

## SESSION 7

**TOPIC:** Group Talks and Effective Presentations

**TIME:** Ninety Minutes; with additional practice time

**OVERALL GOAL:** Go through the process of presenting group talks and create ideas for innovative outreach into communities.

**OBJECTIVES:** By the end of this session, participants will have:

1. Listed three reasons to use group talks to promote reproductive health;
2. Identified how to relate health talk topics to clients= needs;
3. Practiced organizing a health talk using a lesson plan;
4. Used IEC materials and effective presentation skills to deliver a health talk.

**SUMMARY:** Participants will learn the process of developing and implementing an effective group talk and have the opportunity to practice these skills with each other. They should also come away with creative ideas for outreach in the communities.

Session at a Glance			
TOPIC	TIMING	METHODS	MATERIALS
1. Introduction	5 Min	Discussion	Visual Aid 7.1
2. Conducting community outreach: Why and What?	10 Min	Discussion	Handout 7F
3. Relating topic to clients= needs	15 Min.	Exercise, group discussion	Visual Aid 7.2
4. Organizing Health Talks	15 Min.	Discussion	Handouts 7A
5. Using IEC materials and presentation skills to deliver health talks	40 Min.	Small Group Practice/ Simulation	Handout 7B, 7C, 7D, 7E
6. Summary and application	5 Min.	Discussion	

### #1 EFFECTIVE PRESENTATIONS

Health care providers must understand that effective presentations are one of the important aspects of giving information to clients in reproductive health services. This session will address the ways of improving group education talks.

### **TRAINER=S NOTES**

Individual providers may use different presentation styles. Most styles are acceptable as long as it helps clients learn. Methods of presentations should take into consideration assumptions and beliefs on how adults learn and what facilitates learning. The provider has the responsibility to make decisions regarding the content of the talk and for acting as a resource for the clients. Clients make the decision on how, when or whether the ideas presented in the talk will become part of their decisions and daily life. Presentation techniques therefore become important for the provider. This session discusses ways of making presentations interactive and effective.

#### **What makes an effective presentation?**

An effective presentation is **one that achieves its goal : -to increase knowledge, persuade people or encourage action.**

An effective presentation has a clear single message that provides coherence and impact. While presentations will often have many points, one achieves clarity when a single key message provides a framework around which audiences find meaning.

### **#2 CONDUCTING COMMUNITY OUTREACH: WHY AND WHAT?**

- ❖ What do you think the provider=s role is in the community?
- ❖ What role does the provider play in promoting reproductive health in the community?
- ❖ How does this help the community? The provider?
- ❖ Who do you think the most important groups to talk to would be? Why?
- ❖ What are the reasons for service providers to conduct community outreach?

#### **Motivating People about Reproductive Health**

Motivation means the provision of information that encourages and eventually results in a behavioral change in an individual or group.

- ❖ Motivation is a process based on a "felt need," or a realization that a change is necessary. If a person or group of people is convinced that making a change will benefit them, they will make that change.
- ❖ In reproductive health, motivating clients/members of the community means encouraging them to obtain more information about the benefits of proper child care and maternal health procedures as well as the benefits of modern family planning methods and eventually the use of a method.
- ❖ Health care providers have an especially important role in motivating clients/members of the community.

## **Promotion of Reproductive Health**

Promoting reproductive health in the community is the responsibility of ALL health care providers. Each health facility should have their own written work plan or "strategy" for carrying out regular promotional/IEC (information, education, communication) activities in the community every month. A health talk at LEAST once a week is needed to make a difference.

### **Types of audiences include:**

- ❖ community leaders
- ❖ school leaders
- ❖ parents
- ❖ youth/adolescents
- ❖ teachers
- ❖ men=s groups
- ❖ women=s groups
- ❖ religious leaders/religious groups
- ❖ other health care provides
- ❖ traditional healers
- ❖ social groups
- ❖ factory workers

### **Reasons for conducting community outreach to promote reproductive health:**

- ❖ Dispel misconceptions, rumors and false beliefs about family planning by educating people about the safety of modern family planning methods and the advantages of planning the timing and number of children (spacing births).
- ❖ Turn negative attitudes about family planning/reproductive health into positive ones by increasing awareness that modern family planning saves the lives of women and children.
- ❖ Encourage women and their families to use methods that meet their needs by educating couples about their right to decide freely and responsibly the number and spacing of their children.
- ❖ Inform members of the community what services are available and where.
- ❖ Change behaviors which put members of the community at risk, such as the transmission of HIV/AIDS and other STDs.

Providers should try to be creative in promoting family planning and services. Take the opportunity to get to know your community better. The health team can carry out activities such as (Handout 7F):

- ❖ health fairs (get each school/community group to have a table with a different theme)
- ❖ sporting events (especially good for adolescents and for men)
- ❖ concerts/song contests
- ❖ puppet shows (especially good for younger children)
- ❖ film shows (show educational videos with popular films)
- ❖ exhibitions/community festivals
- ❖ competitions: give prize for the best poster, essay, song, etc. promoting family planning.

- ❖ Dances

Local business and groups can be asked to sponsor these events, contribute prizes, and participate.

### #3 RELATING THE TOPIC TO CLIENTS= NEEDS

**Different groups of clients need different information.**

**Service providers need to be sure to relate health topics to clients= needs.**

Not all topics will be relevant to all the people attending that day

What information is needed about the intended audience **before** giving a presentation or conducting a talk?

It is important for providers to know the characteristics of their intended audience before designing a talk. In other words: **Who** are they? **What** do they know? **What** do they **want/need** to know?

Find out the audience=s characteristics:

- ❖ Level of family planning knowledge
- ❖ Attitudes
- ❖ Culture
- ❖ Religious beliefs
- ❖ Educational level
- ❖ Average family size
- ❖ Approximate ages

This information can be collected by:

- ❖ conducting a community analysis (such as a survey);
- ❖ asking a representative(s) of the intended audience;
- ❖ recalling family planning questions that they have been asked during previous talks.

Other ways to identify your possible **sources** of audience's informational needs **before** planning a talk include:

- ❖ Review recent research reports conducted in the area, such as Demographic Health Survey Reports or a focus group discussion reports.
- ❖ Examine clinic records and registration books for common problems and the average age of clients.
- ❖ Observe common trends in the community. Which questions are frequently asked?

What kinds of problems have been seen recently by you and other community leaders?

- ❖ Review the cultural and social characteristics of the community. What is the social background of your audience? What are their religious beliefs? What is the average family size?
- ❖ Discuss with influential people in the community

## #4 ORGANIZING HEALTH TALKS

Review Handout 7A

Why evaluate health talks?

- ❖ Why is it important to evaluate a group talk?
- ❖ When should a service provider evaluate a group talk?
- ❖ What are the two methods a service provider can use to assess the effectiveness of a group talk?

For long term evaluation, they should review client records to see if the number of family planning acceptors is increasing.

Evaluation is an important part of the communication process.

**WHY?** It is important to evaluate a group or motivate talk because it helps the Provider to:

- ❖ assess the audience=s understanding and interest;
- ❖ analyze audience needs in preparation for future talk(s);
- ❖ improve the organization and delivery of future group talks;
- ❖ assess the impact or effectiveness of the talk and determine if the objectives were met.

**WHEN?** Point out to participants that they can evaluate their talk before preparing it, at the beginning of the group or motivation talk, during the talk and at the end of it.

**HOW?** Providers can evaluate their talk by doing either an informal or a formal evaluation. In carrying out an informal evaluation, the agents should:

- ❖ observe the audience=s nonverbal communication;
- ❖ listen to the statements that group members make to assess their level of understanding and interest; even by asking questions (open-ended);
- ❖ ask the group what they intend to do as a result of the talk.

