interested.
 - » For women who do not want to discuss family planning, condoms and spermicides can be placed at various locations in the health facility so women can pick them up without having to ask for them.
- **Men:**
 - » Because men often have little knowledge of reproduction, contraception, and anatomy (particularly female anatomy), the counselor must take time to explain any gaps, using flipcharts or models extensively.

- » The counselor should discuss the relationship between contraceptive methods and sexuality, even if men are hesitant to raise it. Men often have serious misconceptions about how condoms, vasectomy, withdrawal, and fertility awareness methods affect sexual performance and pleasure. For instance, they may believe that vasectomy is the same as castration.
- » A man's concerns about his partner's use of contraception may be linked to concerns about sexuality (for example, that the partner will become frigid or promiscuous). Exploring these feelings and giving accurate information about the effects of different contraceptives will help clarify these issues.
- » Not all men know how to use condoms. The counselor should demonstrate and explain how to use a condom by placing it on a realistic model and also by showing the man how to remove it.
- » For men who do not want to discuss family planning, condoms can be placed at various locations in the health facility so men can pick them up without having to ask for them.
- » Health care providers often need to set up a special place and hours to accommodate men's needs for privacy.
- » When possible, the counselor includes the man's partner in the counseling session.
- **Postabortion women:**
 - » Acceptance of contraception must not be a prerequisite for abortion services or treatment of abortion complications.
 - » Depending upon the receptivity of the woman, counseling about family planning can be offered to the client before the abortion, while she is in the health facility after abortion, or at the follow-up visit.
 - » The counselor approaches the woman at a quiet time when a private discussion is possible. The woman should not be sedated or experiencing considerable pain.
 - » The counselor ensures that the client understands she can become pregnant again before she has her next period.

- » The counselor avoids moralizing about the unintended pregnancy or about the woman's decision to have an abortion.
- » If the woman is not interested in talking about contraception, the counselor can give her referral information so that she can seek out contraceptive services at a later time or return if she is interested.
- » The counselor needs to determine whether the pregnancy was the result of contraceptive failure, since this may influence the woman's interest in using contraception or the information she may need to use a method effectively.
- » For women who do not want to discuss family planning, condoms and spermicides can be placed at various locations in the health facility so women can pick them up without having to ask for them.
- **Unmarried adolescents:**
 - » Adolescents may be most comfortable with methods that are unlikely to be detected (such as Norplant implants, IUDs, or injectables), that are used only at the time of sexual intercourse (such as condoms or spermicides), or that are easily obtained (such as condoms).
 - » Health care providers often need to set aside special places or times to accommodate adolescents' needs for privacy.
 - » Adolescents can be counseled in places where they gather, such as schools, clubs, or community centers.
 - » Adolescents can be trained to serve as peer educators.
 - » The counselor does the following:
 - Helps adolescents understand that they will be sexual beings their whole lives; they do not have to try, understand, or perfect everything now.
 - Avoids harsh moralistic lessons against sex.
 - Presents realistic views of relationships, marriage, and parenthood.

- Helps adolescents who are not ready for sex learn how to say no. Role playing or practicing conversations can be an effective way to do this.
- Fills in gaps in adolescents' knowledge about reproduction and sexuality.
- Is prepared to listen to or raise issues about adolescents' sexuality: self-esteem, appearance, being "normal" within the peer group, pressure from peers or partners.
- Makes condoms easily available, even for those who do not receive counseling.

Conclude:

- *Talking with Clients about Family Planning: A Guide for Health Care Providers* includes information about which methods can be used postpartum and postabortion.

Notes: _____

Step 5

Assessing individual needs

State:

- Although clients from special populations share much in common, individuals will still vary greatly. Let's examine individual differences through some case studies.

CASE STUDIES

Six clients

Ask participants to read the case studies on Handout 13-5. For each case, ask participants to answer two questions:

- What do these two clients have in common?
- What individual needs of each client are relevant to counseling?

The following points should emerge from the discussion:

- **CASE 1:**

- » **In common:** Both women have just had a baby.
- » **Individual needs:** These clients are in different physical and psychological states.

Anne: May be experiencing pain, fatigue, and anxiety about caring for her first child. Family planning is probably not a priority for her now; later she may be interested in a spacing method.

Elizabeth: May be especially concerned about the burden of caring for all her children. May have all the children she wants. May be interested in effective methods to limit future pregnancies. May be interested in talking about contraception before she leaves the hospital.

- **CASE 2:**

- » **In common:** Both women are pregnant.
- » **Individual needs:**

Edith: May have mixed feelings about the baby and concerns about how to take care of it. May need basic information about reproduction and contraception, either now or at a follow-up visit, depending upon her wishes.

Ruth: Is likely to be more knowledgeable about and experienced using contraception than Edith. May still need information about returning to fertility, postpartum contraception, and breastfeeding.

- **CASE 3:**

- » **In common:** Both are men.
- » **Individual needs:**

Brian: Is interested in exploring his sexuality. Is more likely than George to engage in high-risk behaviors. Is likely to have knowledge gaps about reproduction and anatomy (especially female anatomy). Needs information about condoms.

