MALAWI FAMILY PLANNING PROGRAMME

KULERA

INTERPERSONAL COMMUNICATION AND COUNSELLING

A TRAINING MANUAL FOR FAMILY PLANNING PROVIDERS

NATIONAL FAMILY PLANNING COUNCIL OF MALAWI

FOR A HEALTHIER AND HAPPIER FAMILY LIFE

SEPTEMBER 1998

STAFH PROJECT

Support to AIDS & Family Health

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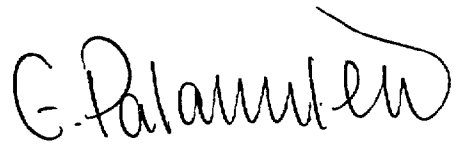
FOREWORD

The educational philosophy that forms the foundation of this manual for trainers of counsellors is that training is an exchange between the trainer and the participants. The role of the trainer is to assist the participants in the learning process. In each session exercise, individual participants share experiences and thoughts which enhance the learning process for everyone. Each participant has a valuable contribution to make and should be encouraged to be an active partner in the learning process. Because of the emphasis placed on this "active partnership," trainers are referred to as "facilitators" throughout this manual. In their role as facilitators, they help structure the session exercises to encourage sharing and learning, rather than simply teaching participants to complete mindless tasks or memorize information.

The purpose of this manual is to guide the facilitators to effectively train family planning providers to utilize interpersonal communication and counselling skills with their clients.



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This Training Manual on Interpersonal Communication and Counselling (IPCC) is a result of concerted efforts of many individuals, infact too numerous to mention. Therefore, the National Family Planning Council of Malawi in collaboration with the John Snow Incorporated Support to AIDS and Family Health (JSI-STAFH) Project and Ministry of Health and Population would like to sincerely thank all the individuals, partner agencies and organizations for their support and valuable contributions at various stages of the development of this IPCC Training Manual.

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SELECTION CRITERIA

WHO SHOULD BE TRAINED

- Nurses, Midwives, Community Health Nurses, Medical Assistants or Clinical Officers providing family planning from all the district facilities, including CHAM, Private Sector and NGOs.

- These should have undergone Family Planning Service Providers Course (4 or 6 weeks as the case may be).

- These should be currently providing FP or are on the list of staff rotating through the FP clinic.

Note: District FP coordinators should select the participants in liaison with District Nursing Officers (DNOs) and IPCC Trainers.

CHARACTERISTICS OF THE FAMILY PLANNING IPCC TRAINER

The IPCC Trainer will be an individual who will incorporate the ideals and philosophy of the family planning programme into his/her personality, attitudes and model which would eventually be reflected in the characteristics of the student. He/she should have a minimum professional qualification of nurse, midwife or clinical officer who has ben trained as a family planning service and has undergone IPCC training of trainers course and has proven training capabilities.

The IPCC Trainer should be able to perform the following roles:

Educational	-	teach family planning service providers and their supervisors both in classroom and in the clinical setting.
	-	be a breast with recent advances in counselling and contraceptive technology.
Administrative	-	plan, organise, coordinate and evaluate IPCC training activities in the district.
Supervision	-	monitor training activities and supervise the personnel during and after training.
Counselling	-	be a role model in family planning counselling as much as possible.
Research	-	identify areas for research and conduct research e.g. simple exit interviews to establish client satisfaction reasons for non use etc.

CHARACTERISTICS OF THE IPCC GRADUATE

The IPCC graduate shall function as a competent counsellor when providing services. He/she shall be able to work independently, dependently and interdependently in meeting the needs of family planning clients.

Upon completion of the course the IPCC graduate should be competent in the following:

1. Counselling family planning clients using the "GATHER" process.

2. Applying principles of counselling and communication skills in providing education on HIV/AIDS, STDs and family planning.

3. Providing counselling services to population groups with special needs e.g. Adolescents, men, widows etc.

4. Demonstrating appropriate use of family planning IEC materials during education and counselling sessions.

5. Portraying a positive attitude when dealing with clients.

The Counsellor as a provider shall utilise the Family Planning Policy and Contraceptive Guidelines in providing family planning services and related reproductive health. In his/her provision of family planning services, the counsellor shall encourage client participation and active involvement in decisions made regarding the services, taking into consideration the rights of the client.

The Counsellor shall act as a source of information and guidance in promoting family planning services among non users, maintain practice among current users and restore use of services among dropouts. The positive and caring attitude of the counsellor shall act as stimulant to the individual, families and community to choose and use family planning methods.

EVALUATION OF TRAINEES

a) Evaluation of the Trainee

i) The Trainees will be given a pre-test at the beginning of the course to assess their knowledge brought to the course and identify knowledge gaps that will be addressed during the training.

ii) At the end of the course the trainees will be given a post-test to assess knowledge gained.

iii) During the training, continuous assessment is provided through the use of performance and observation checklist. For example during Counselling Session and Role Play.

b) Course Evaluation

At the end of the course, the trainees will complete a Course Evaluation Form to provide feedback to the trainers on the effectiveness of the course.

TIPS FOR THE FACILITATOR

TIPS FOR THE FACILITATOR

A. PREPARATIONS FOR THE COURSE

To have a successful course, a good facilitator knows that careful planning must take place many weeks before the actual event. It is useful to have an identified coordinator for each course, who will be responsible for delegating tasks and ensuring that they are completed on time. As you plan for the IPCC course, review the following list and check items as you complete them:

1. **Plan for the training course**

- prepare a schedule (time-table) for the course.
- determine intended audience and establish criteria for selection of participants
- assess training needs.
- decide date and location for the course.
- determine cost per participant for food, lodging, transportation, materials, etc.
- develop a detailed budget.
- identify course facilitators and support staff, check on their availability, subject knowledge, skills and abilities.
- decide how the course session will be evaluated.

2. **Arrange Logistics**

- decide date and location of workshop.
- determine cost per participant for food, lodging, transportation, materials, etc.

3. **Identify Participants**

- communicate with the Regional Family Planning Coordinator through the Regional Health Officer to identify participants.
- send out letters of invitation.
- keep a record of responses (including phone messages).
- prepare a list of participants.

4. **Review and Prepare for each session**

- identify facilitator(s) for each session.
- review all sessions and familiarize yourself with the content.
- prepare for all course activities.
- identify all documents and materials and group them according to the day and session they are to be used.

5 **Prepare Materials and Equipment**

- ensure all materials and equipment for the course are available. Have sufficient copies of all handouts, registration forms, pre-course, questionnaire.
- assemble notebooks, videos, slides, flipcharts, tape, newsprint, chalkboard, paper, pencils, markers, chalk etc.
- arrange use of video, slide projector, overhead projector, etc as needed.

6. **Course Evaluation**

- make sufficient copies of the pre and post-test.
- make sufficient copies of course evaluation forms.

7. **Certificates**

- request copies of certificates.

B. HOW TO USE THE TRAINING MANUAL

1. Read all the parts of the session and each exercise carefully before beginning.

2. Check that all materials needed to complete each session and exercises are ready.

3. Follow the steps described for each session.

4. At the start of each session, explain to the participants the objectives of the session.

5. Give clear instructions to the participants.

6. Provide frequent praise to encourage participation.

7. Record important facts and information on newsprint or chalkboard to facilitate the learning process.

8. Involve all participants in the discussions.

9. Show respect to all participants.

10. Give participants many opportunities to practice their new roles as counsellors. Encourage participants to familiarize themselves with key concepts and processes such as the "GATHER" process in counselling,"ROLES" "CLEAR" and the effective use of support materials.

11. Encourage the participants to ask questions if they do not understand a topic or instructions for an exercise and/or ask them questions to make sure they understand.

12. Review key points of information before concluding a session or an exercise.

13. Ask for comments from the participants regarding what they think of each session and the training as a whole. Use this feedback to improve your training style.

SESSION SUMMARY

SESSION 1: **INTRODUCTION TO THE INTERPERSONAL COMMUNICATION AND COUNSELLING TRAINING**

TIME: **1 HOUR**

OBJECTIVES

By the end of the session, participants will be able to:

1. Name the trainers and other participants
2. State their expectation of the course
3. List the training objectives
4. List and utilize group norms
5. Discuss the rationale for training in IPCC

MAIN POINTS

1. Introduction of trainers and participants and their expectations.
2. Expectations
3. Training objectives
4. Group norms
5. Rationale for training in IPCC

MATERIALS

- Newsprint and marker
- Chalkboard and chalk
- Prepared newsprint on objectives, or use a transparency

REFERENCES

1 Family Health Services Project of Nigeria: *Nigeria Three-Day Curriculum, Interpersonal Communication and Counselling for Family Planning*, JHU/PCS and PATH, Ibadan, 1989.

SESSION SUMMARY

CONTENT

1. Introduction of Trainers and Participants

Brief introduction of trainers by name and welcoming participants to the training.

Partner Introduction

METHOD

Step 1: Course coordinator briefly introduces trainers by name and welcomes participants to the training.

Introduction Exercise

Step 2: Trainer hands out pieces of paper with either a fruit or juice written on it e.g. orange and orange juice.

Step 3: Ask participants to find their partners by matching a fruit with its corresponding juice.

Step 4: Ask each member of the pair to spend about 5 minutes becoming familiar with the other by asking the following questions and writing the answers down:

1. What is your full name?
2. What name would you prefer to be called during the training?
3. Which organisation do you work for and what is your designation?
4. Where did you get your first information about sex?
5. Have you ever used a contraceptive?
6. How did you feel when you used a contraceptive method for the first time?

CONTENT

METHOD

Step 5: Ask each member to introduce his/her partner.

Step 6: After introductions discuss the following questions with the class:

a. How did it feel to discuss these issues?

b. How did you feel introducing each other?

Possible responses to a and b:

- *uncomfortable/uneasy*
- *shy*
- *relaxed*
- *afraid*
- *free*

c. Do clients in your clinics sometimes feel uncomfortable? Why or why not?

Note: Responses will vary with each participant's experience

d. What can happen when clients are afraid to ask questions?

Possible Responses:

- *Do not use methods correctly*
- *Spread rumours*
- *Leave without understanding about the family planning methods, instructions, etc.*
- *Choose inappropriate methods.*

CONTENT	METHOD
	e. What can we do to make our clients feel more at ease in our clinics? Possible Responses: • *Listen to them* • *Treat them with respect* • *Respect and ensure confidentiality* • *Provide clear, thorough explanations* • *Provide encouragement and praise* • *Create a pleasant atmosphere*
2. Participants Expectations	**Step 1:** Trainer asks participants to write his/her expectations on a piece of paper. **Step 2:** Trainer and Co-facilitator collect the written expectations and write them on newsprint. **Step 3:** Trainer presents and discusses the list of expectations with the participants. Trainer and participants agree on those expectations that can realistically be achieved by the end of the course. **Note:** Responses will vary according to participants aspiration.

CONTENT	METHOD
3. Training Objectives: By the end of the course the participants should have: 1. Utilized the skills-based exercises in all the sessions of the Interpersonal Communication and Counselling (IPCC) Curriculum 2. Practiced family planning counselling and feedback, using **GATHER**. 3. Practiced use of verbal and non verbal communication skills, using "**ROLES**" and "**CLEAR**". 4. Practiced effective use of support (IEC materials when counselling clients. 5. Correctly counselled client(s) in a family planning clinic.	**Step 1:** The trainer distributes handout I on objectives or puts the objectives on newsprint or a transparency. Together with participants each objective is discussed. **Step 2:** Trainer asks participants if they wish to add or change any of the objectives.
4. Group norms:	**Step 1:** The facilitator (trainer) explains the rationale of developing the IPCC curriculum. **Step 2:** Trainer asks participants to come up with the norms they would like to observe during the training, to facilitate teaching and learning. She/he should record the responses on newsprint and post these on the wall for the duration of the training.

CONTENT

METHOD

Possible responses:

- *Punctuality*
- *Participation by everybody*
- *Listening to other people's contributions*
- *Going out of the classroom quietly*
- *Raising the hand when they want to ask or answer questions.*
- *Only one person speaks at a time.*
- *Confidentiality.*
- *Be non-judgemental.*

5. Rationale for IPCC Training

The Interpersonal Communication and Counselling (IPCC) training was designed in response to a need for a systematic means to improve and maintain the quality of client - provider communication in Family Planning and other health care services.

The quality of family planning services including education, motivation and counselling can affect the initiation and continuation of individual's contraceptive use. These skills, like any others, need to be learned and further developed through practical experience.

Even when the skills are acquired, attitudes can influence the quality of counselling provided to the client. For example, there are some providers who still harbour negative attitudes towards population issues and family planning. They are sometimes

Step 1: Trainer distributes Handout II to all participants.

Step 2: Trainer requests one participant to read Handout II "Rationale for IPCC Training"

Step 3: Trainer gives clarifications, if needed.

judgemental to the client's choice and use of certain family planning methods, or show reluctance to serve certain groups of clients like the divorced, widowed and teenagers. Such negative attitudes reduce the number of family planning clients and promote client dropout among acceptors.

It is against this background that this training was designed and is being implemented to improve the quality of interpersonal interactions and to promote acceptance and utilization of family planning services.

SESSION 1

HANDOUT 1

Objectives

By the end of the week, the trained participants should have:

1. Utilized the skills-based exercises in all the sessions of the Interpersonal Communication and Counselling (IPCC) curriculum.

2. Practiced family planning counselling and feedback, using GATHER.

3. Practiced use of verbal and non verbal communication skills, using "ROLES" and "CLEAR".

4. Practised effective use of support (IEC) materials when counselling clients.

5. Correctly Counselled clients in a family planning clinic.

RATIONALE FOR TRAINING IN IPCC

The Interpersonal Communication and Counselling (IPCC) training was designed in response to a need for a systematic means to assess, improve and maintain the quality of client - provider communication in Family Planning and other health care services.

The term "Client" rather than "Patient" denotes an active participant in the FP and other health care encounters, and implies the right to courteous and professional treatment at all times.

The quality of FP services including education, motivation and counselling can affect the initiation and continuity of people's contraceptive use.

In the provision of FP services, there are some providers who still harbour negative attitudes towards population issues and FP practices. They are sometimes judgemntal to the client's choice and use of certain or show reluctance to admit certain classes of clients like the divorced, widowed or teenagers.

Such negative attitudes block information and may promote client dropout through lack of accurate or current information. The general public also assists in certain negative attitudes, values, perceptions and misconceptions towards reproductive health including family planning issues in this country as evidenced by the low Contraceptive Prevalence Rate of only 7 percent.

It is with this background that this training was designed and is being implemennted to improve the quality of interpersonal interactions and to promote acceptance and utilization of family planning services.

SESSION SUMMARY

SESSION 2: **COMMUNICATION**

TIME: **2 HOURS**

OBJECTIVES:

By the end of the session, participants will be able to:

1. Define Communication.
2. Describe the communication process.
3. Explain barriers to effective Communication.
4. Explain the factors which influence Communication.

MAIN POINTS

1. Definition of Communication
2. The Communication process
3. Barriers to effective Communication.
4. Factors which influence Communication.

MATERIALS

- Chalkboard and chalk
- Newsprint and markers
- Handouts: Factors which influence Communication

REFERENCES:

1. Hubley J: Effective Communication - Theory and Practice in Health Education - Leeds polytechnic, 1988.

2. MOH (HEU): Information, Education and Communication Messages and Materials Survey Report, Lilongwe, 1974.

3. Saunders DJ: Visual Communication Handbook, United Society of Christian Literature - Lutterworth Education, Guildford - London, 1974.

SESSION OUTLINE

CONTENT

Definition of Communication

Communication is transmitting information, thoughts and feelings through words, actions or signs from one person to another or a group.

2. The Communication process

Communication process is a two way interaction which involves the sender, message, receiver, channel and feedback.

Sender: This is a person or persons from whom information is originated.

Message: The idea that is being passed on, either verbally or non-verbally.

Receiver: Refers to person(s) talked to, who interprets the message being transmitted.

Channel: The means by which the message is transmitted from the source (sender) to the receiver.

Feedback: A response from the receiver(s) of a message which gives the sender knowledge of the results of his/her message.

METHOD

Step 1: Introduce the session by informing the participants that the focus of the session is "COMMUNICATION"

Step 2: Ask the participants to define communication.

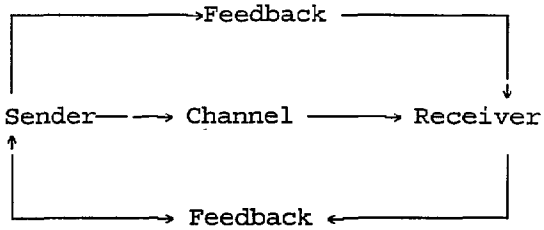
Step 1: Ask the participants to define the terms:

- sender
- message
- receiver
- channel
- feedback.

Step 2: Together, come up with some definitions like those given on left column.

Step 3: Draw a diagram of the communication process on the chalkboard and use it to describe the process and to explain the components of communication process in detail.

The Communication Process, is a two-way process as shown in the diagram below



CONTENT	METHOD
3. **Barriers to effective communication** a. **Sender** • Sex • Knowledge of subject matter • Age • Religion • Attitudes • Culture • Socio-economic status • Language • Level of education • Confidentiality b. **Message** • **Too much or too little information** • **Incorrect target audience** • **Untimeliness** • **Readability of message** • **Illiteracy (audience that can not read and comprehend message)** • **Irrelevance.** c. **Channel** • Quality of channel • Noise • Inappropriate channel • Timeliness	**Step 1:**Divide participants into four groups. **Step 2:**Ask each group to make a list of barriers to communication in relation to the sender, message, channel and receiver. **Step 3:**Ask one person from each group to report. **Step 4:**Make sure that all the barriers in left column are included.

CONTENT	METHOD
d. **Receiver** • Sex • Age • Religion • Culture • Attitudes • Socio-economic status • Language • Level of education • Lack of interest • Physical defects e.g. deafness, dumbness, blindness. e) **Feedback** • Non existence of feedback channel • Size of the audience (very large audience) • Emotional reactions	
4. **Factors which influence communication**	**Step 1:** Distribute the handout on factors which will influence communication and give participants 15 minutes to read it. Ask for any questions or comments. Discuss the following points: 1. For each component of the communication process give 3 factors that will influence: a) the sender b) the message c) the channel d) the receiver e) the feedback. 2. Explain how? **Note:** After going through the factors which will influence communication (Pages: 2.6 to 2.8), ensure that the session summary on page 2.9 is covered.

HANDOUT

Factors which will influence communication

For effective and efficient communication to take place there must be a sender, message, channel, receiver and feedback.

The sender who has the original idea, must formulate this idea into a clear message; choose the correct channel for getting this message to the receiver (i.e. the person/s for whom the message is intended) so that the receiver will be able to interpret this message as it was intended to be; and then respond to this message appropriately, which will be evident in the feedback.

It is impossible to do health education without this input.

Sender factors which will influence communication

1a. The attitude of the sender

The attitude of the sender is determined by how he/she relates to those with whom he/she has contact i.e. clients, colleagues, subordinates and seniors; and also with his/her environment.

Our attitudes can cause our clients and prospective clients to feel welcome or unwelcome at our service points. The family planning provider must therefore be honest, sincere, genuine, caring, open minded, unprejudiced, empathetic, etc.

1b. The formulation of the idea into a message

The sender should be able to take the idea that he/she has in his/her mind, which his/she wishes to convey to the receiver and mould it so that the receiver will understand it. The sender should be able to use a language that is understood by the receiver, at the level of the receiver. He/she should be able to use this message within the cultural structure of the receiver. The family planing provider should be familiar with the culture of the people being served. He/she should have insight into how he/she could positively integrate the message with the culture so as to enable the client retain his/her cultural balance whilst integrating new concepts.

1c. Conveying the message

The sender's body language should be in agreement with his/her verbal communication; whether the message was delivered confidently; whether he/she had control of gestures, posture, facial expressions, body movement and was dressed in a way that would not distract the clients.

2. **Message factors which will influence communication**

The message factors which will influence communication are - how clear, unambiguous, relevant, logical, appropriate it is; how the message is structured and what language is used.

3. **Channel factors which will influence communication are:**

- whether the choice of channel for communication is appropriate, for example, written material to an illiterate person; radio or an audio channel for a deaf person; visual channel for a blind person would all be inappropriate channels.
- the quality of the channel used, for example, distorted sound will interfere with the reception of the message.
- a large or small room, large open space or small open space will determine the projection of the voice/sound of the communicator.
- the other sounds which are present.
- the size of the group or audience.
- the developmental level of the receiver.
- the culture of the receiver i.e., is the channel acceptable or is it associated with some "negative" situations in that culture.
- special needs of the audience for example, deaf or blind.
- the ability of the sender to use the channel.

4. **Receiver factors which will influence communication**

We all bring into all our relationships a richness of experience. This experience may have positive or negative associations which result in "positive or negative" attitudes, which influence communication.

The attentiveness of the client may be influenced by fatigue, interest, fear, anxiety, illness, pain, anger level of mental development, etc.

The level of understanding will influence how one interprets the message received. The family planning provider therefore should be able to assess the client's level of understanding early in the relationship and make the necessary adjustments to his/her approach.

The culture of the receiver may cause an individual not to be able to understand or act on the message especially if the sender does not belong to the community. For example, culturally it may not be permitted for a woman to make any decisions on her own - if this is not known by the family planning provider communication will not be enhanced.

5. **Feedback factors which will influence communication**

The existence or non-existence of feedback channels will affect communication. The size of the audience, for example, feedback from a large group is more difficult to obtain than that from a small group.

Emotional reactions will interfere with feedback and so affect the communication process - as the feedback could be distorted.

CONTENT

METHOD

Summary

Ask the participants the following, to determine if they have understood the session:-

1. Define communication.
2. Explain the communication process.
3. Mention barriers to communication.
4. Briefly describe factors which will influence effective communication.

SESSION SUMMARY

SESSION 3 : **VERBAL AND NON-VERBAL COMMUNICATION**

TIME : **3 HOURS**

OBJECTIVES:-

By the end of the session, participants will be able to:

1. Explain the difference between verbal and non-verbal communication.
2. Identify two types of non-verbal communication used in communication.
3. Review barriers to effective communication.
4. Design strategies to overcome barriers to effective communication.

MAIN POINTS

1. Verbal and non-verbal communitation
2. Types of non verbal Communication
3. Barriers to effective communication.
4. Strategies to overcome barriers to effective communication

MATERIALS

Chalk and chalk board
Newsprint and markers
Reference books
Overhead projector and transparencies
Case Study Handout

PREPARATIONS

1. Newsprint or transparency with session objectives
2. Pieces of papers with different types of emotions written on them.
3. Pieces of paper with different types of feeling statements written on them.
4. Photocopy sufficient copies of the case study (or - put it on newsprint).

REFERENCES

1. AVSC International: Family Planning Counselling: A Curriculum Prototype; Trainers Manual, AVSC International, New York, 1995.

2. Family Health Services Project of Nigeria: Nigeria Three - Day Curriculum: Interpersonal Communication and Counselling for Family Planning, JHU/PCS and PATH, Ibadan, 1989.