## #5. USING IEC MATERIALS AND PRESENTATION SKILLS

Review Handout 7B, 7C, and 7D

### ***Presentation Exercise***

Prepare a 10 minute health education session using the AGroup Talk Outline@ or ALesson Plan.@" data-bbox="111 147 888 166"/>

#### **A. When planning for presentations prepare adequately in advance:**

1. The content - what you want the clients to learn.
2. Prepare outline of major and sub-points. These should help you during the presentation. Avoid writing notes and reading them to the audience. Be natural!
3. Identify and prepare IEC materials you will use.
4. Decide on mode of presentation - how you will make your major points understood?
5. Decide on ways to make the presentation interactive.
6. Practice/rehearse presentation and make sure you have enough time for the content.

#### **B. Other presentation tips include:**

1. Present information in a natural way, be yourself.
2. Maintain physical and psychological contact with clients. e.g., make presentation while standing or sitting at edge of table so that you can see all the clients. Maintain eye contact so that clients can feel that you are interested.
3. Avoid distracting clients by using IEC materials that are unrelated to the topic.

Use Handout 7E to record their observations. After each presentation, allow a *brief* discussion to share their observations and reactions to the work. Use checklist as a major reference.

## ***STEPS IN CONDUCTING A GROUP TALK***

### **Step 1. Assess the Audience's Information Needs**

### **Step 2. Plan the Talk:** There are several steps Providers should follow in order to plan a talk:

*Prepare and design the talk objectives:* What are the goals of the talk? What should the audience know about family planning at the end of the talk?

*Prepare an outline of the talk:* Write out step by step how you will present the information. See the '>Group Talk Outline' below.

*Plan the timing of the talk:* Is the talk planned at a convenient time for the selected audience? Make sure it is not too long.

*Choose or confirm the venue:* Is the location convenient for the selected audience? Is it comfortable and free of too many distractions?

*Select and prepare appropriate visual aids:* Use pictures if you want to keep an audience's attention and reinforce information. A picture is worth a thousand words! A demonstration is perhaps worth more !!! If you do not have access to prepared visual aids, try your hand at making some of your own and at the very least use contraceptive samples.

*Design questions to stimulate and evaluate the talk:* People love to talk and well thought out questions will stimulate your audience to participate in discussion. It will also help you to know whether they understand and are learning what you want them to learn.

### **Develop the Content Using the Group Talk Lesson Plan**

By following these steps, the Providers will be able to decide which information is the most important to include in the talk. It will also help them to use questions to stimulate discussion, and to bring the most appropriate visual aids. The group talk outline should include the following:

Topic: Every talk should have a main topic or subject - for example, infertility, or pills and bleeding, or the benefits of a small family, or breast-feeding. A talk is likely

to be successful if the topic is well defined.

**Objectives:** Every good talk has a purpose or an aim which is derived from the audience's information needs. For example, if the audience is a group of breast-feeding women, then one of the objectives might be to help them decide what family planning method to use and when to start.

**Audience:** The outline should state who the intended audience is. For example it may be husbands, women with infertility problems, new family planning clients, or adolescents.

**Main Points:** The talk should cover the most important items of information about the topic. Each main point will probably have several sub-points as well.

**Questions for Discussion:** Throughout the talk, there should be questions that can be asked to stimulate discussion around the main points.

**Visual Aids:** A good talk is not complete unless it is accompanied by visual aids. These should be used to illustrate key points and to help make concepts and ideas more clear. The outline should also identify which booklets or pamphlets will be given to the members of the audience after the talk.

### **Step 3. Conducting the Talk**

Talks are most interesting when they are no longer than 20 minutes, well organized, and involve the audience.

One of the best ways to involve the audience is to encourage discussion. Providers need very good listening, questioning, paraphrasing and summarizing skills to facilitate discussions. Following is a list of steps that you should follow when conducting a group talk:

- ❖ Introduce yourself and the topic of the talk;
- ❖ Encourage group participation;
- ❖ Guide and stimulate discussion;
- ❖ Encourage participants to respond to each other's questions;
- ❖ Give clear, correct information and answers, using relevant visual aids;
- ❖ Establish eye contact;
- ❖ Use simple, clear, culturally accepted and understandable language.

**Stay calm.** All speakers experience nervousness, some of which creates a feeling of excitement that is advantageous to most presentations. At a certain point, though, symptoms of anxiety can be counterproductive to the presentation's success, so you should note the following:

Adequate preparation is the best way to stay calm. It will help you to become >message-conscious' rather than >self-conscious.'

In most instances, the audience wants the speaker to succeed.

**Develop presence.** Presence is that quality which a speaker has which draws attention and which can be developed. A presenter who has it will exhibit many of the following qualities:

- ❖ a pleasant appearance;
- ❖ the effective use of body language including natural, open gestures;
- ❖ a well-paced delivery style, with effective use of the pause for emphasis and reinforcement; a well-pitched voice, loud enough to be heard well without being grating or obnoxious;
- ❖ a genuine enthusiasm and sincerity;
- ❖ effective eye contact with the audience;
- ❖ a natural, relaxed style that puts the audience at ease;
- ❖ structure the presentation.

**Structure of the Talk.** Explain to participants that a good talk must have a structure or a sequence to it. Every talk therefore has the following parts:

*An effective opening:* The opening sets the tone for the presentation and can >make or break' it.

A good opening will:

- ❖ capture the audience's attention;
- ❖ orient the audience to the facilitator's presentation style;
- ❖ raise the comfort level of the audience; and
- ❖ introduce the topic.

Any number of techniques such as personal anecdotes, jokes or relevant questions can be used as an opening and to warm up the audience.

*The purpose of the talk:* Providers should tell the people what they are going to talk about. Basic information should be worked into the opening or presented immediately afterward. This helps to set expectations.

*The main body of the talk:* This comprises all the information that needs to be given during the talk. It may be organized as a list of major points, each with supporting evidence including facts, figures, examples and rationale for the presentation.

*The closing:* The end of the talk is the most important elements of the entire presentation. It should summarize or restate the most important points, and contain a benefit statement which explains to the audience why the talk is of personal importance to them. It is what they will remember the most, the last impression.

*Questions for Discussion:* Providers should have several questions ready for the group to discuss,

if that is part of their plan.

*Use IEC materials:* The effective use of IEC materials aids encourages the audience to make greater use of their senses. Providers should use visual aids to make their talks more interesting and lively.

**Facilitating Group Discussion.** During a group discussion, it is important for the Provider to ensure that group members can see and hear each other and consider themselves as equal partners in the discussion. Providers can help to achieve this atmosphere if they ask the participants to sit in a semi-circle or circle. The Provider should:

- ❖ give group members a chance to contribute;
- ❖ acknowledge other's contributions;
- ❖ avoid taking sides when settling conflicts;
- ❖ know and be friendly with individual members;
- ❖ summarize important points.

The Provider should ensure that all members' opinions are respected and that no member dominates the discussion. The provider can discourage dominating personalities from speaking all the time and encourage the quiet ones to talk by saying something like, >Yusef, we've already heard a lot from you on this subject today. Let's hear what Sunday has to say.'

Questions are a facilitator's most powerful tool. People cannot avoid thinking, even when asked a hypothetical question. Providers should know what questions they want the group to answer, and encourage people to share their knowledge and experience (Wambui, you have expertise in this area, what do you think...?). Key questions can be found in the goals of the discussion.

The Provider should encourage discussion in the group by asking open-ended questions. These are questions that cannot be answered by a simple one-word answer such as yes or no. The Provider must realize that although he or she may have more family planning knowledge, group members know their own lives and problems much better.

If a participant asks a question, the group leader should direct the question back to the group to see if any one can answer it. The group leader should also:

- ❖ summarize key points of the discussion when necessary;
- ❖ build on the participants' contributions;
- ❖ draw in the shy members and prevent the talkative ones from dominating the discussion.

#### **Step 4. Evaluating the Group Talk**

Evaluation is an important part of the communication process. You should know why it is important to evaluate a group talk, when the agents should do this and how it could be done.

WHY? It is important to evaluate a group talk because it helps the Provider to:

- ❖ assess the audience's understanding and interest;
- ❖ analyze audience needs in preparation for future talk(s);
- ❖ improve the organization and delivery of future group talks;
- ❖ assess the impact of the talk and determine if the objectives were met.