George: Is in a stable relationship. May be interested in vasectomy or in supporting a method his wife wants to use.

Ask participants:

QUESTION: What did you learn from the case studies?

POSSIBLE RESPONSE: Even though the two people in each case seemed similar, they had more differences than similarities.

Summarize:

- The cases show that it is unwise to make snap judgments about a person because he or she belongs to a particular client group.
- The cases provide too few details to fully assess each client's needs. The counselor would need to learn more about each client, so that counseling could be tailored to the individual.
- The cases underscore the importance of assessing each individual's situation.

Notes: _____

Step 6

Other special cases in family planning counseling

DISCUSSION

Introduction

Ask participants for examples of other clients whose needs go beyond those of most family planning candidates. Responses may include the following:

- women who have medical indications to end their fertility
- populations in distressed conditions (for example, refugees, victims of natural disasters, prisoners, members of oppressed minorities)
- mentally disabled clients
- clients who do not speak the same language as staff

Ask participants to describe their own experiences counseling clients from the groups described above. Encourage participants

to explain how they have adjusted counseling to suit the special needs of the clients.

Lead a discussion about each of the special groups, focusing on these two questions:

- What special needs to these clients have that make them different from other clients?
- How can you, the counselor, help a client from this group?

The information below provides background for the discussion.

Medical indications to end fertility

Group: Women who have medical indications to end their fertility
Special needs: Medical problems make pregnancy especially dangerous for these women.

How you can help: Help the client understand the danger pregnancy poses to her. Give the client extra reassurance. Help her consider all her options, with special attention given to contraceptive methods. Try to involve the client's partner, including the option of her partner having vasectomy. The client in this situation may need extra support, since it may be difficult to accept limiting her fertility for medical reasons, rather than as a personal preference.

Populations in distress

Group: Populations in distressed situations (for example, refugees, victims of natural disasters, prisoners, members of oppressed minorities)

Special needs: Decisions are affected by stressful situations that may be temporary; contraceptives may be unavailable; supplies may be erratic; governments may target ethnic groups for contraception, or these groups may be ineligible for health services or lack access to them.

How you can help: Help the client choose a method that is appropriate to the circumstances. If the client is interested in Norplant implants or an IUD, which require follow-up and removal, be sure that she understands that removal will be needed and when. If the client is interested in a method that requires ongoing supplies, discuss the feasibility of obtaining a steady supply. If the client is interested in permanent contraception, try to determine how she or he might feel when or if circumstances change. Emphasize the permanence of the method. Ensure that lack of other contraceptive options or

services is not a factor pushing the client towards permanent contraception.

Mentally disabled clients

Group: Mentally disabled clients

Special needs: These clients need special help in understanding information; they may not legally be able to give informed consent; they may be subject to special legal restrictions.

How you can help: Use terms that the client can easily understand. Consider the client's ability to use temporary methods effectively. Determine if the client is able to make a legally competent decision. Long-term methods are often a desirable alternative to permanent contraception, particularly if there is any possibility that the client's health status could change or be treated. It is advisable to seek the opinion of a doctor, psychiatrist, or other expert.

Explain:

- Legal regulations about contraception for clients with mental disabilities vary according to location. In the case of tubal ligation or vasectomy, family planning staff are responsible for determining whether or not the individual is legally competent to give informed consent. They may need to consult with outside medical or legal experts.

Discuss with participants the laws or policies governing mentally disabled clients in their locale. If they do not know what the laws and policies are, encourage them to find out when they return home.

Language differences

Group: Clients who do not speak the same language as staff

Special needs: Communication is limited because a common language is not shared.

How you can help: Identify someone who can interpret for you and the client. Be sure the interpreter does not have a vested interest that might make him or her try to influence the client's decision. Be sure to use simple and clear language since it will be translated. Rely extensively on visual aids; point to pictures on flipcharts or show actual methods. Use nonverbal communication, especially to assess the client's comprehension and feelings about what she or he hears. If the client appears to be uncomfortable or to misunderstand, explore through the interpreter the source of the problem. If the client seems reluctant, frightened, or unsure, do not dispense methods; most

particularly, do not arrange for the client to receive long-term methods or permanent contraception.

Ask the participants:

- Have you encountered counseling situations that you did not know how to handle?

If participants volunteer cases that were difficult to handle, ask other participants if they have suggestions or how they responded in a similar situation. Use this forum for problem solving.

Notes: _____

Step 7

Postpartum tubal ligation and the postpartum IUD

DISCUSSION

Special concerns

Stress:

- Special care is needed with clients who want to have tubal ligation performed or an IUD inserted immediately after delivery.
- The best time to counsel a woman considering one of these methods is during the prenatal period. This gives the woman time to consider the choice carefully, well before the stressful time of labor and delivery.
- Before performing a postpartum tubal ligation or inserting a postpartum IUD, the provider should speak to the woman to be sure she still wants to go ahead with the procedure. If she has any doubts, the procedure should not be performed.