3. National Family Welfare Council of Malawi: Family Planning Practitioners Training Program Curriculum, Blantyre Print and Packaging, NFWCM, Lilongwe, 1995

SESSION OUTLINE

CONTENT

The difference between verbal and non-verbal communication.

People communicate in two modes; verbal and non-verbal. These are closely bound together during interpersonal interaction. As they communicate, they express themselves through body movements, spoken words, facial expressions and general appearance. These modes convey the same or different messages.

a. **Verbal Communication**

Verbal communication involves talking, i.e spoken or written words. Language is a code that conveys meaning. Language is effective only when each of the persons communicating understands a message clearly. Verbal communication is most effective in conveying information. It is the tone of voice that shows the feelings of the communicator.

METHOD

Guided Discussion/Brainstorming/ Exercise

Step 1: Divide the participants in pairs and ask them to list different ways in which people communicate.

Step 2: Teams should share their lists and discuss the different ways in which people communicate with each other.

Possible Responses

-Touch
-Body movement
-Voice (tone of voice)
-Words
-Facial expression
-Eye contact
-Drums
-Whistles

Step 3: From their list of possible responses, ask the participants to identify which are verbal and which are non-verbal ways of communicating.

Step 4: Explain that a person's tone of voice also communicates different emotions.

Exercise

Give participants pieces of paper with different types of emotions written on them.

CONTENT

METHOD

Possible Feelings or Emotions

- *Pain*
- *Pride*
- *Anger*
- *Boredom*
- *Happiness*
- *Frustration*
- *Defensiveness*
- *Sadness*
- *Fear*
- *Disgust*
- *Disinterest*
- *Impatience*
- *Disapproval*

Step 5: Ask the participants to act out the emotion which is on the piece of paper that he/she has picked.

Step 6: Ask the others to guess which emotion is being displayed and discuss how the feeling is shown.

Step 7: Ask participants "what is the relationship between emotions and one's tone of voice?"

Step 8: Ask participants "which tone of voice would you prefer to be used when you go somewhere for help?". Why?

Non-Verbal Exercise: Display of Feelings

Step 9: Give slips of paper with different statements about feelings to volunteers from the group and ask them to act out the feeling statement before the group.

They may use expressions and body language, but no words or vocal expressions. Other participants should try to guess the emotion or feeling.

b. Non-verbal Communication

This is a language the body speaks, often at an unconscious level, in response to internal or external stimuli. It may be seen as a frown, a scowl, a smile, a tapping of the feet, a turning away of the face or body, etc.

The caring, empathetic and understanding provider will look at her/his client(s) carefully and "read" their body language so that the best possible assistance can be given.

CONTENT

Similarly remember, that for you as a health worker, your non-verbal communication is also sending messages to the client.

METHOD

Suggested Statements About Feelings:

Do not keep me waiting another minute.
I do not want to serve you.
I am very important.
I am afraid of a vaginal examination.
I have abdominal pain.
Let us go, it is late.
I do not want to listen to the health talk.
I do not understand your instructions.

b. After several participants have done this, ask the group:

Was it difficult trying to convey a feeling without words?

Was it difficult to interpret feelings without a verbal explanation?

c. Explain that clients may not feel comfortable expressing themselves verbally and sometimes they read emotions in our behaviour. Ask participants what happens if the client does not feel comfortable in the clinic or with the counsellor.

Possible Results:

- *She/he may not give all information for the counsellor to assist her/him in choice of method.*
- *She/he spreads rumours or believes rumours she/he has heard.*
- *Clients may drop out or default.*
- *Clients may use method incorrectly.*

CONTENT	METHOD
	Key Point to Emphasize • Sometimes people feel uncomfortable expressing their emotions and feelings in words. It is important to recognize non-verbal cues to client's feelings and to be aware of the feelings and/or emotions we may be nonverbally communicating to our clients.
2. Types of Non-Verbal Communication	
a. **Positive Non-verbal Communication**	**Step 1:** Let us discuss examples of positive non-verbal communication and how they influence the communication process. Haveco-facilitator write responses on newsprint. Possible Responses: • *Body leaning towards client, smiling, not tense.* • *An absence of nervousness or inappropriate mannerisms.* • *Facial expressions that inspire trust.* • *Neat appearance and dress that inspire trust and respect.* • *Maintaining eye contact with the client.* • *Encouraging gestures, such as nodding your head.* **Step 2:** Ask participants to explain how each of their nonverbal gestures/ expressions might influence the communication between the provider and the client.

CONTENT	METHOD
b. Negative Nonverbal Communication	**Step 3:** Repeat same questions, only this time ask participants to give examples of negative non-verbal communication. Co -facilitator writes their responses on newsprint. Make sure responses include: • *Reading from a chart rather than speaking naturally.* • *Glancing at one's watch.* • *Yawning or looking through papers or out the window.* • *Frowning* • *Fidgeting* • *Not maintaining eye contact.* **Step 4:**When the list is complete, again ask participants to explain how these qualities will have a negative impact on provider-client interactions. Before moving on, ask someone to review the difference between verbal and non-verbal communication.
3. Review Barriers to effective Communication	**Step 1:** Ask someone to quickly review some of the barriers already disucssed in Session 2 **Step 2:** Ask if there are other external factors that can be a barrier to communication. Think about your clinic and give examples of ways your clinic environment can either promote or hinder effective communication.

CONTENT

METHOD

Possible Responses:

Environmental factors

- *Lighting*
- *Cleanliness*
- *Ventilation*
- *Privacy*
- *Space*
- *Temperature*
- *Furnishings*
- *Noise level*

Step 3: Case study

a. Distribute the case study on Handout Page 3-13 to all participants.

b. Ask participants to form groups of three and ask each group to read the case study.

c. Give each group 10-15 minutes to work on the case study.

d. Ask each group to identify barriers to effective communication from the given case study in relation to:

   a. Sender
   b. Receiver
   c. Message
   d. Channel

e. After 10-15 minutes convene the plenary and ask one person from each group to report.

CONTENT

METHOD

Step 4: Summarize the discussion by explaining:

- A good relationship with a client is not just a result of what the client hears, but what she or he observes and senses about the counsellor.
- Non-verbal communication will vary from culture to culture. Ask for some examples from the group.
- There are many forms of positive and negative non-verbal communication which can promote or hinder effective communication.

4. **Strategies to Overcome Barriers to Effective Communication**

Step 1: Tell participants that some of the barriers they mentioned relate to the following:

a. Lack of knowledge
b. Attitudes
c. Age
d. Religion and Culture
e. Language
f. Sex
g. Level of education
h. Socio economic status

a. **Lack of knowledge** - if speaking about a topic you do not know a lot about.

Strategy:

Make sure your knowledge is up-to-date. If you do not know something, it is okay to tell client(s) that you do not know at present, but you can find out for them.

b. **Attitude** - negative attitude and biases.

Strategy:

Keep them out of your communication, never impose your opinion on clients.

Step 2: Form teams of 2. Assign each team one of the barriers to effective communication (from the list above) and ask them to put on newsprint all the strategies they can think of that health workers can use to overcome these barriers. Give them 10 minutes. Then ask one member of the team to report and others can add.

CONTENT

c. **Age** - some clients do not either feel comfortable with people younger or older than themselves.

Strategy:

Show proper respect; identify yourself as a health worker who deals with sensitive topics and because they are related to serious health issues, there is need to discuss things that are sometimes personal.

d. **Religion and Culture** - sometimes interfere with communication.

Strategy:

It helps to have background information on religious and cultural beliefs of clients. Try to identify times when religious and cultural values might interfere with communication and work with them (do not ignore them). Respect people's values, even when you do not understand or agree with them.

e. **Sex** - some people prefer to communicate with people of the same sex (especially about personal subjects).

METHOD

Step 3: Post thier newsprints around the room as reminders of what we all need to do to improve communication

Step 4: If the strategies on the left hand side are not mentioned, be sure to include them.

CONTENT **METHOD**

Strategy:

Acknowledge that discussion might be embarrassing but for health reasons, it is necessary to discuss personal topics. Acknowledging embarrassment usually helps clients to overcome it.

f. **Economic Status** - clients might find it hard to relate to a person who appears to be of another economic status.

Strategy:

Show respect no matter how poor clients(s) might be. Avoid fancy dress. Sit among group members instead of standing over or sitting away from them. Wearing traditional dress in community settings can help break barriers.

g. **Time** - may not be suitable for a client or a group.

Strategy:

Try as much as possible to find and agree an appropriate time with client or group.

h. **Venue** - noise, temperature and poor seating facilities can make effective communication difficult.

CONTENT

Strategy:

Make sure a venue is suitable and in a location that is accessible.

NOTE:

For all barriers, it is important to know your audience to determine how you can work well with them.

METHOD

Summary

Summarize the whole session by emphasizing the main points in this session and how they are related to the case study.

a. Provider should be aware of the barriers which hinder transmission of messages or information in the communication process.

b. As a provider, try to avoid contributing to the barriers.

c. For all barriers, it is important to know your audience to determine how you can work well with them.

CASE STUDY

HANDOUT

You are a FP provider at Nyasa Health Centre. Your clinic operates on a daily basis starting from 7.30 am. Today you come to the clinic at 10.00am and start giving a group talk using medical terminologies in a bored manner to women who are illiterate, tired and have small hungry, crying babies. The talk lasts 1½ hours and when asked questions, the women do not respond. In the end you distribute leaflets to take home.

SESSION SUMMARY

SESSION 4 : **INTERPERSONAL COMMUNICATION AND COUNSELLING SKILLS**

TIME : **3 Hours**

OBJECTIVES

By the end of this session, participants will be able to:

1. Define Interpersonal Communication
2. Explain the terms:
   a. Motivation
   b. Education
   c. Information
   d. Counselling
3. Explain basic counselling principles.
4. Explain at least five skills of interpersonal communication and counselling.

MAIN POINTS

1. Definition of interpersonal communication and counselling.
2. Explanation of the terms motivation, education and information.
3. Explanation of basic counselling principles.
4. Explanation of the skills of interpersonal communication and counselling.

MATERIALS

Chalkboard and Chalk
Newsprint and markers
Rights of the client charts
Three rectangular pieces of paper boldly marked "Motivation", "Education" and "Counselling"
Handout:- Flyer on Rights of the client
Handout - Motivation, Education and Counselling Exercise
Handout - Answer sheet

REFERENCES

1. AVSC International: Family Planning Counselling; A Curriculum Prototype, Trainers Manual, AVSC International, New York, 1995.

2. Family Health Services Project of Nigeria: Nigerian Three-Day Curriculum, Interpersonal Communication and Counselling for Family Planning, JHU/PCS and PATH, Ibadan, 1989.

3. Mother Care: Interpersonal Communication and Counselling Curriculum for Midwives, Nigeria, August, 1993.

4. WHO: Counselling Skills Training in Adolescent Sexuality and Reproductive Health, Adolescent Health Programme, Division of Family Health. Geneva, August, 1993.

SESSION OUTLINE

CONTENT	METHOD
1. Interpersonal Communication and Counselling:-	**Step1**: Brainstorm/meaning of:
Interpersonal communication is the face to face verbal and non-verbal exchange of information or feelings between two people involving motivation, education and counselling.	• **Interpersonal Communication**
Counselling is a person to person interaction in which the counsellor provides adequate information to enable the client to make an informed choice about the course of action that is best for him or her.	• **Counselling**
Interpersonal communication and counselling is the face to face verbal or non verbal exchange of information or feelings between individuals or in groups, to enable the client or the group make an informed choice about the course of action that is best for him/her/them.	• **Interpersonal Communication and Counselling**
	Step 2: Trainer ensures that the meanings arrived at, are similar to those on the left column.

CONTENT

2. Explanation of the terms:

a **Motivation**

Motivation is a process of encouraging clients to adopt some desirable behaviour; for example practice family planning or breastfeeding.

Examples:

Breastfeeding is good for your baby because it prevents diarrhea and upper respiratory infection.

Family planning is good because it gives the body chance to regain strength and stay healthy.

Using condoms properly will help prevent Sexually Transmitted Diseases and AIDS".

b. **Education**

Education is a process of facilitating learning to enable the audience to make rational decisions and change behaviour over the long term. Education can be carried out through the formal education sector or through non-formal channels.

Examples:

Providing facts about the Family Planning methods. State what they are; How they work.

METHOD

Step 1: Trainer to lead the brainstorming session for definitions of:

a. Motivation
b. Education
c. Information

Step 2: Write down the participants' responses.

Step 3: Make sure definitions are similar to those on the left column.

CONTENT

c. **Information**

Information is creating awareness on a particular issue.

Examples:

Facts about a new rapid assay test for HIV.
Facts about a new Family Planning Method.

Note: These three words are used in Interpersonal Communication and Counselling.

During an encounter, the communication techniques of education, motivation and counselling, may be used; e.g. during counselling a client who cannot use a selected method, will be motivated and educated about alternatives.

METHOD

Motivation, Education , Counselling Game

The Trainer can use the game on steps 4-8 or step 9 - 10.

Step 4: Trainer tells participants that this game or the one that follows will help them learn the differences and similarities between motivation, group education, and individual counselling.

Step 5: Pin the name of each technique to the blackboard.

CONTENT

Rectangular papers with each technique boldly written as follows:

- Education
- Motivation
- Counselling

METHOD

Step 6: Hand out slips of paper with one of the activities listed at the end of this session. Tell the participants that they must find the technique that matches their activity. Have them go to the board in groups of five, and pin their "activity" under the technique in which the activity occurs.

Step 7: After everyone has finished, stop the game. Break the group into small groups and ask them to discuss areas of disagreement and make suggestions for changes. Have each group appoint a rapporteur and facilitator.

Step 8: After 10 minutes, stop the discussion bring the groups together, and give each rapporteur 3-5 minutes to list areas of disagreement, reasons, and suggestions.

WHAT AM I DOING? (30 minutes)

Step 9: Read each statement (or have a participant read) from handout at the end of session.

Step 10: After each statement, ask one person in the group to identify the speaker as a counsellor, educator, or motivator.

CONTENT

3. **Basic Counselling Principles**

When counselling clients, counsellor should apply the following principles.

- **The client has the right to make an informed decision.** The provider should provide clear and adequate information for the client to understand. The provider should be unbiased.

- **The process should be confidential.** The counsellor protects the client's privacy by keeping "secret" information obtained about his/her problem, unless given permission by the client to use it in a professional way.

- **The process must be truthful.** The provider should explain all the benefits, risks, side effects, advantages and disadvantages in a truthful manner.

- **The process must be non judgemental.** Client's attitude and behaviour should be assessed objectively without preconceived ideas.

METHOD

Step 1: Trainer uses the rights of clients wall chart and reviews it with participants.

Step 2: Supplement the wall chart with the information in the left hand column.

CONTENT **METHOD**

- **The client and provider should have freedom of expression.** The client must be allowed to speak her mind even if it means not agreeing with the counsellor.

- **There must be genuine communication without emotional involvement.** The provider should be responsive and empathetic to the client's feelings without getting emotionally involved.

- **There must be auditory and visual privacy**. The place for counselling must be free from noise and disturbances from other people.

- **The atmosphere must be receptive.** The counsellor should greet the client politely and make the client feel comfortable. She/he should show interest and pay attention.

- **The counsellor must recognise his/her limitations and refer when necessary.**

CONTENT

4. **Interpersonal Communication Skills**

Non-Verbal Communication Skills

i) Relax
ii) Open up to client
iii) Lean forward
iv) Eye contact
v) Sit comfortably

a) **Body language, e.g. leaning forward, relaxing, openness**

One of the most important ways of communication is by the body movements. For example, "a nod of the head" conveys approval, leaning forward may indicate a friendly atmosphere. Leaning away from someone tends to be seen as distancing oneself from the client.

METHOD

Step 1: The trainer leads the discussion on non-verbal skills. He/she starts the discussion by pointing out how at times interpersonal communication appears to be a natural skill and as a result, most people pay little attention to the skills that comprise their interpersonal communication styles. Emphasize that interpersonal communication is learned. We should make a conscious effort to improve these skills. Say: "You will be introduced to skills that can help you become a more effective communicator, supervisor, and maternal and child health/family planning worker. You already use some of these skills although you may not be conscious of them. Those other interpersonal communication skills that you don't currently use can be learned, developed, and improved by studying and practising them".

Step 2: The trainer asks the trainees to list the non- verbal skills used to facilitate effective communication. The co-facilitator writes the responses on newsprint. Ensure that the list includes the information in the left hand column.

Step 3: Demonstration and discussion

The facilitator will demonstrate sitting and leaning forward and backward. The participants will interpret the meaning of the postures being demonstrated.

The facilitator will also demonstrate relaxing.

CONTENT

The counsellor should not be tense or appear to be in a hurry, but should be relaxed and open to discuss clients concerns.

b) **Eye contact**

Good interpersonal communication requires appropriate eye contact although there will be cultural differences. An anxious, angry, embarrassed or depressed client may avoid eye contact, but the counsellor should keep her or his face toward the client as an important way of showing interest.

METHOD

Step 4: Discussion/Role Play

The facilitator will discuss with participants some cultural differences why eye contact can be used or cannot be used during a counselling session. Some feel shy when looked upon on the face. Persistent eye contact can be seen as rudeness e.g. a child staring at an elderly person.

Step 5:Trainer ensures that the information in the left hand column is included in the discussion.

Step 6: The facilitator explains that the abbreviation which can assist participants in remembering appropriate non-verbal communication skills is ROLES

Relax
Open and approachable
Lean toward client
Eye contact
Sit comfortably and Smile

CONTENT

Verbal Communication Skills

i) Clarify
ii) Listen
iii) Encourage and praise
iv) Acknowledge
v) Reflect and repeat

a. **Encouraging**

METHOD

Step 7: The Trainer asks the trainees to list the verbal skills used to facilitate effective communication. The Co-facilitator writes the responses on newsprint. Ensure that the list includes the information in the left hand column.

These are simple but powerful signals of active listening just like body language. Encouragers encourage a client to speak or to continue speaking. Such signals include a sound such as "mm hm" or words such as "I see", "go on" etc. These small signals indicate to the client that you are listening, interested and pleased that she/he is expressing her/himself.

Role play and Discussion

Step 8:The facilitator will choose a couple to engage in any conversation and one participant will be observing the use of encouragers. The observer will give feedback to the couple and all the participants.

CONTENT

b. **Asking questions, listening and clarifying**

Asking questions is a technique for learning from the client specific information or general feelings and concerns. Types of questions:

- Open-ended
- Close-ended
- Probing
- Leading

Possible uses:

- Close ended: Medical history Example: "How many children do you have?

- Open ended: To learn about clients' feelings, beliefs, knowledge. Example:

  "What have you heard about family planning"?

- Probing:Follow-up in response to statement by client. Example: "Why can't you feed your child who has diarrhea?"

- Leading: NOT APPROPRIATE
  Example: "Don't you think you should breastfeed your new baby?

METHOD

Questioning

Step 9:The facilitator will use open ended questions by using words which start with: What, Could, Would and How, these will elicit a wide range of responses.

The facilitator will then encourage participants to use open ended questions, e.g. "John, would you tell me more about your family"?

CONTENT

Questions are the most common form of showing that one is actively listening but the way questions are often used may run counter to what is needed in the counselling setting. In this session the distinction is made between "Open" questions which encourage a client to talk more about him/herself and "Closed" questions which discourage it.

METHOD

c. **Paraphrasing and Reflection**

This means repeating back to the client what you heard her say, in short form. This is done to make sure you understood, to show you are listening and help in clarifying feelings. This is most needed when trying to get information e.g.during history taking or if the client is concerned about something.

Step 10:The facilitators will demonstrate how to paraphrase the facts which the client expresses, or paraphrase the emotion or feelings of the client. Then he/she will give an example of reflection of fact and reflection of feeling.

Example:

Client:

"When my boy friend started touching my breasts, I was scared at first".

Paraphrasing fact and reflecting feeling by Counsellor:

"I understand that you were a bit frightened at first when your boy friend started touching your breasts".

Client:

"Yesterday at school I was asked to do some extra homework".

CONTENT

METHOD

Counsellor, Paraphrasing of fact:

> "So you were asked to do some additional home work yesterday".

Step 11: Facilitator leads a brainstorming session on the practice of verbal acknowledgement and asks for examples. Ensure that similar examples to those above on paraphrasing or reflection of feelings, fears, concerns are included.

d. **Acknowledgement**

This is a verbal recognition of fears, concerns, or satisfaction.

e. **Summarizing**

Summarizing is a useful way to close a topic and change the subject in the least disruptive way. Summarizing will include paraphrasing of fact and of feelings, by definition it avoids repetition and is more concise than the client's statements. However, it is important to repeat facts and feelings especially those that have been emphasised by the client.

The facilitator should arrange a TRIAD exercise on a counselling session where the counsellor will have to summarize the counselling session before bringing it to a closure.

The facilitator explains that the abbreviation which can assist participants in remembering verbal communication skill is CLEAR.

Clarify
Listen actively
Encourage
Acknowledge
Reflect and **R**epeat

CONTENT

METHOD

Step 12: Trainer Concludes the Session

KEY POINTS TO EMPHASIZE:

- Accurate reflection and acknowledgement of feelings are necessary and critical to the counselling process.

- Before a client is ready and willing to deal with the situation, listen to options, and make an informed and appropriate decision, she/he must first believe that the counsellor hears and understands her/his feelings and individual needs and concerns

- Listening is a skill that requires constant practice. Summarizing the main points is good discipline for listening, as it helps confirm to the client that she/he is heard and understood.

- Often one is able to point out issues or emotions of which a client may not be aware, particularly when a feeling is communicated non-verbally. This may provide additional information, which in turn can aid the decision-making process.

HANDOUT (EXERCISE)

MOTIVATION/EDUCATION/COUNSELLING
"WHAT AM I DOING?"

I am talking to a group of women gathered at the village well. I ask them about the health problems that they and their small children have. Then I tell them how to prevent diarrhoea. What am I doing?

I am asking a woman in an antenatal clinic if she knows how to reduce the risks of childbearing. What am I doing?

I am talking to the village chief about why family planning is important to the village and to the lives of the women and children in the village. What am I doing?

I am explaining to a mother in the child health clinic about why she should breast-feed her baby. What am I doing?

I am a satisfied user of the pill, and I am talking to my neighbour about why I like it, where I got it, and how it is free. What am I doing?

I am asking a group of women waiting for antenatal care at the clinic what they have heard about the food they should take after delivery; and them explaining those statements that are false. What am I doing?

I am listening to a woman explain that her husband's family opposed to modern methods of family planning, and discussing with her some options. What am I doing?

I am telling the mothers why immunization is very important before I immunize their children. What am I doing?

I am explaining a range of contraceptive methods to a woman who is unhappy with her IUCD and is trying to decide on another method. What am I doing?

At a child health clinic, I am meeting with some new mothers. I am showing them the growth chart and explaining why it is important to weigh children regularly. What am I doing?

ANSWER SHEET (EXERCISE)

MOTIVATION/EDUCATION/COUNSELLING
"WHAT AM I DOING?"

