Counseling the Postabortion Client:

A Training Curriculum

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Introduction
for the Trainers

Course Overview

Course Purpose

Provision of counseling should be an integral part of comprehensive postabortion care (PAC) services. However, most available training materials on postabortion counseling focus primarily on postabortion family planning and do not cover basic client-provider interaction or address other reproductive health needs, both of which are key elements of postabortion counseling. This curriculum is intended to prepare all levels of PAC service providers to meet the information and counseling needs of postabortion clients, including referral for services and issues outside the scope of their current work.

As a result of this training, PAC providers will be able to use communication and counseling skills to perform the following tasks:

- Assess and acknowledge the client's needs
- Listen to her concerns
- Answer her questions
- Give her information about the procedure, what to expect during her visit, postprocedure care, and warning signs
- Help her make decisions about family planning, sexually transmitted infection (STI) and HIV prevention, and other reproductive health services

Course Participants

This new training approach is designed specifically for providers who interact with postabortion clients immediately before, during, and after the postabortion treatment procedure, including nurses, midwives, counselors, physicians, social workers, nurse aides, and other nonmedical staff. In settings where manual vacuum aspiration (MVA) is used for uterine evacuation, the participants should include at least one obstetrician-gynecologist with MVA experience. The workshop is not intended to teach formal "counseling," but rather to demonstrate that all PAC providers can offer a client essential information and support within the context of their work. It is assumed that participants will have clinical experience or knowledge about the treatment procedures in use at the service site, or that this curriculum will be used along with PAC training for clinical skills and infection prevention.

This training is intended for a group of six to 15 participants; a greater number of participants will require more time for presenting small-group work and role plays. The group should include multiple cadres of providers, but physicians will be requested to attend only selected portions of the training. Regardless of the size of the group, however, participants will benefit most if the clinical practicum site has enough postabortion clients for all participants to counsel one to two clients each over the course of two days.

Nurses, midwives, social workers, and counselors (and whatever other staff hold primary counseling responsibility) should attend the full training. Some parts of this course may also be appropriate for administrative or supervisory staff who do not actually work with clients but who supervise or make decisions affecting those who do. Such staff should be encouraged to attend both on-site and off-site training whenever possible.

Trainers for This Course

This curriculum has been designed for use by skilled, experienced trainers. While the curriculum contains information to guide the training process and to assist the trainers in making decisions that will enhance the learning experience, it is assumed that the trainers understand adult learning concepts, employ a variety of training methods and techniques, and know how to adapt materials to meet the participants' needs.

The trainers also must be aware of the standards and guidelines regarding certification, training follow-up, and ongoing supervision of the site or institution sponsoring the training event. While reviewing this curriculum in preparation for conducting the course, the trainers should keep this in mind.

It is imperative that the trainers have a solid grounding in counseling; previous experience in assisting postabortion clients and a familiarity with the treatment of abortion complications are strongly recommended. If, however, the trainers have no background in PAC, they should receive a one- or two-day orientation to PAC-related issues. This should include background in PAC globally and within the specific country, an overview of MVA (if appropriate), and at least half a day spent in a hospital or clinic setting observing postabortion clients before, during, and after treatment.

A team of two trainers (either two co-trainers or a lead trainer and an assistant) is necessary for this intensive training. As one trainer facilitates a session, the other can record information on flipcharts, monitor time, help keep the discussion on track with the session objectives, moderate small-group work, and act in sample role plays.

The Training Curriculum

The training curriculum has three main components: training sessions, handouts, and appendixes.

Training Sessions

Methodology and instructions for conducting the training are included within this section. The nine sessions are grouped thematically to cover related topics. The beginning of each session contains introductory information with essential details about:

- The objectives of the session
- Suggested training methods to use and materials needed when presenting the content of the session
- Advance preparation (including any additional training supplies that will be needed)
- The amount of time estimated to be needed for the training

Before beginning each session, the trainers should review the session's objectives. These can be prepared in advance on a flipchart or as a handout. The objectives should also be reviewed at the end of each session, as a summary of what was covered.

The "Materials" section notes all of the educational and training materials that will be needed for that session. Materials that need to be adapted, developed, or gathered in advance are noted under "Advance Preparation." The estimated time that will be needed for the session's training is noted as well.

The "Training Steps" section gives detailed instructions for conducting the session, with a suggested time for each activity. "Training Tips" provide the trainer with additional background information on content or training approaches. These notes may also include discussion questions, possible responses for brainstorming exercises, and suggested formats for flipcharts. "Training Tips" appear in highlighted boxes following the appropriate step, or, if they are extensive, may appear at the end of the session guide.

Handouts

Handouts are provided to assist the trainers in conducting training activities. When reviewing the training steps for each session, trainers should read the handouts carefully and identify the key points of each to be covered during the group discussions. This advance preparation will facilitate the process of reviewing or summarizing handouts. In this curriculum, the handouts for each session appear following the session activities.

The trainers must make copies of the handouts that they will be using prior to the session. Alternatively, if the trainers cannot or do not wish to make copies of all handouts, they may write the content of selected handouts on flipcharts or on a chalkboard. This option is more appropriate for some of the handouts than for others. For example, the participants will need copies of handouts that instruct them to give written responses. When deciding which handouts to distribute, the trainer should bear in mind that the participants may find it useful to keep copies of handouts containing material that is not otherwise provided. This will enable them to review the material after the training is over.

Appendixes

The appendixes contain materials and tools to be used in conjunction with training activities. These resources can facilitate advance preparation for the trainer. Curriculum appendixes are as follows:

- *Appendix A: Training Outline*. This outline provides the chronology and time of all sessions and subsections, along with a list of the accompanying handouts. The agenda also specifies whether the audience for each session and subsection should include doctors (who are exempt from certain parts of the training).
- *Appendix B: Pretest/Posttest on Postabortion Counseling*. Trainers have the option of using this test at the beginning and at the end of the training event. The trainers can use the results of the pretest to customize the training to best suit the participants' level of counseling knowledge and experience. After the training, trainers can use the posttest to measure change in the participants' knowledge and perspectives. Answers to this test (including sample correct responses for the open-ended questions) appear immediately after the blank version of the test. The test is included as an appendix, rather than as a handout, because it is *not* a required component of the curriculum. Trainers and sponsoring institutions are free to decide on a case-by-case basis whether use of the pretest and posttest is an appropriate and constructive complement to each particular training event.

- *Appendix C: Transparencies and Activity Materials*. Throughout this course, trainers may find it useful to use transparencies or flipcharts to present the content of the sessions or conduct training activities. Appendix C contains sample text and images that can be reproduced and used for transparencies and flipcharts during training sessions.
- *Appendix D: Sample Case Studies*. A background explanation on the use of case studies within this training appears later in this introduction (see "The Case Study Approach," page 6). EngenderHealth strongly recommends that this training curriculum utilize original case studies prepared by participants during the training event, as prescribed in Option 1 of Session 3, Part A (page 35). In certain training situations, however, time may be too limited to complete this case-study development exercise. In such cases, prior to the training, trainers should refer to Option 2 of Session 3, Part A (page 39), and select three or four of the prepared case studies found in Appendix D. The case studies selected should reflect a wide range of client characteristics and situations, including age, parity, marital status, whether the client had a spontaneous or induced abortion, etc. These preselected case studies will then be referred to throughout the training and integrated into various exercises and role plays, in the same manner as would those developed by training participants.
- *Appendix E: The Female and Male Reproductive Systems*. One exercise conducted as part of this curriculum is to have participants label handouts showing the female and male reproductive systems with the names used for particular body parts in their society. The diagrams in this appendix are the same as those in the handout, except with all of the formal names of body parts shown.
- *Appendix F: Additional Trainer's Resources*. There are many valuable reference materials on postabortion care. Trainers should obtain and review as many as possible of the materials listed in this appendix prior to the training.
- *Appendix G: Sample Client-Education Material*. Following the training, participants or institutions may request client-education materials that reinforce critical instructions on postprocedure care and that provide information on postabortion family planning options. EngenderHealth's Dominican Republic program developed a low-literacy brochure that can serve as a guide for what such client-education materials might include. A translated and adapted version of this brochure appears in Appendix G, offering an example for another country or program that might wish to relay this information.
- *Appendix H: Workshop Evaluation Form*. Just as the pretest/posttest on postabortion counseling (Appendix B) is an important aspect of evaluating the impact of post-abortion counseling training, the Workshop Evaluation Form is a vital aid to EngenderHealth in helping us to improve this new curriculum. Thus, all participants should be asked to complete this evaluation form, and all completed forms should be sent to EngenderHealth.

Training Materials, Supplies, and Equipment

Along with the materials provided as part of the curriculum, the trainers should obtain training aids, such as flipchart paper, masking tape or blue tack, and colored markers, for use during the course. In addition, selected training activities may require the use of index cards or large or small pieces of paper.

This training relies heavily on the use of flipcharts to guide or summarize discussions. Most of these can be prepared in advance. However, there are dangers in overusing flipcharts: Paper is expensive and sometimes scarce; participants can become bored with "training by flipchart," even though it is meant to be more interactive; and some information needs to be saved by participants and might work better as a handout. Specific instructions are given for when to write on the flipchart and when not to; try not to do more than is suggested.

If an overhead projector, transparencies, transparency markers, and electricity are available, then transparencies can be used instead of flipcharts in some instances (see Appendix C for material that may be presented using transparencies or flipcharts). Handouts can also be read during the session and then kept for participants' later reference. Here are a few guidelines for when to use flipcharts, transparencies, or handouts:

- Use flipcharts if you are recording suggestions or ideas from participants (e.g., during brainstorming), if you want to post the information on the wall or refer to it later in the training, or if you want the participants to think through a question or concept by themselves (maybe referring to a handout later).
- Use an overhead projector and transparencies if you want to present a piece of text for everyone to read and then discuss, but not save, or if you want to post instructions for group work.
- Use handouts if you want the participants to save the information to refer back to after the training.

Session 7, "Postabortion Counseling," includes the option of using a video camera to record role plays and then give the participants the chance to see themselves on tape. Trainers are free to decide whether the use of video is appropriate and constructive within this session. If trainers choose to utilize video, they will need to obtain a video camera and tape, plus a monitor to play the tape for the group. Trainers should also familiarize themselves with the use of this equipment prior to the training, to avoid delays related to technical difficulties. The main purpose of the exercise should not be sacrificed because of distractions related to the video equipment.

How to Use These Materials

Training Design

This curriculum has been designed to be flexible, to accommodate different types of participants (doctors, nurses, social workers, etc.), different levels of participant experience, and different social, cultural, and political settings (see "Special Considerations for Settings Where Abortion Is Legal," page 11). The course design will be affected by the participants' prior experience and training. While time may be a limiting factor for on-site training in which service providers are participants, it is preferable that all participants be present for all sessions, as dictated by the training agenda (see Appendix A).

The exercises in this curriculum have been carefully designed to achieve specific objectives. Although it will be necessary to adapt certain portions of the training based on the setting, culture, etc., the trainers should follow the instructions as closely as possible.

Use of Training Methods

The content of the curriculum is covered through a combination of training methods, including presentation and interactive exercises (instructions for which are provided within the steps of training sessions). Although the trainers will need to present some of the material through lectures, they will also use more participatory methods, such as large-group and small-group exercises, role plays, and discussion. The trainers should never lecture for more than 15 to 20 minutes at a time. Even while lecturing, the trainers should use visual aids to illustrate the narrative.

Participatory methods, such as brainstorming or role-play exercises, have been shown to be a critical feature of successful adult learning. While it is desirable for these to be as interactive as possible, both to reduce the amount of lecture time and to engage the participants more fully, the content of this training course does not always lend itself to such activities. The trainers can employ principles of adult learning by relying heavily on the participants to discuss issues and generate solutions based on their own experiences.

Time Frame and Chronology

The suggested schedule for this training is three and one-half to four days, including in-class training and hands-on counseling practice with PAC clients. Given the personal and controversial nature of many of the issues involved in postabortion counseling, this intensive approach is probably the most effective. However, the training could be conducted in shorter segments, spread out over a longer period of time. Even if changes are made in the length of the training, however, *trainers should always follow the recommended sequence of sessions*, since the later sessions build on knowledge, attitudes, and skills addressed in the earlier sessions.

The Case-Study Approach

This curriculum is intended to be adaptable across different cultures. To encompass the range of sensitive issues related to abortion and PAC in different countries, participants' input is used to create client profiles that reflect the unique postabortion situation in their given setting. These client profiles are developed into case studies that are used repeatedly throughout the training for small-group work and role plays. The case studies allow the participants to build empathy by constantly applying new concepts to individual clients' personal situations.

Creating client profiles and case studies that accurately cover the range of local issues and challenge providers' stereotypes, biases, and misconceptions requires close attention and sensitivity on the part of the trainers. Guidance is given throughout this curriculum to help the trainers consider the possible range of issues to address and to lead discussions into potentially difficult areas.

The symbol below will appear throughout the training guide to indicate that one or all of the case-study clients whose stories are developed in the beginning of the training should be used in the exercise or role play being described.

The Clinical Practicum

The clinical practicum (Session 8) is a crucial element of the curriculum. After three days of interactive classroom learning, participants are given hands-on practice in applying their skills to counseling sessions with actual postabortion clients. Working in pairs, participants take turns providing counseling before, during, and after the PAC procedure, under the observation of a supervisor and at least one other participant. The clinical setting provides a context in which to apply the lessons covered previously, and it elevates the skill practice to a level of seriousness difficult to approximate in the in-class role plays. Because the clinical practicum is critical to the impact of the overall training experience, each participant should counsel a minimum of two clients, so that he or she can practice adapting the discussion content according to individual client assessments. This multiclient exposure demonstrates how dramatically counseling needs may vary from one client to the next.

Evaluation

Evaluation is an important component of training. Evaluation gives the trainers and participants an indication of what the participants have learned and helps the trainer determine whether the training strategies employed were effective.

The true test of how successful PAC training has been is whether high-quality counseling practices, services, and protocols have been instituted (or improved). This emphasizes the importance of good follow-up of all training events. However, more immediate evaluation of the course itself is also needed. Because this course covers both knowledge-based and attitude-based material, participants' progress will be measured in large part through the assessment of changes in their knowledge and attitudes.

Evaluation opportunities within the curriculum include:

- Assessing participants' progress during the training by asking questions of individuals and groups, to test their knowledge and comprehension
- Using the pretest/posttest to assess improvements or changes in participants' cumulative knowledge or attitudes before and after the training
- Observing role plays followed by the clinical practicum, to assess how participants' counseling skills developed from the middle to the end of the training

After the training event, the trainers should follow up with the participants to learn how they have applied their new knowledge and skills. If a supervisor is responsible for follow-up, the trainers should contact the supervisor to learn how postabortion counseling has improved as a result of the training.

An end-of-training evaluation allows participants to provide feedback on the overall training process and the results of the course. The Workshop Evaluation Form (Appendix H) should be used for this purpose, and participants should be encouraged to be truthful in their responses (which may be more easily achieved if the handout is completed anonymously).

Finally, this is a new training approach for postabortion counseling; evaluation is very important if EngenderHealth is to further improve the curriculum. Please use the evaluation form provided to obtain feedback from each participant, and please return all completed forms to EngenderHealth.

Advance Preparation

Obtaining Background Information

Before the training, trainers should try to find out as much as possible about the course participants—their job responsibilities, background, sex, and experience providing postabortion care services—and about the management hierarchy at their sites, so the training can be adapted to the participants' needs. In addition, the trainers should try to determine the plans of participants' sites regarding comprehensive PAC services in general and postabortion counseling in particular. For example, if there is currently little or no postabortion counseling in practice, or if protocols related to this subject do not exist, the trainers should find out:

- Why the site requested the training
- What the training will entail beyond counseling (e.g., infection prevention, clinical skills, and family planning)
- Who is responsible for supervision of PAC services, including counseling
- What role the participants currently or will soon play in the provision of postabortion counseling services

To obtain this information, EngenderHealth recommends that trainers interview the most involved administrators at the participants' respective sites. To assess the participants' needs and abilities prior to training, trainers may interview them and observe them during service provision or may administer the optional pretest on postabortion counseling (Appendix B).

Guidelines for Training Preparation

The following steps should assist trainers in becoming familiar with the curriculum and preparing to conduct the training event.

First, read the entire curriculum and the handouts one time quickly to get an overall sense of the purpose, content, and approach of the training.

Next, confer with the program administrators at the PAC service site. If you have been asked to present this training, they are probably well aware of its goals, objectives, and intended audience. Nevertheless, after you first read the curriculum, you should meet with them to clarify the purpose of the training, to see if appropriate participants have been selected, and to confirm the time committed for the workshop.

Then, read the curriculum again, this time slowly. Think about each session in terms of the needs of postabortion clients and PAC service providers at the local service sites. Carefully review each handout—the handouts are the "permanent record" of the workshop that will be left with the participants, and possibly will be seen by others who did not attend the training. Revise them as necessary to reflect and be sensitive to the local situation, issues, and attitudes.

After you have reviewed and revised (if necessary) the handouts, make enough copies of them for all participants. (*Note:* Some handouts can be given out at the beginning of the training for the participants to read as background. Other handouts are meant to be distributed as part of a training activity.) Each participant should have a notebook or folder to keep all of his or her materials organized as they are distributed; trainers should ask the facility manager to notify all participants in advance of the need to bring a notebook or folder.

Write the list of objectives for all sessions on a flipchart. At the beginning of each session, briefly state the objectives to be covered. Review the session's objectives during a "wrap-up," to provide a framework for assessing how well objectives were achieved and where there may be gaps in participants' understanding. (These gaps can be addressed in subsequent sessions.)

Additional Trainer's Resources

Prior to the training, trainers should obtain and review as many as possible of the materials listed in Appendix F (available either from EngenderHealth or from the publisher). The curriculum sometimes refers to specific sections as starting points for group discussions. Depending on the participants' level of training and interest, trainers may wish to select one or two of these references to copy and give as handouts to participants. (Beware: Giving all of the materials would almost certainly overwhelm participants and would represent a poor use of materials and financial resources.)

During the Training Course

Creating a Positive Learning Environment

Many factors contribute to the success of a training course. One key factor is the learning environment. Trainers can create a positive learning environment by:

- *Respecting each participant.* Trainers should recognize the knowledge and skills the participants bring to the course. They can show respect by remembering and using the participants' names, encouraging them to contribute to discussions, and requesting their feedback on the course agenda.
- *Giving frequent positive feedback.* Positive feedback increases people's motivation and learning ability. Whenever possible, trainers should recognize participants' correct responses and actions by acknowledging them publicly and making such comments as "Excellent answer!" "Great question!" "Good work!" Trainers can also validate the participants' responses by making such comments as "I can understand why you would feel that way…."
- *Keeping the participants involved.* Trainers should use a variety of training methods that increase participant involvement, such as questioning, case studies, discussions, and small-group work.
- *Making sure the participants are comfortable.* The training room(s) should be well lit, well ventilated, and quiet, and should be kept at a comfortable temperature. Breaks for rest and refreshment should be scheduled.

Presenting Sensitive Content

This training course addresses a topic that may be difficult for the participants to discuss. While this book provides suggestions for ways to discuss many topics in a group setting, trainers may face situations in which individual (or groups of) participants hesitate to join in discussions, are judgmental, or inhibit other participants from expressing their feelings freely. To encourage risk-taking and create an environment in which the participants feel comfortable discussing and absorbing new content and ideas, trainers may use the following techniques:

- Acknowledge that it is normal to feel nervous, anxious, or uncomfortable in new and unfamiliar situations.
- Begin with less-sensitive content, and build up to content that is more sensitive.

Similarly, avoid scheduling sensitive discussions after breaks or at the very beginning of a session or day, if possible, to ensure a more trusting and cohesive atmosphere.

- Use icebreaker activities at the beginning of the training workshop and during breaks to encourage team-building and comfort.
- Use small-group work to allow the participants to express their feelings in front of a smaller audience. Similarly, split the groups up by sex, if appropriate.
- Use paraphrasing and clarification techniques to demonstrate attention to what the speaker has said, to encourage the speaker to continue speaking, and to ensure understanding.
- Share your own experiences, including situations in which you were and were not successful.
- Give constructive feedback to reassure the participant that his or her remarks are acceptable and appropriate and to encourage additional participation.

Participant Feedback

The trainers should set aside a segment of time at the *beginning* of each training day to permit the participants to raise issues that can interfere with learning, such as those related to personal situations, accommodations, or content. Depending on the size of the group, a period of 10 to 15 minutes may be needed.

Similarly, the trainers should set aside a segment of time at the *end* of each training day to allow the participants to share their learning insights and their assessment of what did and did not go well for them that day. This assessment will enable the trainers to make any needed adjustments in the agenda and give the participants the opportunity to comment on the way the training course is progressing. One effective way for the trainers to do this is to conduct a "plus/delta" exercise, which is described below.

At the end of the day before the last training day (e.g., on Day 3 of a four-day training), the trainers might ask the participants if they would like anything discussed in the training to be clarified or if they would like anything else to be included on the last day.

Conducting a Plus/Delta Exercise

Plus/delta exercises provide a useful tool for trainers to solicit feedback about a training workshop. Through these exercises, participants are able to evaluate the workshop experience together, discussing aspects of the workshop that went well and recommending ways to improve it in the future.

To conduct a plus/delta exercise, which may take between 15 and 30 minutes, the trainer asks the participants to call out aspects of the workshop that they liked. The trainer then records them in the left-hand column of a flipchart, entitled "Plus" or "What I liked about this workshop." Next, the trainer asks the participants to call out one way to improve the workshop and records it in the right-hand column of the flipchart, entitled "Delta" or "What could be done to improve this workshop."

For each item listed in the "delta" column, the trainer facilitates a discussion by asking whether many people agree or if only one participant feels this way, and by encouraging the participants to offer ways to make the suggested changes. The trainer continues asking for

ways to improve the workshop until the participants have no more suggestions. (*Note:* If the participants seem reluctant to point out negative aspects of the training, the trainer might mention one way that he or she has thought of to improve future trainings.)

If the participants' suggestions for improvement involve changes to the training room or environment, the trainer should communicate the suggestions to someone who can facilitate the changes.

Adjusting the Curriculum

As the course progresses and the trainers become familiar with the participants' learning styles and level of knowledge, they may need to make selected *minor* adjustments to the course content or the agenda. Time requirements will vary depending on the participants' experience and interests and on the trainers' respective levels of experience.

Adjustments to the curriculum should be few and should not compromise the quality of the training. The trainers should cover all important content—in the order prescribed by the agenda and training sessions—and allow sufficient time for discussion.

Special Considerations for Settings Where Abortion Is Legal

Informed Choice

Where abortion is legal, a central concern is ensuring informed choice, with respect to both termination of pregnancy and selection of family planning methods. Clients often may be pressured by husbands or other family members to terminate a pregnancy, so providers should be alert to this possibility and counsel clients accordingly. When there are indications that an abortion was coerced, it may be appropriate to include the influential partner or family member in counseling (only with the client's explicit permission, however).

It is also a common unofficial policy to pressure or "convince" clients to accept a family planning method at the time of the abortion. Reinforcing the need for family planning to prevent future unwanted pregnancies is appropriate and warranted for elective abortion; however, providers must be careful not to push clients to select a method prematurely (especially in the case of surgical contraception). This could lead to method discontinuation, client dissatisfaction, or a loss of trust in the health system. The provider's role must be to make the client aware of the need for family planning and of her options and to assist her in choosing the method that best fits her needs. If the client requires more time to come to a decision, she should be free to do so, and providers should inform her of the times and places where she can obtain a method later.