Ask participants the following questions about postpartum tubal ligation; possible responses are provided:

QUESTION: When you ask pregnant or postpartum clients when they decided to have a tubal ligation, what are you assessing?

POSSIBLE RESPONSE: Whether the client has had time to carefully consider the decision. If the client chooses tubal ligation well in advance of delivery, she is probably a suitable candidate for an immediate postpartum procedure, if she is well informed and has given careful thought to the decision. It is also a good sign if she has discussed the choice with her partner.

If the decision for tubal ligation was made shortly before or after delivery, the client is probably not a good candidate since she has had little time to consider the choice and may be influenced by the pain and stress of labor and delivery. It is useful to distinguish between when the client chose tubal ligation and when she received counseling from staff at the maternity center.

Sometimes the client arrives at the facility well informed about tubal ligation and certain of her choice, but she has had no prior conversations with maternity staff. In such cases, counseling staff serve as a checkpoint—verifying the accuracy of the information the woman has and ensuring that she has weighed the decision carefully. If the woman meets these criteria, performing an immediate postpartum procedure may be appropriate.

QUESTION: Why is the immediate postpartum period a poor time for a client to decide to end her fertility?

POSSIBLE RESPONSE: Stress, pain, sedatives, or other factors associated with labor and delivery may lead to a decision the client would otherwise not make. Also, the infant's health may be precarious at this time.

QUESTION: What can providers do when clients decide just before or after delivery that they want a tubal ligation?

POSSIBLE RESPONSE: It is best for such clients to be given the option of using an appropriate temporary method during the postpartum period, while allowing them the opportunity to reach a well-considered decision about their fertility and choice of methods. If they continue to be interested in tubal ligation, they can have the procedure performed at the six-week visit or later.

QUESTION: What special questions might you ask a pregnant client who is interested in tubal ligation immediately after delivery?

POSSIBLE RESPONSE: Questions that should be asked in a sensitive manner include the following:

- If something happened to your baby or health problems were discovered, would you wish you had not had the tubal ligation?
- Would the sex of your baby affect how you felt about your decision?

QUESTION: If a woman delivers an unhealthy baby, should the tubal ligation still be performed?

POSSIBLE RESPONSE: Tubal ligation should be postponed until the baby's health has improved. If the baby does not get well, the woman may regret the decision for permanent contraception.

QUESTION: Should tubal ligation be performed at the time of cesarean section?

POSSIBLE RESPONSE: Tubal ligation may be performed if the cesarean section was planned in advance and if the woman seeks the procedure and was thoroughly counseled before the time of surgery. Counseling for tubal ligation at the time of a planned cesarean delivery is the same as for other tubal ligation procedures.

If the cesarean section is done on an emergency basis, tubal ligation is not usually performed. Sometimes, however, tubal ligation or hysterectomy is performed because there are medical indications (the woman's life is at risk or future pregnancies would endanger her life). In these cases, the woman will need postoperative counseling to help her understand the reasons for the surgery and to adjust to the end of her fertility (see the discussion of medical indications, page 13-15).

Conclude the discussion by noting the following points:

- Informed consent cannot be obtained when the client is:
 - » sedated.
 - » in labor.
 - » experiencing stress before, during, or after a pregnancy-related event or procedure.

Notes: _____

MODULE 14: APPLICATION OF SKILLS

Objectives

By the end of this module, participants should be able to:

- apply the skills and knowledge learned in training to their work upon their return.
- identify and overcome obstacles to applying newly learned skills.

Estimated time

2 hours

Advance preparation:

- Display the list of participants' expectations developed in Module 1, Step 2 (see page 1-5).
- Write the three questions from Step 2 on newsprint (see page 14-3).
- Decide which of the small group activities to use in Step 3, page 14-4.
- Decide which of the follow-up activities to use in Step 4, page 14-6. If you choose the alternative activity, ask other trainers or supervisory staff to help.

ESTIMATED TIME	CONTENT	TRAINING TECHNIQUES	SPECIAL AIDS NEEDED
45 minutes	Creating an implementation plan (page 14-3)	Small groups	Lists of expectations from Module 1
45 minutes	Problem solving (page 14-4)	Small groups (or alternative small groups)	None
15-30 minutes	Follow-up to training (page 14-6)	Discussion (or alternative activity)	If alternative activity is used: other trainers or supervisory staff

Step 1

Introduction

Review the objectives with participants.

Explain:

- In this module, you will create a plan for applying the skills and knowledge you have learned in this training at your work sites.

Step 2

Creating an implementation plan

Before beginning this module, have participants review their responses to the participants' expectations exercise (Step 2 of Module 1, page 1-4). Have them use those responses to help complete the following assignment.

Tell participants:

- Think about how you would like to use the knowledge and skills learned in this training in your work. Write responses to the following questions (see the Advance Preparation section, page 14-1):
 - » As a result of this workshop, what specific changes would you like to make in your work over the next six months?
 - » What resources, such as materials, space, time, staff, money, do you need to carry out these changes?
 - » What obstacles or problems do you think you might encounter when you try to make these changes?