I am talking to a group of women gathered at the village well. I ask them about the health problems that they and their small children have. Then I tell them how to prevent diarrhoea. What am I doing? (Education).

I am asking a woman in an antenatal clinic if she knows how to reduce the risks of childbearing. What am I doing? (Counselling).

I am talking to the village chief about why family planning is important to the village and to the lives of the women and children in the village. What am I doing? (Motivation).

I am explaining to a mother in the child health clinic about why she should breast-feed her baby. What am I doing? (Motivation or Education).

I am satisfied user of the pill, and I am talking to my neighbour about why I like it, where I got it, and how it is free. What am I doing? (Motivation).

I am asking a group of women waiting for antenatal care at the clinic what they have heard about the food they should take after delivery; and them explaining those statements that are false. What am I doing? (Education).

I am listening to a woman explain that her husband's family opposed to modern methods of family planning, and discussing with her some options. What am I doing? (Counselling).

I am telling the mothers why immunization is very important before I immunize their children. What am I doing? (Education).

I am explaining a range of contraceptive methods to a woman who is unhappy with her IUCD and is trying to decide on another method. What am I doing? (Counselling).

At a child health clinic, I am meeting with some new mothers. I am showing them the growth chart and explaining why it is important to weigh children regularly. What am I doing? (Education).

RIGHTS OF THE CLIENT

Every family planning client has the right to:

Information

To learn about the benefits and availability of family planning.

Access

To obtain services regardless of sex, creed, colour, marital status or location.

Choice

To decide freely whether to practice family planning and which method to use.

Safety

To be able to practice safe and effective family planning.

Privacy

To have a private environment during counselling or service.

Confidentiality

To be assured that any personal information will remain confidential.

Diginity

To be treated with courtesy, consideration and attentiveness.

Comfort

To feel comfortable when receiving services.

Continuity

To receive contraceptive services and supplies for as long as needed.

Opinion

To express views on the services offered.

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SESSION SUMMARY

SESSION 5 : **PERCEPTIONS OF PROVIDERS AND CLIENTS: ATTITUDES, VALUES AND FEELINGS**

TIME : **1 HOUR 30 MINUTES**

OBJECTIVES

By the end of the session participants will be able to:

1. Define perception.
2. Explain why there are no correct or incorrect ways of perceiving: there are only different ways of perceiving.
3. Define attitudes and values.
4. Assess their own attitudes, feelings and values in relation to the counselling process.
5. Discuss the impact of attitudes, feelings and values on the counselling process.
6. Identify clients' values and the importance of respecting these values in the counselling process.

MAIN POINTS

1. Definition of perception
2. Different ways of perceiving (perception exercise)
3. Definition of attitudes and values
4. Self assessment of attitudes, feelings and values.
5. Impact of attitudes, feelings and values on the counselling process.
6. Identification of clients' values and the importance of respecting those values in the counselling process.

MATERIALS

- Newsprint and markers
- Perception exercise
- Chalkboard and chalk
- OHP and Transparencies
- Handouts: Values clarification worksheet; "Who is responsible"
- Prepared wall charts labelled, "Agree", "Not Sure" and "Disagree".

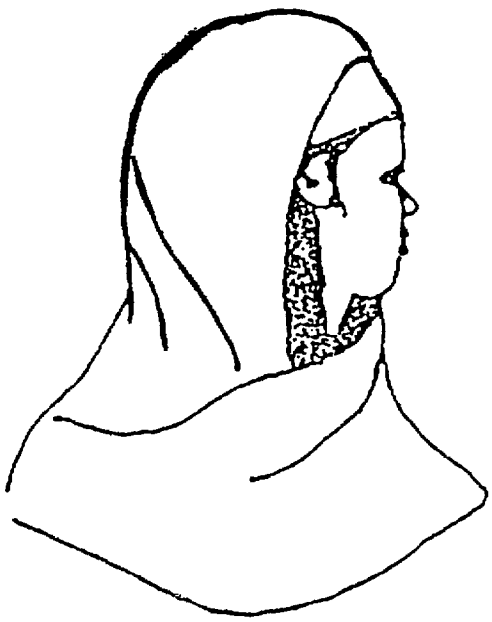
REFERENCES

1. AVSC International: *Family Planning Counselling, A Curriculum Prototype*. New-York, 1995.

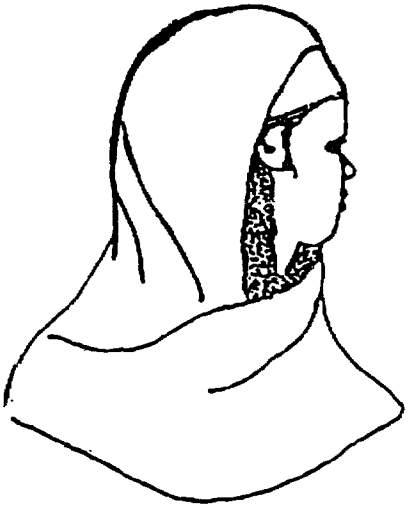
2. Nigeria Five Day Curriculum: *Interpersonal Communication and Counselling*, JHU/PCS and PATH, 1990.

SESSION OUTLINE

CONTENT	METHOD
1. Definition of Perception Perception is how we understand what others show or say to us.	**A. PERCEPTION EXERCISE (20 MINUTES)** **Step 1**: Ask participants to define Perception. Co-facilitator writes responses on newsprint or chalkboard. Ensure that the agreed definition is similar to the one on the left hand column.
2. Different ways of perceiving	**Step 1**: Show the participants the picture of a woman, on the next page. Tell the participants that you would like them to examine the illustration very closely. **Step 2**: Ask participants to describe aloud what they see. *Possible responses* • *a girl* • *a woman* • *a peasant farmer* • *an old woman* • *a man* • *Moslem woman* **Step 3**: Probe (for example, if they say "a girl" or "a woman", ask what kind: if they describe this person further but do not mention age, ask, "How old do you think this person is? • actual ages in years • old • young



The "young woman" in the picture



The "old woman" in the picture

CONTENT

3. **Definition of values and attitudes**

- **Values** are those things we consider important, such as family, happiness, health etc.
- **Attitude** is a view or opinion that is shaped by values and beliefs.

4. **Values Clarification Exercises:**

Assessment of Providers attitudes values and feelings.

METHOD

Step 1:Trainer asks participants the following questions:

a) What are values?
b) What are attitudes?

Let participants discuss each concept separately and agree on definitions similar to the ones on the left hand column.

Step 1:We will now do a few exercises that will help us clarify our own values.

Step 2:Distribute the "Values Clarification Handout" and tell participants to follow the instructions. Give them 5 minutes to complete their values rankings (1 to 10).

VALUES CLARIFICATION EXERCISE

DIRECTIONS

Read each statement. When you have finished, select the value which is most important to you and write a 1 next to it.

Write a 2 next to the value that is second in importance to you and 3 next to the value that is third in importance to you. Continue in this manner until you have ranked the ten items which are of greatest importance to you.

Good physical health _____

Economic security _____

Intelligence _____

Education _____

Cleanliness _____

Marriage _____

CONTENT

METHOD

Children _____

Successful career _____

Happiness _____

Religion _____

Friends _____

Family Reputation _____

Citizenship _____

Taking care of family's needs _____

Making more profit from providing services _____

More training _____

Step 3:Process this exercise by asking few volunteers to read their 3, most important values. Write them on newsprint. Ask who else had these same values. Why do you think many of us have similar values?

Ask who ranked as first and second, values that have not yet been mentioned? Ask for others who shared these top values.

Ask the participants who ranked as their highest value something that has not yet been mentioned? Discuss further until participants observe that different people have different values. Ask: Why is this so?

CONTENT

Agree/Disagree/Not Sure Exercise

METHOD

Step 1: Tape papers labelled "Agree", "Disagree" and "Not Sure", to opposite walls of the room.

Step 2: Read a statement from the values clarification worksheet below and ask the participants to go to the label ("agree", "disagree", or "not sure") that best represents their feelings about that statement.

Values Clarification Statements

Trainer reads out loudly each of the 8 to 10 statements selected from the list below and asks participants to decide whether they agree, disagree or are not sure. The Trainer asks the participants to go to the label which reflects their feelings.

__1. If a woman wishes to have a tubal ligation, she should have one, even if her spouse disagrees.

__2. If a man wishes to have a vasectomy, he should have one, even if his spouse disagrees.

__3. Unmarried adolescents should not engage in sexual activity.

__4. A 21-year old woman with only one child should be refused a tubal ligation.

__5. If a woman never experiences childbirth, she will feel like less of a woman.

__6. Schools should provide sex education (that is growth and development and sexuality).

CONTENT **METHOD**

__7. Some clients want to continue getting pregnant until they have children of both sexes. Providers should discourage this behaviour.

__8. Family planning methods should be available to unmarried adolescents.

__9. In a couple, it is the woman who should be responsible for using contraception.

__10. Women should be virgins when they marry.

__11. Contraceptives should be available to unmarried people only.

__12. The average woman wants sex less than the average man.

__13. Most people who contract STDs have had many sex partners.

__14. Vasectomy should not be considered by a man who has only one or two children or who is under 35 years.

__15. The choice of sterilization should always be entirely voluntary.

__16. Men enjoy sex without love more than women do.

__17. Easy availability of contraceptives encourage sexual activity, especially among young people.

__18. Using family planning is not a good idea before a woman has had her first child.

__19. It is not unusual for people to be in love with more than one person at a time.

CONTENT

METHOD

__20. I would hesitate to marry someone with whom I had not had sexual intercourse.

__21. Parents should not allow their daughters as much sexual freedom as they allow their sons.

__22. Adolescents who have had children should be allowed to go to school.

__23. It is acceptable for a man to be unfaithful to his wife. But it is not acceptable for a woman to be unfaithful to her husband.

__24. A child should be given sex education at home.

__25. Prostitutes provide a useful social service.

__26. Religion is a strong obstacle to acceptance of family planning in Malawi.

__27. Sexually transmitted diseases are common among the poor illiterates.

Step 3:Ask one participant from each of the three groups to explain why he/she agrees, is not sure or disagrees with the statement. Repeat this process for the 8-10 selected statements.

Step 4:Ask participants to return to their seats and discuss the following questions:

a. Did any of your responses surprise you? Why?
b. How did people respond to different statements?
c. How did you feel about other people's response? Why?

CONTENT

METHOD

Possible responses to b & c

- *Defensive*
- *Judgmental*
- *Ambivalent*
- *Afraid to express opinion*
- *Angry*

Step 5: If the group is homogeneous and there are many varying responses to the statements, discuss them.

Possible points to make:

- *You are from similar backgrounds, but had very different responses. Different experiences lead individuals to different conclusions. We must first be aware of our own value systems to ensure that we do not impose our beliefs, especially when counselling.*

- *When counselling clients, it is very important to know one's own values and be aware of them. If a counsellor has a particular bias and cannot deal with an issue (for example, contraception for unmarried women) let someone else who may not hold the same bias counsel the client.*

CONTENT

5. Impact of attitudes, values and feelings on the counselling process

Discussion Activity

Who is Responsible

Charactors:
Mrs Tsala
Mr Tsala
Dr Mabvuto
Fatuma Walani
Tsoka

Scene:

Mrs Tsala. has brought three daughters into the world with much difficulty; she had to have a caesarean section each time.

Mr Tsala. is a businessman, happy with his wife and three daughters. All he is missing is a son.

Dr Mabvuto, Mrs Tsala's doctor, has warned her that a fourth pregnancy could be dangerous. Knowing that Mr Tsala wants a son, however, he does not want to perform a tubal ligation.

Mrs Tsala has stopped breast feeding her youngest child and has asked her doctor to help her avoid becoming pregnant, or to guarantee her that her next pregnancy will be her last and to explain to her how to have a son. Dr Mabvuto. explains that it is the sperm of her husband that determines the sex of the baby. He sends Mrs Tsala to the Family Planning clinic.

Fatuma Walani, the midwife in charge of family planning services, refuses to help Mrs. Tsala without the consent of her husband.

METHOD

Step 1:Distribute "Who is responsible" Handout and give participants 5 minutes to read the scene.

Discussion

This activity is designed to demonstrate the difficulty of keeping personal values out of the service providers' role and the potential danger when the service providers beliefs influence a clients choice.

Step 2:

1. Ask the following questions; Which character would they choose as most responsible and why? Record the responses on newsprint. Ask participants the reasons behind their choices.

2. Ask participants how the characters' personal beliefs influenced their interactions with Mrs Tsala.

3. 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.

CONTENT

Remembering what Dr Mabvuto said concerning the sperm, Mrs Tsala goes to see her cousin Tsoka, a handsome young man who has only sons. She proposes to him that they have sex so that she can have a son so that her husband will agree to the tubal ligation.

Tsoka accepts. Mrs Tsala conceives and dies of a ruptured uterus at 38 weeks of pregnancy.

Who is responsible for this death? Mr. Tsala? Mrs. Tsala? Dr Mabvuto? The midwife? Cousin Tsoka or perhaps the baby?

METHOD

4. As counsellors, should we express our opinions even if they differ from those held by our clients? The difference in our opinions is important in illustrating the danger of assuming that the service provider' values are the same as the clients.

After discussion, summarise the session 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.*

HANDOUT 1

VALUES CLARIFICATION WORKSHEET HANDOUT

Directions: Read each statement. When you are finished, select the value which is most important to you and write a 1 next to it. Write a 2 next to the value that is second in importance to you and 3 next to the value that is third in importance to you. Continue in this manner until you have ranked the items which are of greatest importance to you.

Good physical health	:	_____
Economic security	:	_____
Intelligence	:	_____
Education	:	_____
Cleanliness	:	_____
Marriage	:	_____
Children	:	_____
Successful career	:	_____
Happiness	:	_____
Religion	:	_____
Friends	:	_____
Family Reputation	:	_____
Citizenship	:	_____
Taking care of family's needs	:	_____
Making more profit from providing Services	:	_____
More training	:	_____

HANDOUT 2

WHO IS RESPONSIBLE

Charactors

Mrs Tsala
Mr Tsala
Dr Mabvuto
Fatuma Walani
Tsoka

Scenes:

Mrs Tsala has brought three daughters into the world with much difficulty; she had to have a caesarean section each time.

Mr Tsala is a businessman, happy with his wife and three daughters. All he is missing is a son.

Dr Mabvuto, Mrs Tsala's doctor, has warned her that a fourth pregnancy could be dangerous. Knowing that Mr Tsala wants a son, however, he does not want to perform a tubal ligation.

Mrs Tsala has stopped breast feeding her youngest child and has asked her doctor to help her avoid becoming pregnant, or to guarantee her that her next pregnancy will be her last and to explain to her how to have a son. Dr Mabvuto, explains that it is the sperm of her husband that determines the sex of the baby. He sends Mrs Tsala to the Family Planning clinic.

Fatuma Walani, the midwife in charge of family planning services, refuses to help Mrs Tsala without the consent of her husband.

Remembering what Dr Mabvuto said concerning the sperm, Mrs Tsala goes to see her cousin Tsoka, a handsome young man who has only sons. She proposes to him that they have sex so that she can have a son and her husband will agree the tubal ligation.

Cousin Tsoka accepts. Mrs Tsala conceives and dies of a ruptured uterus at 38 weeks of pregnancy.

Who is responsible for this death? Mr Tsala? Mrs Tsala? Dr Mabvuto? The midwife? Cousin Tsoka? Or perhaps the baby?
Decide for yourself

SESSION SUMMARY

SESSION 6 : **RUMOURS AND MISCONCEPTION**

TIME : **2 HOURS**

OBJECTIVES

By the end of the session, participants will have learned how to:

1. Identify common fears, rumours and misconceptions related to reproductive health and family planning.
2. Allay common fears, dispel rumours and correct misconceptions related to reproductive health and family planning.

MAIN POINTS

1. Common fears, rumours and misconceptions related to reproductive health and family planning.
2. Allaying fears, dispelling rumours and correcting misconceptions.

MATERIALS:

- Newsprint and markers .
- Overhead Projector and Transparencies.
- Chalkboard and chalk.
- Prepared Newsprint on Session Objectives.
- Copies of Family Health series number 23: Rumours, fears and misconceptions (if available).
- Handouts; common family planning methods rumours, pages 6.7 - 6.13 flipchart.
- Copies of Kulera flipchart.

REFERENCES

1. Family Health Services Project: Nigeria Three-day Curriculum, Interpersonal Communication and Counselling for Family Planning, JHU/PCS and PATH, Ibadan, 19

2. National Family Welfare Council of Malawi: Family Planning Practitioners Training Programme Curriculum, Blantyre Print and Publishing, Lilongwe, 1995.

SESSION OUTLINE

CONTENT

1. **Common fears, rumours and misconceptions related to reproductive health and family planning.**

   Definition of a rumour: False information that has no factual origin but spreads fast.

   Misconception: Having a wrong idea about something.

   Rumours and misconceptions on reproductive health and family planning can be grouped as follows:

   1. General fears about contraception
   2. Fears/misconceptions about specific methods
   3. Fears based on poor understanding of the human body
   4. Fears about human desires and sexual satisfaction

METHOD

The importance of this session is to enable family planning providers to learn how to identify common fears, rumours and misconceptions related to reproductive health and family planning. Fears, rumours and misconceptions lower the use of family planning methods. This is why it is important for all family planning providers to know how to identify and deal with them. Therefore this is a very important session for Interpersonal Communication and Counselling.

Step 1: Begin by asking and developing definitions for the words "rumour" and "misconception," write responses on newsprint. Let the group come up with a definition similar to the one in the left hand column.

"Word of Mouth" Game: Rumours and Misconceptions (10 minutes)

The point of this exercise is to show that as information passes from one person to another, it is changed and distorted.

Step 2: Tell the group that we are going to do an exercise that will give us insights into ways rumours spread.

CONTENT

METHOD

Possible story:

"I went to the clinic last week, because I have been having trouble sleeping, and because I have had a rash. I had to wait a long time. When I finally saw a nurse, she had lots of questions about my eating habits, evening activities and hobbies. Then, while I was there, I remembered that my oral contraceptive prescription was almost finished. The nurse asked me if I was happy with the pills or if I had noticed any side effects".

Step 3: Divide the group in half. Tell one half to stand in a line facing the centre of the room. The other half should form a line facing the first group, but out of hearing distance.

Step 4: Tell the first person in each group a story like the one above. Ask him/her to whisper it to the next person in line. The listener should then whisper it to the next person who has not heard the story, and so on.

Tell participants they may talk until it is their turn to listen to the story. Then they must listen. Have every third or fourth person write down what he/she has heard.

Step 5: When the last person in each line has heard the story, have each repeat it out loud. Ask those who have written the story down to repeat what they heard. Then read the story you told them.

Step 6: Process the exercise by asking the group:

a. How did the story change?

CONTENT | **METHOD**

Possible responses:

The responses will depend on the difference between the original story from the trainer and the reported story from the participants. (Responses from different individuals will be different from the original story.

b. *Why?*

Possible responses:

People can't remember so much. People hear selectively based on their values and interests.

A truth can become an untruth when people think they are only repeating what they've heard while unintentionally adding or subtracting some facts; in other words, distorting the message.

Therefore as many people as possible need to hear the correct message directly from the expert who has the information.

c. How does this apply to the spread of rumours and misconceptions?

Possible responses

When people receive a message from different sources (not from the expert, it tends to get distorted).

When people are given too much information at once, it may lead to confusion and misconception.

CONTENT

2. Allaying fears, dispelling rumours and correcting misconceptions related to reproductive health and family planning

e.g The Pill

Rumours and Misconceptions	Possible way to deal with

METHOD

When information is given in a language that people don't understand, they tend to get confused and then misrepresent the facts.

Step 1: Ask the providers what they have heard from their clients about reproductive health and family planning which they have identified to be untrue.

Step 2: We will spend the next hours learning how to identify common family planning methods rumours and solutions.

Step 3: Write the names of the family planning methods at the top of pieces of newsprint and place columns on each sheet. On the left side, put the header "rumours, and misconceptions", on the right put "Possible ways to deal with (see example in left hand column)." For each method, let the group identify the rumours and misconceptions they have heard. Make sure their responses include some of the rumours found in the handout. Also use publication 23, (if available) Rumours, Fears and misconceptions.

CONTENT

METHOD

Step 4:When rumours have been identified for all methods, divide the participants into small groups of two or three if time permits; if not, have the large group do the exercise together. Give each group the sheet for one or two of the methods. Have each small group fill in the second column, "Possible ways to deal with," for each rumour listed about the method. Remind the group to consider the underlying causes of the rumours. Allow approximately 15 minutes.

Step 5:Collect the method sheets and place them on the wall. Reconvene the participants and have each group present their list to the others. Ask whether any additional solutions can be added.

Step 6 :Summarize the key points of the session. Also distribute handout on "Common FP Method Rumours" and point out that providers need to use accurate information when dispelling rumours. Tell the group that they now have a good reference of suggestions for dispelling rumours.

Note: During interaction with client: To help the FP Provider identify fears, rumours, and misconceptions at the clinic it is important for the provider to ask clients what they have heard about family planning methods. While the client is explaining what he/she has heard, the FP Provider must listen carefully to pick up statements that are not true.

If the client's statements are correct then the provider should not dicuss fears, rumours and misconceptions with the client(s) at that point.

METHOD

If the provider identifies any fears, rumours and misconceptions from what the client says, the provider should use facts to allay fears/anxiety, dispel rumours and correct misconceptions e.g. The provider should do the following:

- Give correct information in simple clear language that the client understands.
- Reassure client.
- Explain about anatomy and physiology of the reproductive system so the client understands how the human body works and the effect of the method on the reproductive system.