These principles hold true for PAC services in countries where abortion is illegal as well; however, settings in which abortion is legal may be more vulnerable to a postabortion family planning acceptance "requirement" within the service-delivery protocols.

Provider Attitudes and Client Concerns

Another notable difference from settings where abortion is illegal is a less-judgmental attitude demonstrated by providers toward women who terminate their pregnancies. In settings where abortion is legal, therefore, counseling training may focus less on overcoming

providers' prejudices about abortion. Similarly, clients may feel less guilt and shame about their decision to have an abortion than do women in countries where terminating a pregnancy is a crime. Instead, the emotional needs of women obtaining a legal abortion can center more on the fear of pain or complications as a result of the procedure. The sessions on addressing clients' feelings and providing support before, during, and after the procedure should therefore be adapted as appropriate to fit common concerns in the local setting.

In some countries where abortion is legal and accessible, but where family planning knowledge and use are low, clients may rely on traditional methods or on no method at all, with abortion serving as a back-up contraceptive option. In these cases, providers should be sensitized to barriers that may impede clients' ability to obtain and use modern methods. Being aware of these issues can help them to best aid clients in the free and informed choice of an appropriate and effective method.

At the End of the Training Course

It is important to summarize the content and activities of the course. The trainer should highlight key points and be sure to review any specific concerns or difficulties that were raised during the course.

The trainers may choose to administer the posttest (Appendix B) to assess changes in the participants' knowledge and attitudes regarding postabortion counseling. It is also important for the participants to complete the end-of-training evaluation (Appendix H) so the trainers can examine overall processes and results.

After the Training Course

Follow-Up

Learning about postabortion counseling does not end when this course is completed. At the end of the training, most participants will have gained new knowledge and skills and will have a better understanding of how to integrate comprehensive, high-quality counseling into their routine interactions with postabortion clients. After the course, the trainers might follow up with administrators at the participants' sites to determine whether the new counseling skills are being utilized throughout the provision of PAC services.

Some participants may encounter difficulties integrating counseling into their work without the cooperation of their colleagues and the support of their supervisors. For these and other reasons, the trainers should discuss follow-up with supervisors before the training and with participants during the training.

Before beginning the training, the trainers should understand their role in follow-up. Follow-up can be provided several different ways, depending on the participants' needs, the trainers' availability, and financial considerations. Follow-up mechanisms include:

- *Visiting the participants at their sites.* This is the most effective way to follow up on the course. If possible, trainers should have an opportunity to facilitate a discussion with the participants to talk about the challenges and successes of integrating comprehensive postabortion counseling into existing services. Administrative issues and any problems the participants may encounter can also be discussed at this time.

- *Inviting the participants to visit other sites or meet other providers that provide high-quality comprehensive postabortion counseling.* This enables participants to observe and obtain helpful advice from providers who have successfully integrated comprehensive counseling into PAC services.
- *Requesting participants to establish site logbooks.* Such logbooks, which track detailed counseling information for each client, may include whether the client received counseling, her reproductive intentions, the family planning method she selected (only appropriate for clients wishing to delay a future pregnancy), and referrals given for other services (if applicable). These can be reviewed to assess progress in providing client-centered counseling; however, staff, trainers, and administrators must take care not to misinterpret the data. For example, no site should aim for having 100% of clients leave with a family planning method unless that site is sure that 100% of clients wish to postpone a pregnancy (an unlikely percentage). Counseling and services should match the needs of the individual clients.

Follow-up is an important part of training and should be a planned part of any training course. Participants should know who will conduct follow-up and how it will be conducted.

Session 1:
Opening Session

Objectives

- To name the five elements of postabortion care (PAC)
- To understand the workshop goals and objectives
- To share expectations of the workshop

Training Methods

- Presentation
- Small-group work
- Large-group discussion

Materials

- Flipchart paper, easel, markers, and tape
- Paper and pens (for the participants to take notes with)
- Handout 1-A: Workshop Goals and Objectives (page 21)
- Handout 1-B: Workshop Schedule (page 22)

Advance Preparation

1. Send invitations to guests and arrange for speakers.
2. Provide speakers with the workshop goals, objectives, and schedule, so they have some context for their remarks.
3. Prepare a flipchart listing the objectives of this session.
4. Prepare a flipchart listing the three questions about the participants' expectations for the workshop (see below).

Participants' Expectations for the Workshop

1. What is postabortion counseling?
2. How does postabortion counseling relate to your work?
3. What do you expect to learn from this workshop?

5. Review all handouts and make one copy for each participant, guest, and speaker.
6. Arrange the room for a formal presentation, and arrange for refreshments, if appropriate.

Session Time (total): 1 hour, 20 minutes, to 1 hour, 30 minutes

SESSION 1 TRAINING STEPS

Part A Opening Ceremony

Time: 30 minutes

Activity: Presentation (30 minutes)

1. Welcome and introduce the participants, guests, and speaker(s).
2. Invite the speaker(s) to offer opening remarks.
3. Lead an icebreaker exercise.
4. Conduct the opening ceremony in a manner appropriate to local customs and observant of all necessary protocol. Include refreshments, if appropriate.

TRAINING TIP ○○○

If there are speakers, meet with them before the workshop to provide them with a context for their remarks. The speakers should emphasize the importance of the workshop and remind the participants of the official support of the Ministry of Health (or other key stakeholders) for the program.

In the opening ceremony, either the speaker or the trainer should give a *brief* overview of the five essential elements of the updated expanded model for Comprehensive PAC *(maximum, 10 minutes)*:

- Community and service-provider partnerships—to prevent unwanted pregnancy and unsafe abortion, and to mobilize resources so women will receive appropriate and timely care for abortion complications
- Comprehensive counseling—to identify and respond to women's emotional, physical, and family planning needs and concerns
- Treatment—of incomplete abortion and potentially life-threatening complications
- Contraceptive and family planning services—to help women prevent unwanted pregnancies or practice birth spacing
- Linkages from abortion treatment services—to reproductive health and other services, preferably provided on-site or via referrals to other accessible facilities in the provider's network

Since only 30 minutes are allotted for the opening ceremony, limit the number of speakers to only a few, and remind them that time is short. Additional guests and speakers can be invited for the closing ceremony.

Optional 10-minute break as guests depart.

Part B Workshop Introduction

Time: 50 minutes

Activity 1: Presentation (15 minutes)

1. Distribute Handout 1-A: Workshop Goals and Objectives, and briefly review the goals and objectives of the workshop.
2. Distribute Handout 1-B: Workshop Schedule, and briefly review the daily schedule, including breaks and lunch.
3. Negotiate the schedule and ground rules with the participants.
4. Discuss other logistical issues, such as lodging, per diem, and transport.

Activity 2: Small-group work and large-group discussion (35 minutes)

1. Divide the participants into small groups of three or four each.
2. Display the flipchart "Participants' Expectations for the Workshop."
3. Ask each group to briefly discuss and answer each question. One participant in each group should take notes and list responses on a flipchart. *(15 minutes)*
4. Ask the note-takers to report back to the full group on the groups' discussion of the first question. Repeat for the second and third questions. *(10 minutes total for responses)*

TRAINING TIP ○○○

All of the groups must answer and share responses to *all three* of the questions on the flipchart.

5. Summarize the participants' responses and address differences between the participants' expectations and what the workshop will actually cover.
6. Explain that any participant whose expectations still do not match the goals and objectives of the workshop should see one of the trainers before the end of the day, to clarify the participant's purpose in attending the training and to ensure that the workshop is appropriate for him or her. *(10 minutes)*

Session 1

Handouts

Handout 1-A
Workshop Goals and Objectives

Goals

This training will enable PAC providers to use communication and counseling skills to:

- Assess and acknowledge the client's needs
- Listen to her concerns
- Answer her questions
- Give her information about the procedure, what to expect during her visit, post-procedure care, and warning signs of complications
- Help her make decisions about family planning, prevention of sexually transmitted infections (STIs), and any other needed reproductive health services

Objectives

Attitudes

This training will enable participants to demonstrate:

- Respect for all clients, regardless of their values, social status, or personal situation
- Acknowledgment and respect for a client's need for confidentiality, privacy, and dignity
- Acceptance that a client may have very strong feelings about her situation and openness to discussing those feelings, including those related to sexuality and gender
- Openness to encouraging and answering a client's questions
- Respect for a client's right to informed choice in the use of contraceptives

Skills

This training will enable participants to:

- Assess the client's readiness to discuss her concerns and feelings
- Create a comfortable environment for openly discussing the client's feelings and needs
- Ask open-ended questions
- Listen effectively to the client's reply
- Encourage clients to ask questions and express opinions and feelings
- Use simple language and visual aids to explain basic information about the reproductive system, fertilization, abortion, the medical procedure, contraception, and STIs
- Support the client during the procedure through verbal and nonverbal communication
- Assess the client's need for contraception, her risk for contracting an STI, and her need for other reproductive health services

Knowledge

This training will enable participants to:

- Explain the clients' range of concerns and the different needs of women with spontaneous abortion vs. those with complications from induced abortion
- Provide preoperative information, including information on the client's condition and the medical procedure itself
- Offer postoperative instructions, including how the client should take care of herself after the procedure, common side effects, signs of complications and what to do if these occur, return to fertility, and referral sources for nonmedical problems or concerns
- Present basic information about reproductive tract infections (RTIs) and STIs
- Explain basic information about contraceptive methods, particularly those that can be used immediately postabortion

Handout 1-B
Workshop Schedule

Session	Participants	Time
1. Opening Session		Morning, Day 1
A. Opening Ceremony	All	
B. Workshop Introduction	All	
2. Values and Attitudes Related to Postabortion Care	All	
3. Understanding the Client's Perspective		
A. Developing Case Studies of Postabortion Clients	Nonphysicians	
B. Confidentiality, Privacy, and Dignity	All	Afternoon, Day 1
C. Addressing the Postabortion Client's Feelings	All	
D. Gender Issues	Nonphysicians	
E. Sexuality Issues	Nonphysicians	
4. Interpersonal Communication		Morning, Day 2
A. Two-Way Communication	Nonphysicians	
B. Verbal and Nonverbal Communication	Nonphysicians	
C. Effective Listening	Nonphysicians	
D. Asking Open-Ended Questions	Nonphysicians	
E. Using Simple Language and Visual Aids	Nonphysicians	
5. Family Planning Information and Counseling for the Postabortion Client		Afternoon, Day 2
A. Rationale	Nonphysicians	
B. Informed Choice	Nonphysicians	
C. Individual Factors	Nonphysicians	
6. Related Reproductive Health Needs and Other Issues		
A. RTI/STI Information for the Postabortion Client	Nonphysicians	
B. Referring Clients for Other Services	Nonphysicians	
C. Threatened Abortion	Nonphysicians	
7. Postabortion Counseling		Morning, Day 3
A. Overview of Postabortion Counseling	Nonphysicians	
B. Preprocedure Counseling	Nonphysicians	
C. Being Supportive during the Procedure	All	Afternoon, Day 3
D. Counseling after the Procedure	Nonphysicians	
8. Clinical Practicum	All	Morning, Day 4
9. Workshop Wrap-Up	All	Afternoon, Day 4

*Doctors should attend this session if they hold primary responsibility for providing family planning to postabortion clients.

Session 2:
Values and Attitudes Related to Postabortion Care

Objectives

- To explain the importance of respect for all clients, regardless of their values, social status, or personal situation
- To explain the importance of being aware of one's own values and attitudes, to avoid imposing them on clients

Training Methods

- Warm-up
- Large-group exercise
- Discussion

Materials

- Flipchart paper, easel, markers, and tape
- Handout 2-A: Ambiguous Figure (page 31) (also available as a transparency, Appendix C, page 164)
- Handout 2-B: Values and Attitudes in PAC (page 32)

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. Review the list of values statements (page 25). Select seven statements to use in this exercise, adding other statements if necessary. As the statements are listed in random order, you will need to decide which one you want to read first, second, and so on. See Training Tip on page 26 for guidance.
3. Make three separate signs: AGREE, DISAGREE, and UNSURE. Post these signs on three different walls in spaces where people can gather near them.
4. Arrange the tables and chairs so the participants can move easily between the signs.
5. Review all handouts and make one copy for each participant.

Session Time (total): 1 hour

SESSION 2 TRAINING STEPS

Session Time: 1 hour

Activity 1: Warm-up (10 minutes)

1. Distribute Handout 2-A: Ambiguous Figure to each participant. Ask the participants to look at the picture and decide what it is, then to turn to the person next to them and discuss it.
2. Ask for volunteers to say what they saw. When someone describes an elderly woman, ask others to raise their hands if that is what they saw at first. When someone describes a young woman with a fancy hairstyle, ask others to raise their hands if that is what they saw first.
3. Discuss this exercise by asking the following questions:
   - Did you and your partner immediately agree on what you saw?
   - How can you explain the fact that people in the group saw two very different images in the same picture?
   - How can you apply this to your work in counseling postabortion clients?

Activity 2: Discussion (10 minutes)

1. Ask the participants what the word *values* means and how it might affect their work as PAC providers.
2. Summarize aloud the main points of Handout 2-B: Values and Attitudes in PAC, discuss them, and then distribute the handout to the participants.

Activity 3: Large-group exercise (25 minutes)

1. Explain that the participants will now do an exercise that will help them think about their own attitudes and values about PAC and postabortion clients.
2. Read aloud the following instructions:

   "I will read several statements aloud. After I read each statement, go stand under the sign that best reflects your opinion—whether you agree, disagree, or are unsure. I will then ask one or two participants from each group to describe their thinking about this statement."
3. Read and discuss as many of the values statements on the opposite page as time allows. (*Note:* Do not distribute the values statements as a handout. Participants or others who might see such a handout after the training could misunderstand the intent of the exercise and believe these statements reflect the beliefs of EngenderHealth or the trainers.) After each statement, ask one or two participants from each group to explain their positions. (See Training Tip, page 26.)

❖◆❖ Sample Values Statements ❖◆❖

Please note—these are not to be distributed as a handout, because the participants, or others who read their materials later, may misunderstand the intent of this exercise and may think that these statements reflect the beliefs of EngenderHealth and the trainers.

Statements for All Settings

- Doctors have a responsibility to terminate unwanted pregnancies that result from contraceptive failure.
- A woman's role is to bear children.
- If a man wants his wife to have an abortion, she should have one, even if she wants to carry the pregnancy to term.
- Commercial sex workers are immoral.
- It is okay for an unmarried man to engage in sexual activity. (And what about for an unmarried woman?)
- Providers should promote abstinence as the best family planning method for unmarried women.
- An unmarried schoolgirl who becomes pregnant does not deserve to be expelled from school.
- In a couple, the woman should be responsible for contraception.
- Contraceptive methods should be available to adolescents and unmarried adults.
- It is in man's nature to be a polygamist (to want to be with many women).
- Women who have multiple abortions should be sterilized.
- Parents have a right to know if their daughter has had an abortion (either induced or spontaneous).

Statements for Settings Where Abortion Is Legal

- A married, multiparous woman who terminates a pregnancy does not want to have any more children.
- It is a provider's responsibility to convince abortion clients to accept a family planning method immediately postabortion.

Statements for Settings Where Abortion Is Illegal or Highly Restricted

- If a woman consistently has miscarriages (spontaneous abortions), she must be doing something wrong.
- If a woman deliberately induces an abortion, she is committing murder.
- Women who have induced an abortion deserve to suffer and should expect to feel pain during any postabortion treatment procedures.
- If abortion is legal, people will be more promiscuous and less responsible about sex.
- If a postabortion client has many children, she should be encouraged to be sterilized.
- It is a provider's responsibility to report induced abortion cases to the police.
- Women who have had spontaneous abortions deserve more compassion than women who have induced their abortions.
- Young women who present with abortion complications have probably induced their abortions.
- Women who induce abortions should be made to pay for otherwise free medical services.

Adapted from: Ipas. 1996. Module 2: Patient-provider interaction and communication. In *MVA trainer's handbook*. Carrboro, NC. Additional values statements were provided by EngenderHealth staff.

TRAINING TIP ○○○

For this exercise to be effective, it is essential for the participants to decide whether they agree with, disagree with, or are unsure about these statements. They should not submit anonymous responses to post on the signs, because this will detract from the purpose of the exercise. Practice in discussing their own values will help raise the participants' awareness of how these values can affect their interactions with clients (or others).

Abortion and PAC are among the most controversial and sensitive topics in many countries. However, specific issues and concerns differ from place to place. Therefore, it is important for you to read these statements carefully. Choose only those that are relevant to the values and attitudes of service providers in your country. Add other statements, if necessary. Also, these statements are listed in random order; you need to decide which one you want to read first, second, and so on.

Many of the values and attitudes to discuss differ across settings, depending on whether women have access to safe, legal abortion services. To address this variation, three categories of "Sample Values Statements" are provided: one for all settings, one for settings where abortion is legal, and one for settings where abortion is illegal or highly restricted. Again, use these lists as a *guide,* and choose only the statements that are relevant for your region.

During this exercise, it is important to emphasize that there are no "right" or "wrong" answers. People respond based on their own values and beliefs, and the purpose of the exercise is to help explore differences when they exist. You must remain neutral throughout the exercise and maintain a balance between the different viewpoints presented. You will have to limit each group's responses to just two or three per statement if you are to cover a range of issues.

Activity 4: Discussion (15 minutes)

1. Ask the participants the following questions:
   - Does everyone in the group have the same attitudes, or are there differences?
   - Which statements caused the widest range of disagreement? What could explain these differences?
   - Were any of the results surprising? Which ones?
   - How might these attitudes be expressed to clients, and how might that make clients feel?

TRAINING TIP ❍❍❍

The following are examples of how values and attitudes can negatively influence quality of care:

- Not offering a client family planning counseling if we think that she is not interested in spacing her births
- Making a woman with an incomplete abortion wait until all other women are treated, because we think that she is immoral and deserves the pain
- Withholding medication for pain if we think a woman does not need it or if we think she deserves to suffer pain

2. Summarize the exercise by reviewing ways in which providers' values and attitudes can influence health care service delivery and by noting our responsibility to provide health care in a respectful and nonjudgmental manner.

TRAINING TIP ❍❍❍

Sample summary of this entire session:

"Many of you are from similar backgrounds, but you had very different responses to the statements. People's different experiences lead them to different conclusions. Being aware of our own attitudes helps ensure that we do not impose our beliefs on our clients. We have a professional obligation to provide health care, including postabortion care, in a respectful and nonjudgmental manner."

Source: Ipas. 1996. Module 2: Patient-provider interaction and communication. In *MVA trainer's handbook*. Carrboro, NC.

Session 2

Handouts

Handout 2-A
Ambiguous Figure

Source: Boring, E. G. 1930. A new ambiguous figure. *American Journal of Psychology* July:444.

Handout 2-B
Values and Attitudes in PAC

A *value* is a belief that is important to an individual. Values can be influenced by religion, education, culture, and personal experiences. Our values shape our *attitudes*, or the way that we think about and act toward particular people or ideas.

Every interaction between a woman and the health care staff, from the time she enters the health care system until she is discharged, affects the woman's satisfaction with her care, how quickly she recovers, and how well she takes care of herself after she leaves the facility.

How we communicate our own values and attitudes (both verbally and nonverbally) is an important part of our interactions with the women we treat. Our values are often so ingrained that we are unaware of them until we are confronted with a situation that challenges them.

Our attitudes, feelings, biases, and values will affect how we treat a client's illness. For example, our private reaction to the way she looks, her social class, or her reason for treatment may affect the way we administer pain control, the gentleness or harshness with which we perform procedures, the delay that we may impose, and whether we consider each client's full range of health care needs.

Session 3:
Understanding the Client's Perspective

Objectives

- To identify the different demographic and social characteristics of postabortion clients that are common in the participants' service-delivery settings and the different situations or conditions that lead clients to need postabortion care
- To develop "case studies" for three or four clients who reflect these demographic and social characteristics, situations, and emotional and physical conditions *(These case studies will be used for role plays throughout the remainder of the workshop.)*
- To explain the importance of showing respect for a client's rights of confidentiality, privacy, and dignity
- To identify simple ways in which this respect can be shown during PAC
- To describe the very strong feelings a postabortion client may have about her situation
- To identify ways in which the provider can address the emotional needs and concerns of the postabortion client
- To assist the participants in reflecting upon how their personal experiences and their own sexual development might affect their current views and feelings about sexuality issues, and to explain how these experiences might affect their approach to counseling postabortion clients
- To examine sexuality in the context of PAC, and explain how providers can respond to clients' concerns related to sexuality
- To explain how cultural attitudes about gender can affect the treatment that postabortion clients receive in a service-delivery setting and the client's perception of providers

Training Methods

- Brainstorm
- Large-group work
- Demonstration
- Small-group work
- Discussion
- Demonstration role play
- Presentation

Materials

- Flipchart paper, easel, markers, and tape
- Any materials (such as a sofa, blanket, curtain, or drape) that could be used to depict a clinic setting
- Handout 3-A: Ensuring Clients' Confidentiality, Privacy, and Dignity (page 51)

- Handout 3-B: Gender (page 52)
- Handout 3-C: How Do We Learn about Sex? (page 53)
- Handout 3-D: Sexuality (page 54)

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. When using Option 2 of Part A, select three or four case studies from Appendix D: Sample Case Studies, to reflect a wide range of postabortion client characteristics and situations, and prepare handouts of the selected case studies for all participants.
3. Review all handouts and make one copy for each participant.
4. Gather materials to depict a service-delivery setting.
5. Prepare two flipcharts, one entitled "Demographic and Social Characteristics" and one entitled "Situations and Emotional and Physical Conditions."
6. Prepare one flipchart table for each case-study client (to be developed by the participants during Part A or selected from Appendix D). Each table should be entitled "Addressing the Postabortion Client's Feelings" and should have three columns: "Client's feelings," "Why?" and "Provider's response." (See sample below.)

Addressing the Postabortion Client's Feelings

Client's name: _____

Client's feelings	Why?	Provider's response

Session Time (total): 5 hours, 35 minutes (Option 1), or 4 hours, 30 minutes (Option 2)

SESSION 3 TRAINING STEPS

Part A Developing Case Studies of Postabortion Clients

Option 1: Original Case Studies

Time: 1 hour, 30 minutes

This option should be used if time permits, as it is a key component to helping the participants develop empathy toward and an understanding of the varied needs and feelings of clients. If time for conducting the full counseling training is limited, Option 2 (page 39) may be used to shorten the session.

Activity 1: Brainstorm (20 minutes)

1. Display the flipchart entitled "Demographic and Social Characteristics." Ask the participants to think about the clients they see in PAC and to list their demographic and social characteristics. Write the participants' responses on the flipchart. (Guide the brainstorming by referring to the sample categories listed in the Training Tip below.)
2. Ask the participants to think about the individual situations that cause clients to seek PAC and their emotional or physical condition upon arrival at the facility. Write their ideas on the flipchart entitled "Situations and Emotional and Physical Conditions."