WHEN? Point out to the Providers that they can evaluate their talk before preparing it, at the beginning of the group or motivation talk, during the talk and at the end of it.

HOW? Providers can evaluate their talk by doing either an informal or a formal evaluation. In carrying out an informal evaluation, the agents should:

- ❖ observe the audience's nonverbal communication;
- ❖ listen to the statements that group members make to assess their level of understanding and interest;
- ❖ ask the group what they intend to do as a result of the talk.

If Providers want a more formal evaluation, they should:

- ❖ ask their supervisor to observe them while conducting a group talk and give feedback;
- ❖ have group participants complete a questionnaire following the talk to assess their understanding and interest in the topic and how they would rate the facilitator's performance.

***GROUP TALK OUTLINE***

1. <b>Topic of the talk:</b>
2. <b>Audience:</b> (Describe the people who will hear the talk.)
3. <b>Objective(s) of the talk:</b> (What do you want the audience to know or do after the talk?)
4. <b>Main points:</b> (What are the most important points of your talk?)
5. <b>Questions for discussion:</b> (What questions can you ask the audience to stimulate discussion?)
6. <b>Visual aids:</b> (What posters, flip charts, pamphlets, or models will you use to illustrate the main points?)



***GROUP TALK LESSON PLAN***

CLINIC/COMMUNITY NAME:
TOPIC:
AUDIENCE:
PURPOSE:
Objectives
Major Points
Order of Presentation
Teaching Method
IEC Materials
Evaluation

## ***ADVANCE PLANNING FOR GIVING GROUP TALKS***

- \_\_\_\_\_ Prepare notes for the presentation. Help the audience keep track of what you are saying by organizing the points clearly.
  
- \_\_\_\_\_ Think about the words you will use. Use short sentences and words. Avoid long, drawn-out descriptions, jargon, family planning abbreviations, and technical language. Keep your illustrations brief and to the point.
  
- \_\_\_\_\_ Time the talk so that it is not longer than 15 minutes.
  
- \_\_\_\_\_ Write a list of questions to stimulate discussion and evaluate the talk.
  
- \_\_\_\_\_ Prepare your flip charts in advance if possible. Don't use light-colored markers, as they are not visible from a distance. If you are presenting to a large group, use large print, and do not write on the bottom quarter of the page.
  
- \_\_\_\_\_ Take markers and masking tape with you if you anticipate needing them. Take sufficient numbers of printed materials or handouts with you.
  
- \_\_\_\_\_ If someone is introducing you, you may want to write out suggested ideas for him or her to use. Your suggestions can include >rapport builders' with your audience, such as a common group membership, past contact with them, or your knowledge about the community.
  
- \_\_\_\_\_ Check the room or place where the talk will be given. Choose a quiet place with enough space. Ideally, the arrangements of the room should be for the comfort of the participants. However, you may have no control over how the participants are arranged, although you can make changes in where you will stand. You do not want to be too distant from the nearest member of the audience.
  
- \_\_\_\_\_ If you are using a microphone, make sure it is in good working order so that you do not have to tap it or make adjustments after you begin.
  
- \_\_\_\_\_ Position visual aids where you want them. If you are showing a film, make sure the screen is in the proper position and that the projector is functioning properly.

***CHECKLIST FOR OBSERVATION OF A GROUP TALK***

Check off each behavior observed during the group discussion.

1. Assessment and Preparation:

- \_\_\_\_\_ Introduces topic
- \_\_\_\_\_ Asks questions to assess participants' interest and level of understanding of the subject
- \_\_\_\_\_ Has outlined the talk, including objectives, main points, and discussion questions

2. Facilitation of the Discussion:

- \_\_\_\_\_ Encourages audience participation
- \_\_\_\_\_ Uses open-ended questions
- \_\_\_\_\_ Answers questions clearly
- \_\_\_\_\_ Adjusts the topic to suit the participants' expressed interests and concerns
- \_\_\_\_\_ Uses appropriate visual aids to illustrate important points
- \_\_\_\_\_ Paraphrases and summarizes participants' statements
- \_\_\_\_\_ Maintains eye contact with all group members

3. Evaluation:

- \_\_\_\_\_ Asks questions to assess the quality of the talk

4. Additional Comments:

## ***Song Contest***

1. **Select a health topic** for the song contest. Some ideas are: The importance of family planning, where to get services, who to talk to about family planning.
2. **Discuss the idea** with local decision-makers. Be sure you have their support.
3. **Choose a date and venue** for the song contest. Will it be part of a local festival or a stand-alone event? Be sure to allow plenty of time for planning and preparations. You will need to begin preparations at least one month in advance.
4. **Write a list of key points** that should be mentioned in the song. Use information cards, leaflets and other IEC materials to help you choose your key points. Don't include more than two or three key points. Give a copy of this list to all people interested in composing a song.
5. **Advertise the song contest.** Make posters. Contact songwriters and singers in your community. Hold an information meeting to give interested participants information about the contest and facts about the health issue you want them to sing about.
6. **Select judges** for the song contest. Ask community leaders, health workers and other respected community members to judge the contest. Ideally, you want a panel of 3-5 judges.
7. **Find prizes** for the song contest winners. Ask your community business leaders if they can donate prizes for the song contest. You need to decide who will receive a prize: all entries, or only the winning song? Be sure to explain to them the importance of the contest and how they will benefit from it. Be creative. The prizes do not have to be grand.
8. **Make a list of all the arrangements** you need to make before the contest. Include the following: arrange the venue, advertise the contest, collect the prizes, confirm the judges will attend, confirm who plans to sing at the contest, and collect all the materials you will need to make the contest run smoothly (chairs, paper for judges= notes, sound system, etc.).
9. During the contest you may want to **tape-record** the entries to use the songs at a later date during a health or mother=s club meeting.

## *Sports Event*

### **One week before the match:**

1. Find out from the community which game is the most popular. Maybe you can find a match that is already being organised and just modify it to include health education.
2. Find men and women or youth who are willing to take part in the match. You may want one team of women and one of men, or adults versus youth.
3. Explain to them that the purpose of the match is to bring people together to listen to an important health message. Ask them to volunteer to participate. Let them understand it is the community's own initiative, and not one from the outside.
4. Fix a day, time and venue with team members.
5. Find referees and make rules for the game.

### **Making rules for the game:**

Every effort should be made to help the women's team win the match. So rules must be made to help the women win. New rules will make the game more exciting. Some examples are:

#### *Football*

The goalkeeper on the men's side cannot use his hands to catch the ball. If he uses his hands, the women are awarded a spot kick.

The men can kick the ball only with their left leg. If the men use their right leg, they are given a yellow card. Two yellow cards equal a red card.

When a man fouls a woman, it is not an offence.

#### *Tug of War*

There should be twice as many women as men. If the women need help, more women can join the team.

6. Make sure people are aware of the events. Announce the event at meetings and make posters. Use some type of gong to alert them on that day.
7. Personally invite all the community leaders to the match. Maybe they can provide prizes.
8. Ask the leaders to choose a match commissioner.

**The Match:**

9. Make the rules of the game known to both teams just before the game starts.
10. The referees must be careful to make sure that the men follow the new rules. If playing football, the first half should last no longer than 30 minutes.

**Giving the Health Talk:**

11. After the competition (before prizes are awarded), start the education programme with a speech from an opinion leader. Use as many teaching materials as possible. Allow time for comments and questions. If you are playing football, the health talk should be given during half time. If you are playing tug-of-war, give the health talk between matches.

**Awarding Prizes**

12. At the end of the matches, prizes can be awarded to the players. If you are giving a health talk on family planning, condom packages can be made into garlands or Amedals@ and given to the captains of both teams.