HANDOUT

INDIVIDUAL HOMEWORK READING ASSIGNMENT *COMMON FAMILY PLANNING METHODS' RUMOURS*		
Rumour	:	*Family Planning causes infertility.*
Fact	:	*Provide comprehensive understanding of family planning. When a woman stops using a family planning method, she will return to her normal fertility.* *One of the main causes of infertility today is the increased prevalence of STDs.*
Rumour	:	*Family Planning is a plot to kill black people*
Fact	:	*Explain that family planning is a universal practice. Traditional methods of family planning have been practised in non-white cultures since pre-colonial times. For example, in Africa, traditional methods such as abstinence or breastfeeding have been used to space births.* *The economic, health, and social benefits of Family Planning apply equally to all races.* *Discuss increased effectiveness of modern contraceptives in achieving these aims.*
Rumour	:	*Family planning causes promiscuity*
Fact	:	*Explain that promiscuity in either men or women reflects individual decisions and values. Family planning does not change a person's values and neither encourages nor discourages promiscuity.*
Rumour	:	*Family planning is against God's word.*
Fact	:	*Most religious denominations support family planning. The only difference may be in the methods advocated. References to avoiding pregnancies in certain situations can be found in both the Bible and the Koran. Explain that family planning permits a woman to be healthy and well rested so she can have sex at any time without conception.* *For those who cannot use artificial methods of family planning there are natural methods based on a woman's menstrual cycle.*

RUMOURS AND MISCONCEPTIONS ABOUT COMBINED ORAL CONTRACEPTIVE PILLS

Rumour	*:*	*The combined pill causes cancer.*
Fact	*:*	*Studies have **not** shown that the combined pill causes cancer; in fact, the combined pill protects against cancer of the ovaries and lining of the uterus.*
Rumour	*:*	*The combined pill causes deformed babies and multiple births (twins, triplets).*
Fact	*:*	*The number of babies born with deformities or the number of multiple births is not different when one looks at women who have used combined pills and those who have not.*
Rumour	*:*	*When a woman stops using the combined pill, she will have trouble getting pregnant again.*
Fact	*:*	*After a woman stops taking the combined pill, her ovaries begin to function just as they did before she took it. On average it may take 2 to 3 months to return to fertility after stopping the combined pill. Experts believe that the small number of women who have trouble getting pregnant after taking the combined pill would have experienced this trouble even if they had never taken the combined pill.*
Rumour	*:*	*Women who use the combined pill have either increased or decreased sex drive.*
Fact	*:*	*Sex drive varies from person to person. Some women who use the combined pill enjoy sexual intercourse more than they did before taking the combined pill because they feel less worried about the possibility of getting pregnant.*
Rumour	*:*	*The combined pill causes bleeding in between menses.*
Fact	*:*	*It happens in some women in the first few months of taking combined pill. In reality, for most women, the combined pill makes their cycles much more regular and painless.*
Rumour	*:*	*The combined pill accumulates in the stomach.*
Fact	*:*	*The combined pill is dissolved and absorbed into the blood, like aspirin or any other medicine.*
NB:		***Many of the misconceptions about combined oral contraceptives may apply to Progestin Only Pills; therefore the same factual responses are appropriate.***

RUMOURS AND MISCONCEPTIONS ABOUT PROGESTIN ONLY PILLS

Rumour	*:*	*If you use Progestin Only Pills, and your periods become irregular or absent, it proves the Progestin Only Pill are damaging your body.*
Fact	*:*	*When you use Progestin Only Pill it is NORMAL for bleeding to become irregular, scanty, and even absent. This is because the lining of the womb grows slowly and this shows the Progestin Only Pill is working well. When you stop the Progestin Only Pill, your menstrual periods will return to whatever pattern is normal for your body at the time.*
Rumour	*:*	*When a woman stops using Progestin Only Pill, she will have trouble getting pregnant again.*
Fact	*:*	*Progestin Only Pills do NOT cause a delay in the return to fertility. When a woman stops taking Progestin Only Pills, her ovaries begin to function just as they did before she took them. Experts believe that the small number of women who have trouble getting pregnant after taking Progestin Only Pills would have experienced trouble even if they had never used Progestin Only Pills.*
Rumour	*:*	*A woman will not have enough breastmilk if she uses Progestin Only Pills while breastfeeding.*
Fact	*:*	*Breastmilk supply is NOT decreased by Progestin Only Pills. Breastmilk supply depends on the baby suckling frequently, and the mother having enough liquids to drink, rest, and food.*
		(Note that the combined oral contraceptives are <u>not</u> recommended for breastfeeding women in the first six months postpartum).

RUMOURS AND MISCONCEPTIONS ABOUT DEPO-PROVERA

Rumour	*:*	*Depo-Provera® causes infertility.*
Fact	*:*	*Depo-Provera® does not cause infertility. However, it may delay pregnancy because it can take up to 6-12 months for ovulation to take place after stopping the method.*

RUMOURS AND MISCONCEPTIONS ABOUT DEPO-PROVERA		
Rumour	*:*	*Depo-Provera® causes cancer.*
Fact	*:*	*There has never been a study that has shown that Depo-Provera® causes cancer.* *However, Depo-Provera® may increase the risk of breast cancer in young women.*

RUMOURS AND MISCONCEPTIONS ABOUT CONDOMS		
Rumour	:	*If the condom comes off in the woman's vagina, it will get stuck or lost inside the woman.*
Fact	:	*If the condom comes off in the woman's vagina, it will not get lost. There is no other place within a woman's body to which it can travel, as it cannot get in or out of the womb. It should be pulled out immediately.*
Rumour	:	*Condoms decrease sexual enjoyment for the couple.*
Fact	:	*Some men say they have decreased sexual enjoyment when using condoms. However, sexual pleasure may be increased by lubricating the outside of the condom with a water-based lubricant (such as spermicides or saliva). Many couples enjoy sexual relations more when using condoms because they don't have fear of an unplanned pregnancy or getting STD or HIV/AIDS Condoms can also increase sexual pleasure for men who have premature ejaculation and for their partners.*
Rumour	:	*Condoms are only used with or by prostitutes.*
Fact	:	*All around the world, married couples use condoms to prevent pregnancy. For example, in Japan, condoms are the most popular family planning method among married couples.*
Rumour	:	*Using condoms often, will weaken a man and make him impotent.*
Fact	:	*There is no medical reason behind this myth. Impotence in men has many causes; some are emotional and others are physical. Condoms can help a man maintain his erection longer.*
RUMOURS AND MISCONCEPTIONS ABOUT INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD)		
Rumour	:	*The Intrauterine Contraceptive Device (IUCD) causes discomfort to the man during sexual intercourse.*
Fact	:	*Initially, a man may report that he can feel the Intrauterine Contraceptive Device (IUCD) strings. They should not cause him discomfort if they are properly trimmed. If causing discomfort, the woman can be taught to tuck them in the fornices.*
Rumour	:	*The Intrauterine Contraceptive Device (IUCD) can travel from the uterus to other places in the body such as the heart or brain.*

RUMOURS AND MISCONCEPTIONS ABOUT INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD)		
Fact	:	*The Intrauterine Contraceptive Device (IUCD) cannot migrate to the brain. It normally stays within the uterus like a seed within a shell. Rarely, an Intrauterine Contraceptive Device (IUCD) may puncture the wall of the uterus during the insertion, and rest in the abdomen outside the uterus.* *If the IUCD is applied it normally comes out through the vagina. That is why women are taught to feel for the threads after each period.*
Rumour	:	*The Intrauterine Contraceptive Device (IUCD) causes infertility (inability to get pregnant).*
Fact	:	*The Intrauterine Contraceptive Device (IUCD) does not protect against sexually transmitted diseases, a cause of infertility. A woman who is not at risk of sexually transmitted diseases has a very low risk of pelvic infection and infertility, whether she uses an Intrauterine Contraceptive Device (IUCD) or not.*
Rumour	:	*Intrauterine Contraceptive Device (IUCD) causes abortion.*
Fact	:	*Studies have shown that Intrauterine Contraceptive Device (IUCD) work primarily by stopping the woman's egg from becoming fertilized, rather than by destroying a fertilized ovum.*
Rumour	:	*Intrauterine Contraceptive Device (IUCD) causes sores on the penis.*
Fact	:	*During intercourse the penis does not reach the Intrauterine Contraceptive Device (IUCD) and the threads are usually softened by the vaginal secretions, so the threads will not hurt the penis.*
Rumour	:	*The woman can get pregnant with the Intrauterine Contraceptive Device (IUCD) in place.*
Fact	:	*Yes, this can happen if the Intrauterine Contraceptive Device (IUCD) becomes displaced, but is very rare. In fact, the (IUCD) has a very low failure rate. The user is always taught how to check that the Intrauterine Contraceptive Device (IUCD) is in place.*
Rumour	:	*Some Intrauterine Contraceptive Devices (IUCDs) have been taken off the United States of America (USA) market. Therefore, Intrauterine Contraceptive Devices (IUCDs) must not be safe.*

RUMOURS AND MISCONCEPTIONS ABOUT INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD)		
Fact	*:*	*The Dalkon Shield was taken off the USA and international markets over 20 years ago because the design of the Dalkon Shield increased a woman's risk of pelvic infection and infertility. Some other types of Intrauterine Contraceptive Devices (IUCDs) were discontinued by USA manufacturers. Sales did not provide enough profit in the face of law suits which claimed the Intrauterine Contraceptive Device (IUCD) caused female infertility (see rumour above). As of 1992, <u>two</u> types of Intrauterine Contraceptive Devices (IUCDs) <u>are</u> being sold and used in the USA. These IUCDs are safe and one of them (The Copper T 380A) can be left in place for at least ten years.; this is the type currently being used in Malawi.*
RUMOURS AND MISCONCEPTIONS ABOUT TUBAL LIGATION		
Rumour	*:*	*Tubal ligation causes a woman to lose her sex drive.*
Fact	*:*	*Tubal ligation does not affect normal sexual functions in any way. The woman's body continues to produce female hormones and the woman's sex drive is not changed. Many women enjoy sex even more because they are not worried about getting pregnant.*
Rumour	*:*	*Tubal ligation causes early menopause.*
Fact	*:*	*Tubal ligation does not affect menopause in any way. A woman continues having her monthly periods after tubal ligation, since she still has her uterus and ovaries and still produces normal female hormones.*
Rumour	*:*	*Tubal ligation is the same as turning the womb inside out. When the woman wishes to be pregnant later, the doctor turns the womb back to its usual shape.*
Fact	*:*	*Tubal ligation means that small portions of the tubes which transfer the egg to be fertilized by the sperm are cut, and the ends tied and sealed. It is usually not possible/successful to rejoin these ends so that a woman can get pregnant again.*
Rumour	*:*	*Tubal ligation causes heavy menses.*
Fact	*:*	*A woman who has had a tubal ligation will continue to have normal menses because menstrual blood comes from the uterus and not from the tubes.*

RUMOURS AND MISCONCEPTIONS ABOUT VASECTOMY

Rumour	:	*Vasectomy causes the testicles to shrink.*
Fact	:	*Vasectomy does not affect the size of the testicles in any way they remain the same after the procedure.*
Rumour	:	*Vasectomy causes a man to lose his sex drive.*
Fact	:	*Vasectomy does not affect normal sexual functions in any way. The man's body continues to produce hormones which help the man to continue to have erections, sex drive/feeling and ejaculations.*
Rumour	:	*Vasectomy is similar to castration.*
Fact	:	*In Vasectomy only the tubes that carry the sperms are cut and tied. The testicles are not removed. The semen continues to be produced and there is no change in sexual pleasure.*

RUMOURS AND MISCONCEPTIONS ABOUT NATURAL FAMILY PLANNING

Rumour	:	*Couples who use Natural Family Planning must be highly educated.*
Fact	:	*Studies show that couples with little or no formal schooling can use Natural Family Planning correctly If they are motivated to use the method and are well trained in the procedures.*
Rumour	:	*Natural Family Planning is an unreliable method.*
Fact	:	*Natural Family Planning can be a dependable method If used correctly. The couple must be highly motivated to use the method in order for this method to be effective. They must be willing to abstain for several days when this is necessary.*
Rumour	:	*Most men will not agree to abstain from sexual intercourse during the fertile phase of the woman's cycle.*
Fact	:	*Studies show that for most couples who use Natural Family Planning and who are both keen on delaying pregnancy, the man accepts the abstinence period.*

SESSION SUMMARY

SESSION 7 : **USE OF INFORMATION, EDUCATION AND COMMUNICATION (IEC) MATERIALS TO ENHANCE COMMUNICATION AND COUNSELLING**

TIME : **2 HOURS 30 MINUTES**

OBJECTIVES

By the end of the session participants will be able to:

1. List Information, Education and Communication (IEC) materials appropriate to the teaching/learning situation.
2. Explain the importance of visual aids.
3. List advantages and disadvantages of each IEC material listed in objective 1.
4. Explain how to use various IEC and support materials.
5. Demonstrate appropriate use of IEC materials during education and counselling sessions.

MAIN POINTS

1. IEC materials appropriate to the teaching/learning situation.
2. Importance of visual aids.
3. Advantages and disadvantages of each IEC materials listed.
4. Demonstration of appropriate use of IEC materials during education and counselling.

MATERIALS

- Chalkboard and chalk
- Overhead Projector
- Newsprint and markers
- Handouts: How to use IEC/support materials
- Some IEC Materials
- Drama Scripts
- Jingles
- Cassettes
- Songs
- Tape Recorder
- Video Films, Video Monitor and Deck

REFERENCES

1. Family Health Services Project of Nigeria: Nigeria Three - Day Curriculum, Interperpersonal Communication and Counselling for Family Planning, JHU/PCS and PATH, Ibadan, 1989.

2. Hubley J: Effective Communication - Theory and Practice in Health Education, Leeds Polytechnic, 1988.

3. Ministry of Health and Population (Health Education Unit): Information, Education and Communication Messages and Materials Survey report, Lilongwe, 1991.

4. Saunders D.J: Visual Communication Handbook, United Society of Christian Literature, Lutterworth Education Guildford, Surrey, 1994.

SESSION OUTLINE

CONTENT

1. Information, Education and Communication materials appropriate to the teaching/learning situation.

Information, Education and Communication materials are items that assist people in the teaching/learning process by promoting use of senses of vision, hearing, smell and touch.

Examples of Information, Education and Communication materials include:
Posters, wall charts, flipcharts, leaflets, flyers, models, samples of contraceptives, pictures codes, etc.

Poster: This is a sheet of paper or cardboard with an illustration (pictures) and usually has a few simple words (text).

Wall chart: This is a sheet of paper or cardboard usually larger than a poster and contains a lot of information (illustration and text).

Flipchart: A set of posters bound together in a logical sequence that provides information on a given topic (includes pictures, storyline and text).

Leaflet: A folded sheet of paper usually printed on both sides which contains information on a given topic. The information can be technical and presented as an illustrated text.

METHOD

Step 1: Start the session by asking the participants what IEC means and to give examples of IEC materials. Brainstorm as many types of materials that could be useful to promote or enhance reproductive health/family planning programmes. Ask participants to explain each of the mentioned IEC materials.

Co-facilitator writes responses on newsprint.

NOTE: The trainer should bring examples of IEC materials to class and show each one as it is being discussed.

Step 2: Make sure participants are familiar with/can define or explain each of the types of materials that were mentioned by the group and are now on newsprint.

(If they have any trouble, refer to definitions on left hand side of this page and the next one).

CONTENT **METHOD**

Flyer: A flat sheet of paper usually printed on one side and contains technical information on a given subject.

Model: A sample of an actual object, often not to scale (not the actual size) but designed to enable learners to see the various parts and their relation to the whole.

Drama Script: A story of life or a composition intended to be presented on the stage by an actor.

Audio and Video Cassettes: A holder with a reel of magnetic tape on which there is pre-recorded material, either audio, visual or both.

Picture Code: Is an illustration which shows a familiar problem about which the community or a group has strong feelings. A picture code presents a problem, not a solution (unlike a poster). It is used in a group situation to raise questions and generate discussions.

CONTENT

2. Importance of Visual Aids

METHOD

Step 1: Refer back to the list of visual aids above. Ask participants to pick a partner and together write down as many reasons as possible why health workers should use visual aids. Give each pair 10 minutes.

Step 2: Ask each pair to report.

Possible responses.

Importance for the teacher:

- *to help the health worker by illustrating what she says (i.e., reinforces a verbal message).*
- *to show steps in the process of doing something.*
- *to enlarge something small and make it big enough to see (like a sperm).*
- *to show changes.*
- *to compare similarities and differences*
- *to serve as a trigger (starting point) for a discussion.*

Importance for the learner:

When used properly, support materials can help clients; for example:

- *remember how to perform a health practice correctly.*
- *to understand what to expect when they breastfeed for the first time or use a new health product or contraceptive method.*

CONTENT

METHOD

Step 3: If no one mentions it, tell participants, when used properly, visual aids are effective in reinforcing or supporting a verbal message. Thus we sometimes refer to visual aids as "support material". Ideally, such materials should be developed after discussing the issues, questions, and rumours that concern clients and health workers at the grassroot level.

Step 4: Ask participants if they can think of reasons why using visual aids (or support materials) can make the tasks of the health worker easier. (As they give their responses, you should ask Co-facilitator to write these on the newsprint or chalkboard).

Possible responses

- *holds the client's attention.*
- *helps explain sensitive issues, such as condom use.*
- *helps the client to remember important information.*
- *provides consistent (the same) information to all clients.*
- *provides information on side effects of family planning contraceptives and thus helps clients cope with minor problems.*

CONTENT

3. Advantages and Disadvantages of each major type of IEC or support material.

Type of IEC/ Support Material	Adv	Disadv	When it's appro-priate to use

METHOD

Step 1: Trainer leads a discussion on the advantages and disadvantages of each major type of IEC material.

Trainer divides participants into teams of 3 or 4 and assigns each team one or two different types of IEC/support materials.

Step 2: Ask each team to prepare a matrix on newsprint like the one shown in the left hand column for each type of materials. They should then brainstorm all the advantages and disadvantages they can think of for using this type of IEC material.

Step 3: For example take one material like the video and list the advantages and disadvantages together before breaking into groups:

Possible advantages:

- *holds attention.*
- *helps explain sensitive issues.*
- *helps people remember important information.*
- *attracts attention.*
- *good for illiterate audiences.*

CONTENT

METHOD

Possible Disadvantages:

- *can be misunderstood if poorly designed.*
- *requires special equipment and electricity for use.*
- *must be available in appropriate places.*
- *may require a distribution system.*
- *usually expensive to produce.*

Step 4: Give the groups 10 - 15 minutes to do this exercise. Then have them display the newsprints and explain what they have written.

Step 5: For each type of material, after re viewing the advantages and disadvantages, ask everyone to decide when (or under what conditions) it will be appropriate to use this type of material.

Step 6: Conclude this exercise by asking the following:

1. Which IEC materials have you been using in your clinics?
2. Which other ones would you like to use?
3. Has anyone had special training in how to make effective use of different IEC materials?

CONTENT

4. How to use different types of Visual Aids. For example; Booklets, Leaflets, Posters, Flipchart etc.

Booklets and Leaflets

1. Go through each page of the booklet with the client This will give you a chance to both show and tell about a health problem or practice and answer any questions the client has.

2. If there is a picture, point to it, not to the text that appears on the page. This will help the client to remember what the illustrations represent. This is especially important for clients who do not read very well.

3. Observe the client to see if he/she looks puzzled or worried; if so, encourage him/her to ask questions or talk about any concerns. Discussion helps establish a good relationship and builds trust between you and the client. A person who has confidence in his or her worker will often transfer that confidence to the new health practice selected.

4. After you have explained the information ask the client to repeat it in his/her own words. That way, you will know if the client understood the important messages.

METHOD

Step 1: Explain to participants that different types of visual aids are designed to reinforce or support verbal message of health workers. The materials are not a substitute for good interpersonal communication skills, but, if used properly, they strengthen the messages you give to clients.

Step 2: Trainer leads a brainstorming session on how to use different types of visual aids.

Make sure the points in the content column are made about the use of booklets, leaflets, posters, flipchart

OR

Distribute handout on (pages 7.15 and 7.16) on "How to use support materials" and go through it with participants.

CONTENT **METHOD**

5. Give the client the booklet to keep and suggest that he/she shares it with others, even if the client makes a decision not to use the method or health practice described.

Posters

Display motivational posters in places of high visibility, such as clinics, schools, theatres, small shops, bus and railway stations. Ask permission first so that your poster is not ripped down and wasted.

Educational posters can be placed in the same places if appropriate. Think about what the poster is meant to do and who will see it. That should determine where you want to display it. It may be more appropriate to use a poster describing family planning methods in a family planning clinic than a motivational one as most clients at a family planning clinic are already motivated.

You can also use posters to stimulate discussion with a group (for example, in a clinic).

Flipcharts

A flipchart is made of a number of stiff pages, usually of pictures, that are bound together at the top. It can be stood up on a table or held in someone's hand. Flipcharts can help you remember important things to say. They can help you explain difficult ideas and give clear instructions. You can use a flipchart with a couple, one client, or group. It is very useful for leading a group discussion and counselling clients.

CONTENT **METHOD**

When using the flipchart with a group, be sure to stand where the whole group can see it. Move around the room with the flipchart if the whole group cannot see at one time.

Some specific ways to follow when using a flipchart.

1. Set the flipchart facing the people and, if possible in a place higher than their heads. Then everyone can see it.

2. Stand beside the flipchart so that everyone can see it. Do not stand in front of it. Face the group.

3. If the flipchart has text, use it as a guide, but familiarize yourself with the content so that you are not dependent on the text.

4. Know what you will say before you start. Then you can look at the group while you talk. Do not talk to the flip-chart or your notes. Talk to the clients.

5. If possible, write notes on the backs of the pages. These notes can remind you of what you want to say.

6. Point to the pictures while you talk. Do not point to the text.

7. Ask questions about the pictures. Ask the group if they have any other questions.

How to use nonprint media

Use songs, jingles, plays, television or radio programs, video tapes, and traditional dance to make people aware of maternal and child health services. Entertainment and dramatization can also stimulate people to think about family planning and health issues and can provide information about methods and practices.

CONTENT

As with print materials that are used in a group, nonprint media are more effective when they can be seen and heard clearly by everyone in the group.

To get the most from nonprint media:

1. Use nonprint materials in groups. They are usually intended for an audience of more than one.

2. Be familiar with the material.

3. Ask the group members questions about what they have seen or heard.

4. Ask the group if they have any questions, suggestions or opinions.

5. Use songs, plays etc, to start people talking. For example, if you were showing a film about breastfeeding, you might ask members of the group how they would handle the situation that a couple in the movie encountered, or how they would resolve it.

METHOD

Step 3:Ask participants to mention what type of nonprint media is used to make people aware of family planing and reproductive health issues. For example, radio, drama, etc.

Step 4: Encourage participants to give feedback on how traditional media has been used in Malawi; for example songs, dance, drama poems etc. Have any of these media been used to promote family planning or changing risky behaviours? If yes, how? If no, how can we promote their use?

95

CONTENT

5. Demonstrating use of IEC materials

METHOD

Step 1: Ask each participant to select a partner. Give each pair on IEC support material (leaflet, poster, flipchart, picture code etc). Tell them to take turns practising how they can best use these materials as part of their health education talks or when counselling individual clients, or when working with groups with special needs (for example adolescents). Give them 15 minutes to practice. Ask for a few volunteers to demonstrate to the group.

Step 2: Conclude this exercise by discussing the following:

1. What have you learned in this session that you did not know before?

2. How will proper use of support materials help you provide accurate information to your clients?

HANDOUT

HOW TO USE IEC/SUPPORT MATERIALS

Poster

Display motivational posters in places of high visibility, such as clinics, schools, theatres, shops, bus and railway stations. Ask permission first so that your poster is not ripped down and wasted.

Educational posters can be placed in same places as above, if appropriate. Think about what the poster is meant to do and who will see it. That should determine where you want to display it. It may be more appropriate to use a poster describing family planning methods in a family planning clinic than a motivational one as most clients at a family planning clinic are already motivated.

You can also use posters to stimulate discussion with a group (for example, in a clinic).

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1. Set the flipchart facing the people, and if possible in a place higher than their heads where everyone can see it.