TRAINING TIP ○○○

Explain the difference between demographic and social characteristics, situations, and emotional and physical conditions, using the following examples:

- **Demographic and social characteristics:** age, marital status, parity, income, educational level, and social background
- **Situations:** desired vs. unwanted pregnancy, spontaneous vs. induced abortion, method of induced abortion and whether the partner knows about it, contraceptive failure vs. no use of contraceptives, and referral from a provider vs. self-referral
- **Emotional and physical conditions:** calm vs. hysterical, hemorrhaging vs. in stable physical condition, emergency vs. able to wait for treatment, conscious vs. unconscious, afraid vs. not nervous, and in severe pain vs. in moderate pain

Activity 2: Large-group work (20 minutes)

1. Tell the participants that they will develop client profiles as a large group (based on the list of demographic and social characteristics), and then work in small groups to develop a case study for each profile (based on the lists of situations and emotional and physical conditions).

2. Explain that the profiles should be varied to reflect the range of different demographic and social characteristics seen in postabortion clients. Each case-study client will be given a name, because the clients will be used in role-play exercises throughout the rest of the workshop. In the role plays, the sample case-study clients will be treated as if they are real postabortion clients.
3. Start developing a client profile by asking the participants to suggest and agree on a woman's first name.
4. Write the woman's name at the top of a flipchart, then ask the participants to agree on the following (see sample profiles in the Training Tip below):
   - Her age
   - Her number of children
   - Her marital and socioeconomic status
   - Her educational level
   - Any other demographic and social characteristics that seem relevant
5. When the group is satisfied with this client profile, repeat the process until you have completed three or four profiles.

TRAINING TIP ○○○

Develop three or four client profiles, depending on the number of participants. (Develop at least three, to reflect a range of different demographic and social characteristics and situations of typical postabortion clients. More than four profiles will take too much time to process during the role-play sessions.) Do not divide the participants into small groups until *after* all of the client profiles are complete; otherwise, they risk developing duplicate sets of demographic and social characteristics.

Throughout the workshop, have the participants work in small groups, performing counseling role plays with each "client." Three or four participants per group would be best. Thus, the following numbers can be used as a guide:

- Six to 12 participants: three client profiles, with two to four participants per role-play group
- 12 to 20 participants: four client profiles, with three to five participants per role-play group

As is noted in the introduction, this training will be more difficult to conduct if there are fewer than six or more than 15 participants.

When developing the profiles, focus only on the client's demographic and social characteristics. Do *not* discuss her postabortion situation or condition, because that is what the small groups will do in developing their case studies.

Sample "profiles":

- Lisa: age 35, two children, married, middle class, has her own business
- Nora: age 18, no children, unmarried, did not finish secondary school, living in poverty
- Ella: age 20, one child, married, finished secondary school

Activity 3: Demonstration (15 minutes)

1. Tell the participants that they will work in small groups to develop case studies for each client profile.
2. First, demonstrate how to do this with one of the client profiles. Refer to the lists of situations and emotional and physical conditions and ask the participants which of these would most likely apply to this particular client.
3. Write their responses on the same flipchart with the client's name and her demographic and social characteristics. Then ask the participants to tell a story about this client, including the nature of her pregnancy (wanted or unwanted), her relationship with her partner(s), and specific details about how she came to need postabortion care.
4. Note the participants' suggestions on the same flipchart. Finally, arrange all of the information listed on this flipchart in a logical order, and write the client's "case study" on a new flipchart. (See below for a sample case study.)

TRAINING TIP ○○○

Developing a case study is like writing a little story. First, you think about what you know about the main character (the client profile), then you try to imagine what happened to this woman that resulted in her being in these situations and having these emotional and physical conditions. This information can be taken directly from the brainstorm lists of demographic and social characteristics and situations and emotional and physical conditions. The following is an example, but your demonstration sample should come from the participants' brainstorm lists.

Sample Case Study for "Nora"

Nora is 18 years old, is unmarried, has no children, does not attend school, lives at the poverty level, and plans to marry her long-term boyfriend, John. Nora believes she became pregnant due to contraceptive failure (John was supposed to pull out). Despite the unplanned nature of the pregnancy, Nora and John were happy with the pregnancy. But today, when John was at work, Nora started bleeding heavily. She has come to the hospital alone, with no referral. She is extremely frightened by what is happening to her body and scared about what they will do to her in the hospital. She is also afraid that people will think her abortion was induced, when in fact it was spontaneous.

Activity 4: Small-group work (25 minutes)

1. Divide the participants into small groups (one group for each of the remaining client profiles), and assign one profile to each group.
2. Remind the participants to refer to the list of situations and emotional and physical conditions and to identify those that apply to their client.
3. Allow the groups 20 minutes to write their cases, putting the "final draft" on a flipchart.

TRAINING TIP ○○○

Circulate frequently among the different groups. First, check with each group to see if they understand the assignment. Then keep checking on the groups to make sure that they are making the situations and emotional and physical conditions realistic, and that they are not telling the same "story" about two different clients. You may have to negotiate between groups to convince them to adjust their stories slightly, so the variety of situations and emotional and physical conditions listed by the participants is reflected in these case studies.

Activity 5: Discussion (10 minutes)

1. Ask a volunteer from each group to present the group's case study on a flipchart.
2. Allow a few questions to clarify or suggest changes, but do not encourage major revision.

TRAINING TIP ○○○

When each group presents its case study, the participants in the other groups are likely to have different opinions about how each one should or should not be written. There are endless possibilities for case studies, so it is not necessary to have all of the participants agree on every aspect of each. That is why discussion should be limited. However, if one group has clearly presented a case study that is not realistic for the local situation, work with that group separately to revise it, instead of trying to revise it in front of the rest of the participants.

After the case studies have been presented, post the flipcharts on the wall in a place where they will remain visible and uncovered. The case studies will be referred to repeatedly throughout the training, wherever the following symbol appears in this training curriculum:

Option 2: Adapted Case Studies

Time: 25 minutes

If time is extremely limited, select three or four of the prepared case studies found in Appendix D. (This should be done prior to the session.) The case studies selected should reflect a wide range of client characteristics and situations, including age, parity, marital status, spontaneous or induced abortion, etc.

Activity 1: Presentation and small-group work (15 minutes)

1. Present the three to four case studies preselected from Appendix D. Distribute the handout with the selected case studies (created by the trainer prior to the session) to all participants.
2. Divide the participants into small groups (one for each of the case studies) and assign one case study to each group. Explain that the stories are varied to reflect the range of different demographic and social characteristics, situations, and emotional and physical conditions seen in postabortion clients.
3. Give each group 10 minutes to adapt its respective case study to fit their local situation. Tell each group to write a final draft of the case study on a flipchart.
4. Remind the participants that each case-study client has a name because the clients will be used in role-play exercises throughout the rest of the workshop. In the role plays, the sample case-study clients will be treated as if they are real postabortion clients.

Activity 2: Discussion (10 minutes)

1. Ask a volunteer from each group to present the group's case study on a flipchart.
2. Allow a few questions to clarify or suggest changes, but do not encourage major revision. (See Training Tip in Activity 5 of Option 1, page 38.)

Part B Confidentiality, Privacy, and Dignity

Time: 45 minutes

Activity 1: Brainstorm (10 minutes)

1. Ask the participants what the words *confidentiality*, *privacy*, and *dignity* mean.
2. Briefly note their responses on a flipchart.

Activity 2: Demonstration role play (15 minutes)

1. Tell the participants that you and the other trainer will now perform a role play demonstrating some of the things that can go *wrong* in ensuring a client's confidentiality, privacy, and dignity.
2. Ask the participants to watch carefully for both verbal and nonverbal cues.

3. Perform the role play, using one of the case-study clients developed in Part A (preferably one in an anxious condition) as the client being treated.

TRAINING TIP ○○○

For this demonstration, the trainers (rather than the participants) should perform the role play, to ensure that it achieves the intended objectives and gives appropriate examples for discussion.

Negative cues for possible use in the role play include:

- The client is lying in a busy, open area.
- Her feet are facing the door, with her genitals exposed.
- There are no screens or curtains around her.
- She is not adequately draped.
- The provider openly discusses her case with anyone who walks by.
- People frequently walk in and out of the area, sometimes stopping to talk casually with the provider or nurse.
- The provider attempts to discuss discharge information or to provide counseling in this busy, nonprivate environment.

If items such as a sofa or blanket are not available, the client should lie on the floor in a space visible to all observers.

Activity 3: Discussion (20 minutes)

1. Facilitate a discussion about how the client must have felt in this situation by asking the following questions:
   - How do you think the client felt in this situation?
   - How would you feel if you were this client?
   - Why do these conditions exist in the delivery of PAC services?
2. Distribute Handout 3-A: Ensuring Clients' Confidentiality, Privacy, and Dignity, and review the information with the participants.
3. Ask the participants how they can apply what was discussed in their own service sites. Focus the discussion on ensuring confidentiality, privacy, and dignity, within the realities of the participants' service-delivery settings, rather than imagining an ideal situation.

Part C Addressing the Postabortion Client's Feelings

Time: 1 hour, 35 minutes

Activity 1: Brainstorm (20 minutes)

1. Explain that clients have other needs and concerns besides confidentiality, privacy, and dignity; these may include emotional, informational, or economic needs. Explain that the group will focus on informational needs later in the workshop, and that economic needs can be addressed by referring clients to local resources that may lie outside of the health care system (also to be discussed later in the workshop). Therefore, this exercise will help the participants focus on the emotional needs and concerns of clients during all phases of PAC.

2. Ask the participants to think about the case-study clients they developed or discussed earlier and what feelings those clients might have from the time they arrive at the site until the time they leave.
3. Using the prepared flipchart tables "Addressing the Postabortion Client's Feelings," list the feelings for each case-study client. Leave plenty of space between each feeling listed in the "Client's feelings" column to match up with the longer writing expected in the "Why?" and "Provider's response" columns.
4. When the participants have completed the feelings list for each case-study client, ask them why, for each feeling identified, each client might feel that way. Briefly record their responses on the flipchart. Leave the third column blank until the small-group work.

TRAINING TIP ○○○

Remind the participants to focus on feelings specific to postabortion clients, and clarify the reasons why clients have these feelings (particularly if it seems that the participants have not fully understood the exercise).

In settings where abortion is legal, clients' emotional concerns are often centered on the procedure itself. For example, clients may fear pain during the procedure or may fear potential complications. Another client concern is the implicit or explicit pressure to accept a family planning method immediately postabortion.

In settings where abortion is illegal or highly restricted, clients may commonly feel guilt, shame, anxiety, and fear of an induced abortion being discovered (by family members, local authorities, or others).

Across all settings, women who have had spontaneous abortions may experience a great sense of loss, disappointment, frustration, and guilt over not having been able to carry the pregnancy to term. (For a more detailed exploration of this issue, see Session 6, Part C, page 101, on responding to threatened abortion.)

Activity 2: Small-group work (30 minutes)

1. Divide the participants into the same small groups that developed or discussed the case-study clients. Give the flipchart for each case-study client used above to the respective group.
2. Ask each group to fill in the third column for their respective case-study clients. They should ask themselves: What can the provider do when a client is feeling this way?
3. Ask each group to choose a spokesperson who will report to the rest of the participants during the large-group discussion.

Activity 3: Discussion (45 minutes)

1. Post the "Addressing the Postabortion Client's Feelings" flipcharts on the wall, alongside the respective case-study flipcharts. (Save the flipcharts after this session for use in Session 6.)
2. Ask the spokesperson from each group to share the group's ideas. Ask for comments or questions from the rest of the participants.

Sample completed flipchart—DO NOT COPY CONTENT

Addressing the Postabortion Client's Feelings

Client's name: Nora

Client's feelings	Why?	Provider's response
FEAR ***Where abortion is legal***	***Fear of:*** ■ Feeling pain during the procedure ■ Experiencing complications resulting from the procedure ■ Feeling pressure to accept a permanent or long-term family planning method	***Examples:*** ■ Explain what to expect during the procedure, and tell the client what pain control medication will be used (if any) ■ Tell the client about the risk of abortion complications, relative to the risk of complications during delivery ■ Tell the client that she may choose whether to receive a family planning method immediately postabortion
FEAR ***Where abortion is illegal or highly restricted***	***Fear of:*** ■ Dying ■ Becoming infertile ■ Becoming disabled ■ Being prosecuted (if abortion was illegally induced) or criticized ■ "The unknown" (what will happen at the hospital) ■ Not receiving treatment because of inability to pay for services	***Examples:*** ■ Listen ■ Reassure the client ■ Find out why or what the client fears ■ Provide information ■ Arrange for family planning counseling or referral for other services, if needed ■ Be aware of one's own possible negative bias toward the client, and try not to be judgmental

Adapted from: Ipas. 1996. Module 2: Patient-provider interaction and communication. In *MVA trainer's handbook*. Carrboro, NC.

Part D Gender Issues

Time: 50 minutes

Activity 1: Brainstorm/large-group discussion (5 minutes)

1. Ask the participants to brainstorm a definition of *gender* and write it on a flipchart.
2. Explain the difference between *gender* and *sex characteristics,* and clarify any misconceptions.

TRAINING TIP ○○○

Gender refers to a set of qualities and behaviors expected from a female or male by society. *Sex characteristics* are what make us "male" or "female" and are based on anatomy, physiology, and genetics.

Gender roles are learned and can be affected by factors such as education or economics. They vary widely within and among cultures. While an individual's sex generally does not change, gender roles are socially determined and can evolve over time.

Gender roles and expectations are often identified as factors hindering the rights and status of women, with adverse consequences that may affect family life, education, socioeconomic status, and health. For this reason, awareness of gender, like sexuality, is an important element of reproductive health services.

Activity 2: Large-group exercise (45 minutes)

1. Ask the participants if they were ever told to "act like a man" or "act like a woman" (based on their sex). Tell them to give examples of some experiences in which someone has said this or something similar to them. Ask:
   - Why did the individual say this?
   - How did it make you feel?
2. Tell the participants that the group will now look more closely at these two phrases to see how society can make it very difficult to be either male or female.
3. Print the phrase "Act like a man" on a flipchart.
4. Ask the participants to share their ideas about what this means. (These are society's expectations of who men should be, how men should act, and what men should feel and say.) Write the participants' ideas about "acting like a man" on the flipchart. Some responses might include the following:
   - Be tough
   - Do not cry
   - Show no emotions
   - Take care of other people
   - Do not back down

5. Once the participants have finished their list, ask the following questions and discuss:
   - Is it limiting for a man to be expected to behave in this manner?
   - What emotions are men not allowed to express?
   - How can "acting like a man" affect a man's relationship with his partner(s) and children?
   - How can social norms and expectations to "act like a man" have a negative impact on a man's sexual and reproductive health?
   - How can pressure to "act like a man" influence how a man behaves sexually and how he feels about his sexuality?
   - Do men need to conform to these social norms? Is it possible for men to challenge and change existing gender roles?
6. Next, print the phrase "Act like a woman" on a flipchart.
7. Ask the participants to share their ideas about what this means. (These are society's expectations of who women should be, how women should act, and what women should feel and say.) Write the participants' ideas about "acting like a woman" on the flipchart. Some responses might include the following:
   - Be passive
   - Be the caretaker
   - Put others first
   - Act sexy, but not too sexy
   - Be quiet
   - Listen to others
   - Be the homemaker
8. Once the participants have finished their list, ask the following questions and discuss:
   - Is it limiting for a woman to be expected to behave in this manner?
   - What emotions are women not allowed to express?
   - How can "acting like a woman" affect a woman's relationship with her partner(s) and children?
   - How can social norms and expectations to "act like a woman" have a negative impact on a woman's sexual and reproductive health?
   - How can pressure to "act like a woman" influence how a woman behaves sexually and how she feels about her sexuality?
   - Do women need to conform to these social norms? Is it possible for women to challenge and change existing gender roles?
9. Summarize the activity by asking the following questions and discussing the responses:
   - How can gender roles facilitate and limit what men and women can and cannot do in sexual relationships?
   - How might gender stereotypes have a negative impact on the ways in which providers relate to men and women as clients?
   - Based on gender stereotypes, what messages does society give about men's and women's roles in determining aspects of a sexual relationship (i.e., who makes decisions about when to have sex and whether to use contraception)?
   - As providers, how can we help clients when pressure (internal or external) to conform to gender-role expectations potentially threatens their sexual or reproductive health? (An example of this could be a young woman who places herself at risk of unintended pregnancy because having a contraceptive would indicate that she "planned" to have sex.)

- How do you think an awareness of gender roles and stereotypes can help us in our work as providers?

(This exercise was adapted from: EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. Working draft. New York.)

TRAINING TIP ○○○

When discussing responses to the questions above, include the following points:

- Gender-role expectations or cultural norms may result in unwanted pregnancy. This may occur because women do not have full control over when they have sex, or because women cannot easily access contraceptives, or for other reasons. Providers should be aware of this possibility when dealing with clients.
- Providers may have different expectations for female clients than for male clients. This may mean that they inhibit women's choices without even realizing it. (For example, providers may believe that unmarried women do not have a right to use family planning methods, because women should not engage in sexual activity before marriage.)
- This exercise cannot solve the gender-based problems that face our clients, but it can help us become more aware of how gender roles affect our clients' lives.
- Use the case-study clients as examples throughout the discussion, so the participants can apply this information to hypothetical postabortion clients.

10. Distribute Handout 3-B: Gender to all participants.

Part E Sexuality Issues

Time: 55 minutes

Activity 1: Brainstorm/large-group discussion (10 minutes)

1. Ask the participants to brainstorm a definition of *sexuality* and write it on a flipchart. Discuss this definition and clarify any misconceptions.
2. Present the following definition of sexuality and briefly explain why it is important to discuss its role in reproductive health:

   "Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. It deals with the anatomy, physiology, and biochemistry of the sexual response system; roles, identity, and personality; and individual thoughts, feelings, behaviors, and relationships."

   —Definition developed by the Sexuality Information and Education Council of the United States (SIECUS)

TRAINING TIP ○○○

Sexuality, when defined in this way, is an important part of family planning and reproductive health service delivery. Client-centered counseling and the facilitation of informed choice in reproductive health care depend on providers being aware of issues related to sexuality. A client's sexual history, relationships, and circumstances can play an important part in her contraceptive choice, her decision to be screened for sexually transmitted infections (STIs), and her long-term satisfaction with health care services. In addition, the ability of women to improve their reproductive health and achieve their reproductive intentions is deeply affected by the degree to which they are knowledgeable about and in control of their sexuality and sexual relationships. Health care providers can help to empower women by supporting them in the process of developing knowledge and control.

Activity 2: Small-group work (30 minutes)

1. Distribute Handout 3-C: How Do We Learn about Sex? and a pen or pencil to each participant.
2. Ask the participants to write answers to the questions on the handout, working by themselves. Encourage them to keep their answers short, listing a few main points for each question.
3. After 15 minutes, divide the participants into pairs, and ask each pair to discuss their answers with each other and whether they now agree or disagree with the ideas they were taught from each source.

Activity 3: Large-group discussion (15 minutes)

1. Reconvene the larger group and facilitate a discussion about what we learned about sex and gender as children and how these ideas influence our work as service providers.
2. Address some or all of the following questions during the discussion:
   - Based on your discussions in pairs, what do you think are the most common negative ideas that we are taught about sex?
   - How does our society give us messages about sex?
   - How do the ideas conveyed or the messages received about sex differ for boys and for girls?
   - What messages does society give about when women are supposed to have sex for the first time and with whom (e.g., after marriage, with her husband)?
   - What messages does society give about when men are supposed to have sex for the first time and with whom (e.g., before marriage, with a prostitute)?
   - Do you think your clients learned about sex in the same ways you did? What are the similarities? What are the differences?
   - Why is it important for us to consider how our clients learned about sex and sexuality? How does it apply to our work as providers?
   - How do our own sexual experiences and learning about sexuality affect our ability to counsel clients about issues related to sexuality and gender?
   - How can you be sensitive to gender-based issues that may be facing your clients?

- How can you help your clients to be more comfortable discussing sexuality issues with you?

(This exercise was adapted from: EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. Working draft. New York.)

TRAINING TIP ○○○

When discussing responses to the questions above, include the following points:

- Our own inhibitions and attitudes about sexuality might affect the way we talk to our clients about sex, as well as our comfort in doing so. Understanding where our own feelings and beliefs stem from can help us empathize with the experiences of clients and with the difficulties we all have in talking about our sexuality.
- Sexual practices and relationships are affected by the way we feel about sex, what we think is proper and improper, and what it means to relate to another person in a sexual way. These types of thoughts and feelings are often filled with emotions—including, for example, pleasure, but also some times fear, guilt, shame, or embarrassment. These feelings come from our personal experiences, as well as from the meanings that our society and culture attach to sex.
- This exercise alone might not help us to feel more comfortable discussing sexuality with our clients, but it can be a helpful step in the process.
- Use the case-study clients as examples throughout the discussion, so the participants can apply this information to hypothetical postabortion clients.

3. Distribute Handout 3-D: Sexuality to all participants.

Session 3

Handouts

Handout 3-A
Ensuring Clients' Confidentiality, Privacy, and Dignity

Confidentiality means not discussing the client's personal information with her partner, with the family member(s) accompanying her, or with staff members not directly involved in her treatment (except where required in a life-threatening emergency). Personal information includes her medical history and the conditions bringing her to seek care, the services provided to her, and the family planning decisions she makes. (If she wants to involve a spouse or partner in decision making, however, her wishes should be followed.)

Privacy is critical to protecting the client's confidentiality, sense of security and dignity, and willingness to communicate honestly. Often, simple changes in the physical setting where clients are treated or counseled will offer them more privacy.

Dignity means that a client can feel self-worth and honor, regardless of her physical circumstances. Ensuring privacy and confidentiality can help a client to maintain her dignity.

The following situations may disturb a client's confidentiality, privacy, and dignity:

- Leaving the client lying in a busy, open area
- Facing her feet toward the door, with her genitals exposed
- Not using screens or curtains around her
- Not adequately draping her
- Openly discussing her case with anyone who walks by
- Allowing people to walk in and out of the area frequently
- Having casual conversations with other staff during treatment and/or counseling
- Attempting to discuss discharge information or provide counseling in a busy, nonprivate environment

Handout 3-B
Gender

Gender refers to a set of qualities and behaviors expected by society from a woman or a man. Gender roles are learned and can be affected by factors such as education or economics. They vary widely within and among cultures. While an individual's sex generally does not change, gender roles are socially determined and can evolve over time.

Gender roles and expectations are often identified as factors hindering the rights and status of women, with adverse consequences that may affect family life, education, socioeconomic status, and health. For this reason, awareness of gender, like sexuality, is an important element of reproductive health services.

The following are some examples of gender-role stereotypes:

- Women are supposed to be mothers, and their primary function is to reproduce.
- Men should be sexually experienced.
- Women should remain virgins until marriage.
- Men may demand to have sex with their wives or partners whenever they choose.
- Women do not enjoy sex and do not experience sexual desire.
- Men demonstrate their virility by having sex frequently and with many partners.
- Women who use family planning methods are able to be unfaithful to their husbands without getting "caught."
- Women who were raped were probably asking for it.

Discussion Points

If a provider feels that women who were raped are somehow responsible for this, then he or she may be less sensitive to the client's feelings and needs.

Examine the relationship between gender roles and power, and acknowledge that in some cases women are able to choose neither whether they engage in sexual activity nor whether they use a family planning method.

The experience of becoming pregnant as a result of male coercion, force, or dominance can make a postabortion client distrust a male PAC provider. She may be reluctant to ask questions or to express concerns and may be particularly tense during a procedure under local anesthesia.