SMALL GROUPS

Implementation plans

After individual participants have written their responses to the three questions above, follow these steps:

1. Divide participants into small groups (4-5 participants per group). If possible, create groups of participants who have similar job assignments or who work together at the same site.
2. Ask group members to share their responses with each other. One participant in each group is the recorder, creating a list of changes, resources, and obstacles for the group.
3. On newsprint, make three columns with the following headings: *Changes*, *Resources*, *Obstacles*. When the small groups have finished creating lists, have each recorder share the information with the whole group. Write in a few words

each of the recorder's points in the appropriate column on the newsprint.

4. Tell the group that the obstacles category will form the basis for a problem-solving activity.

Notes: _____

Step 3 **Problem solving**

Complete one of the following two activities.

SMALL GROUPS **Obstacles and solutions**

To complete this activity, follow these steps:

1. Have participants return to their small groups (see Step 2, page 14-3). Ask the groups to pick the obstacles from the group list that are most relevant to them; assign any others that remain. Have small groups discuss solutions to the assigned problems. Before groups begin, make the following points:
 - Although counselors are affected by other staff and work situations that they may not feel they can change, there are many small changes they can make or influence others to make.
 - Recommendations for problem solving should be as specific as possible. For example, "Train personnel" is vague, while "Teach other nurses how to use the illustrated flipchart" is specific. Direct participants' attention to Handout 14-1: Counseling: Problems and Possible Solutions. Tell them the handout gives examples of solutions to problems commonly encountered at family planning service sites. The group should be encouraged not to rely on this list alone but to provide other solutions that could work for them.

Rotate among the groups, helping them focus the discussion on real situations that participants face in the

work setting. Relating the discussion to actual work situations will help in the transition from workshop learning to worksite implementation.

- 2. Ask each small group to report back to the large group, with proposed solutions to their problems or requests for further input from the large group.**
- 3. Summarize the activity. Emphasize positive approaches to potential problems, utilization of existing resources within the work setting, and cooperation with other staff for networking and referral. Focus on strategies that participants themselves can implement.**

**ALTERNATIVE
SMALL GROUPS**

Obstacles and solutions

To complete this exercise, follow these steps.

- 1. Have participants return to their small groups (see Step 2, page 14-3). Assign each group one of the following issues (or assign the obstacles generated during the small group activity in Step 2, page 14-3):**
 - **organizing regular meetings of family planning service providers to improve coordination and address problems**
 - **establishing referral systems from different hospital departments or other health services**
 - **allocating sufficient time for counseling**
 - **coordinating with other health care personnel who inform or counsel clients about family planning or related health issues**
- 2. Have each small group list some of the problems that group members have encountered when trying to address the assigned issue. One member of the group should write these problems on a piece of paper.**
- 3. Ask each small group to identify at least one possible solution to each problem they note, trying to make the solutions as specific and practical as possible.**
- 4. Have each small group share its problems and solutions with the other participants.**

Notes: _____

Step 4

Follow-up to training

Discuss follow-up that the training team will provide to participants. Be careful not to promise more than can be reasonably provided. Avoid building unrealistic expectations among participants. Explain:

- Follow-up is a post-training visit by the trainer or supervisory staff to your worksite.
- Follow-up will be planned and tailored to your needs. It is designed to reinforce the skills learned in training, ensure that these skills can be used on the job, and help in carrying out your implementation plan.

Complete one of the following two activities

DISCUSSION

Follow-up plans

Tell participants that you will use the implementation plans that they developed in Steps 2 and 3 to help plan the follow-up visits, by creating a checklist that details what follow-up actions are needed, who is responsible for the actions, and what the timeframe is for completion. This checklist can be used as the basis for follow-up. Tell participants that they will be contacted regarding possible dates for follow-up.

ALTERNATIVE ACTIVITY

Follow-up plans

Spend 5-10 minutes with each participant, developing a follow-up plan together. Other training staff or supervisors can assist with this activity by working with individual participants. Discuss priority follow-up actions, target dates, any special assistance required, and other issues specific to the participants' needs or work sites.

Following the discussion or activity

To summarize, ask participants to write on Handout 14-2 one action they intend to take to improve counseling as soon as they return to work.

Notes: _____

APPENDIXES

APPENDIX A: EVALUATION INSTRUMENTS

Purpose of each evaluation instrument

Following is a discussion of the purposes and uses of the following evaluation instruments: pretests and posttests, daily feedback exercises, the continuous assessment form, and the participants' final course evaluation. Samples of these instruments are provided.