2. Stand beside the flipchart so that everyone can see it. Do not stand in front of it. Face the group.

3. If the flipchart has text, use it as a guide, but familiarize yourself with the content so that you are not dependent on the text.

4. Know what you will say before you start. Then you can look at the group while you talk. Do not talk to the flipchart or your notes. Talk to the clients.

5. If possible, write notes on the backs of the pages. These notes can remind you of what you want to say.

6. Point to the pictures while you talk. Do not point to the printing (the text).

7. Ask questions about the pictures. Ask the group if they have any other questions.

How to use nonprint media

Use songs, jingles, plays, television or radio programs, video tapes, and traditional dances to make people aware of maternal and child health services. Entertainment and dramatization can also stimulate people to think about family planning and health issues and can provide information about methods and practices.

As with print materials that are used in a group, nonprint media are more effective when they can be seen and heard clearly by everyone in the group.

To get the most from nonprint media.

1. Use nonprint materials in groups. They are usually intended for an audience of more than one.

2. Be familiar with the material.

3. Ask the group members questions about what they have seen or heard.

4. Ask the group if they have any questions, suggestions, or opinions.

5. Use song, plays, etc. to start people talking. For example, if you were showing a film about teenage pregnancy, you may ask members of the group how they would handle the situation that a couple in the movie encountered or how they could prevent it.

SESSION SUMMARY

SESSION 8 : COUNSELLING

TIME : 6 HOURS

OBJECTIVES

By the end of the session, participants will be able to:

1. Define counselling
2. Explain the purpose of counselling
3. Describe the qualities of a good counsellor
4. Explain the counselling process utilising GATHER
5. Explain factors that facilitate or interfere with counselling
6. Identify sources of stress to the counsellor and possible solutions
7. Demonstrate the counselling process utilising GATHER

MAIN POINTS

1. Definition of counselling.
2. Purpose of counselling.
3. Qualities of a good counsellor.
4. The counselling process utilising GATHER.
5. Factors that facilitate or interfere with counselling.
6. Sources of stress to the counsellor and possible solutions.
7. Demonstration of the counselling process.

MATERIALS

- Chalkboard and chalk
- Newsprint and Markers
- TV and VCR (if available)
- Overhead Projector and transparencies (if available)
- Video tapes:

    i) **Counselling: Helping people make an Informed Choice**
    ii) **GATHER**

- Prepared Handouts on:

  i) Exercises on stress and role playing
  ii) Helping a client to choose a method - good and bad dialogues
  iii) Observation checklist for counselling role play

- Prepared Newsprint: Session objectives
- Prepared Newsprint: The Counselling Process
- Sample of contraceptives in a container
- Client card
- Hormonal Contraceptive Checklist
- Method specific information leaflets

REFERENCES

1. AVSC International: *Family Planning Counselling* - A Curriculum Prototype, Participants Handbook, New York, 1993.

2. AVSC International: *Talking with clients about Family Planning* - A Guide for Health Care Providers, New York, 1995.

3. Family Health Services Project: Nigeria Three-Day Curriculum - Interpersonal Communication and Counselling for Family Planning, JHU/PCS and PATH, Ibadan, 1989.

4. National Family Welfare Council of Malawi: *Family Planning Practitioners, Training Programme Curriculum,* Blantyre Print and Publishing, Lilongwe, 1995.

SESSION OUTLINE

CONTENT

1. **Definition of Counselling**

   Counselling is face-to-face communication in which one person helps another make decisions and act on them.

   Family Planning Counselling

   Family Planning counselling is a person-to-person interaction in which the counsellor provides adequate information to enable client to make an informed choice about the contraceptive that is best for him/her.

METHOD

Exercise (10 Minutes)

Step 1: Introduce subject by informing participants that the focus of this session is counselling and that they are going to begin by having a self-test on counselling.

Step 2: Read out to participants the self-test exercise and ask each participant to write down their answers.

Self-test on Counselling

1. What it is counselling? (Choose the correct answer)

   a) Telling the client which method to choose

   b) Helping the client to make her own family planning choice by giving her information, listening to her feelings and allaying any anxieties.

2. List 5 qualities of a good counsellor.

3. What information/help can a counsellor provide to clients who are concerned about infertility.

CONTENT

METHOD

Possible Answers

1. *(b)*

2. *Any of the following:*

- *Understands all available methods*
- *Presents information in unbiased sensitive manner*
- *Gains client's trust*
- *Communicates clearly, using teaching aids as appropriate*
- *Is concerned about client's needs*
- *Knows when she cannot help client and where to refer*
- *Has good listening skills*
- *Respects client*
- *Is empathetic*

3.

- *Information about woman's menstrual cycle and how to recognise the most fertile time of the month.*
- *Information about gynaecological problems and referral.*
- *Arrange appointment with doctor who specializes in infertility treatment.*

CONTENT

2. **Purpose of counselling**

Counselling is done for the following:

i. To give clients correct information on STDs and HIV/AIDS.

ii. To give accurate family planning information to priority groups such as:

- postpartum mothers
- Couples who want to limit their families
- Men
- Adolescents, in and out of school
- Individual men, women and couples with HIV infection and/or AIDS
- Post abortal women regardless of age
- women with obstetric or medical conditions likely to worsen with pregnancy and child birth; for example, sickle cell disease, hypertension, diabetes mellitus, psychiatric conditions, previous caesarian sections, etc

iii To give clients information about high risk groups such as the "4 TOOs":

- women whose last born children are 2 years old or less (too soon).
- women who have had four (4) or more pregnancies (too many).

METHOD

Step 1: Explain to participants that although family planning counselling is a term that means different things to different people, we will work as a group towards a common understanding of its purpose.

Step 2:Ask each participant to write the purpose of family planning counselling on a sheet of paper. Have volunteers list their responses, and Co-facilitator writes them on newsprint.

Possible Responses

Counselling:

- *helps clients weigh the benefits and risks of available contraceptive methods.*
- *helps clients make informed and voluntary decisions about fertility and contraception*
- *provides information and helps the client apply that information to his or her needs and circumstances*
- *helps clients use contraceptive methods correctly*
- *helps clients continue using a family planning method*
- *helps clients identify and dispel rumours.*

CONTENT

- women over 35 years of age (too late).
- female adolescents below age of 20 regardless of marital status or whether in or out of school (too early).

Note: Possible sites to find the clients:

- OPD
- Wards especially Gynae
- Antenatal and Postnatal clinics/wards
- Well baby clinic
- Nutrition clinic/ward

METHOD

Helps establish and maintain a good relationship between the client and the counsellor.

Step 3: Point out that:

Family planning counselling 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. Counselling helps ensure that the client's choice is free and informed.

Step 4:To whom are we providing this family planning counselling?

Have participants work in groups of four and

a) brainstorm all the groups they should target for counselling on family planning.
b) Specify where each group can be reached.

Give the groups 5.10 minutes and then have one person from each group report.

Co-facilitator writes these priority groups on newsprint. Possible responses should include all those listed on page 8.5.

Step 5: Add high risk groups like those listed on page 8.5 (If not already given).

CONTENT

3. Qualities of a good counsellor

A good counsellor is one who is:

- **Honest**: Always tells the truth to clients and provides them with the care and information they desire.
- **Understanding/empathetic**: Empathy means being able to put yourself in the client's place, being able to feel what the clients feel and to demonstrate to the clients that you understand and accept their feelings without bias or judgement.
- **Non judgemental**: The Counsellor should treat clients with respect and kindness, and give information in unbiased manner.
- **Flexible**: The Counsellor should be able to recognise when he/she cannot sufficiently help a client and refer to someone who can.
- **Sensitive to client's needs and concerns:** The Counsellor helps clients to deal with rumours, misconceptions, needs and concerns by discussing fully their fears and anxieties and by providing facts in a sensitive, caring manner.

METHOD

Step 1: Tell the participants:

- Most health care workers need skills, and knowledge to do their jobs well. In addition, they need to develop the personal qualities that will improve their counselling performance.
- In this context the term counsellor refers to a health care worker who has been trained in counselling and is responsible for reproductive health. Health care workers responsible for counselling need certain skills in communication and counselling.

Step 2: BRAINSTORMING ON PERSONAL QUALITIES

On a newsprint, write the heading "personal qualities". Ask the participants to name some of the personal qualities needed by an effective family planning counsellor.

Write participants' responses on the newsprint and discuss each quality such as 'honesty' and 'flexibility'. Compare responses with content on left hand side and review any items that were not mentioned.

CONTENT

- **Genuine**: The counsellor must be a real person and not a role player. The Counsellor uses his/her skills, and past experience to facilitate the client/provider interaction.

- **Active listener**: Active listening facilitates communication and this will allow the client to express herself freely and adequately. This means listening to the client with undivided attention. Counsellor may nod and look at the client.

- **Accepting and respectful**: A respectful counsellor treats clients in a way that the provider would like to be treated if he/she were the client.

- **Establishes rapport with the client**: If the above qualities of a good counsellor are present, the provider promotes the establishment of rapport or a feeling of trust.

METHOD

Step 3:Explain that 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.

Step 4:Create teams of two and assign one of the qualities of a good counsellor to each team. The task of each team is to create a role play that demonstrates the assigned quality.

One member should play the role of a counsellor, the other should be the client.

Allow 15 minutes for the assignment.

Step 5:After 15 minutes, bring the teams back together and ask for volunteers to perform the role plays. When each team finishes, discuss that quality in relation to what usually happens in a clinic setting.

Step 6:Conclude this activity by asking: Will it be difficult to apply these qualities in our day-to-day work? Why/why not?

CONTENT	METHOD
4. **The process of counselling utilizing "GATHER"** **"GATHER"** is an abbreviation which stands for: **G** - Greet clients **A** - Ask clients about themselves **T** - Tell **H** - Help **E** - Explain **R** - Return	**Lecture/ Discussion** On the board or newsprint write the word GATHER. Explain that the ACRONYM is a way of remembering the essential steps of counselling and that each letter stands for a step in the process.
GREET **Greet clients** As soon as you meet clients, give them your full attention Be polite ; greet them, introduce yourself and offer them seats. Ask how you can help Reassure clients that you will not tell others what they say. Conduct counselling where no one else can see or hear.	**Greeting practice** **Step 1**:Read the following scene to the participants or ask for two volunteers to read the dialogue of the two characters and have participants discuss it. **Provider:** Sit down, I assume you want family planning. First, I need to get some medical information from you. Then we'll decide what method you should use. **Client:** But I'm not sure if I want to use family planning. I really just want some information. **Provider:** I don't have the time right now just to talk. Take these leaflets and read them. Come back when you've made up your mind.

CONTENT

METHOD

Step 2: Questions to pose to group:

1. Is this a good or bad way to greet the client? Why?

2. What are the problems in this discussion?

Possible answers

1. The Provider does not greet the client.

2. The provider just assumes the reason for the client's visit rather than asking.

3. The provider becomes impatient. She sends the client away without helping her.

4. The provider gives the client print materials without discussing them.

Step 3: Now read the following dialogue and discuss, as on previous page.

Provider: Good morning, Mrs Kabanja. I'm Mrs Kachimanga. Please sit down. Now, how can I help you this morning?

Client: Well, my husband and I already have three children, and we don't want any more, at least not now. I've heard that there are things a woman can use, like pills and injections, to prevent pregnancy. I'd like more information since I really don't know much about them.

CONTENT

METHOD

Provider: That's okay. You have come to the right place for information. I can tell you about several methods for delaying pregnancy. In addition to pills and injections, we offer loops, condoms, and spermicides. And if you and your husband decide that you do not want any more children, we can refer you to a hospital for a permanent surgical method. Either you or your husband could have this procedure. You and I can talk about all these methods. Let's start with pills. What have you heard about pills?

Step 4: Questions to pose to the group:

1. Is this a good or bad way to start the counselling session?

2. What is good about this discussion?

Possible Answers:

1. The provider greets the client courteously.

2. The provider asks the client her reason for coming to the clinic.

3. The provider listens to the client.

4. The provider reassures the client when she admits that she does not know much about family planning.

CONTENT

METHOD

5. *At the start the provider tells the client what they are going to talk about.*

6. *The provider asks what the client already knows/has heard. What she knows/has heard may be correct or incorrect. This a good opportunity to detect and dispel rumours or give correct information.*

Note: The Trainer ensures that information on the left hand column is included in the discussion on greeting clients.

CONTENT

ASK

Ask clients about themselves/Assess their knowledge and needs

Is this your first visit to the family planning clinic?

- What have you heard about family planning?
- What methods have you heard about?
- What have you heard about them? (Provider listens very carefully for any misconceptions that need to be addressed later on).
- How many children do you wish to have (reproductive goals)? How many years would you like to have between births? (This information will give the provider an idea about whether the client wants to space or stop having children).

METHOD

Step 5: Asking questions

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

Co-facilitator writes the responses on newsprint.

Possible responses

- *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 identify rumours and misconceptions (if any).*

Step 6:What questions can you ask to find out this information?

Responses should include items in the left hand column.

CONTENT	METHOD
• If the client is not new, ask: Has anything changed since your last visit?	
• Ask clients what they know about STDs and HIV/AIDS.	
Ask the client about his or her family planning needs. Providers ask the client how they can help. If it is the client's first visit, the provider will also need to take a medical history that includes the client's: 1. Age, 2. Marital Status, 3. Number of pregnancies, 4. Number of births, 5. Number of living children, 6. Family planning use now and in the past, 7. Basic medical information, including past and current illnesses and current medications.	
During routine follow-up visits, providers ask clients if they have any problems with their methods and if they are still using them. Even those who have come chiefly for more supplies may have something that they want to discuss. Providers ask clients if they are having any side effects. Also, by asking clients to explain exactly how they use their methods, providers can check whether clients know what signs of complications to watch for.	

CONTENT

TELL

Tell Clients About Family Planning Methods

Tell new clients which methods are available at the facility and through other sources.

Briefly describe each method to the client

Talk about:

1. what it is
2. how it works
3. advantages
4. disadvantages
5. when to see a family planning provider when client experiences any problem with contraceptive.
6. whether or not each method protects against STDs/HIV

NB: Information on methods should be given in relation to the gaps. You may learn that the client has all the required information or has wrong information. If it is important, gently correct the mistakes.

METHOD

Step 7:Exercise on Telling

Share content information in the left hand column with participants.

Step 8: Divide participants into groups of four or five. Give each group a box of contraceptives and some method specific information leaflets.

- Each person will take a turn playing counsellor. The counsellor picks a method, without looking, from the container and describes that method to the person at his or her left, who plays the role of a client interested in that particular method. If the client raised questions which indicated misconception about method, correct by giving accurate information at this time. Counsellors can use leaflets or illustrated flipcharts depicting male and female anatomy for this role play.

- Counsellors should practice the skills of using materials effectively and using non technical language.

- Each counsellor has one or two minutes to explain the method. This time limit is important because counsellors give only basic information about methods during the telling step and

CONTENT

HELP

Help Clients Choose a Method

Listening and questioning continue to be important here.

The provider helps the client choose a method by finding out if the client has:

- understood all the information about the methods or
- has any concerns

Taking into account the client's reproductive goals, the provider asks what method the client would like to use.

METHOD

because it simulates real-life situations in which counsellors have limited time.

After each role play, the rest of the group should give feedback, 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 counsellor provided more information than the client needed at this stage in decision making.

Step 9:Helping a client to choose a method (good or bad dialogues)

The Trainer presents the summary information in the content section in the left hand column.

CONTENT	METHOD
NB: If client is unable to choose a method at this point the provider encourages the client to go and discuss the information received with her/his partner if necessary. The provider also gives her/him a return appointment.	
If the client has chosen a method, the provider excludes contraindications by taking the client's history using the client card. (Trainer should show and explain the client card to the trainees).	
After history taking, the provider asks client to lie on the couch for examination.	
During the examination, the provider explains to the client what: - is being done (the examination procedure) - and findings of the examination	
If there are contraindications, the provider gives more information to enable the client to choose a different method.	
If a client is seen at an out-reach clinic or a busy static clinic, the provider excludes contraindications, by using the Hormonal Contraceptive Checklist. (Trainer shows and explains the hormonal contraceptive checklist to the trainees).	
If there are no contraindications, the provider initiates the client on the chosen method.	

CONTENT | **METHOD**

NB:

i. If the client has chosen the condom, spermicide, Lactational Amenorrhoea Method (LAM) or Natural Family Planning (NFP) Method, the provider does not need to perform physical examination or use the checklist, when initiating the method.

ii. If the client has chosen COC, POP or Depo Provera, the provider performs a physical examination or uses the hormonal contraceptive checklist.

iii. If the client has chosen an IUCD, the provider performs a physical examination before insertion.

iv. If the client chooses Norplant or VSC the provider performs a physical examination before insertion.

v. The provider records all findings from the history and examination, on the client card.

vi The provider also records the method given to the client.

CONTENT

METHOD

Step10:Divide participants into groups of three. Explain: Now you are going to practice the helping step in GATHER. Each of you will take turns role playing, counsellor, client and observer roles.

Distribute the dialogue handout. (Page 8.32) Then read the dialogue to the participants:

A. **Client:** I don't want any more children. A friend of mine has an IUCD and she's very pleased with it so I would like one, too.

Counsellor: Yes, we have IUCDs here. It's nice to have a client who knows what she wants. The nurse will see you soon to put it in.

B. **Client**: I don't want any more children. A friend of mine has an IUCD and she's very pleased with it so I would like one, too.

Counsellor: You say you don't want any more children? Then I think you should have sterilization. That would be less trouble for you.

Step 11: Ask what is **wrong** with these dialogues?

Possible Answers

1. The provider does not check what the client knows about the IUCD.

The provider does not check whether the client has medical reasons for not using an IUCD.

The provider does not check whether the client knows that other methods are available.

2. The provider ignores what the client wants.

The provider tries to tell the client what method to use. She does not think the client should make her own decision.

CONTENT		METHOD
Client:	I don't want any more children. A friend of mine has an IUCD and she's very pleased with it so I would like one, too.	**Step12:Repeat the same activity in your groups of three using the dialogue.**
Provider:	Yes, the IUCD is a very effective family planning method for many women. However I can also tell you about other methods too, if you are interested.	
Client:	Yes, I'm sure I want the IUCD, but I would like to know about other methods too.	
Provider:	Fine, let's talk about the IUCD first. What have you heard about it?	
Client:	My friend told me a little about how it is put in. She said it hurts when she had it done. I'm a bit worried about that.	

CONTENT

Provider: It's true that it hurts when the IUCD is put in. But it only takes a few minutes. Some women say it feels like short sharp menstrual cramp. This is what an IUCD looks like (You can hold it and feel it). Let me tell you exactly how the nurse puts it in. If there is anything you don't understand, or if you have any questions, just let me know.

METHOD

Step13: Discuss the following:

1. How does this dialogue compare to the first two?

2. Why is it better?

Possible responses:

The provider does not try to change the client's decision.

The provider tells her client that there are other methods.

The provider shows an IUCD and promises to explain how the provider will put it in.

The provider listens and responds honestly to the client's concern about pain.

3. **Was anything missing from the dialogue?**

CONTENT

METHOD

Possible Responses:

No questions about medical history and lifestyle which are very important. (IUCD is not recommended to clients with past history of STDs or who have several sexual partners).

Lecture and Role Play

EXPLAIN

Explain How to Use a Method

After the client has chosen a method:

Give her or him supplies (according to guidelines).

Explain how to use the method by going through the appropriate method-specific leaflet with the client and give the client a copy to take home.

Ask the client to repeat the instructions. Listen carefully to make sure she or he remembers and understands.

Describe any possible side effects of the chosen method.

Clearly tell the client what to do if side effects occur.

Ask the client to repeat this information.

Tell the client when to come back for a follow-up visit.

Tell the client to come back sooner if she experiences any problems.

Step14:Explain family planning methods

Present summary information in the content section in the left hand column.

Remind participants:

A common mistake is to give clients information they have already received in the telling step e.g. mechanism of action, advantages and disadvantages. In the explaining step, clients only need information about how to use the method they have chosen or about possible side effects and how to handle them.

CONTENT

METHOD

Step 15:Divide participants into groups of four or five. Give each group a box of contraceptives.

Have each group member take a turn playing the counsellor. Without looking, he or she picks a method from the box and explains how to use the method to the person at his or her left, who plays the role of a client who has chosen that method and gives any information she should have about possible side effects and what to do if side effects occur. The counsellor follows the steps for explaining how to use a method. The counsellor should use a method-specific information leaflet to help explain the method.

After each role play, the group practices giving effective feedback. 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 counselling
- observations about the way the information was presented

CONTENT

METHOD

Step 16: Conclude by asking the following:

1. 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.

2. Why is it important to explain possible side effects?

   Possible Responses:

   - *People are less frightened when they know what to expect.*
   - *People are more likely to continue using family planning.*

Step 17:Before the client leaves with the chosen method, let him/her know when to come back. However, let the client know that he/she can come sooner (anytime) if he/she experiences any problems or has any concerns.

Step 18:Divide participants into groups of three. Participants take turns role playing counsellor, client and observer. Assign each group a method which the client has used.

Ask that two clients express dissatisfaction with their currentmethod and say they would like to try a different one.

RETURN VISITS

Make forward appointments for return visits.

Follow-up Visit:

At the follow-up visit the provider still utilizes GATHER for information gathering and providing needed services.

CONTENT

Greet Client

Ask

Ask the client for his/her reproductive goals. These change over time, therefore the service provider needs to check.

Ask the client if he/she is still using the method.

If the client says yes, ask the client if he/she has any problems with the method.

If yes, find out the nature of the problems. Reassure clients with minor side effects that they are not dangerous. Suggest what they can do to relieve them. If side effects are severe, refer for treatment.

Ask how the client is using the method. Check to see that it is being used correctly.

Ask if the client has any questions.

Tell

Tell the client that if they are r t happy about the method they are using, they should feel free to request a change.

Help

If the client has decided to change his/her method, help him/her to choose another one..

Explain

If the client has chosen another method, explain with the aid of the appropriate method-specific leaflet, how to use the chosen method correctly. (Give client a copy to take home)

METHOD

The Counsellor follows the steps for return visits. 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 (counsellor, client and observer).

Ensure that the role players make use of the GATHER steps described in the right hand column.

CONTENT	METHOD
Return Visits Give him/her follow-up appointments. **If the client wants to try another method: Tell the client about other methods. Remember - changing methods is not bad. It is normal. No one really can decide on a method without trying it. Also, a person's reproductive situation can change. Then another method may be better.** **If the client wants to have a child, help her to stop her method. Refer her to have her IUCD or Norplant removed, if necessary. Inform the client that prenatal care is important. Tell the client where to go for prenatal care when she becomes pregnant.**	

CONTENT

METHOD

Step 19:Summary of the GATHER steps for counselling

- We have now practiced all six of the GATHER steps: **G**reeting **A**sking/assessing, **T**elling, **H**elping, **E**xplaining, and **R**eturn visits.
- The order of the steps, and the content of the counselling may change to fit each client's needs. The full six-step process may only be necessary on the first visit and subsequent visits may be much shorter, based on the client's needs.
- Even for first-time clients, counselling may not be lengthy, since many clients already have some information and preferences. This is one reason why individual assessment is important.