Handout 3-C
How Do We Learn about Sex?

Please write short answers to the following questions, identifying two or three main ideas in response to each question.

When you were growing up:

1. What did you learn about sex from your family?

2. What did you learn about sex from your friends?

3. What did you learn about sex from your religion?

4. What did you learn about sex from your schools and teachers?

5. What did you learn about sex from music, movies, newspapers, and other media?

6. What did you learn about sex in your professional training or education?

7. What else did you learn about sex, and where did you learn it?

Handout 3-D
Sexuality

"Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. It deals with the anatomy, physiology, and biochemistry of the sexual response system; roles, identity, and personality; and individual thoughts, feelings, behaviors, and relationships."

—Sexuality Information and Education Council of the United States (SIECUS)

As defined in this way, sexuality is an important part of family planning and reproductive health service delivery. Client-centered counseling and the facilitation of informed choice in reproductive health care depend on providers' being aware of issues related to sexuality. A client's sexual history, relationships, and circumstances can play an important part in her contraceptive choice, her decision to be screened for sexually transmitted infections, and her long-term satisfaction with health care services. In addition, the ability of women to improve their reproductive health and achieve their reproductive intentions is deeply affected by the degree to which they are knowledgeable about and in control of their sexuality and sexual relationships. Health care providers can help to empower women by supporting them in the process of developing knowledge and control.

The following are examples of characteristics that relate to sexuality:

- Being newly sexually active
- Being unmarried and pregnant
- Surviving rape, incest, or sexual abuse
- Lacking choice or control over when and how to engage in sexual activity
- Discontinuing use of a contraceptive method because of its negative effects on sexual activity

Responses to the client's concerns might include:

- Assuring the client that all conversations will be kept confidential
- Addressing concerns in a respectful, nonjudgmental manner
- Acknowledging to the client that it may be difficult to talk about the sexual activity or relationship that resulted in an unwanted pregnancy, but letting her know that it may be helpful if she is to prevent unwanted pregnancy in the future
- Referring clients to family planning counselors, psychologists, or other resources within or outside of the institution

Session 4:
Interpersonal Communication

Objectives

- To describe the differences between one-way and two-way communication
- To explain the benefits of two-way communication for counseling the postabortion client
- To describe the impact of ineffective vs. effective listening in one-to-one communication
- To describe two basic categories of questions and the ways they are used in communications with postabortion clients
- To explain the importance of asking open-ended and feeling questions for effective assessment of the client's needs and knowledge
- To demonstrate the use of simple language and visual aids to explain the reproductive system, fertilization, miscarriage, abortion, and the postabortion medical procedure

Training Methods

- Warm-up
- Large-group exercise/discussion
- Role play
- Brainstorm
- Presentation
- Small-group work

Materials:

- Flipchart paper, easel, markers, and tape
- Erasable transparency markers or pencils (one per participant); use pencils if lamination and transparency markers are not available
- Overhead projector (optional)
- Two pieces of paper and one pencil for each participant
- One small piece of paper for each participant with an "emotion" word written on it
- Transparency 4-A: Sample Diagram (page 165)
- Handout 4-A: One-Way vs. Two-Way Communication (page 67)
- Handout 4-B: Effective Listening (page 68)
- Handout 4-C: Closed-Ended vs. Open-Ended Questions (page 69)
- Handout 4-D: The Female and Male Reproductive Systems (page 70)
- Handout 4-E: Anatomy, Physiology, and Pregnancy (page 73)
- IUD simulator/hand-held model and Karman Cannula #6 for MVA explanation (optional; see Training Tip, page 64)

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. Prepare a transparency of Transparency 4-A, and make one paper copy for use by a volunteer. If an overhead projector is not available, make one paper copy for each participant.
3. Review Handouts 4-A, 4-B, 4-C, and 4-E and make one copy for each participant.
4. Prepare small pieces of paper (enough to give one to each participant) with one "emotion word" written on each piece (e.g., sad, cynical, anxious, relieved, confused, angry).
5. Prepare several flipcharts like the example shown below:

Closed-Ended/Information Questions vs. Open-Ended/Feeling Questions

Questions	Structure (C or O)	Content (I or F)

6. Prepare two flipcharts with the diagrams from Handout 4-D (one of the female reproductive system and one of the male reproductive system).
7. Review Handout 4-D and make one laminated two-sided copy for each participant. If lamination is not available, copy this handout on paper along with the others.

Session Time (total): 3 hours, 45 minutes

SESSION 4 TRAINING STEPS

Part A Two-Way Communication

Time: 30 minutes

Activity: Warm-up (30 minutes)

1. Briefly brainstorm: What is *one-way communication*? What is *two-way communication*?
2. Ask for a volunteer to assist in this exercise.
3. Distribute paper and pencils to participants. Explain that the volunteer is going to describe a drawing to them and their task is simply to follow instructions in sketching what the volunteer describes. They cannot ask any questions or say anything.
4. Provide the volunteer with a copy of Transparency 4-A: Sample Diagram.
5. Ask the volunteer to describe what he or she sees on the sample diagram so the others can sketch it on one of their pieces of paper. The volunteer should not make eye contact with any of the participants and can use only verbal communication (no gestures or hand signals). Only one-way communication is allowed (no questions from the group).
6. After the volunteer has finished describing the diagram and before the next step of the exercise, ask the volunteer how she or he feels about the exercise. Ask him or her to check the other participants' drawings to see how close they came to the sample diagram. (Do *not* show the sample diagram to the participants.)
7. Ask the other participants how they felt about the exercise. Write their comments on a flipchart labeled "One-Way Communication."
8. Repeat this activity with a different volunteer and the same sample diagram. This time, however, allow the volunteer to make eye contact with the group and to have full and free two-way communication (i.e., participants can ask questions). Repeat the discussion questions as before.
9. When the exercise is over, project the correct figure on the overhead projector (or distribute copies).
10. Summarize by asking the following questions:
    - In the first attempt, how many of you got confused and just stopped listening? Why?
    - Why was the one-way communication so difficult to follow?
    - Why is two-way communication more effective than one-way communication?
    - Even two-way verbal communication cannot ensure complete understanding. How can we make our communication efforts more effective?
    - How does this exercise apply to our communications with postabortion clients?
11. Distribute and summarize Handout 4-A: One-Way vs. Two-Way Communication.

Part B Verbal and Nonverbal Communication

Time: 30 minutes

Activity: Large-group discussion and exercise (30 minutes)

1. Ask the participants to brainstorm a definition of *verbal communication*.
2. Explain that when they interact with clients, it is important for them to choose their words carefully, to be sensitive to clients' feelings, and to provide nonjudgmental care.
3. Ask the participants to give examples of words or statements that can be hurtful to clients and create a communication barrier.

TRAINING TIP ○○○

Examples of hurtful statements include:

- "You should not be having sex if you are not prepared to raise a child."
- [To a crying client] "I bet you were not crying when you got yourself into this situation."
- "You deserve to suffer for what you have done."

4. Ask the participants to brainstorm a definition of *nonverbal communication*. Ask them to list examples of how they can communicate with clients nonverbally.

TRAINING TIP ○○○

Examples of how to communicate nonverbally include:

- Nodding
- Holding the client's hand
- Maintaining eye contact*
- Giving looks of reassurance

Factors affecting nonverbal communication include:

- Eye contact*
- Body language
- Tone of voice
- Facial expression

*Depending on cultural norms regarding eye contact.

5. Explain that nonverbal communication can sometimes send a stronger message to clients than verbal communication, making it harder to mask our own feelings and judgments.
6. Give an example of a simple phrase, such as "Good morning," with which one can convey two completely different emotions by varying aspects of nonverbal communication (e.g., by tone of voice or facial expression).

7. Give each participant a small piece of paper labeled with an emotion word.
8. Going around the room, ask each participant to repeat aloud the example phrase above ("Good morning") and demonstrate the emotion on the piece of paper by using nonverbal communication.
9. Summarize by emphasizing the importance of recognizing the verbal and nonverbal signals that we send to clients. Remind the participants of the impact that these signals may have on their interactions with clients (and, therefore, on the quality of care that their clients receive).

Part C Effective Listening

Time: 35 minutes

Activity 1: Large-group exercise/discussion (20 minutes)

1. Ask the participants to count off by twos (1-2-1-2, etc.).
2. Ask all of the "1s" to leave the room. The second trainer will go with them and do the following:
   - Provide the "1s" with a topic to discuss that should generate a lot of interest. (This can be a job-related matter, a news item of local interest, or a personal topic.)
   - Tell the "1s" that they will be asked to talk about this topic with their partner for approximately four minutes when they return to the room. Ask them to think about what they would like to say on this topic to their partner.
3. While the "1s" are out of the room, give the following instructions to the "2s":
   - This exercise is about listening.
   - When the "1s" come back in the room, they will start talking to their respective "2s" (you).
   - At first, you must act like you are not listening.
   - I will clap my hands after two minutes to signal that you can start listening.
4. Quickly brainstorm some ways in which the participants can show that they are not listening (e.g., by not making eye contact [depending on cultural norms], by playing with a pen, or by looking at their watches).
5. Ask the "1s" to return to the room and join their "2" partners.
6. Ask the "1s" to start talking to their partners about the assigned topic.
7. After two minutes, clap your hands and allow the discussion to continue for another two minutes.
8. Facilitate discussion about this exercise by asking:
   - How the "1s" felt when their partners were ignoring them
   - What the signs were that the "2s" were not listening
   - How it felt for the "2s" to act like they were not listening, and how it felt for the "2s" when they began listening
   - How this exercise relates to their work
9. Distribute Handout 4-B: Effective Listening.

Activity 2: Demonstration role play (15 minutes)

1. Model a few of the skills listed in Handout 4-B, including empathy and reflection, in a short role play. Describe the skills displayed in the role play, and briefly summarize Handout 4-B.

TRAINING TIP ○○○

Explanation of terms in Handout 4-B:

- **Empathy** is achieved by putting oneself in the client's position and understanding her point of view as if it were your own.
- **Interpreting the feelings and emotions behind what is being said** and **reflecting** involve using paraphrasing and responding to feelings and emotions. By doing this, we can confirm and convey our understanding of how the client really feels.

Part D Asking Open-Ended Questions

Time: 45 minutes

Activity 1: Brainstorm (10 minutes)

1. Ask the participants to brainstorm questions that providers might ask one of the case-study clients from Session 3.
2. Write each question, in full and exactly as it is asked, in the "Questions" column on the flipchart entitled "Closed-Ended/Information Questions vs. Open-Ended/Feeling Questions..." (*Note:* A sample completed flipchart is provided on the next page [top].)
3. Stop when you have at least 15 to 20 questions.

Activity 2: Presentation (10 minutes)

1. Explain that questions can be considered in terms of two categories: their structure (closed-ended vs. open-ended) and their content (information vs. feeling).
2. Distribute and review Handout 4-C: Closed-Ended vs. Open-Ended Questions.
3. Discuss the role of each type of question in counseling. Give one or two additional examples of questions for each category.

Activity 3: Large-group exercise/discussion (25 minutes)

1. Return to the flipchart. For each question, ask the participants, "Is this a 'closed-ended' or an 'open-ended' question?" and then, "Is this an 'information' or a 'feeling' question?"
2. Write "C" (for "closed-ended") or "O" (for "open-ended") in the first column; write "I" (for "information") or "F" (for "feeling") in the second column, as shown on the next page (bottom).

Sample completed flipchart for Activity 1—DO NOT COPY CONTENT

Closed-Ended/Information Questions vs. Open-Ended/Feeling Questions

Questions	Structure (C or O)	Content (I or F)
1. How many children do you have?		
2. How did you feel when you found out that you were pregnant?		
3. What do you understand about miscarriage? About abortion?		
4. Were you using a family planning method when you got pregnant this time?		
5. How were you using it?		
6. How would you feel about using a family planning method so you do not get pregnant again until you are ready?		
7. What other family planning methods do you know about?		

Sample completed flipchart for Activity 3—DO NOT COPY CONTENT

Closed-Ended/Information Questions vs. Open-Ended/Feeling Questions

Questions	Structure (C or O)	Content (I or F)
1. How many children do you have?	C	I
2. How did you feel when you found out that you were pregnant?	O	F
3. What do you understand about miscarriage? About abortion?	O	I
4. Were you using a family planning method when you got pregnant this time?	C	I
5. How were you using it?	O	I
6. How would you feel about using a family planning method so you do not get pregnant again until you are ready?	O	F
7. What other family planning methods do you know about?	C	I

3. Add up the total numbers of closed-ended, open-ended, information, and feeling questions.
4. Ask the participants how they would describe the questions most commonly used with clients, based on this exercise, and ask the participants to explain why they most commonly use certain questions.
5. Demonstrate how closed-ended questions can be made open-ended and how information questions can be changed to feeling questions, using two or three questions from the list.
6. Ask the participants to practice turning closed-ended questions into open-ended questions and information questions into feeling questions. For each closed-ended or information question on the brainstorm list, ask one participant to suggest how to ask it using an open-ended or feeling question. Go around the room until each participant has given a suggestion for changing at least one question.
7. Remind the participants that some closed-ended questions cannot and should not be converted into open-ended questions (see below).

TRAINING TIP ○○○

It is important to recall that some closed-ended and information questions are necessary in counseling, to assess the client's needs. The purpose of this activity is not to eliminate closed-ended and information questions, but rather to increase the use of open-ended and feeling-oriented questions, to allow the participants to better assess the client's informational and emotional needs and concerns.

8. Ask the participants how they can use this skill in their interactions with clients.

Part E Using Simple Language and Visual Aids

Time: 1 hour, 30 minutes

Activity 1: Discussion (20 minutes)

1. Distribute Handout 4-D: The Female and Male Reproductive Systems and one transparency marker or pencil to each participant.
2. Using the prepared flipchart, review female and male reproductive anatomy, identifying each body part shown. As you discuss, ask the participants what terms are used locally to refer to each body part (see Appendix E, page 183).
3. List the locally used terms for female and male reproductive anatomy on the flipchart. Ask the participants to use the transparency marker or the pencil to label each body part on the handout, using whatever local term is appropriate for their clients. (If you distributed paper rather than laminated copies of the handout, the participants should use pencils to label them, so the terms can be erased.)
4. Ask the participants how they can use the local terms when communicating with clients.

TRAINING TIP ○○○

Medical professionals are generally trained to use technical language when they refer to body parts and functions. Therefore, when asked to give information to clients, they often reply that clients are not able to understand such technical terms or concepts. The problem here, and the challenge for trainers and providers alike, is to find *simple words and images* to explain medical procedures, anatomy, and physiology in ways that clients can understand.

Even the least-educated client has some way of describing menstruation, sex, fertilization, contraception, pregnancy, miscarriage, abortion, and birth. Thus, it is the trainer's and the service provider's responsibility to learn how clients already describe such concepts and to build on their current level of knowledge, so they can give clients the information necessary for answering their questions and addressing their concerns.

Activity 2: Presentation (20 minutes)

1. Explain the importance and challenge of giving simple explanations to clients.
2. Distribute and review Handout 4-E: Anatomy, Physiology, and Pregnancy. As you discuss each item, ask if there are other ways in which it is described locally.
3. Ask the participants how they currently describe the medical procedure(s) used to treat women needing postabortion care.
4. Write their responses on a new flipchart, and ask the participants to draw a sample diagram of the medical procedures on a piece of paper. (This diagram can be used as a visual aid in Activity 3.)

Activity 3: Small-group skills practice (35 minutes)

1. Explain that the purpose of this activity is to practice the skills of giving simple explanations and using visual aids.
2. Divide the participants into groups of three. Within each group, ask for one volunteer to be the "provider" and another to be the "client." The third person will be an observer. (The roles will shift for each role play, so that by the end of the exercise, each participant will have played the role of "provider.")
3. Give the following instructions: For each role play, the "provider" will have five minutes to explain some basic concepts and terms to the "client." *Remember to build on the client's current level of knowledge and to use the handouts as visual aids*. The "client" can ask questions at any time. After the role play is completed, the observer and the "client" will have five minutes to give feedback to the "provider" (within each small group), including what was done well and what could be improved.
4. Give the task for the first role play: Using handouts, visual aids, and simple language, explain *menstruation, sex, fertilization*, and *contraception* to the "client."
5. Announce when the first five minutes have elapsed, and instruct the participants to end the role play and begin giving feedback. Announce when the second five minutes have elapsed, ending the feedback. *(10 minutes total)*

6. Ask the participants to shift roles (with each person taking on a new role, including the observer), and give the second task: Using handouts, visual aids, and simple language, explain *pregnancy, miscarriage,* and *abortion* to the client.
7. Again, announce when five and 10 minutes have elapsed. *(10 minutes total)*
8. Repeat the process for the third task: Using handouts, visual aids (including the sample diagram sketched in Activity 2), and simple language, explain the uterine evacuation procedure (either MVA or dilation and curettage [D&C], depending on which technique is used at the service site) to the client. *(10 minutes total)*

TRAINING TIP ○○○

Although the use of the IUD simulator/hand-held model and cannula can be helpful for describing the MVA procedure, they are not essential to the explanation. If these materials cannot be obtained, the participants can still use other methods to explain PAC treatment, such as drawing a rough picture freehand.

During the role plays, remember to move from group to group to observe and to make sure that the instructions have been understood correctly. If one group is not following the instructions, correct them gently but immediately. If more than one group is confused, stop the role plays, explain the instructions again to all of the participants, and start over. If one participant in particular is having problems with the task, come back to that group for the feedback session and add your comments to the discussion.

If necessary, remind the participants to show visual aids to the client, rather than use them only for their own reference.

Activity 4: Discussion (10 minutes)

Ask the participants what they have learned from this session, both as "providers" and as "clients" in the role play, and how it can be applied in their work with postabortion clients.

Session 4

Handouts

Handout 4-A
One-Way vs. Two-Way Communication

The effects of one-way communication:

- Only one person is actively talking, giving no chance to the other person to ask questions or express feelings and opinions.
- In health care, the provider is not able to determine if the client has accurately understood the information given, which often leads to misunderstanding.
- It may take less time, but it is *not efficient* in terms of establishing understanding.

The effects of two-way communication:

- Both persons are active in sharing information and opinions and in clarifying information with questions.
- This creates more discussion and interaction between the client and the provider, which enhances understanding by both parties, and allows the provider to know if the communication has met the client's needs.
- While it may take more time, it is *more efficient* in terms of ensuring that each person has been accurately understood.

Handout 4-B
Effective Listening

Listening skills can be improved by:

- Maintaining eye contact with the speaker (within cultural norms)
- Showing a genuine interest in the topic
- Being attentive to the speaker (i.e., not doing other tasks at the same time and not interrupting)
- Not talking to other people while listening
- Asking questions
- Showing empathy
- Reflecting (i.e., repeating, or using your own words to confirm understanding)
- Interpreting the feelings and emotions behind what is being said
- Integrating what has been said into further discussion

Handout 4-C
Closed-Ended vs. Open-Ended Questions

Closed-ended questions usually can be answered with a very short response, often just one word. A closed-ended question calls for a brief, exact reply, such as "yes," "no," or a number. Examples include:

- How old are you?
- How many children do you have?
- Is your house far from this clinic?
- When did the bleeding start?
- Did you try to do anything before you came here?

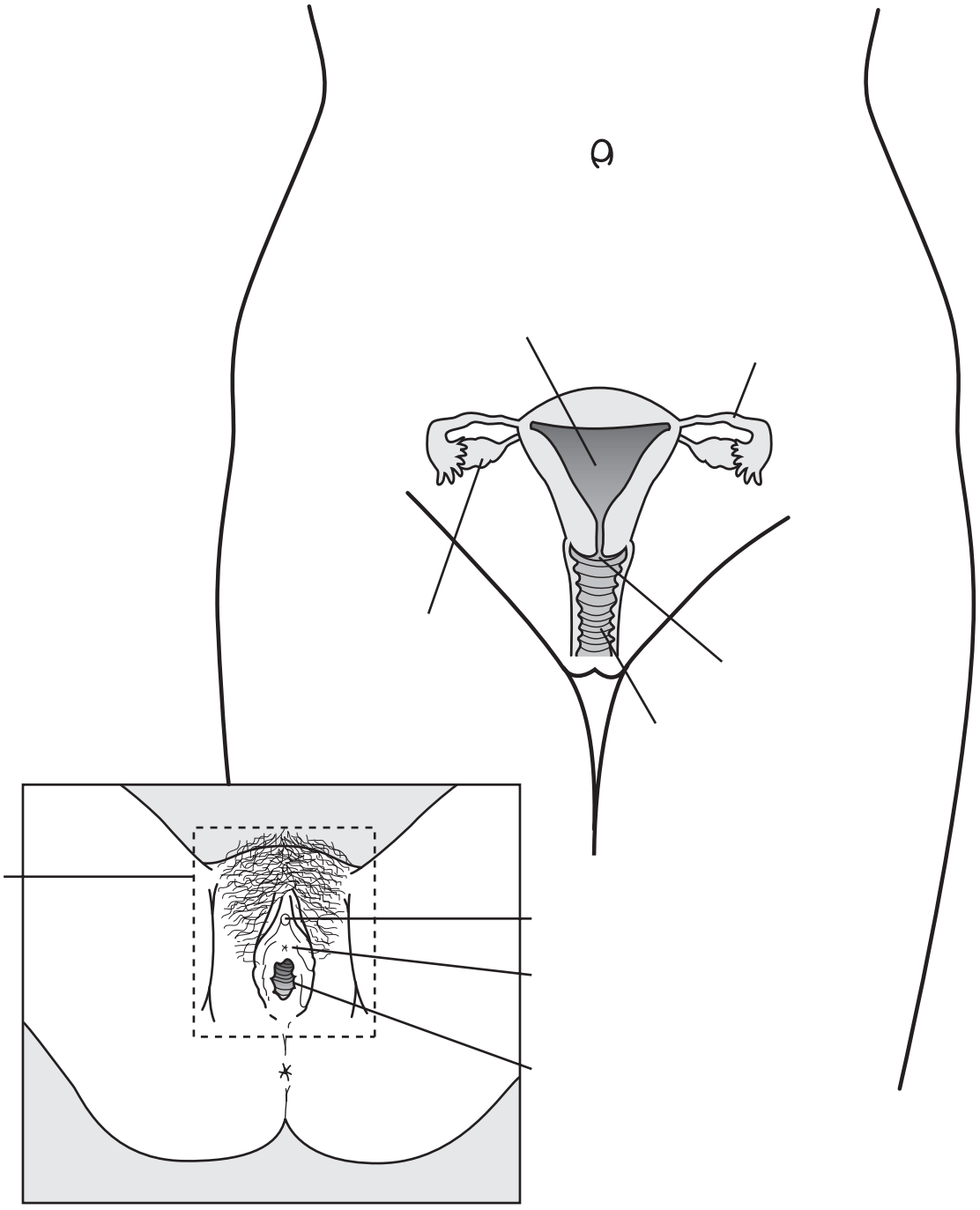
These questions may be suitable to determine the client's condition and medical history at the beginning of medical treatment or counseling.

Open-ended questions are useful for exploring the opinions and feelings of the client, and usually require longer responses. These questions are more effective in determining the client's needs (in terms of information or emotional support) and what she already knows. Examples include:

- How did you feel when you first found out you were pregnant?
- What did you do after the bleeding started?
- How do you feel now?
- What do you think is going to happen while you are here? What concerns do you have about that?
- What questions or concerns does your husband or partner have about your condition?
- What do you plan to do to protect yourself from getting pregnant again?
- What made you decide to use the same method as your sister?