PRETESTS AND POSTTESTS

Pretests and posttests provide a simple way to assess participants' knowledge about and attitudes towards counseling and contraception. Pretests and posttests serve the following purposes:

- Information from the pretest can help you, the trainer, determine participants' knowledge in different areas, and adjust the training accordingly. Conversely, if the pretest reveals deficiencies in knowledge, you may need to expand the training.
- Information from the pretest can help you determine how the participants view counseling and can provide baseline information about participants' attitudes.
- Since the same test is used for both the pretest and the posttest, a comparison of the results gives a snapshot of the knowledge that was acquired and of any changes in attitudes that resulted from the training.

Note that pretests and posttests do not provide information about participants' skill levels: this can only be assessed through observation.

DAILY FEEDBACK EXERCISES

Daily feedback gives you timely reactions from participants about the training. It can be collected using specialized exercises. Daily feedback lets you judge the pace of the course, to determine whether participants are engaged and interested, or bored, overloaded, or overstimulated. Based on the results, you can adjust the schedule and pace of the next day's training, and identify any unclear items for review.

Daily feedback focuses on parts of the training, rather than on the whole. While it provides specific recollections about

particular sessions, it does not necessarily give a clear perspective on the overall training.

**CONTINUOUS
ASSESSMENT
FORM**

The continuous assessment form allows participants to record their views about individual training modules. They can also note areas where they feel they need additional help or information. Participants can give the form to the trainer at the end of the course to complement, or in place of, a final evaluation.

**FINAL
EVALUATION
INSTRUMENT**

On the final evaluation instrument, participants give their impressions of the content of the training, the trainers, and the learning environment. Participants' responses can help you to determine how well the training objectives were met and to assess what adjustments should be made in future trainings.

Suggestions for the use of each instrument

**PRETESTS AND
POSTTESTS**

Two sample pretests/posttests are given on pages A-6–A-9. Before the training begins, you may administer either test or neither of them, depending upon the training schedule. Since taking tests reminds many adults of when they were students and makes many people anxious, it is important to set participants' minds at rest about the use of any evaluation instrument, especially one identified as a test. This should be done before the pretest, so that the test-taking experience does not make participants apprehensive about the workshop in general.

There are several ways to create a comfortable climate. First, tell participants that the tests will not be used to judge them. Rather, you will use the test results to tailor the training to their needs and to provide a basis for measuring changes in knowledge or attitudes that result from the training.

Another way to make participants comfortable is to tell them that they do not need to put their names on the tests. Instead, participants can label their pretests and posttests using an identifying symbol or short phrase (such as a birthdate or nickname). This enables you, the trainer, to compare each participant's results, while still keeping them anonymous.

Finally, pretests and posttests should be brief—in terms of the number of items to respond to, the number of pages, and the time required to complete the test.

It is important to review the pretest results early in the training, so that you can use the findings to adapt the course. Usually, trainers tally the results themselves.

For the posttest, participants can review the responses themselves. Collect the completed posttests and hand them out to participants, being sure that no one gets his or her own paper. Participants then take turns reading items and providing answers. They mark correct and incorrect responses on the papers. This approach saves your time (although it does take a few moments of training time) and lets participants quickly know the answers.

DAILY FEEDBACK EXERCISES

At the end of a long day, participants want to break for the evening, rather than complete a long written exercise, especially one they have to do every day. Therefore, be sure daily feedback exercises are brief and capture participants' attention. Reserve longer exercises for the final evaluation.

Daily feedback can be done orally or in writing, through various impressionistic activities (see pages A-11–A-13). This curriculum provides three samples.

CONTINUOUS ASSESSMENT FORM

You may also choose to use the continuous assessment form (see pages A-14–A-15). Distribute the form to participants at the beginning of the training. Participants then fill it out as the training proceeds, while the information is fresh in their minds. You may ask them to share their perceptions midway through the training. Collect the completed forms at the end of the training.

FINAL EVALUATION INSTRUMENT

The final evaluation (see pages A-16–A-18) usually precedes the closing remarks and is the last exercise of the workshop. At this stage, participants are often eager to leave or socialize. For this reason, be sure participants complete the evaluation before leaving the training room. Encourage participants to write comments, and emphasize that their perceptions and opinions help you and fellow trainers improve future trainings.

Trainer's assessment

It is useful, and often required, for the trainer to write an assessment of the training at the conclusion of the workshop. While this curriculum does not provide an instrument for this purpose, points that might be presented in a written assessment include the following:

- suggested changes in the curriculum or training design, including why the changes are suggested
- suggested ways to improve future trainings
- notable events or findings from the training
- any particular follow-up required or other support from managers

PRETEST/POSTTEST A

Instructions: For each of the following items, circle the letter next to the best answer.