5. Factors that facilitate Counselling.

Brainstorming/Guided Group discussions

Step1: Divide participants into two groups.

Ask Group A to brainstorm all the factors they feel can facilitate the counselling process (Ask for one or two examples to get them started e.g. a private room, enough time).

Ask Group B to brainstorm all the factors they feel can interfere with the counselling process.

Ask for examples, such as, a provider who is too busy to listen to a client who speaks a different dialect not known to the provider.

Positive Factors:

- adequate auditory and visual privacy and confidentiality.
- showing concern/care for client and empathy.
- preparedness and competency of the counsellor to generate client trust in the service.
- flexibility, e.g. referral if counsellor cannot sufficiently help the client.
- accuracy of information
- respect and understanding

CONTENT

METHOD

Both groups should list their responses on newsprint and be prepared to share with the large group. Make sure responses include the factors in the left hand column.

Give each group 10 minutes.

- use of visual aids to enhance understanding
- language if common or understood by everybody
- age, e.g., a young client being counselled by a middle aged provider or peer counsellor.
- appropriate use of verbal and non-verbal communication skills.

Step 2: After 10 minutes discuss both lists and ask the groups what we can do in our clinics to maximize the factors that will improve counselling.

Factors that interfere with Counselling

Negative Factors:

- language barriers, if language not common or understood by everybody. Using complicated language.
- age differences, e.g., an elderly widow being counselled by a very young counsellor.
- educational background, the difference in educational background is important e.g., if one person is well educated and the person counselling is not well educated.

CONTENT	METHOD
• values and beliefs, e.g., if the counsellor is a Catholic and is biased towards the use of natural family planning methods and the client is non-catholic. • lack of privacy, clients may be embarrassed to give out personal information while others are hearing. • lack of confidentiality.	

CONTENT

6. Sources of stress to the Counsellor and possible solutions.

Possible stress:

At work

- Commodity shortage
- Client with difficult problem
- Lack of counselling room
- Staffing shortage with high client load
- Outdated clinic routines
- Role conflict - religious/cultural
- Inadequate knowledge and skills
- Lack of ownership and accountability
- Time management
- Lack of incentives
- Lack of supervision/support at all levels of management
- Playing several roles at the same time.

Outside work

- Child care
- Transport
- Family responsibilities
- Illness of oneself or family members

METHOD

Explain that:

Step 1: Counselling requires concentration, compassion and energy. Sometimes it is a source of stress because it demands so much of the counsellor. Learning to identify and handle stress associated with counselling is an important way to ensure continued quality of care given to clients.

Step 2: Ask participants as a group to define stress and to write down three major stresses that they encounter at work, and three stresses that occur outside work that affect their work. Make sure responses include those in the left hand column.

CONTENT

Workable Solutions

- Take a walk to relax.
- Plan a special weekend with the family etc.
- Develop a support network with other family planning providers to provide coverage and share problems and solutions.
- Hold regular staff meetings to discuss immediate and long-term solutions.
- When faced with commodity shortage, assist and encourage clients to explore other options and possibly make another choice until regular contraceptive is resupplied.

METHOD

Step 3:Ask participants to imagine the "ideal" response to or escape from an irritating or anxiety-producing problem, and encourage them to be as free in their thinking as possible.

Then have participants think of a "realistic" response. Ensure that responses include the workable solutions on the left column.

Step 4: Summarise the commonest stresses among the group and brainstorm workable solutions.

Possible Responses:

Workable solutions should be similar to those in step 3. (See left hand column)

Step 5: Distribute handout on:

"Special stress when working in a family planning clinic" (See page 8.36) and allow 5 minutes for participants to fill in their responses.

After the exercise the Trainer explains that:

participants with many responses in the "makes you furious" category may be experiencing a high level of stress that may affect their ability to perform effectively.

CONTENT	METHOD
7. Demonstration of the counselling process utilizing GATHER **Role Play Script:** See page 8.37	**Role Play Process** **Step 1**: Distribute handout with several counselling scenarios suitable for role plays (see page 8.37.) and the observation checklist (see page 8.38). • Explain the purpose of the checklist: using the observation checklist, the observer will assess whether the service provider dealt with the situation appropriately. **Step 2**:Divide participants into groups of three and assign at least one role play to each group. Have group members take turns practicing being the client, the provider and the observer. (Remind the observer to use her/his checklist). **Step 3**: Give groups 15 to 20 minutes to practice. Then ask for volunteers to present their role plays to the group. i) Explain to the rest of the class that they will observe the role plays and try to imagine how it feels to be a client, coming to a family planning clinic for help and how they would expect a service provider to meet their needs and concerns. ii) Proceed with role play. iii) Obtain feedback from the learners who conducted the role play on how it felt to play the role of the client and service provider.

CONTENT	METHOD
	iv) Elicit feedback from the class on their evaluation of the role play.
	Step 4: Process the information by asking:
	1. What skills and process used in counselling family planning clients were demonstrated in these role plays?
	2. Which skills were not demonstrated?
	Why do you suppose this is true?
	3. When you return to your clinic, will you be able to counsel others the way you have done in these role plays? Why/why not?
	Process the Role play by:
	Summarizing the skills and process used in counselling family planning clients.
	Conclude the session as follows:
	1. Describe your main learnings from this session on counselling: Enumerate new knowledge acquired, improved or enhanced.
	2. Evaluate your participation in this session, focusing on the exercises:

CONTENT	METHOD
	a. Discuss your own participation in the exercises, skills acquired or existing skill(s) enhanced; b. Describe the other exercises done and how these would help improve/enhance your own skill in dealing with clients after the training.
	3. List any areas relating to counselling which you wish to have more training on in the future.

SESSION 8

HANDOUT 1

Help a client to choose a method (good and bad dialogues)

A.	**Client**	:	I don't want any more children. A friend of mine has an IUCD and she is very pleased with it so I would like one, too.
	Counsellor	:	Yes, we have IUCDs here. It's nice to have a client who knows what she wants. The nurse will see you soon to put it in.
B.	**Client**	:	I don't want any more children. A friend of mine has an IUCD and she is very pleased with it so I would like one, too.
	Counsellor	:	You say you don't want any more children? Then I think you should have sterilization. That would be less trouble for you.
C.	**Client**	:	I don't want any more children. A friend of mine has an IUCD and she is very pleased with it so I would like one, too.
	Provider	:	Yes, the IUCD is a very effective family planning method for many women. I can tell you about other methods too, if you are interested.
	Client	:	Yes, I am sure I want the IUCD, but I would like to know about other methods too.
	Provider	:	Fine, let's talk about the IUCD first. What have you heard about it?
	Client	:	My friend told me a little about how it is put in. She said it hurt when she had it done. I am a bit worried about that.
	Provider	:	It's true that it hurts when the IUCD is put in. But it only takes a few minutes. Some women say it feels like a short share menstrual cramp. This is what an IUCD looks like (You can hold it and feel it). Let me tell you exactly how the nurse puts it in. If there is anything you don't understand, or if you have any questions, just let me know.

SPECIAL STRESSES WHEN WORKING IN A FAMILY PLANNING CLINIC

HANDOUT

The following quotes referring to family planning work are from various sources. Rate your reaction to these quotes based on your honest feeling if the statement were directed to you. If you have some other feeling, describe it in the blank space.

	NO REACTION	MILDLY IRRITATING	MAKES YOU FURIOUS
When FAMILY AND FRIENDS say to you:			
1. "Why do you work at that place"?			
2. "You mean you promote family planning"?			
3. "I thought you could get a better job than that"?			
When CLIENTS say to you:			
1. "I waited so long because I was scared".			
When CO-WORKERS say to you:			
1. "That's not my job".			
2. "I'm held up. Please take my client". (all time).			
When the COMMUNITY says to you:			
1 "We have run out of pills, condoms and Depo Provera"			
2. "There are 50 women in the waiting room and the provider has only two hours to see them".			
3. "The clinic is filthy".			
4. "We know this provider and we had high expectations of her."			

SESSION 8

ROLE PLAY SCENARIOS

HANDOUT

1. I am a 27 year old woman using the IUCD. Three other women that I know in my village, use the IUCD. Two of them got pregnant using the IUCD and one went crazy. I want to get my IUCD removed.

2. I am a 40 year old farmer with two children. My wife says the family planning worker has told her about a method she can use to stop having children forever. I do not like it at all.

3. I am a 23 year old male finishing college this year. I will be married to a traditional young woman. I want her to come for family planning so we can have a child after I get established in my job. She refuses family planning because she wants to have a baby right away.

4. I am a 38 year old woman who has been married for 10 years. My husband travels to the capital city frequently and I suspect he has other women. I have been feeling very tired lately and have lost weight. I am afraid I might have AIDS or some other sexually transmitted disease.

5. I am a 22 year old married woman. My husband has a good job and we have our first baby. I do not want any more. I want to be sterilised.

6. I am a 35 year old married woman with three children. I have been using the pill for two years now and I am tired of remembering to take it every day.

7. I am a 23 year old married night school student with one child. I do not want to have another baby until I complete my studies, but I can not seem to find a family planning method that is good for me. My husband is tired of using condoms and I got pregnant while using the pill because I kept forgetting to take it.

8. I am 44 year old housemaid. Sometimes I feel terrible, very hot and always perspiring. My period had been very scanty for 2 months now. I am sure I'm pregnant, but I do not want any more children at my age.

ROLE PLAYING OBSERVATION CHECKLIST

HANDOUT

You are to be observers of what takes place between the Counsellor and client. Try to feel what it would be like if you were the client. Determine how well the Counsellor assisted the client. Place a tick (✔) in the appropriate column: " Yes" if task/activity is performed satisfactorily, in "No" for unsatisfactorily or "N/D" if not done.

	YES	NO	N/D
1. Did the counsellor show a gentle and caring attitude to the client?			
2. Did the Counsellor ensure visual and auditory privacy and confidentiality?			
3. Did the Counsellor use verbal communication/counselling skills appropriately as follows?			
Clarifying			
Listening			
Encouraging			
Acknowledging			
Reflecting and repeating			
4. Did the Counsellor use non-verbal Communication/Counselling skills as follows?: **R**elaxed **O**pen **L**eaning towards the client, appropriately **E**ye contact, as appropriate Sit comfortably			
5. Did the Counsellor Keep It Short and Simple?			
6. Did the Counsellor respond to the client's needs and concerns?			
7. Was the Counsellor comfortable in dealing with the client?			
8. Did the Counsellor use the knowledge of STD and HIV/AIDS infection and contraceptive technology in assisting the client?			

		YES	NO	N/D
9.	Did the Counsellor meet the client's needs effectively?			
10.	Did the counsellor use the counselling process as follows: Greet client Ask client about themselves Tell clients about family planning and other reproductive health issues Help client to choose a family planning method Explaining the use of chosen method Return visit appointment made			

SESSION SUMMARY

SESSION 9 : **INFORMED CHOICE AND INFORMED CONSENT**

TIME : **1 Hour and 30 Minutes**

OBJECTIVES

By the end of this session, participants will be able to:-

1. Explain the concept of informed choice.
2. Explain the concept of informed consent.
3. Identify different factors that influence decision making.
4. Explain the adoption process.

MAIN POINTS

1. Informed choice
2. Informed consent
3. Factors that influence decision making
4. Adoption process

MATERIALS

- Chalkboard and chalk
- Newsprint and markers
- Overhead projector and transparencies
- Video on Counselling
- Copies of the Family Planning Policy and Contraceptive Guidelines (Section on Informed Consent)
- Prepared Newsprint: Session objectives

REFERENCES

1. AVSC International: Family Planning Counselling - A Curriculum Prototype, Trainers Manual, New York, 1995.

2. ZNFPC and JHU/PCS: Zimbabwe Counselling and Interpersonal Communication for CBDs, Training Module, Harare, April, 1992.

SESSION OUTLINE

CONTENT

1. Informed Choice

This is a voluntary choice made by a person after effective access to information on reproductive choices and to the necessary counselling services to help him/her choose and use an appropriate method of family planning, if desired.

Informed choice should be seen as a continual process as new acceptors try out one method and then shift to other methods or non use as their needs or preferences change.

2. Informed Consent

This is a voluntary decision made by a person who has been fully informed, has made the choice to have the surgical procedure done and understands the consequences. For surgical procedures the client needs to sign a consent form. (See an example of consent form on page (9-11).

3. Factors that influence decision making

One of the counsellor's main responsibilities is to assist clients make a decision regarding their reproductive health and family planning, based on his/her awareness of some of the following factors:

Individual Factors :

- Age
- Number and sex of children
- Risk of contracting or transmitting HIV infection or other sexually transmitted diseases.
- Knowledge of family planning

METHOD

Step 1:Ask participants to brainstorm the meaning of the concepts 'informed choice' and 'informed consent'. How are they different?

Have co-facilitator write all ideas on newsprint, then use this information to arrive at two definitions similar to those in the left hand column.

Step 2: Point out that the two concepts are often confused, because the names are so similar but in reality, they have little in common. As service providers, your main task is to ensure your client makes an informed choice. In order for them to do that they must receive information and counselling from you or other service providers.

Step 3: Ask participants to brainstorm factors that influence clients' choices about reproductive health and family planning. Write their responses on newsprint under two headings: Individual factors' and 'Community influences'.

Point out that community influences can be both positive and negative.

(See text on left and make sure that those items among others, are mentioned)

CONTENT **METHOD**

- 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, (even to unmarried, adolescents and widowed), their knowledge and skills.

- **Information:** Educational messages and promotional efforts concerning family planning.

- **Misconceptions:** Common misconceptions about contraceptive methods.

CONTENT

METHOD

Step 4: After the lists are complete, divide participants into two groups. Tell them they are going to stage a debate.

Team A will argue that individual factors are the most important influences when a woman is making an informed decision/choice.

Team B will argue that community influences are stronger/more important to a woman when she is making such a decision/choice.

Have the two teams write down all their arguments. They must also anticipate the arguments of the other side (opposition), so they can discuss how to counter those arguments.

Each team should then select two persons who will argue their team's position. Give each team 10 - 15 minutes to prepare their "case".

Step 5: The selected members of each team debate the issue. The rest of the participants become the audience, and at the end, comment on which influence they feel has a stronger impact on a woman's decision/choice concerning her reproductive health/family planning needs.

Step 6: After the debate, process the exercise by asking the following:

1. Which influence is stronger for most Malawian women, their personal condition or community influences?

CONTENT

METHOD

2. Which influence should be stronger? Why? What can you, as service providers, do to help women consider their own needs before those community influences?

4. Adoption process

This is a process of adopting a new health behaviour.

The Counsellor should be aware that decision making is a process, involving several steps abbreviated HICDARM.

1. Hearing: The person hears about family planning/ reproductive health related information.

2. Informed: The person is given details e.g. family planning methods or STD symptom recognition.

3. Convinced: The person is convinced that they do not want an unplanned pregnancy or STD infections/untreated STDs.

4. Decide: The person decides to seek help

5. Act: The person begins to use a method or take prescribed drug, and suggest that partner(s) do so too.

Step 7: Go through each step of the adoption process with participants (use a transparency or newsprint).

CONTENT

6. Reinforce: The person returns to the health facility with concerns and is given quality care.

7. Maintain: Person continues to use the method or completes treatment.

METHOD

Let's take an example to see how this step by step decision making/ behaviour change process can work.

Step 8: Read to the group the case study below and ask the participants to identify the steps:

Mrs Jonasi had a baby five weeks ago. Her friend from Blantyre visits and tells her that she is using the injection contraceptive.

Pause and ask; which step is this?

Response:

Heard

Mrs Jonasi visits the Health Centre in her village and is told about all the family planning methods available; their names, how they prevent pregnancy; their advantages; and disadvantages.

Pause and ask; which step is this?

Response:

Informed

She is convinced she does not want to become pregnant for at least six years because she has had three children.

Pause and ask; which step is this?

CONTENT

METHOD

Response:

Convinced

She decides to use the Copper T380A IUCD which can last up to 10 years.

Pause and ask; which step is this?

Response:

Decided

The provider examines her to ascertain suitability of the method for her, and then she has the IUCD inserted.

Pause and ask; which step is this?

Response:

Act/Adopted

She has some problems with heavy bleeding and returns to the Health Centre for consultations. She is reassured that this is normal.

Pause and ask; which step is this?

Response:

Reinforced

She goes back home happier, with her IUCD still in place and continues to use it.

Pause and ask; which step is this?

Response:

Maintained

CONTENT

The adoption process can be easily remembered using the abbreviation HICDARM which is visually illustrated on the right hand column.

The decision making ladder 'HICDARM'

Maintain
Reinforcement
Act/Adopt
Decide
Convinced
Informed
Heard

METHOD

Step 9: The facilitator explains that some people move through the adoption process faster than others. But all people who adopt a behaviour move through all the steps. The adoption process can be remembered using the abbreviation HICDARM.

However, ask if the decision making/behaviour change process is always a continuous climb up the ladder or stairs? For example, what would have happened at step 2 if, when Mrs Jonasi went to the clinic, the providers were rude to her and said they had no time to explain the methods and answer her questions?

Similarly, what could happen when she returns complaining of heavy bleeding and no one takes the time to explain to her why this has happened, that it's normal, and that she has nothing to worry about?

Possible response:

She asks for removal and/or returns to her village unhappy with her Family Planning choice at this point, she may not even be convinced of the usefullness of using a Family Planning method.

CONTENT

METHOD

Step10: Conclude this session by asking the participants the following questions:

1. What do you understand by the concept informed choice?

2. What do you understand by the concept informed consent?

3. Mention five factors that influence decision making.

4. How can service providers help ensure that clients make choices that are right for them?

HANDOUT

INFORMED CONSENT FORM
SURGICAL CONTRACEPTION CLIENTS

I _____, the undersigned, wish to have surgical
(print client's name)

contraception via _____,
(specify the procedure)

I make this request of my own free will, without having been forced or given any special inducement. I understand the following:

1. There are temporary methods of contraception I can use instead of surgical contraception for planning my family.

2. The procedure is a surgical one. As in all surgery, there are some risks, in addition to benefits, the details of which have been explained to me. I will be able to have sexual relations with my partner. I will continue to have menstrual cycles (female clients only).

3. The procedure should be considered permanent. However, no surgical procedure can be guaranteed to work on all people. There is a small chance of failure. If the operation is successful, I will be unable to have any more children.

4. I have applied for this procedure of my own free will without coercion or inducement I can change my mind and refuse the procedure and no medical health, or other services or benefits will be withheld from me as a result.

_____ _____
Signature or mark of client Date

_____ _____
Signature of attending physician or delegated assistant Date

_____ _____
Signature of spouse (if required) Date

If the client cannot read, a witness of the same sex and speaking the same language must sign the following declaration

I, the undersigned, attest to the fact that the client has affixed his/her thumb print or mark in my presence.

_____ _____
Signature or mark of witness Date

SESSION SUMMARY

SESSION 10 : **CLINICAL PRACTICUM**

TIME : **8 HOURS**

OBJECTIVES

By the end of the session, participants will be able to:

1. Counsel at least two clients
2. Give and receive feedback, using performance checklist
3. Observe three family planning special procedures during the practicum (if possible)

MAIN POINTS

1. Counselling real clients
2. Giving and receiving feedback, using performance checklist

PREPARATION AND MATERIALS

- Letters to the clinical area
- Transport arrangements and other logistical support
- Outside catering for meals (if necessary)
- Several sheets of performance checklists
- Feedback guidelines

REFERENCES

1. AVSC International: Family Planning Counselling - A. Curriculum Prototype, Trainers Manual, New York, 1995.

2. Family Health Services Project: Nigeria Three-Day Interpersonal Communication and Counselling for Family Planning, JHU/PCS and PATH, Ibadan, 1989.

3. National Family Welfare Council of Malawi (NFWCM): Family Planning Practioners Training Programme Curriculum, Blantyre Print and Publishing, Lilongwe, 1995.

SESSION OUTLINE

CONTENT

1. **COUNSELLING CLIENTS**

The following is a list of groups, from which clients can be selected, for counselling:

- Family Planning clients
- Men
- Adolescents
- Pregnant women
- Post abortion women
- Widows/divorcees
- Infertile couples
- STD clients
- Women with non supportive husbands

Preparations for the Practicum

Points to Note:

Effects that the trainee counsellors and Trainer could have on clients comfort, the efficiency of the clinic staff and client flow:-

The presence of the trainee counsellors and trainer increases the number of personnel to be accommodated at each counselling session: This may result in the following:

1. Violation of one of the basic principles of counselling which is to provide the client with privacy and confidentiality.

METHOD

Step 1: Divide participants into pairs. Each pair is accompanied by a Trainer for each counselling session.

Depending on available services and trainers, each pair will be assigned to counsel at least two clients from among the list in the left hand column.

Give each participant two performance checklists which they would use to assess and provide feedback. Trainer reviews the checklists with participants.

Encourage participants to keep records of all clients counselled and other services offered.

Step 2:Trainer asks what could be the possible effects of having a large number of people in a counselling situation. Co-facilitator writes responses on newsprint. Trainer ensure that responses include those in the left hand column.

CONTENT	METHOD
2. Difficulty on the part of the counsellor to establish a trusting relationship with the client. 3. Intimidation and anxiety on the part of the client and the councellor. 4. The practicum being less like a real counselling session.	
The role of observers must be spelt out: • Observers (including the trainers) must not interfere in the counselling 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 counsellor or client feel nervous. • The observer will assess the counsellor using a performance checklist on pages 10.10 - 10.11	**Step 3**:Trainer leads a discussion which highlights the role of the observers. Points in the left hand column should be emphasized.
	Step 4:At the facility the trainer holds a pre-clinical conference with trainees. The trainer reminds the trainees to use the knowledge and skills learnt in class and to remember GATHER, ROLES, and CLEAR during each counselling session in view of identification, reflection of feelings, decision making and stages of the adoption process.

CONTENT

2. **FEEDBACK**

To give participants self-confidence and a positive attitude for working on problem areas, feedback should begin by focusing on:

- the participants strengths
- problem areas identified as clearly and specifically as possible.
- observers should focus on behaviour that can be changed and information that can help the participant improve the quality of counselling

For example, saying that the participant's attitude 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.

METHOD

Trainer reminds trainees that in real life counselling they must put together all of what they have learnt in the past few days.

Step 5:During the discussion that follows the practicum, the trainer closely, monitors any feedback that the observer gives about the participant's counselling skills. The points in the left hand column should be emphasized.

Step 6:After the practicum, participants return to the training room. The trainer reviews the counselling process 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 counsellor.

CONTENT

METHOD

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.

3. **SPECIAL PROCEDURES TO BE OBSERVED DURING PRACTICUM:**

Step 7:The trainer explains that the participants are expected to observe special procedures during and after training (if the facility offers such services).

- Voluntary Surgical Contraception.
- Norplant insertion and removal (if possible).
- Intra Uterine Device - insertion and removal.