Handout 4-D
The Female and Male Reproductive Systems

The Female Reproductive System

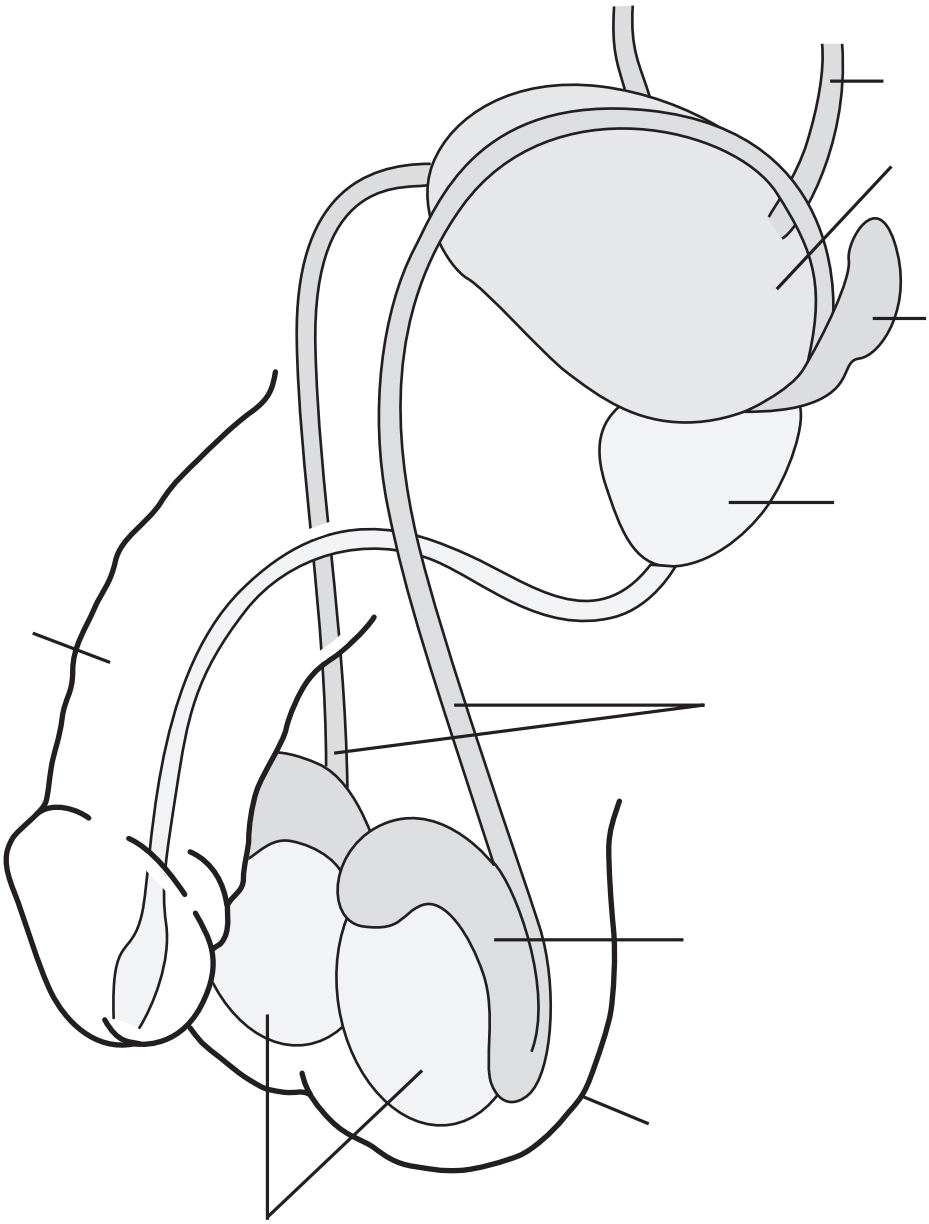


Adapted from: AVSC International. 1995. *Family planning counseling: A curriculum prototype*. New York.

(continued)

Handout 4-D (continued)
The Female and Male Reproductive Systems

The Male Reproductive System



Adapted from: AVSC International. 1995. *Family planning counseling: A curriculum prototype*. New York.

Handout 4-E
Anatomy, Physiology, and Pregnancy

Female Anatomy

- The **cervix** is the narrow neck of the womb that connects the uterus with the vagina. When a man climaxes (has an orgasm), sperm travel through the cervix to reach the womb. Menstrual blood and babies leave the womb through the cervix. The cervix has to widen to let a baby through, which is what happens when a pregnant woman goes into labor.
- The **clitoris** is a small bud of tissue covered with a soft fold of skin and located above the urinary opening. It is very sensitive to touch. During sexual arousal, the clitoris swells and becomes erect. It plays an important role in a woman's sexual pleasure and climax (orgasm).
- The **fallopian tubes** connect each ovary with the womb. When the egg leaves the ovary, it travels through one of the tubes to the womb. The tubes also provide a favorable place for fertilization.
- The **ovaries** produce eggs and female hormones. Female hormones give women their female characteristics (like breasts and the way their voices sound) and their sex drive.
- The **uterus** is where the fertilized egg implants and over the course of nine months grows into a baby.
- The **vagina** is the passage that connects the uterus with the outside of the body. Intercourse takes place in the vagina, and menstrual blood and babies pass through the vagina.

Male Anatomy

- The **epididymis** is where sperm cells are stored.
- The **penis** is the organ that carries the semen with the sperm into the vagina.
- The **prostate gland** produces the majority of the fluid that constitutes semen.
- The **scrotum** is the sack of skin that holds the two testicles.
- **Semen** is the liquid that comes out of the penis when a man climaxes. It contains sperm and other fluid. Sperm make up only a tiny amount of the semen. After a man has a vasectomy, the semen no longer contains sperm.
- The **seminal vesicles** are two pouches located on either side of the prostate gland that contribute more than half of the fluid to semen, which transports sperm. (The seminal fluid also provides nourishment for sperm.)
- The **testicles** produce sperm and male hormones. Male hormones give men their masculine characteristics (such as facial hair and muscles) and their sex drive.
- The **vas deferens** are the tubes through which the sperm travel to merge into semen.

Physiology

- The woman's ovaries produce an egg once a month.
- The egg moves through the (fallopian) tube.
- The man's testicles produce sperm ("seeds"), which travel through two tubes (the vas deferens), mix with semen, and come out of the penis.

(continued)

Handout 4-E (continued)
Anatomy, Physiology, and Pregnancy

Menstruation

Every month that a woman of reproductive age is not pregnant, the uterus sheds its lining. This is the bleeding during menstruation.

Fertilization

Fertilization is when the man's "seed" enters the egg.

Pregnancy

Pregnancy occurs when the fertilized egg travels down the fallopian tube and attaches itself to the womb.

Miscarriage

A miscarriage is the spontaneous loss of a pregnancy before the developing baby is old enough to survive outside the womb.

Abortion

An abortion is when a pregnancy is ended prematurely. (Abortions may be spontaneous or induced.)

Adapted from: AVSC International. 1995. *Family planning counseling: A curriculum prototype*. New York.

Session 5:
Family Planning Information and Counseling for the Postabortion Client

Objectives

- To identify the essential information about family planning that all clients *must* have before they leave the service site
- To explain the importance of informed choice by the client for effective family planning services
- To describe personal and clinical factors that should be considered in family planning counseling for postabortion clients

Training Methods

- Brainstorm
- Large-group work
- Presentation/discussion
- Case study

Materials

- Flipchart paper, easel, markers, and tape
- Overhead projector (optional)
- Transparency 5-A: Minimum Essential Information about Family Planning for the Postabortion Client (page 166)
- Transparency 5-B: Family Planning Information and Counseling for the Postabortion Client (page 167)
- Handout 5-A: Simple Answers to Clients' Questions about Postabortion Family Planning (page 85)
- Handout 5-B: Statements on Contraception, Informed Choice, and Postabortion Care (page 86)
- Handout 5-C: Individual Factors for Family Planning Counseling during Postabortion Care (page 87)
- Handout 5-D: Guidelines for Contraceptive Use, by Clinical Condition (page 89)
- Handout 5-E: Guidelines for Selecting Contraception, by Method (page 91)

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. Review all handouts and make one copy for each participant. If possible, copy them on different colors of paper (especially Handouts 5-D and 5-E), to help keep them separate.

3. Prepare transparencies or flipcharts of Transparencies 5-A and 5-B.
4. Prepare a flipchart like the example shown below:

Individual Factors for Family Planning Counseling during Postabortion Care

Case-study client	Factors	Considerations
	1. If the client does not want to be pregnant soon	
	2. If the client is under stress or in pain	
	3. If the client was using a contraceptive method when she became pregnant	
	4. If the client had stopped using a contraceptive method	
	5. If the client has a partner who is unwilling to use condoms or will prevent use of another method	
	6. If the client was the victim of sexual abuse or rape	
	7. If the client wants to become pregnant soon	

5. Find out where family planning services are provided locally for each site, including location, hours, methods available, and cost.

Session Time (total): 2 hours, 15 minutes

SESSION 5 TRAINING STEPS

Part A Rationale

Time: 30 minutes

Activity 1: Large-group discussion (10 minutes)

1. Ask the participants to describe the rationale for linking family planning services to PAC services.
2. Note that regardless of the legality of induced abortion or our personal feelings about it, establishing linkages between PAC and family planning services may be the best opportunity to help people avoid further unwanted pregnancies and thus prevent the need for more abortions.
3. Ask the participants to describe *their role* as PAC providers in delivering family planning methods and services to postabortion clients.

TRAINING TIP ○○○

The role of the PAC provider in regard to family planning service delivery will vary from country to country and, possibly, from site to site. In some cases, the provider will only make referrals to services outside the PAC site. In other cases, the provider will provide initial counseling for family planning services located within the same institution. In some programs, PAC and family planning may be totally integrated, with the same staff providing both PAC and family planning services.

Regardless of the relationship between PAC and actual family planning service delivery, the PAC provider is a crucial link in terms of helping postabortion clients to recognize their need for contraception, overcoming possible misconceptions and fears regarding contraceptive methods, and building confidence and trust in the health care system, which will increase a postabortion client's likelihood of following through on a family planning referral. The rest of this session addresses the basic information about contraception needed by all PAC providers if they are to carry out these minimum essential tasks. If family planning service delivery or family planning counseling are to be provided by PAC staff, additional training in family planning is required.

Activity 2: Brainstorm/discussion (20 minutes)

1. Ask the participants to brainstorm what family planning information postabortion clients may need before they leave the service site.
2. Explain that three pieces of information *must* be provided to each postabortion client who does not want to get pregnant again soon. Display Transparency 5-A: Minimum

Essential Information about Family Planning for the Postabortion Client, and review each point:

- She will be at risk of repeat pregnancy as soon as 11 days after treatment.
- A variety of safe contraceptive methods can be used immediately to avoid pregnancy.
- She needs to know where and how to get family planning services (either at the time of treatment or after discharge).

3. If the participants do not know where family planning services are provided, provide that information, including location, hours, methods available, and cost.
4. Using Handout 5-A: Simple Answers to Clients' Questions about Postabortion Family Planning as a guide, review typical clients' questions about pregnancy and family planning, reading aloud the *questions only*. Ask the participants to provide the answers to the clients' questions, and correct any misconceptions, if necessary.
5. Note the family planning methods that clients can start to use either during or immediately after PAC, and which of these are available at their service sites.
6. Distribute Handout 5-A.

Part B Informed Choice

Time: 30 minutes

Activity 1: Large-group discussion (30 minutes)

1. Ask the participants: "What is informed choice?" After hearing several responses, read aloud the definition (the first quotation) on Handout 5-B: Statements on Contraception, Informed Choice, and Postabortion Care.
2. Ask one participant to give an example of how this definition applies to PAC services at his or her site.
3. Ask the participants to respond to the following questions:
   - If a woman has an IUD inserted against her will during postabortion treatment, what can she do about it? What if she is sterilized? How would these women feel about the health care system after this has happened?
   - If a woman is sterilized or given an IUD without adequate information, what are some of the possible results?
   - What impact would this practice have on women's willingness to seek medical care for abortion complications?

TRAINING TIP ○○○

Possible responses to these three questions are as follows:

- Providers may believe that they are acting in a client's best interest by inserting an IUD without her consent, but they must remember that a woman who does not want this contraceptive method can and will have it removed, thereby undoing the measure that the provider has taken to "protect" her from future pregnancy. Sterilization is an even more extreme example, as reversal is not feasible in most countries, so a woman who has the procedure performed against her will has no recourse afterward. At the very least, such forced use of contraception will leave clients feeling bitter toward the health care system.
- Inadequate information for contraceptive users about method use and possible side effects can have two results: The user may ignore warning signs of complications that can have a serious impact on her health or that mean the method is not working properly; or she may assume that every physical ailment that occurs after she started to use the contraceptive is somehow related to it, leading to complaints, excessive follow-up visits, and discontinuation. With the IUD, this confusion may result in a woman not recognizing warning signs, mistakenly attributing unrelated conditions to the IUD, or having the device removed unnecessarily. With sterilization, this can result in chronic complaints or in death, if a complication is over looked.
- While coercive practices may prevent further unwanted pregnancies among the individual women involved, other women who hear about these practices may be reluctant to seek medical care for abortion complications. This can result in greater morbidity or more deaths.

4. Summarize: While it is important to make family planning *available* and *accessible* to postabortion clients, women should *not* be required to choose a contraceptive method in order to receive treatment.
5. List the points below as reasons why family planning should *not* be required of all postabortion clients, and give examples of the potential negative impact that coerced contraceptive acceptance can have on women and communities.
   - A contraceptive method's effectiveness is generally related to users having enough information to be able to use the method effectively, and to their feeling good about continuing its use or about switching to another method if it is not satisfactory.
   - When a contraceptive method is provided through coercion, it may prove to be less effective, because the user received inadequate information about how to use the method properly or resented being forced to accept it, all of which can lead to discontinuation.
   - This can result in more unwanted pregnancies, and possibly to more abortions.
   - Additionally, the health care system may develop a reputation of being abusive to its clients, which will drive people away from seeking needed services, including family planning and postabortion care.

- While providers may not be aware of any short-term impact, the potential long-term effects of not allowing clients to make informed choices are reduced family planning use and greater morbidity and mortality from abortion complications that go untreated (or for which treatment is delayed).

6. Distribute Handout 5-B.

Part C Individual Factors

Time: 1 hour, 15 minutes

Activity 1: Discussion/brainstorm (30 minutes)

1. Explain that you will spend the rest of this session discussing personal and medical factors that should be considered when talking with postabortion clients about family planning.
2. Post the flipchart entitled "Individual Factors for Family Planning Counseling during Postabortion Care." For each entry in the "Factors" column, fill in the name of the case-study client from Session 3 who most closely matches the description (whenever possible—if not, make up a name for a new client to fill in on the flipchart). Ask: "How would you approach family planning counseling for this client? What would you discuss, and why?" Write the participants' responses in the "Considerations" column for each factor.

TRAINING TIP ○○○

If participants overlook key points during this discussion, you can refer to Handout 5-C: Individual Factors for Family Planning Counseling during Postabortion Care to guide the discussion. However, to help the participants think this through for themselves, do not distribute the handout until they have finished discussing all of the factors. Then, briefly review each factor, noting any differences between the participants' discussion and what is written on the handout.

Reminder: Factors 3, 4, 5, and 7 on the flipchart entitled "Individual Factors…" involve sexuality and gender issues that were identified in Session 3 (Parts D and E). Work with the participants to fill in the columns in the handout for this important point.

3. Distribute Handout 5-C and discuss any points that were not mentioned during the activity (see Training Tip, above). Then summarize by noting the importance of considering the individual's personal situation and history of contraceptive use before trying to give information about family planning methods.

Activity 2: Discussion (45 minutes)

1. Explain that another important factor in the use of contraception after postabortion treatment is the client's clinical condition. Distribute Handout 5-D: Guidelines for Contraceptive Use, by Clinical Condition, and *briefly* review. *(30 minutes)*

TRAINING TIP ❍❍❍

It may be difficult to complete this discussion in 30 minutes. Given the participants' medical background, they may be curious and may have many questions about specific clinical conditions and the family planning precautions and recommendations related to those conditions. Remind the participants that the purpose of this workshop is to enable PAC providers to give basic information and answer clients' questions, to ensure that clients will follow up as necessary to get family planning and other reproductive health services. This discussion is meant to familiarize them with the category of clinical condition that a family planning provider would need to consider for each client and which methods would be suitable. If the participants will be providing family planning services on-site, they will need more in-depth training to cover both the clinical and counseling aspects.

2. Distribute Handout 5-E: Guidelines for Selecting Contraception, by Method, and explain that it is useful as a counseling reference, because clients often have a particular method in mind when they ask about family planning. Tell the participants that they can look over the handout on their own and can use it to prepare for their counseling role plays later in the workshop. *(5 minutes)*
3. Summarize by reminding the participants that all of these factors—the family planning service-delivery structure at their sites, informed choice, the individual client's situation, her clinical condition, and characteristics of the contraceptive methods—should be considered for their individual case-study clients (from Session 3) when they practice counseling through role plays later in the workshop. Some clients may want or need family planning information before treatment or after, and some may not be interested at all. One of the provider's tasks is to determine the best time to give this information and to ensure that at least the three key points are covered with every client. *(10 minutes)*
4. Display Transparency 5-B: Family Planning Information and Counseling for the Postabortion Client. Ask for a volunteer to read the quotation aloud.

Session 5

Handouts

Handout 5-A

Simple Answers to Clients' Questions about Postabortion Family Planning

Q: When can I resume sexual activity?

A: After your bleeding has stopped.

Q: How soon can I become pregnant?

A: Almost immediately—even before your next period.

Q: How can I avoid becoming pregnant again?

A: Start using a family planning method now.

Q: Which methods can I use right away?

A: Ask your family planning counselor which methods may be right for you. The family planning methods that can be safely used immediately after abortion include:

- Condoms
- Oral contraceptives (the Pill)
- Injectables (DMPA, NET-EN)
- Norplant implants
- Spermicidal foams, jellies, tablets, sponge, or film
- Diaphragm or cervical cap
- IUD (The IUD should not be inserted following possible infection, injury to the genital tract, or severe bleeding with anemia.)
- Female or male sterilization

Q: Which methods protect against STIs and HIV?

A: Only *condoms* and *abstinence* offer protection against STIs and HIV.

> *Note:* If you have intercourse without using a family planning method, ask your provider about emergency contraception. If you take a special dose of birth control pills within 72 hours (three days) after intercourse, you have a much lower chance of becoming pregnant.

Adapted from: Winkler, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium.

Handout 5-B
Statements on Contraception, Informed Choice, and Postabortion Care

"Free and informed choice means that the patient/family planning client chooses a contraceptive method voluntarily, and without pressure or coercion. It is based on a clear understanding of the benefits and limitations of the methods that are available. The patient/client should understand that almost all methods can be used safely and effectively immediately after treatment of an incomplete abortion and that she can choose another method later if she wishes to change [except in the case of sterilization]."

—Winkler, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium, p. 9-4.

"Remember: Acceptance of contraception or of a particular contraceptive method should never be a prerequisite for obtaining emergency postabortion care."

—Winkler, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium, p. 9-4.

"The provision of emergency abortion care or elective abortion procedures must not be made conditional on the acceptance of family planning in general, or of a specific method of contraception. Women need information on a wide range of contraceptive methods in order to make their own selection, in consultation with clinic staff. Managers can ensure that coercion is not being used in method selection by monitoring trends in contraceptive distribution to women after abortion."

—World Health Organization. 1995. Information and counselling for the patient. *Complications of abortion: Technical and managerial guidelines for prevention and treatment*. Geneva, p. 76.

"Service providers should establish mechanisms to assure women the opportunity to make informed, voluntary choices about post-abortion family planning use. Provision of abortion care should never be contingent on acceptance of a family planning method, and a woman should never be given a method to which she does not consent. Furthermore, no woman should leave a service setting without all the information necessary to enable her to continue or discontinue use of the method she has chosen. Adherence to these principles is particularly important where long-term or provider-dependent methods are concerned and in the crisis context of emergency care settings."

—Wolf, M., and Benson, J. 1994. Meeting women's needs for post-abortion family planning: Report of a Bellagio Technical Working Group, Bellagio, Italy, February 1–5, 1993. *International Journal of Gynecology and Obstetrics* 45 (Suppl.):S18.

Handout 5-C
Individual Factors for Family Planning Counseling during Postabortion Care

Factors	Recommendations	Rationales
1. If the woman does not want to be pregnant soon	Consider all temporary methods.	Seeking treatment for abortion complications suggests that the woman does not want to be pregnant.
2. If the woman is under stress or is in pain	Consider all temporary methods. Do not encourage use of permanent methods at this time. Provide referral for continued contraceptive care.	Stress and pain interfere with making free, informed decisions. The time of treatment for abortion complications is not a good time for a woman to make a permanent decision.
3. If the woman was using a contraceptive method when she became pregnant	Assess why contraception failed and what problems the woman might have had using the method effectively. Help the woman choose a method that she will be able to use effectively. Make sure she understands how to use the method, get follow-up care and resupply, discontinue use, and change methods.	Method failure, unacceptability, ineffective use, or lack of access to supplies may have led to the unwanted pregnancy. These factors may still be present and may lead to another unwanted pregnancy.
4. If the woman had stopped using a contraceptive method	Assess why the woman stopped using contraception (e.g., side effects, lack of access to resupply). Help the woman choose a method that she will be able to use effectively. Make sure she understands how to use the method, get follow-up care and resupply, discontinue use, and change methods.	Unacceptability or lack of access may have led to the unwanted pregnancy. These factors may still be present and may lead to another unwanted pregnancy.
5. If the woman has a partner who is unwilling to use condoms or will prevent use of another method	If the woman wishes, include her partner in counseling. Protect the woman's confidentiality (even if she does not involve her partner). Discuss methods that the woman can use without her partner's knowledge (e.g., injectables). Do not recommend methods that the woman will not be able to use effectively.	In some instances, involving the partner in counseling will lead to his use of and support for contraception; however, if the woman, for whatever reasons, does not want to involve her partner, her wishes should be respected.

(continued)

Handout 5-C (continued)
Individual Factors for Family Planning Counseling during Postabortion Care

Factors	Recommendations	Rationales
6. If the woman was the victim of sexual abuse or rape	Inform her about emergency contraception (or other contraception, if appropriate).	The woman may be at risk for repeat assault or rape, and may have continuing need for emergency or other contraception.
7. If the woman wants to become pregnant soon	Do not try to persuade her to accept a method. Provide information or a referral if the woman needs other reproductive health services.	If the woman has had repeated spontaneous abortions, she may need to be referred for infertility treatment.

Adapted from: Winkler, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium.