## *Community Festivals*

1. Work with the health group and community members to identify a health issue to address during the health festival.
2. Decide on a theme for the health festival. Examples of themes are: AGo today for Family Planning, @ AThere is a method best for you!@
3. Set the objectives you want to achieve during the health festival.
4. Inform the community leaders of your plans to gain their support.
5. Decide on which day or days the festival will take place. Plan the festival to take place at the same time as other events or visits by important people.
6. Involve as many people and groups as possible in the festival.
7. Contact schools and local groups. Ask them to take part in the festival by doing a drama, poster competition, or demonstration.
8. Invite local health officials to attend.
9. Contact other community members well ahead of time if they are expected to take part and donate money and materials.
10. Inform the community with posters, announcements at meetings, and if possible, newspaper and radio announcements.
11. Use a mixture of health education methods to make the health festival interesting: role-plays, dramas, health talks, displays, demonstrations, etc.
12. After the festival, have a community meeting to thank everyone for taking part.
13. Plan follow-up activities to keep the level of community interest high.

### **For existing festivals and special events:**

1. Select a health issue that you want your community to address
2. Introduce the problem and try to make it a priority for the festival planners if they do not already recognise it as a problem.
3. Contact the festival planning committee and ask for space on the program. Ask to include a

message in the speeches of key speakers.

4. Keep constantly in touch with the planners to ensure that the space and key messages remain on the program after every major meeting and review of the festival program.
5. Create opportunities for the item and program to be publicised.
6. Make yourself readily available to be consulted on the messages, space and any related issues for explanations.
7. Participate in the festival and monitor how your messages are delivered, how it is received and immediate reactions of the audience. Use these for improving any future involvement.

### **Setting up a Health Stand at a festival:**

1. Discuss educational activities with the festival planning committee and request a place in the festival grounds.
2. Set tables and arrange educational materials
3. Decorate stand with posters, banners, etc.
4. Arrange with the Master of Ceremonies of the main events to announce the presence of a health education/information stand.
5. Provide correct and adequate information on health-related issues demanded by the visitors to the stand.
6. Give out leaflets and pamphlets to your audience.

## SESSION 8

**TOPIC:**        **Interpersonal Communication and Counseling: Special Populations**

**TIME:**        **Ninety Minutes; with additional practice time**

**OVERALL GOAL:** Participants should gain insights into their own views on special populations and treat clients with special needs respectfully and non-judgmentally.

**OBJECTIVES:**        By the end of this session, participants will have:

1. Describe the unique characteristics of post-abortion clients and adolescents and men;
2. Describe the distinctive concerns of these special populations;
3. Describe the specific counseling issues of these special populations.
4. Practice effective counseling with unique audiences: men, adolescents and post-abortion women.

**SUMMARY:** Participants will identify the unique characteristics and needs of special populations: men, post-abortion women and adolescents. They will practice counseling with these types of clients through role-plays. Emphasis should be on creating a safe environment for participants to make mistakes and learn as they develop the skills.

<b>Session at a Glance</b>			
<b>TOPIC</b>	<b>TIMING</b>	<b>METHODS</b>	<b>MATERIALS</b>
1. Introduction	15 min.	Discussion Individual exercise	
2. Special Needs	30 min.	Small group, plenary discussion	Visual Aid 8.1 Flip charts
3. Counseling clients from special populations	30 min.	Discussion	Handout 8A
4. Challenging Moments in counseling	30 min.	Discussion Group Exercise	Handout 8B
5. Practice	30 min.	Role plays	Handout 8C
6. Summary	15 min.	Discussion	

## #1 INTRODUCTION

Youth Exercise

## #2 SPECIAL POPULATIONS WHY ARE THEY SPECIAL?

What is a special population with regard to family planning. Special populations are those who:

- ❖ are likely to be overlooked by traditional family planning approaches; and
- ❖ have unique characteristics
- ❖ have specific needs.

Members of certain client groups have something in common either because they are at a particular time in life (adolescents), they are of the same gender (men), or they are going through a particular life experience (having a baby, having an abortion). Understanding common experiences and needs of these different groups can lead to more sensitive and appropriate counseling.

Specialized counselors are not needed to work with special populations. However, counselors at sites that offer particular services may be more likely to see certain clients than are other counselors. For example, facilities that serve pregnant and postpartum women need to consider how to counsel these clients, whereas sites that have no prenatal or maternity services will have little contact with these clients.

The skills and attitudes needed for counseling clients from special populations are the same as those needed for other kinds of clients. All the skills learned in this training still apply, as do the basic principles and steps of counseling.

### **Steps to successful counseling across social differences:**

- 1. Awareness of our attitudes and values about these clients.**
- 2. Knowledge of the needs of special populations**
- 3. Skills to balance biases and stereotyping.**

The attitudes needed when counseling clients from special populations, such as empathy and openness, are the same as those needed for all clients. However, some counselors find that they may not feel comfortable working with certain populations. This is often a function of exposure and practice. Or they find that their own values come into play with certain client groups, such as postabortion women or adolescents or men. It is important for counselors to be aware of any views they hold about different types of clients, so that they do not let those views interfere with treating clients respectfully and nonjudgmentally.

Counselors do need additional knowledge to counsel special populations. For example, they need to know which contraceptive methods are appropriate to use while breastfeeding, or they need to know the typical concerns of adolescents or men have serious misconceptions about some family planning methods.

**Counselors must remain non-judgmental**, putting themselves in their client's shoes. Our attitudes, values and perceptions greatly influence how we counsel clients. If we allow our attitudes and values to impose themselves on our counseling relationship, it is unlikely that we will attain our primary goal of helping the client.

For this workshop, we will focus on postabortion women, adolescents and men.

### #3 COUNSELING SPECIAL POPULATIONS

#### *Small Group Brainstorm*

§ What are the special **characteristics** and **needs** to consider in counseling  
a) Postabortion women, b) Adolescents and c) Men?

#### *Large Group Discussion*

Findings:

#### **Postabortion 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, and/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, especially if she induced the abortion herself.
- ❖ The woman may be worried that her efforts to terminate her pregnancy will be discovered.
- ❖ Women who have just had an abortion may be especially concerned about confidentiality.
- ❖ A woman who became pregnant because her method failed may be distrustful of

contraception.

- ❖ Women often do not realize that their fertility will return soon after abortion. A woman can ovulate within two weeks after an abortion.

## **Adolescents**

- ❖ Adolescents undergo physical, emotional and hormonal changes that influence their sexuality.
- ❖ Adolescents' sexual activity is often unplanned and infrequent.
- ❖ Adolescents are risk takers and often believe that unfortunate events happen to other people, not themselves. With respect to sexuality, adolescents often take emotional risks as well as risks related to pregnancy and STDs.
- ❖ Adolescents may deny that they are sexually active (especially girl, as this may not be acceptable by their culture or family). For this reason, they may not want to plan for sexual activity by acquiring contraception. They may find it easier to accept sexual activity if it "just happens."
- ❖ Adolescents' sexual activity is often based on needs outside of sex--for instance, their need for approval or affection or acceptance.
- ❖ Adolescents are particularly susceptible to peer influences.
- ❖ Some adolescents may want to get pregnant.
- ❖ Unmarried adolescents tend to be particularly concerned about privacy. They may be afraid to go to a family planning clinic for fear they will see someone they know there.
- ❖ Adolescents worry that their parents or friends will find out they are using contraception.
- ❖ It may be culturally unacceptable for young unmarried men and women to go to family planning clinics.

## **Men**

- ❖ Men need to encourage and support women's use of family planning methods or use family planning methods themselves
- ❖ Men often have less information or are most likely to be misinformed about FP methods, male and female anatomy and reproductive functions because they tend to talk less about these issues than women.
- ❖ Men are often more concerned about sexual performance and desire than women.
- ❖ Men ask more sensitive and difficult questions, seek the counselor's opinion more often and raise broader issues: economic difficulty, politics, social issues, rumors.
- ❖ Men seldom directly state the needs, purposes or expectations on the visit. They often indirectly indicate needs by asking questions or stating opinions, placing the responsibility on the provider to interpret or respond.
- ❖ Men have serious misconceptions and concerns that FP methods will negatively impact their sexual pleasure and/or performance.