Observation of special procedures can help trainee counsellors to gain an understanding of such procedures so that they can explain them to clients. Examples of clinical procedures are listed in the left hand column.

Arranging Observation of Clinical Procedures

Step 8:The trainer makes arrangements with a clinic or hospital well in advance for the observations. 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 practicum. Every effort should be made to minimize the disruption of service delivery.

The trainer arranges for adequate transport and other logistical support.

CONTENT

Preparations for Observations of Special Procedures

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 client flow.

- It violates the principle of privacy and confidentiality.
- It may make both the client and /or clinician nervous.
- It may distract/interfere with the concentration of the clinician.
- Increases risk of introducing infection.

WAYS OF MINIMIZING THE IMPACT OF OBSERVERS' PRESENCE

Ways to minimize the impact of observers on service delivery or norms for behaviour during observation. Some sample norms are as follows:

- Observers do not interfere with 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 make notes, but they wait until after the client has left the room, to avoid making the client or the clinician(s) nervous.

METHOD

Step 9:Trainer asks what could be the possible effects of having observers, on the clients comfort and the efficiency of the clinic staff when conducting the special procedures. Trainer ensures that possible responses include the points in the left hand column.

Step 10:Trainer asks participants to list ways to minimize the impact of observers during the performance of special procedures or develop norms for behaviour during the observation.

Co-facilitator writes the responses on newsprint and ensures that the sample norms on the left hand column are included.

CONTENT

METHOD

Step 11:At the clinic or hospital, the trainer holds a pre-clinical conference where the 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 post observation discussion period.

Each group first observes the clinic staff in their interactions with the clients. In the procedures room or operating theatre, 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: pre-operative area, operating theatre and recovery room.

CONTENT | **METHOD**

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.

Step 12: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 procedures, 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.

The trainer concludes by asking the participants to:

- state what they learnt from the observations.
- state what could have been improved in the counselling process.

ADDITIONAL NOTES FOR THE TRAINER

ARRANGING A PRACTICUM

Arrangement should be made with the clinic in-charge 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 counselling 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.

If there are not enough trainers to sit in with each participant in the counselling session, a trained and experienced counsellor from the clinic staff may be substituted. This counsellor is briefed beforehand so that she or he understands her or his expected role.

The trainers need to arrange for transport and other logistical support.

INTERPERSONAL COMMUNICATION AND COUNSELLING (IPCC) PERFORMANCE CHECKLIST

Instructions:

You are to be observers of what takes place between the counsellor and client. Try to feel what it would be like if you were client. Determine how well the counsellor assisted the client. Place a tick (✔) in the appropriate columns Yes if task/activity is performed satisfactorily, in No for unsatisfactorily or N/D if not done and comment as appropriate.

	YES	NO	N/D	COMMENTS
1. Did the counsellor show a gentle and caring attitude to the client?				
2. Did the counsellor ensure visual and auditory privacy and confidentiality?				
3. Did the counsellor use verbal communication/counselling skills appropriately as follows? • Clarifying • Listening • Encouraging • Acknowledging • Reflecting and repeating				
4. Did the counsellor use non-verbal communication/counselling skills as follows?: • Relaxed • Open • Leaning towards the client, appropriately • Eye contact, as appropriate • Sit comfortably				
5. Did the counsellor Keep It Short and Simple?				
6. Did the counsellor respond to the client's needs and concerns?				
7. Was the counsellor comfortable in dealing with the client?				
8. Did the counsellor use the knowledge of STD and HIV/AIDS infection and contraceptive technology in assisting the client?				

	YES	NO	N/D	COMMENTS
9. Did the counsellor meet the client's needs effectively?				
10. Did the counsellor use the counselling process as follows: • Greet client • Ask client about themselves • Tell clients about family planning and other reproductive health issues • Help client to choose a family planning method • Explaining the use of chosen method • Return visit appointment made				

COMMENTS

.....

.....

.....

.....

NAME OF OBSERVER: .....

SIGNATURE OF PERSON OBSERVED: ..... **DATE:**.....

SESSION SUMMARY

SESSION 11 : **COUNSELLING POPULATION GROUPS WITH SPECIAL NEEDS**

TIME : **2 HOURS 30 MINUTES**

OBJECTIVES

By the end of the session, participants will be able to:

1. Identify population groups with special reproductive health and family planning needs.
2. Explain strategies for handling clients with special needs.
3. Demonstrate the ability to use interpersonal communication and counselling skills in counselling population groups with special needs.

MAIN POINTS

1. Identification of population groups with special reproductive and family planning needs.
2. Identification of strategies for handling clients with special needs.
3. Use of interpersonal communication and counselling skills in counselling population groups with special needs.

PREPARATION AND MATERIALS

- Newsprint and markers
- Chalkboard and Chalk
- TV and VCR
- Overhead Projector and transparencies
- Video Tapes:- Catch them young, Consequences, Its not easy, Living positively with HIV, The broken calabash, Why Mrs X died, Nigeria PARIAH, Dangerous numbers and More Time, etc.
- Flipcharts e.g. (Kabanja)
- Handouts: Additional information on client groups with special needs; Tips for Counsellors to consider when dealing with such clients; Facts about STDs, HIV and AIDS.

NOTE: **HANDOUTS SHOULD BE GIVEN ON THE NIGHT BEFORE AND PARTICIPANTS INSTRUCTED TO READ THEM BEFORE THE SESSION**

SESSION OUTLINE

CONTENT

1. **Identifying population groups with special reproductive health and family planning needs.**

   Very often counsellors encounter clients whose personal characteristics or circumstances require special consideration; this can affect their reproductive options. Counsellors must learn to identify clients with "special needs" and determine the counsellor's capacity for dealing with those needs.

   Identifying Clients with Special Needs

   - Men
   - Adolescents
   - Pregnant women
   - Post abortion women
   - Postpartum women
   - Widows/divorcees
   - Infertile couples
   - STD and HIV/AIDS clients
   - Women with non-supportive husbands
   - Mentally and physically disabled
   - Religious groups
   - Women with health problems or whose health will be jeopardised if they have another pregnancy or delivery.

METHOD

Step 1: Introduce this session with information in the left hand column and tell participants, that we will spend this session discussing strategies to meet the needs of special population groups.

Step 2: Ask participants to list some of the clients whom the provider may find "difficult", whose needs are out of the ordinary, who have not traditionally been served or who fall outside of the realm of a "typical" client profile.

Step 3: Write some of the "special client" groups on the board or newsprint, leaving space under each for comments. Make sure that, when the list is completed groups identified in the left hand column are included.

Step 4: Divide participants into teams of four. Ask each team to make statements about what typifies a particular client group. Assign each team two or three special needs client groups depending on how many are identified by the participants. The statement can be a value judgement, opinion (what seems to one as probably true), or "fact" the client believes.

Before they break into small teams, do one set of comments together.

CONTENT	METHOD
	Possible example: Under adolescent, participants might note any of the following: • Not accustomed to attending a clinic; • single: so some might think not deserving of services; • promiscuous: need special method considerations due to life style. **Step 5**:When teams have finished, one person should present, then the large group discusses the team's comments. **Step 6**: Stimulate discussion by asking: Are these statements true? Why or why not? Whose responsibility is it to find out and to distinguish between fact and opinion?
2. Strategies for Handling Clients with Special Needs a. <u>Whose need is it</u>? • Men b. <u>What makes them different</u>? • It's not their health that is affected. • Possible high-risk behaviour	**Step 1**: Explain the format we can use for developing strategies for handling clients with special needs: **Step 2**: Using men as our special group. a. Have participants discuss the special needs of this group. b. In what way is this client group diffferent from others and in what ways is it similar?

CONTENT

- Multiple partners especially in polygamous communities
- Not accustomed to visitng a health clinic unless they are ill.

c. What are their Informational Needs:

Information on transmission and prevention of STD, HIV and unplanned pregnancies

d. What should the counsellor do:

Provide information and be non-judgemental

METHOD

Ensure that participants' responses include those in the left hand column.

c. What are the client's informational needs?

Participants should be encouraged to use the information from Handout 1, 2 and 3 (given out to participants on the night before the session).

d. Imagine that you are a client in this category. Name the most important thing you want from your Family Planning counsellor.

Step 3:After completing the strategy for men together, divide participants into small teams and assign each team a client group for whom they will design a strategy.

Using the same format.

a. Whose need is it?
b. What makes them different?
c. What are their informational needs?
d. What should the counsellor do?

Step 4:Repeat the process for other groups with "special needs," that have not yet been addressed.

CONTENT	METHOD
	Make sure participants have a copy of Handout 2 "Tips to consider when dealing with clients with special needs".
	Tell them, this should help any other particular groups they may come across.
3. Demonstrate ability to use IPCC skills in counselling population groups with special needs	**Step 1:** Tell participants that they will now have an opportunity to counsel some "imaginary" clients with special needs. Remind them to use the GATHER process from Session 8 in counselling, as well as the handout on "Tips for counselling clients with special needs".
	Step 2: Divide participants into teams of three. Have one member of each team pick a situation from a hat/box/ container and then that team will role play the situation. The team takes turns playing the various roles; the observers should use the observation checklist from Session 8 to critique both verbal, non verbal communication skills and steps in the counselling process. Example of a situation: Charity aged 18 years has had unprotected sex with her boy friend and is now worried that she could get pregnant and have to drop out of school. She just started her period yesterday (Use the 10 short scenarios - see page 11.23).

CONTENT

METHOD

Step 3:After 15 minutes ask for volunteers to present their role play. Then discuss the situation and the approach taken by the counsellor.

Step 4: End the session by discussing the following:

1. Will you feel comfortable counselling clients with special needs?

   If "yes", Why?

   If "not", Why not?

2. If not, what can we do together to help you feel more comfortable?

HANDOUT 1

FACTS ABOUT STDs, HIV AND AIDS:

What is HIV?

HIV is Human Immunodeficiency Virus, the pathogenic organism that causes AIDS. HIV is found in body fluids of infected persons (particularly blood, semen and vaginal secretions; the virus has also been found in the breast milk of HIV infected mothers). It is believed that most or possibly all people infected with HIV will develop AIDS. HIV can be transmitted whether symptoms of AIDS are present or not.

What is AIDS?

AIDS is Acquired Immune Deficiency Syndrome, a condition caused by HIV, which attacks the immune system and renders it unable to fight disease and infection. AIDS is manifested by a number of symptoms, of which many, but not all, are visible. Even if the symptoms of AIDS subside for a while, the virus that causes them is still present and infected persons can still transmit the disease. AIDS is almost always fatal. At present there is no cure for AIDS.

How is HIV contracted?

HIV is contracted:

- Through unprotected sexual contact (anal, oral or vaginal intercourse) with an infected person.
- Through use of infected blood and blood products.
- Through use of skin-piercing instruments that have been in contact with infected blood/body fluids and have not been properly sterilized (needles, syringes, razor blades, circumcision instruments etc).
- In infants, from an infected mother during pregnancy or childbirth or through breast milk.

How is HIV not contracted?

HIV is not contracted through ordinary social contact, shared clothing, dishes, food, kissing, hugging, shaking hands, toilet seats, insect bites or touching or living with an infected person.

What are the symptoms?

Persons infected with HIV may be asymptomatic; it can take as long as 8 - 10 years between infection and the onset of AIDS. Once AIDS begins to develop, however, symptoms may include:

- An unexplained loss of weight within one month.
- Diarrhoea for several weeks
- A white coating on the tongue
- Enlarged or sore glands in the neck/or armpit.
- A cough that persists for more than a month.
- Persistent fever
- Discoloured areas on the skin

Since these symptoms characterize other diseases (a persistent cough may mean tuberculosis, diarrhoea may indicate an intestinal illness), only a test for the presence of HIV can confirm AIDS.

Who is at risk?

Anyone can become infected with HIV, but only through the means described above. Clients who are at high risk include prostitutes, persons who have multiple sexual partners or whose sexual partners have had sexual relations with others. Many women in Malawi are known to have contracted HIV in marriage; whereby the only risk factor, has been having sexual intercourse with the spouse. Users of intravenous drugs, persons who have received unscreened blood products and persons with STDs are also at high risk.

Who should be tested for HIV?

Anyone presenting with any of the symptoms of AIDS who fits the high-risk profile is a strong candidate for testing.

Anyone who wishes to have an HIV-test can receive counselling and testing at an anonymous centre for testing and counselling.

Can HIV infection and AIDS be prevented?

HIV infection and AIDS can be prevented by avoiding high-risk behaviour. The only way to be absolutely certain of avoiding HIV infection through sex is to abstain from sex. But in general the best advice is to:

- Keep one faithful uninfected sexual partner and remain faithful to him or her.
- Use latex condoms. Condoms are a wise choice for avoiding HIV infection, other STDs and pregnancy. They are even more effective when used with a spermicide.
- Avoid sharing needles or using any skin-piercing instrument that has not been sterilized.

The ABCs of HIV prevention are: Abstinence; Be faithful to one uninfected, faithful sexual partner; Consistent and Correct Condom Use

Advice for HIV infected persons

Clients who are infected or ill require special care, information and counselling. In general they should be advised to:

- Protect themselves against further infection from STDs (including reinfection with HIV) and other stresses on the immune system.
- Avoid passing the infection to others through sexual intercourse and use condoms and spermicides if they do engage in sexual relations. Inform their partner(s) of their condition before initiating intercourse.
- Continue to enjoy loving care and affectionate contact with partners, family members and friends. (The counsellor who is permitted to speak with the client's family and friend should stress this to them, also).
- Eat nourishing food.
- Get plenty of rest.
- Avoid pregnancy, both for the health of the client and to avoid passing the virus to the child.

HANDOUT 2

TIPS FOR HANDLING CLIENTS WITH SPECIAL NEEDS

1. GENERAL COUNSELLING TIPS

- Be non-judgemental.
- Ensure confidentiality.
- Encourage discussion of feelings and beliefs.
- Discuss career and life goals, and the advantages of finishing school in achieving the goals.
- Avoid lecturing; use open-ended and probing questions to promote discussion.
- Discuss risks of early childbearing and unsafe abortion.
- Discuss risks and means of transmission of STDs, including HIV/AIDS
- Explain reproductive anatomy, fertility and the process of conception.
- Discuss and dispel myths (unreliable means of preventing conception, who can and cannot catch STDs, etc).
- Use visual aids.
- Be especially gentle and explain each step during a young woman's first pelvic examination.
- Follow-up to ensure support and concern.

2. TIPS FOR INVOLVING MEN IN FAMILY PLANNING

To involve men in the family planning:

- Seek endorsement from community leaders.
- Use men as outreach workers to motivate and educate other men or arrange peer group teaching/learning sessions.

- Arrange clinic sessions in the evenings or on weekends at times convenient for men and working women.
- Make the clinics male friendly.
- Use visual aids that show male examples
- Find out the concerns of local men and emphasize the benefits of family planning in dealing with those concerns, for example wife's health, economic status, children's education.
- Encourage male clients to discuss their beliefs, doubts and concerns.
- Dispel misconceptions.
- Emphasize how men can be supportive of their partner's use of contraception such as helping to insert the diaphragm or reminding her to take the pill.
- Address men's stated concerns about family planning and female promiscuity by pointing out advantages of family planning, such as improved health and increased availability (to the husband) for sexual relations.
- Skeptical male clients can be encouraged to take responsibility for use of condoms or keeping and dispensing other methods, thereby keeping "control" of their partner's fertility. For highly motivated men, Natural Family Planning can be discussed as a method requiring mutual effort and promoting a closer relationship between the man and his spouse. Condom use and vasectomy should be discussed as effective male contraceptive methods.

3. **TIPS FOR HANDLING CLIENTS AT RISK FOR (OR WITH) STDS INCLUDING HIV/AIDS**

For high-risk clients:

- Encourage and praise behaviour that lessens the risk of infection.
- Assist the client in finding alternatives to high-risk behaviour.
- Be non-judgemental.

- Explain risks and dispel myths in an objective manner.

- If the client presents with any symptoms suggestive of AIDS, refer him/her for counselling and testing.

For infected clients:

- As always, ensure confidentiality.

- Encourage, support and praise the client for avoiding behaviour that puts others at risk.

- Encourage the client to discuss her/his fears and feelings.

- Encourage the client to continue all normal activities (except unprotected sexual intercourse) as long as he/she is healthy.

- Follow good interpersonal communication and counselling procedures.

- If appropriate, offer to discuss the client's condition and the nature of AIDS with his/her family and friends.

- Refer the client to a Counselling Centre, health facility or other community resource (clergy, traditonal counsellor, etc), if he/she is having difficulty managing the physical or psychological effects of the disease.

4. TIPS FOR HANDLING RELIGIOUS GROUPS

The counsellor should spend some time exploring and clarifying any personal biases that he/she may harbour. Beyond this the counselor has to follow some specific steps including:-

- Demonstrating respect and concern for the client.

- Reassuring the client that all religious groups are in favour of good maternal and child health practices.

- Pointing out and praising cultural practices that support reproductive health including family planning.

- Supporting the use of Natural Family Planning (NFP) by clients for whom this is the only option.

- Referring clients who wish to practice Natural Family Planning (NFP) to special Natural Family Planning specialists, where appropriate.

5. **TIPS FOR HELPING THE MENTALLY DISABLED**

The following considerations apply when dealing with mentally disabled clients:

- How severe the disability is.
- Who is responsible for the client.
- How much sexual activity is occurring.
- What is the competence or responsibility level of the client's partner.
- The client with a minor disability can learn about family planning if it is explained patiently and clearly using visual aids.
- The client's situation may indicate certain methods, including the injectable and /or NORPLANT® (which may also help the client by reducing or avoiding menstruation) and the IUCD. Whatever method is chosen , the client and her/his family must be taught about side effects and danger signs in case of problems.
- Make every effort to give such person simple illustrated instructions to take home with them and to share with care-givers.

6. **TIPS FOR UNDERSTANDING AND HELPING THOSE WITH HEALTH AND PHYSICAL CONSTRAINTS**

a. **Cardiovascular problems:**

Heart disease, stroke and high blood pressure are contra-indications for hormonal contraceptives.

b. **Diabetes:**

- Barrier methods or the IUCD may be the best choice for the client with diabetes, depending upon his or her life style.
- The Natural Family Planning methods (NFP) may be good but may have a high failure rate when menses are irregular.

- Hormonal methods may be appropriate because the diabetic needs a highly effective method, as another pregnancy may be contra-indicated.

c. **Reduced Mobility**

- Clients suffering from arthritis, spinal injury, paralysis may have limited mobility which would cause difficulty in the use of barrier methods, which involve manipulation. However, partners can be taught to assist with use of these methods.

  Reassure clients that, in general, their disability does not have to interfere with their sexual life.

  Counsel or refer clients whose injury or condition might be aggravated by sexual relations. For example, clients with spinal injuries may have to use alternatives to traditional sexual intercourse for example, mutual masturbation.

  Encourage and support the use of family planning by clients for whom childbearing would pose a hardship or a further threat to health.

7. TIPS FOR HELPING INFERTILE COUPLES

Family Planning so often focuses on preventing or spacing pregnancies such that the problem of infertility is often overlooked. Because infertility can create tremendous stress in individuals, it requires great sensitivity on the part of counsellors.

SPECIAL TIPS TO PROMOTE EFFECTIVE COUNSELLING:

- Ensure confidentiality.
- Encourage client(s) to relax.
- Sensitively explain causes while being careful to avoid "blaming" client or partner.
- Probe for possible causes, such as history of multiple sex partners or PID, impotence, nutritional status or stress. (This should be done when meeting with the partners separately).
- Meet with both partners (if client agrees).

- Refer if necessary, explaining examination procedure and possible treatments.

- Follow-up to ensure support and show concern.

8. TIPS FOR HELPING WIDOWS AND DIVORCEES

Many family planning providers are often hostile and unwilling to assist widows/divorcees with their reproductive health and family planning needs. These women may not have steady partners and therefore are at risk of unwanted pregnancies, STDs and HIV/AIDS. Special consideration should be given to providing these women with reliable methods for the prevention of pregnancies, STDs and HIV/AIDS.

Avoid moralizing about the woman's decision to use a contraceptive while she is still unmarried/single.

Provide adequate information for the client to make an informed choice of a contraceptive method.

If the client does not choose the condom, the counsellor should encourage her to use a condom in addition to any other chosen method (to prevent STDs and HIV).

9. TIPS FOR HELPING WOMEN WHOSE HUSBANDS DO NOT SUPPORT FAMILY PLANNING PRACTICES

In the past, in order to obtain family planning services within Malawi, a wife was required to show evidence of her husbands consent. This is no longer true (see Family Planning Policy and Contraceptive Guidelines for Malawi).

The provider should be cautious on issues of confidentiality. Perhaps the husband could be reached through male motivation programmes at home, at work and other meeting places.

Let the woman know that she can make an informed choice without her husband's approval.

10. TIPS FOR COUNSELLING POST-ABORTION WOMEN

Acceptance of contraception must not be a pre-requisite for treatment of abortion complications.

Depending upon the receptivity of the woman, counselling about family planning can be offered to the client while she is in the health facility after treatment for abortion through for example Manual Vacuum Aspiration (MVA); following care for complications; or at the follow-up visit. This should ideally be done when the woman is still more easily accessible in the gynae or female ward.

The counsellor approaches the woman at a quiet time when a private discussion is possible. The woman should not be sedated or experiencing considerable pain.

The counsellor ensures that the client understands she can become pregnant again before she has her next period. This is very important!!

The client needs to understand the grave dangers she subjects herself to when she undergoes a self inflicted or illegal abortion. Such procedures often lead to infertility so that the women (or young girls) cannot get pregnant when they so desire. This and other serious complications (anaemia and bleeding to death) can be avoided by selecting an appropriate method of contraception.

The counsellor 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 counsellor can give her referral information so that she can seek out contraceptive services at a later time or return if she is interested. However be sure to mention that if she has unprotected sex she may find herself with an unwanted pregnancy.

The counsellor 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 that women can pick them up without having to ask for them.

11. TIPS FOR HANDLING PREGNANT AND POST-PARTUM 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 (LAM)], can be an effective contraceptive if certain conditions are met: the woman breastfeeds the baby on demand, or the baby is receiving no other food or liquid besides breast milk, she has not yet menstruated, the baby is younger than six months. If a woman does not want to use LAM, she can use other contraceptive methods while breastfeeding but must not use Combined pills during the first six months.

Family planning counselling 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 labour 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 counselling. Labouring women are pre-occupied with their own pain and the birth outcome.

Unless the pregnant woman has expressed an interest in getting an IUCD or tubal ligation immediately after delivery, there is no reason to counsel during labour. Even if a woman is interested in the IUCD or tubal ligation immediately post- partum, providing counselling in early labour 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 counselling is not part of the labour and delivery team, since these staff members have other responsibilities and an unpredictable workload.

Providers may offer family planning counselling after delivery, while the woman is recovering and before she goes home with the new baby.

In the busy and crowded maternity wards, the counsellor will need to make special efforts to provide privacy and confidentiality for the women.

If the woman is not interested in talking about contraception, the counsellor 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.