Handout 5-D
Guidelines for Contraceptive Use, by Clinical Condition

Clinical condition	Recommendations	Precautions
No complications after treatment of incomplete abortion	Consider all temporary methods. *Norplant implants:* Can be used immediately. *Injectables (DMPA, NET-EN):* Can be used immediately. *IUD:* Can be used immediately. *Oral contraceptives (combined or progestin-only):* Can be used immediately. *Condoms (male/female):* Can be used when sexual activity is resumed. *Spermicidal foams, jellies, tablets, sponge, or film:* Can be used when sexual activity is resumed. *Diaphragm or cervical cap:* Can be used when sexual activity is resumed.	*Natural family planning:* Do not recommend until a regular menstrual pattern returns. *Female sterilization:* The time of treatment for abortion complications usually is not the best time for clients to make decisions about methods that are permanent. *Diaphragm or cervical cap:* Should be refit after a second-trimester abortion.
Confirmed or presumptive diagnosis of infection: ■ Signs and symptoms of sepsis/infection ■ Signs of unsafe or unclean induced abortion ■ Unable to rule out infection	*Norplant implants:* Can be used immediately. *Injectables (DMPA, NET-EN)*: Can be used immediately. *Oral contraceptives (combined or progestin-only):* Can be used immediately. *Condoms (male/female):* Can be used when sexual activity is resumed. *Spermicidal foams, jellies, tablets, sponge, or film:* Can be used when sexual activity is resumed. *Diaphragm or cervical cap:* Can be used when sexual activity is resumed.	*Female sterilization:* Do not perform until infection is fully resolved (approximately three months) or until risk of infection is ruled out. *IUD:* Do not insert until infection is fully resolved (approximately three months) or until risk of infection is ruled out.
Injury to genital tract: ■ Uterine perforation (with or without bowel injury) ■ Serious vaginal or cervical injury, including chemical burns	*Norplant implants:* Can be used immediately. *Injectables (DMPA, NET-EN):* Can be used immediately. *Oral contraceptives (combined or progestin-only):* Can be used immediately. *Condoms (male/female):* Can be used when sexual activity is resumed. *Spermicidal foams, jellies, tablets, sponge, or film:* Can be used when sexual activity is resumed (can be used with uncomplicated uterine perforation). *Diaphragm or cervical cap:* Can be used when sexual activity is resumed (can be used with uncomplicated uterine perforation).	*Female voluntary sterilization:* Do not perform until serious injury is healed. *IUD:* Do not insert until serious injury is healed. *Spermicidal foams, jellies, tablets, sponge, or film:* Do not begin use until vaginal or cervical injury is healed. *Diaphragm or cervical cap:* Do not begin use until vaginal or cervical injury is healed.

(continued)

Handout 5-D (continued)
Guidelines for Contraceptive Use, by Clinical Condition

Clinical condition	Recommendations	Precautions
Severe bleeding (hemorrhage) and related severe anemia (Hb <7 g/dL or Hct <20)	*IUD (progestin-releasing):* Can be used with severe anemia (decreases menstrual blood loss). *Combined oral contraceptives:* Can be used immediately (beneficial when hemoglobin is low). *Condoms (male/female):* Can be used when sexual activity is resumed. *Spermicidal foams, jellies, tablets, sponge, or film:* Can be used when sexual activity is resumed. *Diaphragm or cervical cap:* Can be used when sexual activity is resumed.	*Female sterilization:* Do not perform procedure until the cause of hemorrhage or anemia is resolved. *Progestin-only pills:* Use with caution until acute anemia improves. *Norplant implants:* Delay insertion until acute anemia improves. *Injectables (DMPA, NET-EN):* Delay starting until acute anemia improves. *IUD (inert or copper-bearing):* Delay insertion until acute anemia improves.
Second-trimester abortion	*Norplant implants:* Can be used immediately. *Injectables (DMPA, NET-EN):* Can be used immediately. *Oral contraceptives (combined or progestin-only):* Can be used immediately. *Condoms (male/female):* Can be used when sexual activity is resumed. *Spermicidal foams, jellies, tablets, sponge, or film:* Can be used when sexual activity is resumed.	*Female sterilization:* Use postpartum minilaparotomy. If this technique is not possible, delay procedure until uterus returns to prepregnancy size (four to six weeks). *IUD:* Use postpartum insertion technique with high fundal placement. If an experienced provider is not available, delay insertion four to six weeks. *Diaphragm or cervical cap:* Should be refit when uterus returns to prepregnancy size (four to six weeks).

Adapted from: Winkler, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium.

Handout 5-E
Guidelines for Selecting Contraception, by Method

Method	Timing postabortion	Advantages	Remarks
Nonfitted barrier methods: latex and vinyl male/female condoms; and vaginal sponge and suppositories (foaming tablets, jelly, or film)	These methods may be used as soon as sexual intercourse is resumed.	■ Are inexpensive ■ Are good interim method if use of another method must be postponed ■ Require no medical supervision ■ In the case of condoms (latex and vinyl), provide protection against sexually transmitted infections (STIs), including HIV ■ Are easily discontinued ■ Are effective immediately	■ Are less effective than IUD or hormonal methods ■ Require use with each episode of intercourse ■ Require continued motivation ■ Require resupply to be available ■ May interfere with intercourse
Fitted barriers used with spermicides: diaphragm or cervical cap with foam or jelly	The diaphragm can be fitted immediately after first-trimester abortion; after second-trimester abortion, fitting should be delayed until uterus returns to prepregnancy size (four to six weeks). Fitting the cervical cap should be delayed until bleeding has stopped and the uterus has returned to its prepregnancy size (four to six weeks).	■ Are inexpensive ■ Require no medical supervision for use ■ Provide some protection against STIs, including HIV ■ Are easily discontinued ■ Are effective immediately	■ Are less effective than IUD or hormonal methods ■ Require use with each episode of intercourse ■ Require continued motivation ■ Require resupply to be available ■ Are associated with urinary tract infections in some users ■ Require fitting by trained service provider
Oral contraceptives: combined and progestin-only	Pill use may begin immediately, preferably on the day of treatment.	■ Are highly effective ■ Can be started immediately, even if infection is present ■ Can be provided by nonphysicians ■ Do not interfere with intercourse	■ Require continued motivation and daily use ■ Require resupply to be available ■ May have reduced effectiveness if client has used certain medications (e.g., rifampin, dilantin, or griseofulvin) long-term ■ Necessitate condom use if client is at risk for STIs, including HIV

(continued)

Handout 5-E (continued)
Guidelines for Selecting Contraception, by Method

Method	Timing postabortion	Advantages	Remarks
Injectables: DMPA and NET-EN	Injection may be given immediately after first- or second-trimester abortion. Method may be appropriate for use if a woman wants to delay choice of long-term method.	■ Are highly effective ■ Can be started immediately, even if infection is present ■ Can be provided by nonphysicians ■ Do not interfere with intercourse ■ Are not user-dependent (except for injection every two or three months ■ Do not require client to obtain supplies	■ May cause irregular bleeding, especially amenorrhea (excessive bleeding may occur in rare instances) ■ May cause delayed return to fertility ■ Require injections every two or three months ■ Necessitate condom use if client is at risk for STIs, including HIV
Progestin-only implants: Norplant implants	Implants may be inserted immediately after abortion. If adequate counseling and informed decision making cannot be guaranteed, insertion must be delayed and an interim method provided.	■ Are highly effective ■ Provide long-term contraceptive protection (effective for at least five years) ■ Allow immediate return to fertility upon removal ■ Do not interfere with intercourse ■ Do not require client to obtain supplies	■ May cause irregular bleeding (especially spotting) or amenorrhea ■ Require a trained provider to insert and remove ■ Are cost-effective only if used long-term ■ Necessitate condom use if client is at risk for STIs, including HIV
IUD	Insertion should be delayed until serious injury is healed, hemorrhage is controlled, or acute anemia improves. Insertion should be delayed until infection has been resolved (three months). *First-trimester abortion:* IUD can be inserted if risk or presence of infection can be ruled out. *Second-trimester abortion:* Insertion should be delayed for six weeks *unless* equipment and expertise for immediate postabortal insertion are available.	■ Is highly effective ■ Provides long-term contraceptive protection ■ Allows immediate return to fertility upon removal ■ Does not interfere with intercourse ■ Does not require client to obtain supplies ■ Requires only monthly checking for strings (by client) ■ Requires only one follow-up visit, unless there are problems	■ May increase menstrual bleeding and cramping during the first few months ■ Can result in uterine perforation during insertion ■ May increase risk of PID and subsequent infertility for women who have chlamydia or gonorrhea infection at the time of insertion ■ Necessitates condom use if client is at risk for STIs, including HIV ■ Requires a trained provider to insert and remove

(continued)

Handout 5-E (continued)
Guidelines for Selecting Contraception, by Method

Method	Timing postabortion	Advantages	Remarks
Female sterilization	Sterilization after a first-trimester abortion is similar to an interval procedure; sterilization after a second-trimester abortion is more similar to a postpartum procedure. Technically, sterilization procedures usually can be performed immediately after treatment of postabortion complications, unless infection or severe blood loss are present. Sterilization should not be performed until an infection is fully resolved (three months) or an injury healed.	■ Is a permanent method ■ Is the most effective female method ■ Requires no further action once completed ■ Does not interfere with intercourse ■ Produces no change in sexual functioning ■ Causes no long-term side effects ■ Is immediately effective	■ Requires adequate counseling and fully informed consent before being performed, which often is not possible at the time of emergency care ■ Has slight possibility of surgical complications ■ Requires trained staff and appropriate equipment ■ Necessitates condom use if client is at risk for STIs, including HIV
Natural family planning	Natural family planning is not recommended for immediate postabortion use. The first ovulation after an abortion will be difficult to predict, and the method is unreliable until after a regular menstrual pattern has returned.	■ Is associated with no cost ■ Produces no change in sexual function ■ Has no long-term side effects	■ Is difficult to use immediately after abortion ■ Necessitates use of alternative methods until normal cycles have resumed ■ Requires extensive instruction and counseling ■ Necessitates condom use if client is at risk for STIs, including HIV ■ Requires the woman and her partner to have continued motivation and a thorough understanding of how to use the method

(continued)

Handout 5-E (continued)
Guidelines for Selecting Contraception, by Method

Method	Timing postabortion	Advantages	Remarks
Vasectomy	Vasectomy may be performed at any time.	■ Is a permanent method ■ Is the most effective male method ■ Requires no further action once completed ■ Does not interfere with intercourse ■ Produces no change in sexual functioning ■ Causes no long-term side effects ■ Is effective after 12 weeks following the procedure	■ Requires adequate counseling and fully informed consent before being performed ■ Has slight possibility of surgical complications ■ Requires trained staff and appropriate equipment ■ Necessitates condom use if client is at risk for STIs, including HIV ■ Is not effective until after 12 weeks following the procedure

Adapted from: Winkler, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium.

Session 6:
Related Reproductive Health Needs and Other Issues

Objectives

- To explain why postabortion clients may need information about reproductive tract infections (RTIs) and STIs
- To identify the essential information that all postabortion clients *must* have about RTIs and STIs before they leave the service site
- To describe the medical, social, economic, emotional, or other issues that postabortion clients may face that do not directly relate to PAC
- To identify referral resources that are available for clients' non–PAC-related needs
- To explain how to recognize the need for referral
- To help clients with threatened abortion manage their feelings related to the condition of their pregnancy

Training Methods

- Discussion
- Small-group work
- Presentation
- Brainstorm
- Role play

Materials

- Flipchart paper, easel, markers, and tape
- Flipcharts of the client case studies (from Session 3)
- Paper and pens or pencils for each participant
- Transparency 6-A: Sample Case Study 1: "Daisy" (page 168)
- Transparency 6-B: Sample Case Study 2: "Diana" (page 169)
- Handout 6-A: Background Information on STIs (including HIV) and RTIs (page 105)
- Handout 6-B: Sexuality and HIV/STI Risk: Broaching the Subject with Clients (page 107)
- Blank index cards (two per participant)

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. Review all handouts and make one copy for each participant.
3. Prepare transparencies or flipcharts of Transparencies 6-A and 6-B, or make one copy each of case studies for distribution to small groups.

4. Prepare a flipchart like the example shown below

Other Reproductive Health Issues and Resources for Referral

Category	Example(s)	Resource(s)
Medical		
Social		
Economic		
Emotional		
Other		

5. Prepare *two* flipcharts as shown below (one for each of the two case studies):

Addressing the Feelings of Clients with Threatened Abortion

Client's name: _____

Client's feelings	Why?	Provider's response

Session Time (total): 2 hours, 15 minutes

SESSION 6 TRAINING STEPS

Part A RTI/STI Information for the Postabortion Client

Time: 1 hour, 10 minutes

Activity 1: Discussion (40 minutes)

1. Ask the participants: "Why is it important for postabortion clients to get information about RTIs and STIs?" The discussion should cover the following points *(10 minutes):*
   - Information about RTIs and STIs is particularly important for women who did not want to be pregnant this time, because a woman who has had an unwanted pregnancy may also have been exposed to infections or diseases during sex. Although unwanted pregnancy is often the result of bad planning in terms of contraceptive use, it may also result from unwanted sex, as in the case of rape or sexual abuse, or from commercial sex. Women in these situations may need help to learn how to avoid this situation in the future and how to protect themselves from STIs. (Referral for other reproductive health and nonmedical problems is discussed in Part B of this session.)
   - Although women who have had an unwanted pregnancy are considered to be especially in need of information and counseling about RTIs and STIs, we must not assume that other postabortion clients do *not* need this information, for the following reasons:
     - Women who report that the pregnancy was planned may actually be reluctant to say that they did *not* want to be pregnant.
     - Even women who are trying to get pregnant with a regular partner may be exposed to STIs due to their partner's sexual behavior "outside" their relationship.
     - All women are at risk for RTIs. It is important to know about RTIs, both to maintain reproductive health and to know that not every discharge or sore is an STI. RTIs are infections of the reproductive system; they include both STIs *and* infections not caused by sexual contact. Some causes of RTIs outside of sexual contact include an imbalance of normal reproductive tract microorganisms (bacterial vaginosis and yeast infections) and medical procedures (often when there is a failure in aseptic technique).
2. Ask the participants to suggest ways in which to begin talking about RTIs and STIs with postabortion clients, given the sensitive subject matter.
3. Write their responses on a flipchart. If necessary, share some of the following examples *(10 minutes):*
   - "The information I am about to discuss with you is information that we provide to all of our clients. Have you ever heard of sexually transmitted infections (or STIs)?" *Continue to define, describe signs and symptoms, treatment, prevention, etc. This way, the client does not feel that either she or her partner is being singled out as someone who is suspected of having an STI.*
   - "Have you ever heard of sexually transmitted infections (or STIs)? These infections are common, and any one of us may acquire them. Therefore, it is important that we know about their signs and symptoms, how they are transmitted, how we prevent them, and where to go for treatment if we have the signs and symptoms. The signs and symptoms are..." *Discuss details.*

4. Distribute Handout 6-A: Background Information on STIs (Including HIV) and RTIs, and briefly review. Explain that this is not meant to be a complete reference, but rather an example of how the information can be presented in a simple way that nearly all clients can understand. Ask if additional information should be added for clients at the participants' sites, and note the participants' suggestions on a flipchart. Remind the participants that they can use the handout, along with notes from the additional suggestions, as a quick guide when providing information on RTIs and STIs to clients. *(20 minutes)*

TRAINING TIP ○○○

Remember to refer to sexuality and gender issues that might be involved in discussions about STIs—e.g., that the woman got pregnant through unwanted sex, or that her husband has "outside" relationships that may have exposed her to an STI.

Activity 2: Large-group work/discussion (30 minutes)

1. Explain that because providers may not have sufficient time to discuss all of the information on Handout 6-A with each postabortion client, it is important to prioritize which information to provide. *(5 minutes)*
2. Ask each participant to choose *three key points* that every postabortion client should know about RTIs and STIs before being discharged from the site. Ask each participant to write these on a piece of paper. *(5 minutes)*
3. Going around the room, ask each participant to report his or her three points. List each *new* point on the flipchart. (Do not write any suggestion more than once.) Then, from the large group, choose *three key points* from the complete list that each client should know about RTIs and STIs before she leaves the service site. *(15 minutes)*

TRAINING TIP ○○○

We ask that the group identify "three key points" because three items are easy to remember. However, four or five points are okay, as long as the group agrees that these are "key" for every client.

Expected key points may include:

- An understanding of the signs and symptoms of STIs
- Knowledge of where to go if one suspects an STI because of signs or symptoms
- Information on treatment
- Awareness of susceptibility and prevention

4. Note that when a particular postabortion client wants to know more about RTIs and STIs, the provider should discuss as much other relevant information as possible.
5. Remind the participants that they will need to incorporate these points into their counseling role plays with their case-study clients (from Session 3). As with family planning counseling, the provider must determine the best time to give information on RTIs and STIs and to somehow ensure that the key points are covered with every client. However, this is a little more difficult than family planning counseling, because most clients are

not at all interested in hearing about RTIs and STIs. Overcoming this lack of interest (and embarrassment) will be one of the challenges for the role plays conducted later in the training. *(5 minutes)*

6. Distribute Handout 6-B: Sexuality and HIV/STI Risk: Broaching the Subject with Clients as a reference item to remind the participants how to approach the subject of RTIs, STIs, and HIV with their clients.

Part B Referring Clients for Other Services

Time: 30 minutes

Activity 1: Presentation (5 minutes)

1. Tell how this topic builds on the discussion of RTIs and STIs from the previous session.
2. Explain that beyond RTIs and STIs, postabortion clients may be dealing with other types of medical and nonmedical issues.
3. Review the issue categories listed in the "Category" column of the flipchart entitled "Other Reproductive Health Issues and Resources for Referral."

TRAINING TIP ○○○

Now that the providers are aware of the need to watch for signs and symptoms of RTIs and STIs, they must learn to whom they may refer postabortion clients for further treatment and information on those and other issues (including medical, social, economic, and emotional issues).

Activity 2: Brainstorm (10 minutes)

1. Ask the participants to think about the case-study clients (from Session 3) and to generate examples for each category of what other non–PAC-related issues those clients may face. Write their ideas on the flipchart in the "Example(s)" column.
2. Ask the participants to think of appropriate resources within the institution or community that can be used for referrals, and write their ideas on the flipchart in the "Resource(s)" column. (See the sample completed flipchart on page 100 for examples of responses.)

Sample completed flipchart—DO NOT COPY CONTENT

Other Reproductive Health Issues and Resources for Referral

Category	Example(s)	Resource(s)
Medical	■ Tuberculosis ■ Respiratory infection ■ Loss of an intended pregnancy; inability to carry a pregnancy to term	■ Obstetric-gynecologic specialist ■ Other specialists (e.g., fertility) ■ Other health care providers
Social	■ Rape ■ Domestic violence ■ Incest	■ Rape crisis center ■ Legal services ■ Other social or women's services ■ Religious institution
Economic	■ Inability to afford a family planning method ■ Limited or insufficient food or money	■ Referral to free or low-cost family planning services ■ Social services
Emotional	■ Emotional distress from social issues listed above	■ Psychologist or counselor ■ Religious institution
Other		

Activity 3: Presentation (5 minutes)

1. Describe the signs that a client may exhibit when dealing with non–PAC-related reproductive health or other issues.

TRAINING TIP ○○○

Signs of other issues include the following:

- Physical indicators, such as bruises, scratches, or other evidence of abuse, trauma, accident, or malnutrition (possibly an indicator of economic problems)
- Emotional indicators, such as distress or fear regarding the client's partner or the termination of the pregnancy, or depression over loss of the pregnancy
- Conversational indicators, such as questions on issues not directly related to the PAC procedure (such as STIs and HIV, sexuality, vaginal discharge, and others)

2. Explain the kinds of questions a provider can ask to find out about a client's needs.

TRAINING TIP ○○○

Examples of questions for assessing a client's reproductive health needs (in addition to questions regarding family planning and RTIs and STIs) include:

- What other concerns or fears do you have regarding future pregnancies?
- Can you talk to your partner, family, or friends about these concerns?

Activity 4: Role play (10 minutes)

1. Ask for a volunteer to act as a postabortion client in a short role play. Tell the volunteer and other participants that they will create a scenario in which one of the case-study clients (from Session 3) needs to be referred for non-PAC services.
2. Choose a case-study client for the scenario. Tell the participants that you will play the role of the "provider" to model how to use effective questioning to assess a client's non–PAC-related needs (and provide referral). (Assume that you have already covered family planning and RTI and STI issues with the client.)
3. Leave the room and give the group two minutes to come up with a situation.
4. Return to the room and instruct the volunteer not to offer you any information unless you ask questions that invite his or her response. Demonstrate how to ask questions that assess the client's needs, and refer her to the appropriate resource.
5. Discuss the role play with the participants.

Part C Threatened Abortion

Time: 35 minutes

Activity 1: Small-group work (20 minutes)

1. Divide the participants into two groups, and post the flipchart entitled "Addressing the Postabortion Client's Feelings" from Session 3.
2. Display Transparency 6-A: Sample Case Study 1: "Daisy" and Transparency 6-B: Sample Case Study 2: "Diana," and assign one to each group, or give each group one copy of the case study.
3. Give each group a copy of the flipchart entitled "Addressing the Feelings of Clients with Threatened Abortion." Tell the participants to read their respective case studies and to list on the flipchart what feelings the client may experience while she is at the facility.
4. Likewise, for each feeling identified, tell the participants to list the reason(s) why the client might feel that way, using the case-study flipchart from Session 3.
5. Ask each group to fill in the third column for their respective case-study clients. For this column, they should ask themselves: What can the provider do when a client is feeling this way?

6. Ask each group to choose a spokesperson who will report to the rest of the participants during the group discussion.

Activity 2: Discussion (15 minutes)

1. Post the flipchart entitled "Addressing the Feelings of Clients with Threatened Abortion" on the wall, alongside the respective case-study flipchart.
2. Ask the spokesperson from each group to share the group's ideas.
3. Ask for comments or questions from the rest of the participants.

Session 6

Handouts

Handout 6-A
Background Information on Sexually Transmitted Infections (STIs) (Including HIV) and Reproductive Tract Infections (RTIs)

STIs

What are STIs?

- Sexually transmitted infections (STIs), including HIV infection (the cause of AIDS), are infections transmitted through sex (vaginal, anal, or oral).
- If not treated, STIs can lead to serious health problems, such as infertility.
- No cure exists for HIV/AIDS, and the infection usually results in death.
- Some STIs can be passed to the baby during pregnancy, delivery, and breastfeeding, causing serious infections.
- HIV and some other STIs can also be transmitted through unclean injection needles, skin-cutting tools, and blood transfusions (where the blood is not tested).
- STIs are sometimes called "venereal disease" (VD), and they are widespread throughout the world.

What are some common STIs?

- Chancroid
- Chlamydia
- Gonorrhea
- Hepatitis B
- Hepatitis C
- Herpes
- HIV/AIDS
- Human papillomavirus (HPV)
- Syphilis

How do you know if you have an STI?

Many people who have STIs, especially women, have no symptoms. (Symptoms are signs or indications in your body that may tell you when something is wrong.) When symptoms appear, these may include:

- Unusual discharge from the vagina or penis
- Pain or burning with urination
- Itching or irritation of the genitals
- Sores or bumps on the genitals or anus
- Rashes, including rashes on the palms of hands and soles of feet
- In women, pelvic pain (pain below the belly button)

Having one of these symptoms does not necessarily mean you have an STI, but if you have symptoms, you (and any sexual partners) should get checked at a clinic or hospital.

(continued)

Handout 6-A (continued)
Background Information on STIs (Including HIV) and RTIs

How can you protect yourself from getting an STI?