1. Informed choice means:
 - a. the doctor or nurse informs the client about the most suitable contraceptive method.
 - b. the client is fully informed about the contraceptive options and allowed to choose.
 - c. the doctor or nurse chooses the best method for the client, then informs him or her.
2. Talking about sexuality during counseling:
 - a. should be avoided if it makes clients uncomfortable.
 - b. can help clients choose a method they will be satisfied with.
 - c. is only important for clients at risk of sexually transmitted diseases.
3. Discussing side effects of family planning methods:
 - a. scares clients away from using methods.
 - b. is not necessary for most methods.
 - c. can help prepare clients for what to expect.
4. If a woman who is interested in tubal ligation wants to discuss reversal, the counselor should:
 - a. simply restate that tubal ligation is permanent.
 - b. explain that reversal is an option.
 - c. explore the client's feelings about ending fertility.
5. Client assessment is a way of:
 - a. sizing up which method best suits the client.
 - b. seeing whether a client can follow instructions about using contraception.
 - c. determining each individual's needs.
6. Counseling a woman about postpartum contraception when she is in labor is:
 - a. desirable, since she is very motivated to use it.
 - b. appropriate for tubal ligation, since she can have the procedure right after delivery.
 - c. usually not appropriate since it is a time of stress and discomfort.
7. Men who have had vasectomy usually find that their ejaculations:
 - a. are less pleasurable.
 - b. produce less semen.
 - c. are no different.
8. An effective counselor:
 - a. gives the client advice about which family planning method to use.
 - b. determines which family planning method best suits each client according to his or her profile.
 - c. tries to ensure that each client uses contraception.
 - d. none of the above.

PRETEST/POSTTEST A *continued*

9. Paraphrasing is a way of:
 - a. asking good questions.
 - b. restating information.
 - c. exploring feelings.
 - d. none of the above.
10. One difference between counseling and giving information is that counseling:
 - a. does not require giving client facts.
 - b. includes advising the client about what to do.
 - c. includes a discussion of feelings and concerns.
 - d. none of the above.
11. Norplant implants are considered effective for:
 - a. three years.
 - b. five years.
 - c. seven years.
 - d. none of the above.
12. If a woman forgets to take a pill one day, she should:
 - a. take one right away.
 - b. wait until the next day and take two.
 - c. use another form of contraception for the rest of the month.
 - d. none of the above.
13. Changes in menstrual bleeding are common for women using:
 - a. the IUD.
 - b. injectables.
 - c. Norplant implants.
 - d. all of the above.
14. A factor that may influence a client's decision about family planning is:
 - a. the client's age.
 - b. the gender of the client's children.
 - c. the partner's views.
 - d. all of the above.
15. HIV infection can be transmitted by:
 - a. kissing someone who has HIV infection.
 - b. mosquito bites.
 - c. dirty needles.
 - d. drinking from a glass used by someone with HIV infection.
16. Breastfeeding is a very effective contraceptive:
 - a. if the infant receives only breast milk and no other foods or liquids.
 - b. if the woman has not yet had her period.
 - c. if the infant is less than six months old.
 - d. all of the above.

PRETEST/POSTTEST B

Instructions: Read each statement. Circle T if the statement is true. Circle F if the statement is false.

1. Men usually gain weight after they have vasectomy.

T F

2. Instructions to clients about method use should include information about side effects.

T F

3. A major advantage of informational materials is that they save time since they can be handed out to clients and do not require additional explanation from clinic staff.

T F

4. Because clients may feel uncomfortable talking about sexually transmitted diseases, counselors should bring up this topic only with clients who have multiple partners.

T F

5. Breastfeeding can be an effective contraceptive if the baby is younger than nine months old.

T F

6. Illiterate clients do not need to receive written instructions.

T F

7. The words *HIV infection* and *AIDS* can be used interchangeably.

T F

8. It is helpful for counselors to share their own experiences and beliefs regarding contraception with clients.

T F

9. Adolescents' sexual activity is often frequent and planned in advance.
T F
10. People's family planning needs usually change over time.
T F
11. Clients who want to switch methods should be encouraged to continue using the method they are using.
T F
12. If family planning staff motivate clients to use contraception, counseling may not be needed.
T F
13. Men usually have less information than women about reproduction and family planning.
T F
14. Women who have had an abortion may be fertile again within two weeks.
T F
15. If a client does not speak the same language as clinic staff, her husband or in-laws are the most appropriate translators.
T F

**Answers for
Pretests/
Posttests**

Test A

1. b
2. b
3. c
4. c
5. c
6. c
7. c
8. d
9. b
10. c
11. b
12. a
13. d
14. d
15. c
16. d

Test B

1. F
2. T
3. F
4. F
5. F
6. F
7. F
8. F
9. F
10. T
11. F
12. F
13. T
14. T
15. F

DAILY FEEDBACK EXERCISE A

Instructions to the trainer: Ask participants to write a one- or two-sentence response to one or both of these questions. Collect the written responses.

1. What was *not* clear to you in any of today's sessions?
2. How could we improve the training tomorrow?

DAILY FEEDBACK EXERCISE B

Instructions to the trainer: Read one or more of the statements below, and ask participants to write a few words to finish each statement. Collect the written responses.

1. Tomorrow, I hope that the trainer . . .
2. I think we are spending too much time on . . .
3. I think we are not spending enough time on . . .
4. At the end of today's session, I felt (write one word).
5. I wish that the trainer would . . .