ADDITIONAL INFORMATION: CLIENT GROUPS WITH SPECIAL COUNSELLING NEEDS

1. **FACTS ABOUT ADOLESCENCE AND SEXUALITY/REPRODUCTIVE HEALTH:**

Adolescents are especially susceptible to pressure from peers and sometimes from adults, to engage in sexual relations whether they feel ready or not. Because they may not feel ready to take responsibility for sexual behaviour or may be too young to have a clear sense of cause and effect, they may be less likely than other clients to aknowledge or act on the need for protection against STDs, HIV/AIDS and pregnancy. Family planning counsellors can help these clients by assisting them in clarifying their own views towards their sexuality and by assisting those who have decided to be sexually active in making informed contraceptive choices.

A 1993 Investigation of Community Based Communication networks of Adolescent Girls in rural Malawi for STD/HIV/AIDs prevention messages, revealed that girls are expected to wait to begin sexual relationship until they are 14 years of age but "nowadays one can find a girl of 12 or 13 already having sexual relationships".

Furthermore, the youth give the following reasons for having sexual intercourse:

- Pressure from the opposite sex.
- Pressure from friends and peers.
- Pressure through sexual desire.
- Pressure from family (mentioned by boys).
- Lack of money (girls)

A focus-group discussion on Sexual and Reproductive Health in Malawi (1995), where all young girls and young boys (participants) admitted having had sexual intercourse, the girls had seen condoms but they did not mention them as a means of protection from STDs. The younger boys expressed the belief that they were too young to impregnate a girl. In the same study the parents insisted that the children knew how babies are conceived and that condoms encourage sexual promiscuity and hence, the parents would not advice their children to use them. In the same study, some girls, who had had sexual intercourse, did not link sexual intercourse with either pregnancy or STDs.

Other girls knew about pregnancies from having seen a pregnant woman, but they did not know what caused the condition. In general, several studies show that there is, among youth, a widespread lack of knowledge about risks and consequences of sexual activity.

The National Family Planning Programme has been in operation in Malawi since 1992. During the intervening period, many lessons have been learnt from experiences locally and elsewhere. The following are excerpts of the Family Planning Policy in relation to the youth.

The Government of Malawi recognizes the risks of maternal, infant and child morbidity when pregnancies are too early, too many, too late and too frequent. Consequently the Government considers that family planning services should be made available to all those of reproductive age who seek the services regardless of marital status or parity, provided adequate counselling is given and there are no contra-indications.

In view of the increasing problems associated with adolescent sexuality and teenage pregnacies in Malawi, it is considered appropriate that Family Life Education should begin in families, in the primary school and continue at all levels of education with special effort being made to educate out-of-school children and youth.

All persons of reproductive age, regardless of marital status, shall have the fundamental right to determine for themselves how many children to have and when to have them based on informed consent.

Since pregnancy before the age of twenty (20) years places the health and welfare of the adolescent at risk, individuals and families shall be encouraged to delay the first pregnancy.

Women and men in the reproductive age shall be eligible to use family planning methods with or without the consent of relatives, spouse or partner. However, dialogue between relatives, partners and spouses will be encouraged.

2. MEN AND FAMILY PLANNING

Men are sometimes considered a neglected group in the area of family planning. They are "secondary" in most programs because reproduction and family planning are not seen as having direct consequences for their health and well being, and also because the aim of some programs is to give women control over their own fertility. In many parts of Malawi, men are thought to oppose modern family planning. Because men do exert influence on their wives' decision, their support and participation can make a big difference in the success of women's efforts to practice family planning. Encouraging male participation in the family planning process is a challenge to family planning service providers.

RELIGIOUS GROUPS

Clients whose religious affiliation or ethnic origin is different from the family planning provider's may constitute special needs cases because the provider must be especially aware of diferent values and possible biases. He/she may also be dealing with language barriers. If the client is a member of a minority group in the area, fears and doubts may interfere with the client's decision-making ability.

Some community-based solutions are to:

- Enlist the support of local religious leaders.
- Enlist satisfied clients of different ethnic groups or religions to act as interpreters, outreach workers and peer counsellors.
- Meet and discuss issues and concerns with members of the groups. Learn as much as you can about the culture so that you can assist clients in dealing with these issues.
- Seek out colleagues who belong to different ethnic or religious groups and exchange ideas for meeting client needs.

4. POST ABORTION WOMEN

- 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.

5. 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 clinic 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 stresses.

- 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, or during the postpartum period they may wonder if their spouses or partners are having sexual intercourse with someone else. 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.

The following situations depict clients with special counselling Needs.

1. Nagama is 35 years old and works at a supermarket. She is married with 3 children. Her husband wants more children and therefore does not want her to use any Family Planning method. She would like to wait until her youngest child is 4 years old before becoming pregnant; therefore does not want her husband to know that she is using a family planning method.

2. Jones is 30 years old and married. The couple has been married for three years now, has been trying to have a child but unfortunately they have not been successful.

3. Mrs Chambo is 36 years old. Her husband died two years ago. She does not have a steady sexual partner but has had several partners within the last few months. She is worried and comes to your clinic for help.

4. James and Mala are both 21 years old and still in school. They engage in sexual intercourse from time to time. Mala always gets worried about becoming pregnant everytime they have sexual intercourse.

5. Kangalude is 19 years old. He has had several episodes of chancroid and gonorrhoea. He has come to the clinic complaining of pussy urethral discharge for the past 2 days.

6. Nasoko has four children and does not want anymore. Her religious denomination vehemently protests against any form of modern family planning.

7. Nasimango is a young woman with three children. She just delivered a fourth child and as with the other three, was delivered through caeserian section.

8. Chimwemwe is a man of 39 years. He is married with 5 children. He wonders if he should become involved in family planning and discusses his concern with a CBD agent.

9. Melisa is a 29 year old single mother with 3 children. She does not know any of the children's fathers. She has been referred to the family planning clinic from the psychiatric hospital.

10. Mary is 17 years old and has just returned from theatre following an evacuation for an incomplete abortion.

SESSION SUMMARY

SESSION 12 : PROCUREMENT AND DISTRIBUTION OF INFORMATION, EDUCATION AND COMMUNICATION (IEC) MATERIALS.

TIME : 1 Hour 30 Minutes

OBJECTIVES

By the end of the session, participants will be able to:

1. Identify possible sources of Information, Education and Communication materials.
2. Explain the procedures for procurement of Information, Education and Communication materials.
3. State the importance of effective distribution of Information, Education and Communication materials.
4. Describe the problems associated with the distribution of Information, Education and Communication materials and possible solutions.

MAIN POINTS

1. Sources of Information, Education and Communication materials.
2. Procedures for procurement of Information, Education and Communication materials.
3. Importance of effective distribution of Information, Education and Communication materials.
4. Problems associated with the effective distribution of Information, Education and Communication materials and possible solutions.

MATERIALS

- Chalkboard and chalk
- Overhead Projector and Transparencies
- Newsprint and markers
- Some IEC materials

REFERENCE

1. MOH (HEU): Information, Education and Communication Messages and Materials Survey Report, Lilongwe, 1991.

SESSION OUTLINE

CONTENT

Sources of Information, Education and Communication materials

Information, Education and Communication materials may be obtained from a variety of sources and at different levels.

A. **Ministerial level:**

i) Ministry of Health and Population

Contact: The Officer Incharge at the Health Education Unit and the IEC Officer at the AIDS Secretariat.

ii) Ministry of Information.

Contact: The Research and Planning Unit.

iii) Ministry of Women, Youth and Community Services.

Contact: Community Based Population Project, Gender, Population and Development Project, Family Life Education for Out of School Youth and National Youth Council.

iv) Ministry of Agriculture and Livestock Development

Contact: Agriculture Communication Branch and Integration of Population IEC in Extension Services Project.

v) Ministry of Education, Sports and Culture.

METHOD

Step1: Ask the participants to identify the possible sources of Information, Education and Communication materials in Malawi. Co-facilitator writes responses on newsprint or chalkboard

Ensure that the participants' responses of sources of IEC materials includes those in the left hand column.

CONTENT **METHOD**

Contact: Malawi Institute of Education

B. **Regional Level:**

i) Regional Health Offices

Contact: Regional Health Education Officers

ii) Information Offices

Contact: Regional Information Officers.

iii) Regional Community Development Offices

Contact: Regional Community Development Officers.

iv) Agriculture Development Divisions (ADD)

Contact: nearest ADD

- Shire Valley
- Blantyre
- Machinga
- Lilongwe
- Salima
- Kasungu
- Mzuzu
- Karonga

Contact: Integration of Population IEC in the Extension Services.

CONTENT | **METHOD**

C) **District level:**

i) District Health Offices

Contact: District Health Education Officers.

ii) District Information Offices

Contact: District Information Officers

iii) District Community Development Offices

Contact: District Community Development Officers.

iv) Extension Planning Areas (EPA)

Contact: Development Officers

v) District Youth Offices

Contact: District Youth Officers

D) **Other Sources**

i) NGOs - Banja la Mtsogolo (BLM), Malamulo Hospital-Makwasa etc

ii) Parastatal - National Family Planning Council of Malawi (NFPCM)

CONTENT	METHOD
iii) Educators can also produce their own materials locally as the need arises.	
Procedures for Procurement of Information, Education and Communication materials	**Step2:** Ask the participants to explain how they procure Information, Education and Communication materials for their respective facilities.
Ministry of Health and Population (Health Education Unit (HEU) stocks most of the Information, Education and Communication materials needed.	Co-facilitator writes on chalkboard/newsprint all the responses from the participants.
i) Regional Health Offices order from the HEU	If the responses do not include all the sources listed in the left hand column find out why and lead a discussion on how to improve the procurement system.
ii) Districts order Information, Education and Communication materials from the Regional offices	
iii) Health centres order from District Health Offices	
iv) Community Based Services request from the health centre e.g. youth clubs, CBDAs and other support groups.	
3. **Importance of effective distribution of IEC materials.**	
Effective distribution of IEC materials will:	
a) facilitate timely use by the intended audience while the information is still applicable.	**Step 3:** Divide the participants into small groups to brainstorm and discuss:
b) reduce the chances of IEC materials going to wrong target groups.	the "Importance of effective distribution of IEC materials. Reporter records all responses on newsprint.

CONTENT

4. Problems associated with effective distribution of Information, Education and Communication materials

a) Information, Education and Communication materials are distributed on an ad hoc basis.

b) Transport may not be available for the distribution of Information, Education and Communication materials.

c) The materials may not be available at certain levels when requested.

d) No system developed for ordering and distribution of IEC material.

Some ways and means to overcome the problems associated with effective distribution:

a) Develop a systematic way of distribution at all levels.

b) Main sources of Information, Education and Communication materials for example MOHP should maintain regular stocks of Information, Education and Communication materials that are frequently in high demand.

METHOD

Step 4: Reporters from the different groups will report to the large group.

Step 5: Divide the participants into small groups to brainstorm and discuss:

a) the "Problems associated with the distribution of IEC materials".

b) the "Ways to overcome the problems".

- Reporter records all responses on newsprint.
- Reporters from the different groups will report to the large group.

CONTENT

c) The family planning providers should liaise with the Information, Education and Communication officer regularly to influence the availability and distribution of the Information, Education and Communication materials.

METHOD

Step 6: Conclude this session by asking:

1. What have you learnt about the importance of IEC materials distribution?

2. What have you been doing before which can now be improved through what you have learnt in this session?

SESSION 12

HANDOUT

PROCUREMENT AND DISTRIBUTION OF IEC MATERIALS

A. **Ministerial level:**

i) Ministry of Health and Population

Contact: The Officer In-charge at the Health Education Unit and IEC Officer at AIDS Secretariat .

ii) Ministry of Information.

Contact: The Research and Planning Unit.

iii) Ministry of Women Youth and Community Services.

Contact:
- Community Based Population Project
- Gender Population and Development Project
- Family Life Education for Out of School Youth
- The National Youth Council

iv) Ministry of Agriculture and Livestock Development

Contact: Agriculture Communication Branch, Integration of Population IEC in Extension Services Project

v) Ministry of Education, Sports and Culture

Contact: Malawi Institute of Education

B. **Regional Level:**

i) Regional Health Offices

Contact: Regional Health Education Officers

ii) Information Offices

Contact: Regional Information Officers.

iii) Regional Community Development Offices

Contact: Regional Community Development Officers

iv) Agriculture Development Divisions (ADD)

Contact nearest ADD

Shire Valley
Blantyre
Machinga
Lilongwe
Salima
Kasungu
Mzuzu
Karonga

Contact: Integration of Population IEC in Extension Services Project

C) **District level:**

i) District Health Offices

Contact: District Health Education Officers

ii) District Information Offices

Contact: Information Officers

iii) District Community Development Offices

Contact: Community Development Officers.

iv) Extension Planning Areas (EPA)

Contact: Development Officer's

v. District Youth Offices

Contact: District Youth Officers (Family Life Education Project)

D) **Other Sources**

i) NGOs - Banja la Mtsogolo (BLM)
- Malamulo Hospital (Makwasa) etc.

ii) Parastatal and Others- National Family Planning Council of Malawi (NFWCM).

::::) Educators can also produce their own materials locally as the need arises.

ANNEX 1

INTERPERSONAL COMMUNICATION AND COUNSELLING TRAINING MANUAL

PRE-TRAINING QUESTIONNAIRE

Name: . . . . . .

Address: . . . . . .

Occupation/Designation: . . . . . .

Telephone: . . . . . .

1. Why do you think you were invited to attend this course?

. . . . . .

. . . . . .

. . . . . .

2. Is counselling an important component of your work?

Yes..... No.....

If yes, describe what counselling tasks you perform.

. . . . . .

. . . . . .

. . . . . .

3. Have you ever participated in any IPCC Training before?

Yes..... No.....

If yes, where?.....

.....

When?..... For how long?.....

4. What content was covered during that course?

. . . . . .

. . . . . .

. . . . . .

5. What are your expectations for this course?

. . . . . .

. . . . . .

. . . . . .

ANNEX 2

INTERPERSONAL COMMUNICATION AND COUNSELLING COURSE

PRE-TEST

Name : .....

Date : .....

Time : **One Hour**

1. List the components of the Communication Process?

   i) .....

   ii) .....

   iii) .....

   iv) .....

   v) .....

2. List three barriers to effective communication.

   i) .....

   ii) .....

   iii) .....

3. Briefly explain three strategies to overcome them.

   i) .....

   ii) .....

   iii) .....

4. The abbreviation "ROLES" can remind you of non-verbal communication skills. What do the letters stand for?

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5. The abbreviation "CLEAR" can remind you of verbal communication skills. What do the letters stand for?

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Tick the right response to the following statements:-

		True	**False**
6.	The Counsellor should choose a method for the client.	[ ]	[ ]
7.	After vasectomy a man cannot have an erection.	[ ]	[ ]
8.	The Counsellor tells the client how to use a method correctly.	[ ]	[ ]
9.	Contraceptive methods make one to become promiscuous	[ ]	[ ]

10. The Counsellor tells the client about all the available family planning methods [ ] [ ]

11. Breastfeeding can be effective for family planning for at least six months post delivery, if a woman is not menstruating and is exclusively or nearly fully breastfeeding. [ ] [ ]

12. Sexually active adolescents should not be given contraceptive methods. [ ] [ ]

13. What does IEC stand for?

i) .....

ii) .....

iii) .....

14. List any three examples of family planning IEC materials

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15. List two possible sources of any IEC materials.

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16. What are the two methods that family planning providers can use to assess effectiveness of a group discussion on reproductive health talk.

i) .....

ii) .....

17. List six steps of the counselling process.

i) .....

ii) .....

iii) .....

iv) .....

v) .....

vi) .....

18. List six qualities of a good counsellor.

i) .....

ii) .....

iii) .....

iv) .....

v) .....

vi) .....

19. In each pair, which is the better way of asking a question? (Please circle)

a) "Are you worried about using hormonal injectable method?" **or**
b) "How do you feel about using hormonal injectable method?"

a) "What do you know about the IUCD?" **or**
b) "Have you heard of the IUCD?"

a) "Do you remember what to do if you miss one pill?" **or**
b) "What will you do if you miss one pill?"

20. In the following conversations, which provider's response is better? (Please circle)

Conversation One:

Client: "I've been waiting to see the doctor for two hours. Will I have to wait forever?!"

Response A: "The doctor has been very busy. Please sit down, and I'll call you when it's your turn."

Response B: "I understand you're angry. Two hours is a long time to wait. Let me check to see how much longer it will be."

Conversation Two:

Client: "But if the injectables make my menstrual periods stop, I might get sick."

Response A: "Oh, there's nothing to worry about. You won't get sick just because your menstrual periods stop."

Response B: "Tell me why you might get sick if your menstrual periods stop."

ANNEX 2

INTERPERSONAL COMMUNICATION AND COUNSELLING COURSE

POST-TEST

Name : .....

Date : .....

Time : **One Hour**

1. List the components of the Communication Process?

   i) .....

   ii) .....

   iii) .....

   iv) .....

   v) .....

2. List three barriers to effective communication.

   i) .....

   ii) .....

   iii) .....

3. Briefly explain three strategies to overcome them.

   i) .....

   ii) .....

   iii) .....

4. The abbreviation "ROLES" can remind you of non-verbal communication skills. What do the letters stand for?

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5. The abbreviation "CLEAR" can remind you of verbal communication skills. What do the letters stand for?

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.....

Tick the right response to the following statements:-

		True	**False**
6.	The Counsellor should choose a method for the client.	[ ]	[ ]
7.	After vasectomy a man cannot have an erection.	[ ]	[ ]
8.	The Counsellor tells the client how to use a method correctly.	[ ]	[ ]
9.	Contraceptive methods make one to become promiscuous	[ ]	[ ]

10. The Counsellor tells the client about all the available family planning methods [ ] [ ]

11. Breastfeeding can be effective for family planning for at least six months post delivery, if a woman is not menstruating and is exclusively or nearly fully breastfeeding. [ ] [ ]

12. Sexually active adolescents should not be given contraceptive methods. [ ] [ ]

13. What does IEC stand for?

i) .....

ii) .....

iii) .....

14. List any three examples of family planning IEC materials

.....

.....

.....

15. List two possible sources of any IEC materials.

.....

.....

.....

16. What are the two methods that family planning providers can use to assess effectiveness of a group discussion on reproductive health talk.

i) .....

ii) .....

17. List six steps of the counselling process.

i) .....

ii) .....

iii) .....

iv) .....

v) .....

vi) .....

18. List six qualities of a good counsellor.

i) .....

ii) .....

iii) .....

iv) .....

v) .....

vi) .....

19. In each pair, which is the better way of asking a question? (Please circle)

a) "Are you worried about using hormonal injectable method?" **or**
b) "How do you feel about using hormonal injectable method?"

a) "What do you know about the IUCD?" **or**
b) "Have you heard of the IUCD?"

a) "Do you remember what to do if you miss one pill?" **or**
b) "What will you do if you miss one pill?"

20. In the following conversations, which provider's response is better? (Please circle)

Conversation One:

Client: "I've been waiting to see the doctor for two hours. Will I have to wait forever?!"

Response A: "The doctor has been very busy. Please sit down, and I'll call you when it's your turn."

Response B: "I understand you're angry. Two hours is a long time to wait. Let me check to see how much longer it will be."

Conversation Two:

Client: "But if the injectables make my menstrual periods stop, I might get sick."

Response A: "Oh, there's nothing to worry about. You won't get sick just because your menstrual periods stop."

Response B: "Tell me why you might get sick if your menstrual periods stop."

ANNEX 3

INTERPERSONAL COMMUNICATION AND COUNSELLING COURSE

PRE-TEST/POST TEST ANSWER GUIDE

1. **List the components of the Communication process**

   i) Sender
   ii) Message
   iii) Channel
   iv) Receiver
   v) Feedback

2. **List three barriers to effective communication**

   i) Age, religion, attitude, culture, marital status, knowledge of subject matter etc.

3. **Explain three strategies to overcome them**

   i) Session 3: Pages 3-11 to 3-14

4. **The abbreviation "ROLES" can remind you of non-verbal communication skills. What do the letters stand for?**

   i) Relax
   ii) Open
   iii) Lean forward
   iv) Eye contact
   v) Sit comfortably

5. **The abbreviation "CLEAR" can remind you of verbal communication skills. What do the letters stand for?**

   i) Clarify
   ii) Listening
   iii) Encouraging
   iv) Acknowledging
   v) Reflecting/repeating

Tick the right response to the following statements:-

		True	False
6.	The counsellor should choose a method for the client	[ ]	[✔]
7.	After vasectomy a man cannot have an erection	[ ]	[✔]
8.	The counsellor tells the client how to use a method correctly	[ ]	[✔]
9.	Contraceptive methods make one to become promiscuous	[ ]	[✔]
10.	The counsellor tells the client about all the available family planning methods	[✔]	[ ]
11.	Breastfeeding can be effective for family planning for at least six months post delivery, if a woman is not menstruating and exclusively or nearly fully breastfeeding	[✔]	[ ]
12.	Sexually active adolescents should not be given contraceptive methods	[ ]	[✔]

13. **What does IEC stand for?**

    i) Information
    ii) Education
    iii) Communication

14. **List any three examples of family planning IEC materials**

    i) Posters
    ii) Leaflets
    iii) Flipcharts
    iv) Picture codes
    v) Flyers etc

15. **List two possible source of any IEC materials**

MOH&P, RHO, DHO, NFPCM, AIDS, NGO's, Like BLM, CHAM etc.

16. **What are the two methods that family planning providers can use to assess effectiveness of a group discussion on reproductive health?**

i) Question and Answer
ii) Return demonstration

17. **List six steps of the counselling process**

i) Greet
ii) Ask
iii) Tell
iv) Help
v) Explain
vi) Return visit

18. **List six qualities of a good counsellor**

i) Good listener, patient, trust worthy
ii) Genuine, honest, understanding
iii) Non-judgemental, flexible
iv) Active listener, accepting
v) Respectful, sensitive to clients
vi) Needs etc.

19. **In each pair, which is the better way of asking a question: (Please circle)**

b) • How do you feel about using the hormonal injectable method?

a) • What do you know about the IUCD?

b) • What will you do if you miss one pill?

20. **In the following conversations, which provider's response is better? (Please circle)**

Conversation One

Client: "I've been waiting to see the doctor for two hours. Will I have to wait for ever".

Response **B.** "I understand you're angry. Two hours is along time to wait. Let me check to see how much longer it will be.

Conversation Two

Client:	"But if the injectables make my menstrual periods stop, I might get sick."
Response **B.**	"Tell me why you might get sick if your menstrual period stop."

ANNEX 4

REPORT WRITING FORMAT

At the end of each training session the trainers will write a comprehensive report which should contain the following:-

- Introduction
- Names of participants, cadre, duty station and the year they were trained as provided
- Course's daily proceedings
- Pre and Post Test results
- The course evaluation results including the participants' general comments
- Conclusion, to include constraints, strengths and any mechanisms to follow-up on course graduates.

Note: *Financial and course reports at the end of the training should be sent to the appropriate funding agencies.*