Practice safer sex:

- Have sex with only one partner who is not infected and who has no other partners.
- If this is not possible or if you do not know if your partner is infected:
  - For vaginal or anal sex, use a condom each and every time you have sex.
  - For oral sex, use a condom over the penis or cover the vagina or anus with plastic wrap or a condom that has been cut open.
  - Engage in other forms of sexual activity, such as using your hand to stimulate your partner. (Always wash your hands immediately afterward.)

***REMEMBER:* Communication between partners is important for practicing safer sex successfully. Partners can discuss issues about risk, trust, and condom use. The more partners can talk about practices that might put them at risk, the better they will be able to identify ways to reduce their risk of infection.**

How do you use a condom correctly?

Providers should demonstrate how to use a condom correctly, then have the client repeat the demonstration. To avoid getting an STI, *always* use a condom.

RTIs

What are RTIs?

Reproductive tract infections (RTIs) are infections of the reproductive system. RTIs include both STIs *and* other types of infections that are not caused by sexual contact.

RTIs that often are *not* sexually transmitted include:

- Yeast infection
- Bacterial vaginosis

What are the symptoms and signs of RTIs?

- Unusual discharge from the vagina
- Pain during urination
- Pain during sexual intercourse
- Vaginal itching

What are the possible complications of untreated RTIs?

- Bacterial vaginosis may increase the risk of infections following vaginal surgery or abortion and may increase the risk of early labor and delivery.
- Severe yeast infections or bacterial vaginosis may cause some women to experience extreme discomfort.

STI information adapted from: EngenderHealth. 2000. *What every client should know: STI/HIV prevention quick-reference cards for health care providers*. New York.

Handout 6-B
Sexuality and HIV/STI Risk: Broaching the Subject with Clients

When counseling clients on sexual and reproductive health issues, we often need to ask very personal, sensitive questions. This can be challenging for the client, who may not be accustomed to discussing such personal issues with someone other than a family member (or with anyone at all). It can be challenging for providers or counselors as well, since they must be able to obtain the information to address clients' risk of unintended pregnancy and infection with HIV and other STIs, as well as clients' concerns about sexuality.

Getting Started

It is best to get the conversation rolling with general, open-ended questions. Asking open-ended questions, such as about a client's reasons for coming to the service site or about her general health, will help pave the way for the more sensitive questions you will ask.

Later, you can probe with more pointed questions to obtain specific information. You may introduce the discussion in your own way, depending on the setting, the client, and the type of service she seeks or the complaint she presents with.

Examples

- Assure the client that the questions are routine and that everyone is asked the same questions. For example:
  "I am going to ask some very personal questions now. We ask these questions of everyone, because we believe that one's sexual life is an important aspect of health."
- Assure the client that the questions will have a direct bearing on her health care and the decisions made during the visit:
  "It is important for me to ask you these types of questions so that I can help you to make health decisions that are right for you."
- Be sure that she feels comfortable:
  "If there are any particular questions you do not feel comfortable answering, feel free to let me know."
- Introduce the questions within the context of HIV and STI risk:
  "As you may know, HIV and other sexually transmitted infections occur a lot in this area. I would like to talk with you more about your situation so that we can determine if you might be at risk. We discuss this with all of our clients so that we can make sure everyone gets the information and family planning method that best meets their needs."

General Questions

You may start with some very general questions to get the conversation going, such as:

- Do you have any questions or concerns that you would like to discuss about your sexual relationships?
- Can you tell me about your spouse, sexual partner, or partners? Whom do you live with?
- Tell me about your sexual experiences.
- What questions do you have about what might happen to your body during sex?
- Are you happy with your sex life? Why or why not? Do you talk with your partner about it?
- Tell me about your first sexual experiences. (This is a particularly important matter to raise with younger clients.)

(continued)

Handout 6-B (continued)
Sexuality and HIV/STI Risk: Broaching the Subject with Clients

Getting Specific

More pointed questions can often be integrated into a discussion of medical history, demographics, or risk factors pertinent to the service being provided. If the information does not emerge through general discussion, ask probing questions on HIV and STI risk, family planning, antenatal or postpartum concerns, or other relevant issues.

Probing: Asking specific questions

This list of issues should *not* be used as a checklist; it is merely a guide to help you remember the information points that are key to elicit. Questions about a client's sexual life, sexual practices, sexual risks, and social context should be worked into a two-way conversation about her individual situation.

HIV/STI risk

During the exploratory discussion, try to elicit information about key issues so you can assist the client to perceive and determine her risk for STIs, including:

- Number (and gender) of current and past sexual partners
- Knowledge of her partner's sexual practices and other partners
- Condom use
- History of STIs and other infections
- Sexual practices and behaviors

Family planning concerns

In addition to obtaining information about contraceptive history and needs, reproductive intentions, and potential contraindications, explore factors associated with sexuality that may affect contraceptive choice and continuation, including:

- Fear of becoming pregnant or fear of disease
- Concerns about the negative impact of the method (e.g., condoms, other barrier methods) on sexual pleasure
- Diminished sexual response due to use of hormonal methods
- HIV and STI risk (see above)

Other issues for any client

- Past surgery or diseases relevant to sexual functioning
- Sexual concerns with onset of menopause
- Sexual dysfunction in client or partner
- Pain during sex
- Lack of desire, orgasm, or sexual satisfaction
- Insufficient lubrication
- Age at first intercourse
- Experience of recent or past sexual coercion or violence
- Impact of drug or alcohol use on sexual activity and risks
- Partner's use of, support for, and communication about contraceptive use or disease prevention

(continued)

Handout 6-B (continued)
Sexuality and HIV/STI Risk: Broaching the Subject with Clients

Some sample questions about a variety of topics

- When did you first become sexually active?
- Can you tell me about how many sexual partners you have had?
- Were these partners male or female?
- Did you agree or consent to all of your past sexual experiences?
- Have you ever used any kind of contraception (family planning method) in your sexual relationships? If so, which methods? How frequently have you used these methods? How did you feel about them? How did your partner feel about them?
- Specifically, have you ever used condoms?
- If not, would you be interested in using condoms in your current or future relationships?
- To your knowledge, have you or any of your past or current partners ever had a sexually transmitted infection?
- What kinds of sexual practices have you and your past or current partners engaged in together? How do you have sex? (*Note:* A client will often respond, "We have sex." It is important to be specific about what "sex" means to the client. If she says, "intercourse," find out if that is vaginal or anal, as well as whether she has performed or received oral sex. Be sure to use a gender-neutral term when referring to a client's sexual partner until the client has revealed the partner's sex.)
- Do you have any other partners besides your primary partner? Do you think that your partner may have other partners?
- Do you experience any pain during or after sex with your partner?
- Do you experience any burning or other discomfort when you urinate?
- Do you feel any itching, burning, or other discomfort at any other times? Do you or have you ever had an unusual discharge from your penis/vagina?
- Do you have any questions or concerns about your sexual relationship that you would like to discuss?
- How do you feel about your current sexual relationship?
- How likely do you think it is that you may be at risk for HIV or other STIs? How likely do you think it is that your partner could be at risk for HIV or other STIs?
- How would you feel about a (or another) pregnancy at this time? How do you think your partner would feel?

Adapted from: EngenderHealth. 2001. *Sexuality and sexual health: Online minicourse*. http://www.engenderhealth.org/res/onc/sexuality/index.html.

Session 7:
Postabortion Counseling

Objectives

- To describe the purpose and three phases of counseling for postabortion clients
- To examine postabortion counseling in the context of existing PAC services
- To explain how to create a comfortable environment for openly discussing clients' needs and concerns
- To list information that should be provided to clients "preprocedure," including the client's health condition and a description of the medical procedure
- To demonstrate preprocedure counseling, using communication skills to address clients' needs, as follows:
  - Assess the client's readiness to discuss her concerns and feelings
  - Encourage the client to ask questions and to express her opinions and feelings
  - Answer the client's questions with simple explanations
- To identify concerns and needs of the client during the postabortion medical procedure
- To describe verbal and nonverbal ways to address the client's needs during the procedure
- To demonstrate showing support for the client during the procedure through role plays
- To describe the postabortion client's state of mind after the procedure, as well as her immediate concerns and needs
- To describe postprocedure instructions for the client (including how to take care of herself, common side effects of the procedure itself, signs of possible complications, and what to do if these occur), as well as return to fertility and referral for nonmedical problems or concerns
- To demonstrate talking with the client after the procedure, including postprocedure instructions, basic information about reproductive health and contraception, and referral, as necessary

Training Methods

- Presentation/discussion
- Brainstorm
- Role play

Materials

- Flipchart paper, easel, markers, and tape
- Flipcharts of the client case studies (from Session 3)
- Flipcharts of "Addressing the Postabortion Client's Feelings" for each client (from Session 3)
- Transparency 7-A: Sample "Map" for Case-Study Client Walk-Through of PAC Services (page 170)

- Transparency 7-B: General Requirements of Pain Control (During Uterine Evacuation with an Awake Client) (page 171)
- Handout 7-A: Postabortion Counseling (page 125)
- Handout 7-B: Counseling the Postabortion Client (page 126)
- Handout 7-C: Counseling Guidelines for the Provider: Before the PAC Procedure (page 127)
- Handout 7-D: Counseling Guidelines for the Provider: After the PAC Procedure (page 128)
- Handout 7-E: Postprocedure Information Sheet (for clients) (page 129)
- Handout 7-F: Postabortal Syndrome (for providers) (page 131)
- Handout 7-G: Supportive and Informational Counseling Before, During, and After the Treatment Procedure (page 133)
- "Props" for role plays, such as client-education materials, a blanket, a curtain, drapes, or other materials that can be used to make the role plays more realistic
- Video camera and television or monitor (optional)

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. Review all handouts and make one copy for each participant.
3. Prepare three flipcharts, one entitled "Needs and Concerns," one entitled "Assessing a Client's Readiness to Talk," and one entitled "Creating a Comfortable Environment for Discussion."
4. Prepare the room so that each group can sit near its respective case study and feelings flipcharts.
5. Prepare a flipchart of Transparency 7-B: General Requirements of Pain Control (During Uterine Evacuation with an Awake Client).
6. Gather the materials and prepare the room for the demonstration and practice role plays of a medical procedure (i.e., four procedure "rooms").
7. Set up the video camera and television or monitor (optional).

Session Time (total): 4 hours, 5 minutes, to 4 hours, 20 minutes

SESSION 7 TRAINING STEPS

Part A Overview of Postabortion Counseling

Time: 45 minutes

Activity 1: Large-group exercise/discussion (25 minutes)

1. Ask for a volunteer to provide a "walk-through mapping" of PAC services at his or her site, as follows: The volunteer should play the role of his or her case-study client and "walk through" that client's steps from the time she arrives at the facility until the time she leaves (or returns for follow-up). As the volunteer describes the steps of the client, map a corresponding diagram on a flipchart.

> **TRAINING TIP ○○○**
>
> The sample "walk-through/mapping" of a case-study client should make the exercise interactive *and* should clarify what happens during each phase of treatment for postabortion clients at the participants' respective sites. The map should identify actual points of contact with different departments and service providers, and it can be used as a reference for how and when to counsel clients at different points in the service-delivery process. (See page 168 for a sample map.)

2. Briefly identify which services are lacking or need improvement. This will provide the participants with a tangible and familiar framework for considering and applying the three phases of counseling.

Activity 2: Discussion (20 minutes)

1. Ask the participants to describe the role of counseling in PAC. Clarify any misconceptions and answer questions raised by the participants, and distribute Handout 7-A: Postabortion Counseling (which includes the World Health Organization [WHO] definition of counseling).

> **TRAINING TIP ○○○**
>
> Handout 7-A clarifies the role of counseling in PAC and reviews elements of counseling, including who can provide counseling and the qualities and skills that are necessary. Presenting this material at this point serves three purposes: It gives a framework in which to fit skills, attitudes, and knowledge addressed in Sessions 2 to 6; it prepares the participants for the counseling practice in the remainder of the training; and it can give postabortion counseling added credibility in the eyes of participants by referring to the WHO publication.

2. Explain to the participants that counseling skills and steps should always be integrated into their routine work with postabortion clients. Remind them that the responsibility for counseling is shared by *all staff* who interact with clients, even if only for a short time. If the participants still perceive counseling as a "new" staff position that is outside of their job description, the role plays that follow (Parts B to D) will allow you to focus on that concern.

> **TRAINING TIP ○○○**
>
> The WHO document uses the term "abortion care" to include both emergency abortion care and elective abortion. Our emphasis is on the aspects of counseling that relate specifically to emergency, or postabortion, care.

3. Distribute Handout 7-B: Counseling the Postabortion Client and briefly summarize the different phases of counseling in postabortion care.

> **TRAINING TIP ○○○**
>
> Use case-study examples to emphasize that the content of counseling may shift between different phases. For example, if Case-Study Client X arrives in shock, discussion about her future fertility intentions must wait until she has been treated, is stabilized, and is able to converse coherently and comfortably.

Part B Preprocedure Counseling

Time: 1 hour, 30 minutes, to 1 hour, 35 minutes

Activity 1: Brainstorm/discussion (15 minutes)

1. Ask the participants: What information does the client need prior to the procedure? What other needs and concerns might she have? If necessary, refer to Handout 7-B to help identify needs and concerns, as well as to the flipchart "Addressing the Postabortion Client's Feelings."
2. Write the participants' comments on the flipchart entitled "Needs and Concerns," and post the flipchart on the wall.
3. Distribute Handout 7-C: Counseling Guidelines for the Provider: Before the PAC Procedure, and summarize by reviewing the preprocedure counseling guidelines.

Activity 2: Brainstorm/discussion (30 minutes)

1. Ask the participants: How can you determine if it is a good time to talk with a client about her needs and concerns? Write their ideas on the flipchart entitled "Assessing a Client's Readiness to Talk."

TRAINING TIP ○○○

The process of assessing the client's readiness to talk and creating a comfortable environment will differ from place to place, depending on her condition, the local culture, and specific features of the PAC service site (e.g., hospital vs. clinic setting). The following examples may be used to help guide the discussion:

- Observing the client's appearance: Is she conscious, alert, oriented? Does she look sleepy, in pain, scared, or agitated? Does she make eye contact when you greet her?
- Asking: "How are you feeling?"
- Asking: "You may have some questions about what is going on. Is this a good time for us to talk?"

The participants should be aware that although a provider can and should attempt to communicate with a semiconscious client, she may not retain or recall essential preprocedure or postprocedure information or instructions. This information should be covered when she is awake and alert.

2. Post the completed flipchart on the wall for reference during the remainder of this session.
3. Ask the participants to list ways of creating a comfortable environment for openly discussing clients' needs and concerns.
4. Write their ideas on the flipchart entitled "Creating a Comfortable Environment for Discussion."
5. Demonstrate how to arrange the setting and speak softly when sitting or standing close to the client, as described below.

TRAINING TIP ○○○

Some examples of ways to create a comfortable environment for discussion include:

- Arranging the setting so it is conducive to a confidential discussion with the client (e.g., drawing a screen or curtain for visual privacy, or making sure you are far enough away from other clients and staff so you cannot be overheard if you speak softly)
- Sitting or standing close to the client and speaking softly
- Assuring the client of confidentiality (i.e., that everything she says will remain between you and her, unless other medical staff who are treating her need to know)
- Acknowledging that feeling scared, confused, or worried are common emotions for most women in this situation
- Asking if there is anyone else that she would like to have involved in the discussion (e.g., her partner or family members)

6. Post the completed flipchart on the wall, for reference during the remainder of the workshop.

TRAINING TIP ○○○

After the participants have developed flipchart lists specific to their own cultures and sites, you may want to have them typed, copied, and distributed as handouts before the end of the workshop.

Activity 3: Role-play preparation (15 minutes)

Note: During the role plays, the participants will use the case-study clients (from Session 3) as characters.

1. Divide the participants into the same case-study client groups as on the first day of the workshop, seating each group near where its case-study and feelings flipcharts are posted on the wall.
2. Ask each group to:
   - Develop a *5- to 10-minute* role play for preprocedure counseling that accomplishes the following communication tasks:
     - Assessing the client's readiness to discuss her concerns and feelings
     - Encouraging the client to ask questions and to express her opinions and feelings
     - Answering the client's questions with simple explanations
   - Remember to use the open-ended or feeling questions that the participants developed during Session 4 and to address the sexuality and gender concerns identified in Session 6.
   - Remember to show examples of reflecting (interpreting the feelings behind a client's words).
3. Distribute "props" to each group.
4. Walk around the room and offer help as the participants develop their role plays.

Activity 4: Role-play practice (20 to 25 minutes)

1. Randomly select one group to conduct its role play for the other participants to observe.
2. Introduce the role play by reminding the participants of the circumstances of the case study.
3. Videotape the role play (optional).
4. Stop the role play if it exceeds the 10-minute time limit. *(10 minutes, maximum)*
5. Play the videotape of the role play (if video is used) and discuss *(10 minutes)*, asking:
   - How do you think the "client" felt during this role play?
   - Which communication tasks were achieved?
   - What did the group do well?
   - How could they improve?

TRAINING TIP ❍❍❍

You may need to remind the participants to:

- Take the role play seriously. (This is an opportunity to practice for interactions with real clients the next day.)
- Be realistic in the scenarios they present. (A client may not be forthright in telling a provider that she induced an abortion in a country where abortion is illegal.)
- Tailor the conversation to fit the individual client's needs, rather than using a discussion "script" with irrelevant information. (If a client wants to be pregnant again soon, she is probably not interested in long-term family planning methods.)
- Ask questions about what the client needs or wants, rather than make assumptions.

6. Summarize the feedback and add any points that were not covered by the participants.

Activity 5: Discussion (10 minutes)

1. Summarize the role plays by asking the following questions:
   - What did you learn from this session?
   - How could you apply what you have learned in your own work setting?
2. Be prepared to conduct your own demonstration role play in case key steps or skills need to be reinforced.

TRAINING TIP ❍❍❍

The role plays will work best if each group is able to practice in front of the others and get feedback. However, this takes more time, particularly if the number of participants is large. The groups can practice their role plays at the same time if there is enough space and if there are enough trainers to supervise each group. You would still want to have one group demonstrate for the others and to conduct a large-group discussion and feedback for that role play. After the participants demonstrate their role plays, the trainer should identify the aspects that were not done very well and show how to do better.

During this and the next two sessions, the time for the practice sessions will vary. In this session, the role plays will take longer, since the participants are unfamiliar with the process. Subsequent practice sessions will take less time, as the participants get used to the format and improve their skills. Be flexible on time; this practice is one of the most important aspects of the entire training. (*Note:* Including the videotaping option will add an additional 5 to 10 minutes to the time required for the exercise.)

Part C Being Supportive during the Procedure

Time: 50 to 55 minutes

Activity 1: Brainstorm/discussion (10 minutes)

1. Refer to the "Needs and Concerns" flipchart from Activity 1 of Part B of this session, and ask the participants to identify needs and concerns that the client would feel during the medical procedure.
2. Emphasize the range of emotions that a client might feel. (If this is not listed by the participants, remind them about the earlier sessions on respecting the client's rights to confidentiality, privacy, and dignity.)
3. Ask the participants how the service provider can address these needs, both verbally and nonverbally.
4. Summarize by explaining the importance of offering the client reassurance and attention—through touch and words—for pain control.
5. Introduce the pain control requirements as follows:

   "All sensations of pain are increased by fear; constant attention and reassurance by touch and words ('verbal anesthesia' or 'verbacaine') are important to help a woman to cope with this aspect of the experience."

   —Margolis, A., Leonard, A. H., and Yordy, L. 1993. Pain control for treatment of incomplete abortion with MVA. *Advances in Abortion Care* 3(1):1–8.
6. Display the flipchart entitled "General Requirements of Pain Control," and review the requirements:
   - A procedure room that is quiet and nonthreatening
   - Health care workers who are calm, friendly, gentle, and unhurried
   - Continuous attention to the client from the medical team
   - A clear explanation of what to expect before the procedure, what is happening during the treatment, and what, if any, discomfort she may expect to feel
   - A competent, efficient, and well-trained team of providers who communicate well with the client

TRAINING TIP ○○○

Remind the participants that PAC treatment is not limited to the MVA procedure, but encompasses the broader aspect of managing abortion complications. The retained products of conception are just one subset of these complications.

Activity 2: Role-play preparation (15 minutes)

Note: During the role plays, the participants will use the case-study clients (from Session 3) as characters.

1. Refer to the flipcharts developed and posted in Part B, reminding the participants to use them as a resource for the role-play exercises.

2. Divide the participants into the same case-study client groups as on the first day of the workshop, seating each group near where its case-study and feelings flipcharts are posted on the wall.
3. Ask each group to:
   - Identify the specific needs and concerns of its case-study client
   - Develop a *5-minute* role play for counseling during the medical procedure in which verbal and nonverbal skills are used to address the client's needs and concerns
   - Remember to show examples of reflecting (interpreting the feelings behind a client's words) in the role plays
4. Distribute "props" to each group.
5. Walk around the room and offer help as the participants develop their role plays.

Activity 3: Role-play practice (20 to 25 minutes)

1. Randomly select one group to conduct its role play for the other participants to observe.
2. Introduce the role play by reminding the participants of the circumstances of the case study.
3. Videotape the role play (optional).
4. Stop the role play if it exceeds the 5-minute time limit. *(5 minutes, maximum)*
5. Play the videotape of the role play (if video is used) and discuss *(10 minutes)*, asking:
   - How do you think the "client" felt during this role play?
   - Which communication tasks were achieved?
   - What did the group do well?
   - How could they improve?
6. Summarize the feedback and add any points that were not covered by the participants.
7. Give the following example to show how a provider can address a client's needs and feelings during the procedure:

   "In some cultures, women may feel ashamed to sit for an extended period of time with their legs open, even though this is part of a clinical procedure. While providers cannot completely erase such feelings of shame, they can be sensitive to the client's concerns by means of simple gestures, such as draping her lower body whenever possible, holding her hand, telling her that many women feel a little uncomfortable in this situation, and reassuring her that this feeling is normal."

Activity 4: Discussion (5 minutes)

1. Summarize the role plays by asking the following questions:
   - What did you learn from this session?
   - How could you apply what you have learned in your own work setting?
2. Be prepared to conduct your own demonstration role play if key steps or skills need to be reinforced.

TRAINING TIP ❍❍❍

See the Training Tip from Part B, Activity 5 (page 117), for options on how to conduct the practice role plays. As before, you should identify aspects that were not done adequately and demonstrate how to do them better.

Address situations where the client is semiconscious due to her medical condition (not due to medication). Tell the participants how they can still be supportive in these cases, by reassuring the client with touch and words and by paying close attention to the client's needs (using effective listening and two-way communication).

Remind the participants that other staff present during future procedures may not have received this training. However, the participants can share with others what they have learned (and improve the facility's overall quality of services) by modeling communication skills and offering support during the procedure.

The time for this role play is only five minutes, because there are fewer communication tasks to practice. However, body language and expressions of verbal support are still important. These may also present different challenges for participants who are accustomed to relying on words only for communication. Therefore, if the participants are not able to demonstrate appropriate body language and support during the five minutes for the role play, give them more time and additional guidance.

Part D Counseling after the Procedure

Time: 1 hour to 1 hour, 5 minutes

Activity 1: Large-group discussions (25 minutes)

1. Refer to the "Needs and Concerns" flipchart and identify which items would apply to the client's state of mind *after* the treatment procedure has been conducted.
2. Ask the participants if any other feelings, needs, or concerns should be added to the list that would apply to the client after the procedure. List these on another flipchart.