- ❖ Men are often concerned that women will become promiscuous if they use FP.
- ❖ Men do not know how to use condoms correctly.
- ❖ Men are not comfortable going to a Health facility, especially if it serves women primarily.
- ❖ Men do not discuss about FP with their partners
- ❖ Men usually dominate the decision over the right of women to use FP methods

### #3 COUNSELING CLIENTS FROM SPECIAL POPULATIONS

Suggestions for counseling these special populations.

#### **Postabortion Women**

- ❖ Acceptance of contraception must not be a prerequisite for abortion services or treatment of abortion complications.
- ❖ Depending upon the receptivity of the woman, counseling about family planning can be offered to the client before the abortion, while she is in the health facility after abortion, or at the follow-up visit.
- ❖ The counselor approaches the woman at a quiet time when a private discussion is possible. The woman should not be sedated or experiencing considerable pain.
- ❖ The counselor ensures that the client understands she can become pregnant again before she has her next period.
- ❖ The counselor avoids moralizing about the unintended pregnancy or about the woman's decision to have an abortion.
- ❖ If the woman is not interested in talking about contraception, the counselor can give her referral information so that she can seek out contraceptive services at a later time or return if she is interested.
- ❖ The counselor needs to determine whether the pregnancy was the result of contraceptive failure, since this may influence the woman's interest in using contraception or the information she may need to use a method effectively.
- ❖ For women who do not want to discuss family planning, condoms and spermicides can be placed at various locations in the health facility so women can pick them up without having to ask for them.

#### **Adolescents**

- ❖ Adolescents may be most comfortable with methods that are unlikely to be detected (such as injectables, Norplant implants, or IUDs), that are used only at the time of sexual intercourse (such as condoms or spermicides), or that are easily obtained (such as condoms).
- ❖ Health care providers often need to set aside special places or times to accommodate adolescents' needs for privacy.

- ❖ Adolescents can be counseled in places where they gather, such as schools, clubs, or community centers.
- ❖ Adolescents can be trained to serve as peer educators.
- ❖ The counselor does the following:
  - ◆ Helps adolescents understand that they will be sexual beings their whole lives; they do not have to try, understand, or perfect everything now.
  - ◆ Avoids harsh moralistic lessons against sex.
  - ◆ Presents realistic views of relationships, marriage and parenthood.
  - ◆ Helps adolescents who are not ready for sex learn how to say no. Role playing or practicing conversations can be an effective here.
  - ◆ Fills in gaps in adolescents' knowledge about reproduction and sexuality.
  - ◆ Is prepared to listen to or raise issues about adolescents' sexuality: self-esteem, appearance, being "normal" within their peer group, pressure from peers or partners.
  - ◆ Makes condoms easily available, even for those who do not receive counseling.

## **Men**

- ❖ Men need encouragement to support women's use of FP methods or use FP methods themselves
- ❖ Counselors should clarify myths and rumors about FP methods during encounters with clients
- ❖ Counselors should always demonstrate correct condom use, using a model when possible.
- ❖ Providers should bring the information to places where men gather such as work places, bars, sporting events, to discuss FP whenever possible.

Answer Handout 8.B Personal perceptions, values and attitudes for youth, for adolescent and for Men.

If they do not have enough time, they can finish the questions after the session is over.

### **#4 CHALLENGING MOMENTS IN COUNSELING**

Developing awareness of our own particular dislikes, blind spots or fears about making counseling mistakes or dealing with unexpected situations can prepare a counselor to handle difficult moments.

Every counselor deals with inevitable surprises as well as nightmare moments. They are definitely challenging moments. The skill lies in how the counselor recovers from these situations.

**Some difficult issues with clients:**

- ❖ Silence
- ❖ Client does not stop crying
- ❖ Client believes there is no solution to their problem
- ❖ Counselor makes a mistake
- ❖ Counselor does not know the answer to the factual question
- ❖ Client refuses help
- ❖ Client is uncomfortable with the counselor's gender, age, ethnic group etc.
- ❖ Counselor is uncomfortable with the client's gender, age, ethnic group etc
- ❖ Counselor can not establish good rapport
- ❖ Counselor and client know each other socially
- ❖ Client talks continuously and inappropriately
- ❖ Client asks personal questions to counselor
- ❖ Counselor is embarrassed by subject matter

See Handout 8.B Challenging Moments in Counseling.

#### #4 PRACTICE

##### *Role Play*

Ask participants divide into teams of three, triads. Each team gets role-plays (Handout 8C). Participants will select **three** of the counseling situations. For each situation they choose, one participant will play the service provider, another the client and the third will observe. With each new situation participants should change roles. At the end, each participant has played each part once. The observers should provide feedback to the service provider at the end of each situation.

Some volunteers can discuss the experience. What was difficult? What was easy? How was this experience different or similar to previous role-plays? How did you feel as the provider? How did you feel as the client? What will you do differently in your counseling of these special populations when you return to your clinic?

## #5 SUMMARY

Recap the main points and objectives of the session. Ask participants to share one new insight they gained from this session that they hope to apply to their work.

### Exercise: Retracing our Youth

While we may not have experienced an abortion, we have all been adolescents. It may be useful to remember what that was like and remind ourselves that we were not much different from today's teens when we were young. Ask participants to get comfortable in their chairs. Ask them to close their eyes and just listen to you. They are not to answer the questions, but rather think about them. You will read the following slowly. Allow participants time to think in their minds.

*"We are all adults, but for a moment let us go back in time. Take yourselves back 10 years. What were you doing? Were you married? Did you have children? What kind of work did you do?"*

*Now go back a few more years. Were you married? Who was president? What was happening in your community?"*

*Now go back to when you were 15 years old. What did you look like? Did you have long hair, short hair, dark hair? Were you slim? Who were your friends? What did you like to do? Were you in school? What were your concerns?"*

*Did you care about your looks? How others thought of you? Did you notice the opposite sex? Did you have a boyfriend/girlfriend? What were your parents like? Were they strict? Did they talk to you about the changes in your life? What was your opinion of adults?"*

*What was your body like? Was it changing? Were you menstruating/having wet dreams? Who talked to you about sex and relationships? What were your feelings about these issues? Was this a happy time? A confusing time? A difficult time? Why?"*

*Now, I want you to remember those thoughts and feelings. Let us slowly move forward in time. You are now in your 20's...you are now back to the present day. Slowly open your eyes."*

Ask if anyone would like to share any insights they gained in this exercise. Remind participants that we have all been in the shoes of our adolescent clients. They need our compassion, care and guidance.

## **SPECIAL CHARACTERISTICS AND NEEDS**

- § What are the special characteristics and needs to consider in counseling:
  - § Postabortion Women
  - § Adolescents
  - § Men





**Personal perceptions, values and attitudes (men)**

1. What perceptions, values and attitudes do I hold that help when I counsel men?

2. What perceptions, values and attitudes do I hold that may hinder when I counsel men?

3. Ways I can balance the perceptions, values and attitudes that hinder my effectiveness during counseling with men?

## CHALLENGING MOMENTS IN COUNSELING

### CHALLENGING MOMENTS IN COUNSELLING

**1. Silence** - The client is unwilling or unable to speak for some time. This is common among clients who are very anxious or angry. If it happens at the very beginning of a session it is best for the counsellor to, after a little while, gently call attention to it, saying perhaps: "I can see that it is a bit difficult to talk (*reflect feeling*). It's often that way when someone first comes to see me. (*Validation*) I wonder if you're not feeling a bit anxious?" Or, alternatively, if the silence seems an angry one (e.g. the client is looking away from you) you might say "You know sometimes when someone comes to see me who doesn't really want to be here, they decide not to say anything. I wonder if that's how you're feeling?" These statements should be followed by another period of silence, with the counsellor looking at the client and maintaining body language that indicates a sympathetic interest.

Sometimes silence will occur in the middle of a session. In those circumstances the context is very important, and the counsellor will have to judge why it has occurred. It may be because the client is finding it very hard to make an admission of a secret, or that he or she is unhappy with how the counsellor has just reacted to something. Generally it is best to wait, as it is crucial that the client makes the effort to express his or her feelings or thoughts, even though the counsellor may initially find it uncomfortable. There are times when a silence is simply the result of thoughtfulness on the part of the client. There is no need to break the silence nor to indicate in any way that it is not acceptable.