DAILY FEEDBACK EXERCISE C

Instructions to the trainer: Give each participant a piece of paper with the three faces below printed on it. Before they leave the room for the day, ask participants to put a mark below the face that best describes how they feel about the day.



CONTINUOUS ASSESSMENT FORM

Instructions: Rate the quality of the sessions and the support materials. For each module, check one box under “Was this session useful?” and one box under “Were the support materials useful?”

Module title	Was this session useful?			Were the support materials useful?			Comments For example: Is more needed? Was information clear? Is information applicable?
	Yes	No	Sometimes	Yes	No	Sometimes	
1. Introduction to the Workshop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Introduction to Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Values and Attitudes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Factors in Client Decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Effective Communication Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. The GATHER Technique: Greet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. The GATHER Technique: Ask/Assess	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. The GATHER Technique: Tell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. The GATHER Technique: Help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. The GATHER Technique: Explain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. The GATHER Technique: Return Visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

CONTINUOUS ASSESSMENT FORM (continued)

Module title	Was this session useful?			Were the support materials useful?			Comments For example: Is more needed? Was information clear? Is information applicable?
	Yes	No	Sometimes	Yes	No	Sometimes	
12. Permanent Contraception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Section 1. Introduction to Counseling Considerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Section 2. Telling Clients Interested in Tubal Ligation about the Procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Section 3. Telling Clients Interested in Vasectomy about the Procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Section 4. Helping Clients Interested in Permanent Contraception Make a Decision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Section 5. Explaining Permanent Contraception to Clients Who Have Chosen the Method	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Section 6. Postoperative Instructions and Return Visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Counseling Needs of Special Populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Application of Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

FINAL EVALUATION FORM

Name (optional) _____

Instructions: For each item, check the box that best reflects your opinion. Your honest responses will help us improve future trainings. Your comments are also welcome.

1. The objectives of the training were:

- very clear.
- clear.
- not clear.

Comments: _____

2. The objectives of the training were:

- completely met.
- mostly met.
- insufficiently met.

Comments: _____

3. The length of the training was:

- too long.
- adequate.
- too short.

Comments: _____

4. The workshop content maintained my interest:

- all of the time.
- most of the time.
- some of the time.

Comments: _____

5. The material presented in the course was:

- almost all new to me.
- mostly new to me.
- mostly known to me.

Comments: _____

6. The skills I acquired are:

- directly applicable to my everyday work.
- somewhat applicable to my everyday work.
- not very applicable to my everyday work.

Comments: _____

7. The training facilities were:

- very satisfactory.
- somewhat satisfactory.
- unsatisfactory.

Comments: _____

8. The logistical arrangements (transportation, lodging, etc.) were:

- very satisfactory.
- somewhat satisfactory.
- unsatisfactory.

Comments: _____

Instructions: Please answer the questions below.

9. Which topics or activities did you find most useful?

10. Which topics or activities did you find least useful?

11. In future workshops, would you allow more time for some topics or activities? If yes, which ones?

12. What suggestions for improvement do you have for the trainer?

13. What additional suggestions do you have for improving future trainings?

APPENDIX B: GUIDELINES FOR A COUNSELING PRACTICUM

The ability to include a practicum in the counseling training depends upon factors related to both the training and the local family planning service site(s).

Arranging a practicum is desirable if all or most of the following criteria are met:

- The number of participants is small.
- Enough time is available in the training schedule.
- The practicum is scheduled at or near the end of the training, so that participants first have a chance to develop skills.
- The family planning clinic is willing to accommodate the participants, and the practicum will not cause a major disruption to the provision of services.
- There are enough family planning clients so that each participant can be given a chance to practice.
- There are enough trainers to observe and provide feedback to the participants who practice.
- There are enough trainers so that participants who are not practicing their skills can be otherwise engaged.
- The training site is close to the clinic site.
- The clinic has adequate space for observation and counseling.

A practicum that does not meet most of the preceding criteria will have few benefits for either the participants or the family planning clients. If most of these criteria cannot be met, other activities, such as role plays or practice at the participants' worksites, should be substituted for the practicum.

Arranging a practicum

Arrangements should be made with the clinic director well in advance of the practicum. The trainers or clinic manager discuss the purpose and expected implementation of the practicum with the clinic staff. The roles of the participants and the clinic staff, particularly those who usually do counseling, are reviewed and agreed to in advance. All clinic staff members, even those who

are not directly involved, are well informed about the activity, since their work will be affected by the presence of participants during the practicum. Every effort should be made to minimize the disruption of service delivery.

Since most clinics have the highest volume of clients in the morning, it is usually preferable to arrange practice during this time. Since clinic hours often start before workshop hours, it may be possible to schedule a practicum before the beginning of several training days. This is done towards the end of the workshop, after participants have had a chance to develop skills. If this is done, another trainer is on hand at the workshop site, so that the training can be started on time, even if the practicum team gets delayed.

If there are not enough trainers so that one can sit in the counseling session with each participant, an experienced counselor from the clinic staff may be substituted. This counselor is briefed beforehand so that she or he understands her or his expected role.