**2. The Client Cries** - A client who starts to cry or sob may make the counsellor uncomfortable. A natural response is to try to stop it, perhaps by comforting the client, but that is usually not best in the counselling session. Crying may occur for different reasons. For some it is a very helpful release of emotion, and an appropriate response is to wait for a while, and if it continues say that it is all right to cry, it is a natural reaction when you feel sad. This gives them permission to express their feelings. The crying will usually cease in a little while. Crying, however, sometimes occurs for another reason. It can be used to elicit sympathy or to stop any further exploration. It may be a way in which the client is trying to manipulate the counsellor much the way he or she will do it at home. Again, it is best to let the client cry, indicating that although you are sorry they feel sad, it is nevertheless a good thing to express their feelings. If the client is being manipulative it will soon come to an end, with the client learning that the counsellor cannot be manipulated in the same way that others have been.

Some counsellors in some cultures will want to comfort the client by touching him or her. While it may be appropriate, touching a client, especially of the opposite sex, should be treated with

extreme caution. There are several reasons for this. If the difficulties a client is experiencing are sexual in nature, touching the client, even in a relatively non-sexual way (such as on the hand, or on the shoulder), it may be misinterpreted and frighten the client. The decision should be appropriate to the culture as well as to the gender and age of the counsellor and client, but it is important that a professional - not social - relationship be established.

**3. The Counsellor Believes there is No Solution to the "Problem"** - This is an anxiety often expressed by trainees and results in their becoming "stuck", i.e. not knowing how to proceed. It is important to remember that the primary focus of counselling is on the person, not the problem. Even the most intractable difficulties, including the recognition by a client that he is homosexually-oriented when he doesn't wish to be; a young girl wanting to have an abortion when it is impossible to obtain one; or even a person facing untimely death in the knowledge that she/he has become infected with the HIV virus, do not mean that the counsellor cannot help the client. One of the most appropriate ways to deal with a client who insists on a solution to the problem as he or she defines it, is to say that while you may not be able to change some things, in your experience it is always helpful to get to know the person better, and sometimes the perspective on things changes. In practice sessions, it is not uncommon for a participant role-playing a counsellor to quickly make some mistaken assumptions. A girl is anxious about what has happened with her boyfriend. The counsellor quickly jumps to the conclusion that she is pregnant. An adolescent hints at incestuous feelings. The counsellor assumes sexual intercourse has taken place, etc. The more the client is able to explore him or herself, the more possibilities will exist for dealing with the difficulties, including their underlying causes.

**4. The Client Threatens Suicide** - This is perhaps the most anxiety provoking situation for a counsellor. Most young people who threaten suicide do not commit suicide, but are nevertheless desperate enough to cry out for attention in this way. There are some things one needs to remember. It is virtually impossible to stop anyone from committing suicide who wishes to do so. A panic reaction on the part of the counsellor may be more frightening to the client than a measured one. It is appropriate to say that while no one can stop a person from taking their own life, you would feel terribly sad if that were to happen. You are just getting to know each other and you see much that you like and admire in the client. Those who commit suicide are often hopeless. They feel that they have no relationship with anyone who cares. The lifeline that the counsellor throws to the client is that he or she does care and that may give them sufficient hope to continue living.

Some young people threaten suicide in a manipulative fashion to get their own way. They are equally in need of help but must be shown that there are other ways to get the attention and concern they need. A client who has very little self-esteem will not believe that anything but a threat of suicide will matter to others--perhaps it has worked in the past, but it should not work in the same way with the counsellor. A comment indicating positive feelings about the client, not about the threat, is the most valuable approach.

It is not uncommon for such a threat or hint of suicide to occur just at the end of a session. The reason for this is that the client feels "safe" enough to raise it because she/he knows the session is

about to end and will not have to talk about it at the time. It is best for the counsellor to indicate that what the young person has said is very important, that you are glad he has been willing to share his feelings with you on such an important issue, and that he come to the next session. It is then important to confirm the next session with the client. An inappropriate reaction is to panic and say "if you feel that way, don't go, we had better do something about it right away." Even if you prolong the session at that point, it may communicate panic and not be as helpful as the measured reaction that expresses concern and faith that the client will return.

Because suicide is so tragic in the young, each counsellor will have to make his or her own judgement as to the best way to deal with it. The better the rapport with the client, the less likely it is to occur, so that much emphasis needs to be placed from the very outset on the establishment of that rapport. It is the best protection against suicide in the client.

**5. The Counsellor Makes a Mistake** - There are many ways in which the counsellor can make a mistake. He or she may make a factual error about something the client has said earlier. The counsellor may provide some incorrect information. The counsellor may become inappropriately embarrassed or angry at something the client has said. The single most important rule in establishing a good relationship with the client, the kind of relationship that you want him or her to have with other people, is to be honest. Basic respect for the client is one of the key principles of counselling. That respect and confidence in the client can be best demonstrated by admitting that you have been mistaken. An apology is appropriate if you were wrong. Factual errors are easiest to deal with. You might say: "I am sorry, I'd forgotten that you told me you have a younger brother." If you do something which you regret--perhaps getting angry at a client who is being provocative, it is also appropriate to acknowledge that. You might say: "You know, a moment ago when you said that you didn't see how I could help anyone your age because I was too old to know how a young person feels, I was angry for a moment. Perhaps you noticed it. It's a natural way to react, but it's not really fair to you . After all, why wouldn't you think that? I have a different idea about that since I think that people have the same kinds of feelings at any age, although the things they care about may be different. Would you like to talk about that T' You can be sure that any emotional reaction you express, unwittingly or otherwise, will be perceived by the client in some manner even without being fully aware of it. The more openly you can deal with your feelings when it is appropriate (without making personal revelations about your life outside the session), the better example you will be providing to the client to do the same thing. The counsellor's mistake can be turned to the good of the client.

**6. The Counsellor Does Not Know the Answer to a Factual Question** - This is a common anxiety expressed by counsellors. As with the above circumstances, it is perfectly appropriate to say that you don't know the answer but will try to get the information for the client, if it is appropriate for you to do so. You may alternatively identify another source of that information for the client. Evading the question or answering without adequate knowledge will do far more harm to the all-important relationship you are establishing with your client than simply admitting your lack of knowledge.

**7. The Client Refuses Help** - Gently probe as to the reason. In discussing the Initial Interview, it was noted that one of the most important first tasks is to establish why the young person has come. Many clients are sent for help when they may not want help. Helping the young person

say why they are there will usually open the subject up. It is then appropriate to say something like: "Well, I can understand how you feel. I'm not sure whether I can help, but perhaps we could take a few minutes just to see what you think, and together we can decide if it might be worthwhile to talk a bit more." Often the client will say that something like "My father thinks I have a problem with this boy at school, but I really don't. He just won't listen when I tell him." The client may be quite right, but she may instead be experiencing difficulties in her relationship with her father, and the skilled counsellor may be able to help her remain in counsel to deal with that. If the client is completely unwilling to talk, stress the positive, that at least he or she did come, you've met each other now, and maybe he/she might like to reconsider. Suggest another appointment and try, if possible, to leave it open. The client then has a "lifeline" and may indeed return.

**8. The Client is Uncomfortable with the Counsellor's Gender** - This difficulty may be made explicit if the client says, "I don't think I can talk to a woman (or man) about this" or "I was expecting a woman (or man)". It may not be stated but sensed by the counsellor. If this is the case, it is best for the counsellor to raise the issue by saying something like - "I wonder if you were expecting to see a man (or woman)?" Once the issue is in the open it is appropriate to say something like "Some young people are, at first, more comfortable with someone of the same (or opposite) sex, but in my experience that usually becomes less important once they get to know each other. Why don't we try to continue, and see how we get on?" The client will usually accept that, and the problem is likely to vanish if the counsellor is attentive, respects the client and is non-judgmental. The use of encouragers and reflections are particularly helpful since they give the client a sense that what he or she is saying is acceptable. If the client is adamant from the outset that they wish to see someone of the other sex, and it is possible to arrange that before going any further, it may be necessary to try. But, in fact, it would probably be better for the client to learn to work with a person of the sex which makes him or her uncomfortable. The counsellor should therefore first see if the client can be given sufficient confidence to try.