Either the training organization or the clinic site needs to arrange for transport and other logistical support.

Conducting a practicum

Participants can prepare for the practicum by discussing the effects that they could have on clients' comfort, the efficiency of the clinic staff, and clinic flow. They can list ways to minimize their impact on service delivery or develop norms for behavior during the practicum.

On the day of the practicum, all clients should be informed about the presence of participants and the purpose of the practicum. Each client should be asked whether she or he agrees to be observed or counseled by participants.

Each participant must at all times be supervised by a trainer or a trained counselor.

It is strongly advised that no more than one observer, in addition to a trainer, be present at each participant's counseling practice. Observation by a larger number of people is inappropriate for the following reasons: (1) it violates one of the basic precepts of counseling, which is to provide the client with privacy and confidentiality; (2) it makes it difficult for the counselor to

establish a trusting relationship with the client; (3) it intimidates participants, and makes them anxious as they practice their new skills; (4) it makes the practicum less like a real counseling session.

The role of observers must be spelled out: observers (including the trainers) must not interfere in the counseling session. They hold all questions and comments until the session is completed and the client has left the room. Observers may take notes, but they wait until after the session, to avoid making the counselor or client feel nervous.

During the discussion that follows the practicum, the trainer closely monitors any feedback that the observer gives about the participant's counseling skills. To give participants self-confidence and a positive attitude for working on problem areas, feedback should begin by focusing on strengths. Next, problem areas are identified as clearly and specifically as possible. Observers focus on behaviors that can be changed and information that can help the participant improve the quality of counseling. For example, saying that the participant's demeanor is unfriendly *is not* acceptable feedback. Pointing out that the participant did not make good eye contact with or smile at or take the time to greet the client *is* acceptable feedback.

After the practicum, participants return to the training room. The trainer reviews the counseling steps by asking participants to report their observations about doing each step. Participants identify—from their observations of the practicum—which skills have been well developed and which areas need more practice. Participants give observations to the large group without naming the trainee who was in the role of counselor.

The follow-up session is also an opportune time to answer any questions participants have about how to handle a particular situation or about any information of which they were uncertain.

APPENDIX C: OBSERVATION OF CLINICAL PROCEDURES

Observation of clinical procedures can help participants gain an understanding of such procedures so that they can explain them to clients. Examples of clinical procedures are Norplant implant insertion or removal, IUD insertion or removal, tubal ligation, and vasectomy.

Arranging observation of clinical procedures

Arrangements should be made with the clinic or hospital well in advance of the observation. All staff in the clinic area, even if they are not directly involved, need to be well informed about the activity, since their work will be affected by the presence of participants during the observation. Every effort should be made to minimize the disruption of service delivery.

Either the training organization or the clinic site arranges for transport and other logistical support.

Observing clinical procedures

As with the practicum, participants prepare for the observation by discussing the effect that observers have on clients' comfort, the efficiency of the clinic staff, and clinic flow. Participants list ways to minimize their impact on service delivery or develop norms for behavior during the observation. Some sample norms are as follows:

- Observers do not interfere with the work of the clinicians.
- Observers hold their questions and comments until after the procedure is completed and the client has left the room.
- Observers avoid making remarks that may disturb or embarrass the client.
- Observers avoid speaking to each other during the procedure.
- Observers may take notes, but they wait until after the client has left the room, to avoid making the client or the clinician(s) nervous.

At the clinic or hospital, participants are divided into small groups. Each group is then assigned to a client. The size of the groups depends on the number of clients scheduled and on the

amount of space available for observers. The client's comfort and safety must always be the first priority in determining how many people observe. The trainer or other clinic staff explain to the client why additional people are observing. The client's oral consent should be obtained.

A trainer should accompany the participants at all times during the observation. This helps to ensure that the observation does not seriously disrupt service delivery. It also helps prepare the trainer to answer participants' questions during the postobservation discussion period.

Each group first observes the clinic staff in their interactions with the clients. In the procedure room or operating theater, a nurse or doctor describes the equipment and set-up to the participants, using clear and simple language so that participants, in turn, can clearly explain the equipment and set-up to clients. For tubal ligation and vasectomy, each group follows at least one client through three areas: preoperative area, operating theater, and recovery room.

After the first observation of a tubal ligation or vasectomy, participants may, if qualified, assist with any subsequent procedures. They may provide preoperative care, reassure the client during surgery, or provide recovery care. Because of time limitations, not all participants will be able to practice these activities. Throughout the observation and practice, the clinic staff must remain responsible for each client; participants follow any instructions given by the staff. If the observation includes practice, participants must be supervised by a trainer or other qualified staff member.

After the observation, participants return to the training room. The trainer reviews the main steps of the procedures observed by asking participants to report their observations about each step. The trainer guides the discussion to follow the sequence of steps in the procedure, from the client's arrival at the clinic to her or his discharge. The trainer answers questions and clarifies any misunderstandings participants may have about the procedures they have witnessed.

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