**9. The Counsellor is Short of Time** - It is always of benefit to the client to know approximately how much time he or she will have with the counsellor, and it is best if that amount of time remains more or less constant. On occasion, it may happen that the counsellor has less time than usual. It is then extremely important to say so at the outset, provide the reason, if that is feasible, and apologize, indicating that she or he will hope to meet the client again at a specific time. A great deal can be accomplished even in a few minutes, as will have been demonstrated to the participants in the role-plays. It is best to make use of that time rather than send the client away.

**10. The Counsellor Cannot Establish Good Rapport** - Sometimes it may be very difficult to establish satisfactory rapport with the client. This is not necessarily a reason for ending counselling or referring the client to someone else. Rather, the counsellor should ask for help from others in reviewing the sessions to understand better where the difficulty may lie. If there is something about the client which the counsellor finds himself rejecting, it is essential that it be dealt with, if at all possible. One of the important aspects of training is for the counsellor to learn what may make him or her uncomfortable and to try to deal with those issues before beginning counselling, or at least to seek help while working with someone with whom it is difficult to establish rapport.

If, after discussing it with an experienced counsellor, the difficulty appears to be that the client has never been able to have a close relationship with anyone, sending the client away or to someone else will not help, but is likely to damage the client. It is far better to try to continue, especially by helping the client to feel better about him/herself.

11. **The Counsellor and Client Know Each Other** - It is quite common in small communities that a client will know who the counsellor is and may know him or her quite well. If the relationship is a casual one, it may be possible to serve as a counsellor, but it must be made clear early on that confidentiality will be completely respected, and that the way you will relate to your client is quite different from the way you would relate to a friend or acquaintance. If, however, you are well known to each other, it is not possible to serve as a counsellor. It will be necessary to explain that to the client and arrange for someone else to help. The counsellor must indicate that in his/her experience it is not helpful to work with someone he/she knows well. The role of a counsellor is a different one. It is not possible to change roles when meeting outside the counselling session, and this will inevitably give rise to confusion and hurt feelings.

12. **The Client Talks Continuously and Inappropriately** - This is the opposite of a client being unduly silent or refusing to talk, but it may arise from the same kind of anxiety which makes talking difficult. If a client persists in talking continuously and saying things that are essentially trivial (to the client) and repetitive, it is appropriate to interrupt after some time, and say, e.g., "Excuse me Mary, but I wonder if you realize that for some time now you have been repeating the same thing? Are you feeling a bit nervous or finding it hard to talk about other things?" This may help to alter the focus of the conversation from something outside the session to the client herself, which may be sufficient to halt the flow of inappropriate talk.

13. **The Client Asks a Personal Question of the Counsellor** - A counsellor/client relationship is a professional one, not a social one. This is valuable because it enables the counsellor to react in different ways than the other people in the young person's life, and can help the young client to learn more constructive and rewarding ways of relating to people. This may be difficult for the client to understand at first, especially if the counsellor is being warm and caring at the same time. One hazard to this relationship is responding to personal questions from the client about oneself. This is almost never advisable for several reasons. It takes attention away from the client. It may lead to a series of questions which, while starting innocuously, may end with very private matters which the counsellor then refuses to answer. This gives the wrong message to the client, suggesting that something is wrong, either with the counsellor or with the client, for being concerned about such things. Sometimes the client will want to know if the counsellor has the same problem. Saying "yes" may make the client feel that counsellor will not be able to offer help with that particular problem, while saying "no" may make the client feel the counsellor does not understand the problem. It is far better to respond to a personal question by saying that it is not helpful to the client if the counsellor talks about herself and that is why he or she makes it a rule not to. The client will accept that rule. It is far better than either answering some but not all questions, or, worse, evading the issue, which will destroy the honesty of the relationship.

14. **The Counsellor is Embarrassed by the Subject Matter** - It may happen that something the client says embarrasses the counsellor. The more training he or she has had in sensitive subjects, the better he or she will be able to identify areas in which he/she feels most vulnerable, and the

less likely he or she is to be unprepared. Nevertheless the counsellor may be embarrassed. It is always best for the counsellor to be honest with the client, especially if he/she has responded emotionally, since the client will be aware of it. This can be turned to an advantage, by acknowledging having had such a feeling and then returning to the subject if the client has raised it. The counsellor may wish to say something like: "You may have noticed that when you mentioned that fact that you were masturbating, for a moment I was taken aback. That sometimes happens when people aren't expecting something, but in fact, I'm glad you brought it up. Maybe it would be useful to talk about that." After the session it may be helpful to talk with whoever is providing supervision about what happened, and see if such uncomfortable feelings can be overcome.

*Acknowledgment:* W.H.O.: Counselling Skills Training in Client Sexuality, and Reproductive health; a Fact Guide, Geneva, August 1993.

## **Role-Plays: Special Populations**

You and your team members should choose three of the following four role-plays. With each situation, one person will play the service provider, one person the client and one will observe. At the end of each role-play, the observer will provide feedback to the “provider.” For each new situation, change roles.

1. Sarah is 16 years old. When she arrives in your clinic she seems nervous and distracted. She says she is having some pain in her stomach, but seems vague about what is wrong. You suspect that the stomach pain is not why she came to the clinic.
2. Mariam is coming in for her follow-up visit after having her second abortion. She seems excited and relieved that she is not pregnant anymore. She reassures you that this won't happen again, but she hasn't mentioned anything about using contraceptives.
3. Fatima is resting in the health facility just after her abortion. She is feeling okay considering the situation. The pain is fairly slight so she hasn't taken pain medication. You would like to take this opportunity to talk with her about family planning. But you notice she seems to be concerned about something and she hasn't said what it is.
4. Lydia is 17 years old and says she wants to marry her boyfriend. They have been together for a year now and according to her “everything is absolutely wonderful.” Can things really be so wonderful? Why does she seem to be in a hurry to marry him?
5. A couple in their mid 20s comes to the health facility. During the counseling session, the husband says he wants to have a male child. The wife wants to postpone her next pregnancy. How should the counselor respond?
6. Abraham is married with four children. He arrives at the health center seeking information about STD/S HIV. How can you help him?

## **SESSION 9**

**TOPIC:**     **Integrated Skills Practice**

**TIME:**       **Ninety Minutes**

**OVERALL GOAL:** Participants will begin use all the IPCC skills in an integrated fashion before they return to work

**OBJECTIVES:**     By the end of this session, participants will have:

1. Reviewed GATHER, Micro-Skills, and Effective Use of IEC Materials;
2. Used the observation checklist;
3. Practiced integrated counselling skills with use of IEC materials for effective counselling and small group discussions.

**SUMMARY:** This is a key session to pull together all the skills learned during the workshop. Emphasis should be on working out any last questions or clarifying any last skills before participants return to their work site.

<b>Session at a Glance</b>			
<b>TOPIC</b>	<b>TIMING</b>	<b>METHODS</b>	<b>MATERIALS</b>
1. Introduction and review	15 Min	Discussion	Handout 9A, Visual Aids from previous sessions (GATHER, Micro-Skills)
2. Integrated Skills Practice: One-on-one counselling situation	20 Min	Small Group Task/Practice	Handout 9B 6 to each participant
3. Integrated Skills Practice: Two-on-one counselling situation	20 Min.	Small Group Task/Practice	
4. Integrated Skills Practice: Small group presentation	25 Min.	Small Group Task/Practice	Handout 9C
5. Summary and conclusions	10 Min.	Large Group	Handout 9A

## #1 INTRODUCTION AND REVIEW

Read the Ninja Story (Handout 9A).

The *Ninja Story* explains the process of learning to be a Ninja. The story illustrates the ancient wisdom underlying integrating skills.

A crucial component of the counselling training workshop is supervised practice. Even though initial sessions are designed to be participatory and experiential, participants learning to counsel effectively need the opportunity to integrate all the counselling skills by practicing and receiving feedback on their performance.

During this session, participants are not only integrate cognitive information learned during the workshop, but also integrate the discrete skills taught during specific previous sessions, increase awareness of their counselling strengths and weaknesses and become more skillful observers of the counselling process. This session aims to pull together everything shared thus far.

### *Review*

Review of GATHER

Review the key Micro-Skills of effective counselling.

Review the key principles in using IEC materials during counselling situations.

## #2 INTEGRATED SKILLS PRACTICE: ONE-ON-ONE

This section will focus on a counselling situation with one client. Be sure to focus on the counselling skills and appropriate use of IEC materials to support the situation. The role-play will last 4 minutes. At the end, the observer will present his/her feedback, written and verbal (Two minutes). Handout 9.B

Then the group of three will shift roles, a new provider, client and observer. Repeat the process again.

Lastly, the group of three will shift roles again and repeat the process a third time. By the end, each participant will have played each role.

## #3 INTEGRATED SKILLS PRACTICE: TWO-ON-ONE

This section will focus on a counselling situation with two clients, such as a husband and wife or parent and adolescent. Be sure to focus on the counselling skills and appropriate use of IEC materials to support the situation. The role-play will last 4 minutes. At the end, the 2 “clients” should provide verbal feedback and if possible, complete the Observation Checklist (2 minutes). Handout 9.B.

Then the groups will shift roles, a new provider and 2 new clients. Repeat the process again. Lastly, the groups will shift roles again and repeat the process a third time. By the end, each participant will have played the provider role once.

#### **#4 INTEGRATED SKILLS PRACTICE: SMALL GROUP**

This section will focus on a counselling situation with a small group, such as a clinic health talk. Ask participants to form new groups of four. See Handout 9C. One participant will role play the provider and the other three are the clients. The “provider” will select a topic that he/she wishes to practice perhaps something they are familiar with and can easily talk about. The “audience” will role-play as described by the “provider.” Again, be sure to focus on the counselling skills and appropriate use of IEC materials to support the situation. The role-play will last 4 minutes. At the end, the “audience” should provide verbal feedback and if possible, complete the Observation Checklist (2 minutes). Handout 9.C

Then the group of four will shift roles, a new provider and 3 new clients. Repeat the process again.

Repeat until each participant has had the opportunity to role-play the provider.

#### **#5 SUMMARY AND CONCLUSION**

##### ***Discussion***

Volunteers describe one strength they now have for giving effective counselling and one area (skill) they would like to strengthen. Volunteers identify what would keep them from implementing this skill in their work situation. Summarize the major points of the session.

## **Becoming a Ninja Swordsman**

Japanese master swordsmen learn their skills through a complex set of highly detailed training exercises. The process of masterful swordsmanship is broken down into specific components studied carefully, one at a time. In this process of mastery, the naturally skilled person often suffers and finds handling the sword awkward. The skilled individual may even find his performance dropping during the practice of single skills. *Being aware of what one is doing can interfere with coordination and smoothness.*

Once the individual skills are practice and learned to perfection, the Ninja retire to a mountaintop to meditate. They deliberately forget about what they have learned. When they return, they find that the distinct skills have naturally been integrated into their styles or way of being. The Ninja then seldom have to think about skills at all. They have become Ninja swordsmen.

The same holds true for cooking, farming, dancing, tennis, basket weaving, and many other activities of life. Rehearsal and practice of basic skills builds mastery, which later becomes integrated into our own natural style. The new, unique whole is often larger than the sum of the distinct parts.

You likely found discomfort in practising the single skills of questioning, listening, etc. This happens to both the beginner and the advanced counsellor. Improving and studying our natural skills often results in a temporary and sometimes frustrating drop in performance, just as it does when we learn single skills like the Ninja.

Consider driving. When you first sat at the wheel, you had to coordinate many tasks, particularly if you drove a car with a shift lever. The clutch, the gas pedal, the steering wheel, and the gear ratios had to be coordinated smoothly with what you saw through the windshield. When you gave primary attention to the process of shifting, you might have lost sight of where you were going.

But practice and experience soon led you to forget the specific skills and you were able to coordinate them automatically and give full attention to the world beyond the windshield. The mastery of single skills led you achieve your objectives!

*Acknowledgement: Ivey, Allen E. Intentional Interviewing and Counselling, Monterey, California: Brooks/Cole, 1983; (Revised by Hiza, M.T. CTT Member, NFPP (MOH) 1997.*

## OBSERVATION CHECKLIST: INTEGRATED SKILLS PRACTICE

**Instructions to Observer:** You have the opportunity to help your colleague improve their counselling skills. Please watch the “provider-counsellor” carefully. Take special note of those behaviours that are to be practice. For now, focus on the process NOT the solution, the advice or the answer. Tick (T) the behaviours that occurred or did not occur. Use the “notes” section to write specific examples to help you give the best, most specific feedback possible to the provider.

OBSERVED BEHAVIOUR	YES	NO	NOTES
<b>I. ESTABLISHING RAPPORT</b>			
Pays attention to physical environment (ensures privacy, that is attractive and comfortable for the client)			
Maintains appropriate eye contact			
Facial expression, posture, gestures (smiling, leaning forward, communicates warmth)			
Rate of speech, tone communicates warmth, is easy to understand			
Assures confidentiality			
Asks reason for visit			
Uses Encouragers and praise to foster dialogue			
Uses open-ended questions to foster dialogue			
Asks about feelings			
<b>II. GATHERING &amp; PROVIDING INFORMATION</b>			
Follows client’s issues or concerns			
Only talks about self if the information is directly pertinent			
Doesn’t interrupt			
Asks one question at a time			
Refrains from leading questions or Across-examining”			
Legitimizes client’s concerns			
Knows client-group’s issues or where to find out			
Asks about risks of STD/HIV			

<b>III. PLANNING, DECISION-MAKING PROBLEM SOLVING</b>			
<b>Lets client do most of the talking</b>			
<b>Reflects content</b>			
<b>Reflects feelings</b>			
<b>Comfortable discussing sexuality/sex-related issues</b>			
<b>Helps client identify decision areas or problems</b>			
<b>Assists client to develop options</b>			
<b>Assists client to examine consequences of each option</b>			
<b>Lets client make the decision</b>			
<b>IV. NEXT STEPS</b>			
<b>Knows support/referral resources</b>			
<b>Summarises</b>			

**OBSERVER=S CHECKLIST**

Presenter: \_\_\_\_\_

Session: \_\_\_\_\_

Please rate the presenter on the following items. Then provide written comments on how to improve.

How prepared was the presenter?	1 poor	2	3	4	5 excellent
How would you describe the opening?	1 uninteresting	2	3	4	5 engaging
How would you describe the presenter=s knowledge of the topic?	1 poor	2	3	4	5 excellent
How did you find the presenter=s style of delivery?	1 uninteresting	2	3	4	5 dynamic
Did the presenter change the action regularly to keep participant=s attention?	1 poor	2	3	4	5 excellent
Did the presenter invite and encourage participation from all participants?	1 poor	2	3	4	5 excellent
How did the presenter handle different points of view?	1 poor	2	3	4	5 excellent
Did the presenter maintain control of the discussion/group work/individual work?	1 poor	2	3	4	5 excellent
Did the presenter relate the topic to participant=s work (how will it help them?)	1 poor	2	3	4	5 excellent
Did the visual aids support or distract from the presentation?	1 distract	2	3	4	5 support
How well did the presentation hold your attention?	1 poor	2	3	4	5 excellent
How was the presenter=s non-verbal communication (eye contact, facing the participants, gestures, walking around, interacting with participants, etc.)	1 poor	2	3	4	5 excellent
How would you describe the closing?	1 uninteresting	2	3	4	5 memorable
Describe the overall performance	1 poor	2	3	4	5 excellent
List 3 improvements the presenter can make:					
1.					
2.					
3.					
Comments:					