TRAINING TIP ❍❍❍

If this has not happened already in the role plays, the groups should address referral for family planning (Session 5), RTI and STI information (Session 6, Part A), and other reproductive health or social health services, as noted earlier (Session 6, Part B). You may need to add demographic and social characteristics to the case-study clients to make sure that different groups address these different issues.

3. Ask which of these feelings, needs, or concerns the PAC service provider can actually address and which need to be referred to providers or resources outside the PAC setting. Note referral resources, as identified in Session 6, Part B.
4. Distribute Handout 7-D: Counseling Guidelines for the Provider: After the PAC Procedure, and briefly review.
5. Explain that besides addressing the client's needs and concerns, the provider must be concerned about the client's safe recovery from the postabortion procedure. Therefore, providers must explain postoperative instructions to clients (and to other family members, as appropriate) in a way that they can understand. In addition to verbal explanation, written postoperative instructions should also be provided.
6. Distribute Handout 7-E: Postprocedure Information Sheet, and review each point. Distribute Handout 7-F: Postabortal Syndrome, as a reference item for providers.

Activity 2: Role-play preparation (10 minutes)

Note: During the role plays, the participants will use the case-study clients (from Session 3) as characters.

1. Divide the participants into the same groups as in Session 7, Part B, and tell them that they will work with the same case-study clients as before. (Refer to their case studies, if necessary, either on flipchart or handout.)
2. Ask each group to:
   - Identify the specific needs and concerns of its case-study client.
   - Develop a *5- to 10-minute* role play for postprocedure counseling that includes postoperative instructions, basic information about reproductive health and contraception, and referral, if necessary (see Handouts 5-A, 7-E, and 7-F).
   - Remember to show examples of reflecting (interpreting the feelings behind a client's words) in the role plays.
3. Distribute "props" to each group.
4. Walk around the room and offer help as the participants develop their role plays.

TRAINING TIP ○○○

For some clients, other members of the family, such as the husband or his mother, may make the key decisions about how much rest the client gets, whether and when she takes her medication, or whether she gets follow-up care, if this is necessary. In such a situation, postoperative instructions can be given to the client along with the key decision makers in her home setting. When helping the groups to prepare, be sure that one group includes this scenario in their role play.

Activity 3: Role-play practice (20 to 25 minutes)

1. Randomly select one group to conduct its role play for the other participants to observe.
2. Introduce the role play by reminding the participants of the circumstances of the case study.
3. Videotape the role play (optional).

4. Stop the role play if it exceeds the 10-minute time limit. *(10 minutes, maximum)*
5. Play the videotape of the role play (if video is used) and discuss *(10 minutes)*, asking:
   - How do you think the "client" felt during this role play?
   - Which communication tasks were achieved?
   - What did the group do well?
   - How could they improve?
6. Summarize the feedback and add any points not covered by the participants.

Activity 4: Discussion (5 minutes)

1. Summarize the role plays by asking the following questions:
   - What did you learn from this session?
   - How could you apply what you have learned in your own work setting?
2. Be prepared to conduct your own demonstration role play in case key steps or skills need to be reinforced.

TRAINING TIP ❍❍❍

See the Training Tips from Part B, Activity 5 (see page 117), and from Part C, Activity 4 (see page 120), for options on how to conduct the practice role plays. As before, you should identify the aspects that were not done adequately and demonstrate how to do them better.

The time for these role plays is 10 minutes each, because there are some minimum requirements on information exchange. Again, be flexible on time.

3. Distribute copies of Handout 7-G: Supportive and Informational Counseling Before, During, and After the Treatment Procedure, which summarizes the lessons covered in this session.

Session 7

Handouts

Handout 7-A
Postabortion Counseling

Postabortion counseling:

- Focuses on helping individuals to make choices and to manage the emotions raised by their situation
- Goes beyond just giving facts; it enables clients to apply information to their particular circumstances and to make informed choices
- Includes a discussion of feelings and concerns, since they are relevant to the client's choices, particularly regarding sexual behavior, reproductive health, and fertility

Counseling always involves two-way communication between the client and the provider, in which each spends time talking, listening, and asking questions.

According to the World Health Organization:

"Counselling—face-to-face communication in which a counsellor assists the woman in making her own decisions and acting on them—must be a part of all abortion care….Ideally, the same counsellor should provide support before, during, and after treatment; however, this is often difficult in a health care facility with limited staff and high caseloads. Nevertheless, a supportive and caring staff can do much to meet the psychological and emotional needs of women seeking emergency abortion care or elective abortion.

Counselling in abortion care can be provided by a variety of staff members, including nurses, midwives, physicians, social workers or nurse aides. [*Note:* This list of providers will vary, depending upon the country.] Volunteers have been used successfully in some situations. A professional counsellor is not necessary; however, training in counselling techniques should be provided for any staff functioning as counsellors.

Staff who provide counselling must be non-judgemental, extremely sensitive to and respectful of the woman's emotions and feelings, in order to adapt the session to the woman's specific needs. Counsellors should be knowledgeable, well-trained, and able to give accurate information. Counselling staff must always be aware of the need for privacy, confidentiality, and, in some cases, anonymity….Critical elements of all good counselling include the ability of the counsellor to elicit and listen to a woman's needs, concerns, and questions, and to inform, educate, and reassure, using language and terms that the woman understands….It is also useful to augment verbal explanations with written and pictorial materials to reinforce what has been said in the counselling sessions."

—World Health Organization. 1995. Information and counselling for the patient. In *Complications of abortion: Technical and managerial guidelines for prevention and treatment*. Geneva.

Handout 7-B
Counseling the Postabortion Client

Preprocedure

- Assess the client's ability or capacity to give or receive information
- Explore the client's needs and feelings
- Examine the client's values and life plans
- Based on the client's condition, provide information about the following, as appropriate:
  - Exams and findings
  - Treatment procedure/anesthesia
  - Possible side effects, complications, and risks
  - Human reproductive processes
  - Available contraceptive methods

During the procedure

Maintain emotional support by providing:

- Positive, empathetic verbal and nonverbal communication
- Gentleness while performing the procedure

Postprocedure

- Explore the client's feelings, questions, and concerns after the procedure—provide support and encouragement
- Remind the client of possible side effects, risks, and warning signs, and that she should return if warning signs occur
- Tell the client how to take care of herself at home
- Give her written postprocedure information
- Remind the client of the importance of follow-up
- Discuss available contraceptive methods, as appropriate
- Discuss RTIs and STIs
- Assess the need for additional counseling or referral for other reproductive health needs or nonmedical issues

Handout 7-C
Counseling Guidelines for the Provider: Before the PAC Procedure

It is important to obtain sufficient medical information to make an accurate diagnosis and develop a treatment plan. Assure the client that these questions are being asked to get the information needed to best treat her medical condition. Examples of questions that should be asked are:

- When did the bleeding start? Is it a lot or a little?
- How did the bleeding start? Was something done to start the bleeding? (Ask these questions with sensitivity and discretion.)
- Have you passed anything from the vagina besides blood? Did it look like skin or clotted blood with tissue?
- Do you have pain? Where? When did it start? How bad is it?
- Have you had a fever? Chills?
- Have you felt weak? Fainted? Collapsed?

All women being treated for abortion complications have a *right to information* about their condition, including:

- Their overall physical condition
- Results of physical and pelvic examinations and lab tests
- The time frame for treatment
- The need for referral and transport to another facility
- Procedures to be used, as well as risks and benefits

Providers *must* have the client's consent for treatment or, if she is unable to give it, that of a family member or other responsible adult.

Be sensitive to the client's physical and emotional condition when providing information; forcing her to listen when she is not ready will just be a waste of your time and hers.

Always ask the client if she has any questions for you.

Explore her needs and feelings about her situation, and future plans, if her condition permits.

Adapted from: Winkler, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium.

Handout 7-D
Counseling Guidelines for the Provider: After the PAC Procedure

Once the surgical procedure has been completed:

- Approach the client when she is already calm and recovering from the procedure. Be sensitive to her physical and emotional condition; forcing her to listen when she is not ready will just be a waste of your time and hers.
- Be flexible about where you conduct counseling. Sometimes clients may feel strong enough to get up and talk to the provider in a separate room; others may prefer to remain in bed and be counseled while still in the recovery room.
- Be aware that the important thing is to provide the client with useful information that is suitable to her needs.
- If others have accompanied the client to the service site, ask if she would like to include them in the discussion.
- Start the counseling by exploring the client's feelings, questions, and concerns after the postabortion procedure.
- Follow the postabortion counseling diagram (Handout 7-B) to check what information may be given to the client.
- Explore the client's postprocedure plans.
- Provide the client with the Postprocedure Information Sheet (Handout 7-E) and review it with her (and with others, as appropriate).
- Offer to help her with whatever she needs, as appropriate, before saying good-bye.

Handout 7-E
Postprocedure Information Sheet

How to Take Care of Yourself

- Resume normal activities only when you feel comfortable enough to do so.
- Take the medications you have been given *correctly and completely:*

  - _____ is an antibiotic to prevent or treat infection.
    Take _____ pills _____ times a day for _____ days until all pills are gone.
  - _____ is for discomfort.
    Take _____ pills every _____ hours, as needed.
  - Iron tablets will make your blood normal and healthy again.
    Take ___ tablets _____ times a day.

- Keep your follow-up appointment as scheduled on _____. Return at any time if you have concerns.
- If you are interested in using a family planning method, talk to a provider about starting one *right away*. It is possible to become pregnant as soon as you resume sexual relations.

Avoid:

- Strenuous activity for 2 to 3 days
- Sexual relations until the bleeding has stopped

What Is Normal:

- Bleeding and cramping similar to a normal period for up to one week
- Mild fatigue for a few days
- Mild depression or sadness for several days

What Is Abnormal:

- Fever
- Dizziness, lightheadedness, or fainting
- Abdominal pain
- Severe cramping
- Nausea or vomiting
- Bleeding that is twice as heavy as a normal period
- Vaginal discharge that smells bad

Return *immediately* if you experience any of these symptoms!

Special Instructions:

_____

_____

_____

Handout 7-F
Postabortal Syndrome

What Is It?

Postabortal syndrome (also called postabortal hematometra) is severe cramping and discomfort due to the collection of blood in the uterus that can occur following evacuation of the uterus. Postabortal syndrome can present either immediately following the procedure or several days later.

What Causes It?

Normally, following a curettage or aspiration, the endometrial lining and any remaining pregnancy-related tissue flow out through the cervix. In the case of postabortal syndrome, after the procedure:

- The cervical os becomes blocked.
- The uterus fills with clots and continues to bleed.
- The uterus cannot contract.

What Are the Symptoms and Signs?

Symptoms include:

- Severe cramping
- Sweating
- Lightheadedness
- Nausea
- Vomiting and diarrhea (occasionally)

On examination, the client may exhibit the following signs:

- Sweating
- Paleness
- Slightly rapid heartbeat
- Tense, tender, or enlarged uterus on bimanual exam (often equal to or larger than the uterine size before the procedure)

If postabortal syndrome occurs immediately following the procedure, the client generally reports increased cramping and discomfort rather than the expected decrease of these symptoms. With delayed onset, the client will usually report feeling well until the sudden onset of symptoms, often with very light or no bleeding following the procedure.

How Is It Treated?

Prompt reevacuation of the uterus produces rapid relief of symptoms. Aspiration will yield blood and clots. There is rarely any remaining pregnancy tissue; however, it should be ensured that the uterus is completely evacuated.

(continued)

Handout 7-F (continued)
Postabortal Syndrome

How Can It Be Prevented?

It is not possible to prevent all cases of postabortal syndrome, but its incidence can be reduced by:

- Using the appropriate-sized cannula
- Ensuring the completeness of uterine evacuation
- Carefully monitoring clients in the recovery area, including their level of comfort and amount of bleeding, to detect early symptoms of postabortal syndrome

What Else Should Be Considered?

The following conditions (and their treatment) should also be taken into account when considering a diagnosis of postabortal syndrome:

- *Retained products of conception:* Reevacuate the uterus.
- *Uterine perforation:* Avoid repeat aspiration if perforation was suspected at the time of the procedure, though the cervix and uterus may be carefully probed with a cannula or uterine sound. This may relieve blockage of the internal cervical os.
- *Infection:* Infection is less likely with immediate onset, but must be considered when onset of symptoms is delayed. The clinical presentation of uterine tenderness and symptoms mimicking mild shock can be confusing. The history of feeling well up until the sudden onset of symptoms and the immediate relief of symptoms with reevacuation can help distinguish postabortal syndrome from infection. If there is any question, use of antibiotics should be initiated.

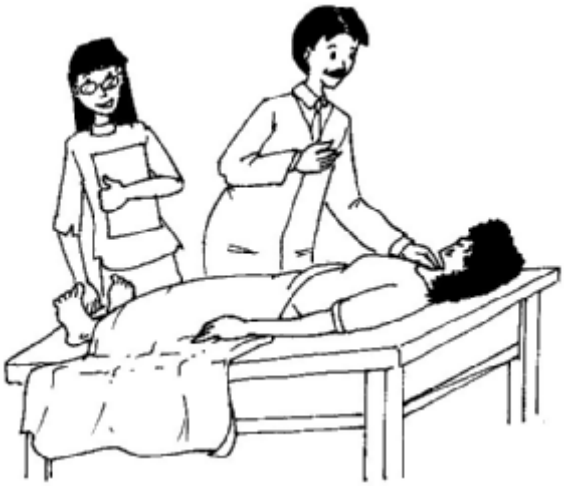
What Does the Client Need to Know?

The diagnosis and treatment should be explained in simple terms. The client should be instructed to watch for the usual postabortion warning signs, including fever, heavy bleeding, and abdominal pain. If she experiences any of these symptoms, she should return for immediate care. If she does not experience other complications, no further special care is necessary.

Handout 7-G
Supportive and Informational Counseling Before, During, and After the Treatment Procedure

Before the procedure...

Introduce yourself to the client and ask how she is feeling.



Inform the client about treatment and the medical procedure(s) that will be done.

(continued)

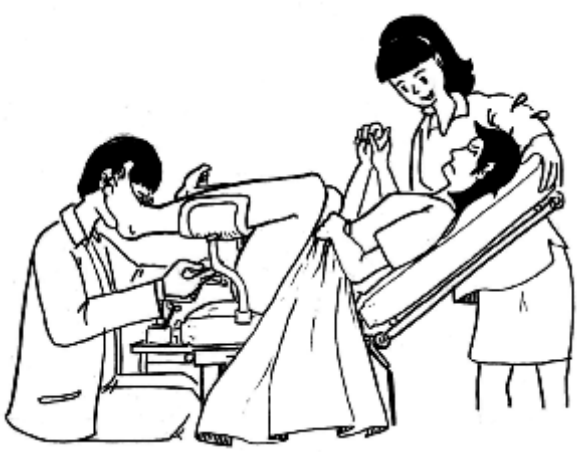
Illustrations: Ahmad Fauzi

Handout 7-G (continued)
Supportive and Informational Counseling Before, During, and After the Treatment Procedure

During the procedure...

Help the client into the bed or onto the operating table.

Assisting providers can give support by holding the client's hand.



All providers can offer words of reassurance to help relax the client.

"You can hold my hand if you feel pain."

"You are doing well, and the procedure is almost finished."

"Take a deep breath please..."

(continued)

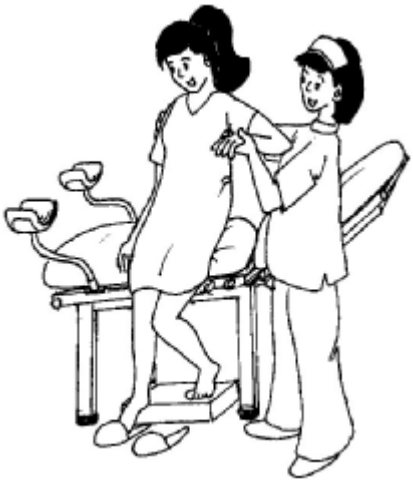
Illustrations: Ahmad Fauzi

Handout 7-G (continued)

Supportive and Informational Counseling Before, During, and After the Treatment Procedure

After the procedure…

Help the client off the bed or operating table.



Conduct postabortion counseling, including a discussion of family planning, if appropriate.

Explain about informed consent for acceptance of a family planning method. (If the client has no further questions, ask her to sign.)

Illustrations: Ahmad Fauzi

Session 8:
Clinical Practicum

Objectives

- To practice counseling skills in an actual PAC setting
- To provide feedback and discuss lessons learned in skills practice

Training Methods

- Practicum (during normal clinic or hospital hours)
- Large-group discussion

Materials

- Flipchart paper, easel, markers, and tape
- Transparency 8-A: Sample Postabortion Counseling Checklist (page 172)
- Handout 8-A: Counseling Observation Checklist (page 143)
- Handout 8-B: Client Interview Guidelines (page 145)
- Client-education materials

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. Schedule practicum assignments with the service site well in advance.
3. Review all handouts and make one copy for each participant.
4. Gather client-education materials on postprocedure care, family planning, or other appropriate topics.
5. Obtain permission from site staff and from clients for the participants to counsel the clients.
6. Assign each participant to a supervisor or trainer.

Session Time (total): 1/2 day to 1 day

SESSION 8 TRAINING STEPS

Session Time: 1/2 day to 1 day

Activity 1: Presentation/discussion (30 minutes)

1. Present an overview of the practicum process:
   - The participants will work individually with clients, preferably seeing a client through all three phases of postabortion care. Supervision, either by a site staff person or by a member of the training team, will be provided at all times.
   - Other participants can observe a colleague who is counseling a client. Handout 8-A: The Counseling Observation Checklist can be filled out immediately following the observation or during breaks in counseling. (This may work best if the participants are grouped in teams of two to work together throughout the day, with one observing when ever the other is counseling.) (*Note:* During the practicum, the participants can also refer to the Sample Postabortion Counseling Checklist, Transparency 8-A, on page 172.)
   - Other participants can "interview" a client before she leaves the service site, using the Client Interview Guidelines (Handout 8-B).
2. Distribute and review Handouts 8-A and 8-B.

Activity 2: Practicum (during normal clinic or hospital hours)

1. Instruct the participants and trainers to arrive at the site prior to the beginning of service delivery so they can be involved in preprocedure counseling.

> **TRAINING TIP ○○○**
>
> Each participant should counsel *at least* two clients before, during, and after the procedure. This will allow them to see the range of situations they may encounter and reinforce the lesson that they must tailor their counseling style and content to the particular client. The priority is for the participants to counsel *postabortion* clients, due to the specific nature of this curriculum. If there are not enough postabortion cases at the site, the counseling skills can be applied to other clients receiving maternity care (after the counseling information content is adjusted accordingly).

2. Instruct the participants and trainers to stay on-site as long as there are clients available for counseling. Coordination with site staff is crucial; the presence of the workshop participants and trainers should not delay or interrupt their services.

Activity 3: Discussion (1 hour)

1. Discuss the practicum experience at the end of the day. To begin, ask each participant to summarize his or her case in two or three sentences.
2. Then ask each participant the following questions:
   - How did it feel to counsel a "real" client?
   - Do you feel that you communicated effectively with your client?
   - Do you feel that you were able to help the client?

- If so, in what way were you able to help?
- If not, what will enable you to help clients in the future?

- Do you feel like you were sufficiently prepared to talk to the client?
  - If not, what will enable you to talk to clients in the future?
- What lesson(s) have you learned from the experience that may be applied in your own work setting?

3. Share the observations recorded on the Counseling Observation Checklist (Handout 8-A).
4. Summarize by going around the room and asking the participants how they will apply what they learned in their own work setting:
   - Each participant must identify at least one change that he or she will make as a result of this experience in the way he or she works with clients.

TRAINING TIP ○○○

As the participants identify which changes they will make in their client-provider interactions as a result of this experience, remind them of the need to *integrate* these skills into their non–PAC-related work. Emphasize that the principles of counseling can be applied to their communication and contact with all clients.

Session 8

Handouts

Handout 8-A
Counseling Observation Checklist

Name of provider: _____

Name of observer: _____

Client number: _____

1. Does the provider make the client feel comfortable? (Describe.)

_____

_____

_____

2. Does the provider try to explore the client's feelings?

❑ Yes

❑ No

_____

_____

_____

3. Does the provider use effective interpersonal communication? (Check all that apply.)

❑ Two-way communication

❑ Listening

❑ Verbal/nonverbal communication

_____

_____

_____

4. Does the provider encourage the client to talk (e.g., to ask questions or express feelings)?

❑ Yes

❑ No

_____

_____

_____

(continued)

Handout 8-A (continued)
Counseling Observation Checklist

5. What kind of information is given to the client?

- ❑ PAC procedure
- ❑ Anesthesia
- ❑ Possible side effects/risks
- ❑ Contraception
- ❑ Access to other reproductive health services

_____

_____

_____

6. Does the provider encourage the client in making any decision/plan after the postabortion procedure is completed?

- ❑ Yes
- ❑ No

_____

_____

_____

7. What was the overall provider-client interaction like? (Describe.)

_____

_____

_____

8. What was the client's reaction and responses? (Describe.)

_____

_____

_____

Handout 8-B
Client Interview Guidelines

Name of provider: _____

Name of interviewer: _____

Client number: _____

When was the client interviewed?

- ❑ Before the PAC procedure
- ❑ After the PAC procedure

1. What is your opinion about the way the staff have communicated with you since you arrived here?

_____

_____

_____

2. What was the provider's attitude toward you?

_____

_____

_____

3. What kind of information did the provider give you?

_____

_____

_____

4. Were all of your questions answered? Did you understand the answers?

_____

_____

_____

5. Did you have any questions that you did not ask? Why did you not ask those questions?

_____

_____

_____

(continued)

Handout 8-B (continued)
Client Interview Guidelines

6. Is this your first visit to this clinic?

_____

_____

_____

7. Based on the way you have been treated, would you tell other people to come here?

_____

_____

_____

8. What would you recommend to improve the quality of this clinic's services?

_____

_____

_____

Session 9:
Workshop Wrap-Up

Objectives

- To evaluate the effectiveness of the workshop in achieving its objectives
- To discuss training follow-up plans
- To share closing thoughts and impressions

Training Methods

- Discussion

Materials

- Flipchart paper, easel, markers, and tape
- Appendix H: Workshop Evaluation Form (page 189)
- Participants' certificates of attendance
- Refreshments

Advance Preparation

1. Send invitations to guests.
2. Provide speakers with the workshop goals and objectives, so they have some context for their remarks.
3. Ask the participants to select a representative to speak on their behalf.
4. Prepare a certificate of attendance for each participant.
5. Review the Workshop Evaluation Form and make one copy for each participant.
6. Plan follow-up efforts (page 12).

Session Time (total): 55 minutes to 1 hour, 25 minutes (depending on local protocol)

SESSION 9 TRAINING STEPS

Session Time: 55 minutes to 1 hour, 25 minutes

Activity 1: Individual written evaluation by the participants (15 minutes)

1. Distribute the Workshop Evaluation Form (page 189) to each participant.
2. Allow the participants approximately 15 minutes to complete the handout.
3. Collect the evaluation form.

Activity 2: Discussion (20 minutes)

1. Ask each participant what changes he or she plans to make in his or her own work site as a result of this training.
2. List these on a flipchart, with each participant's name next to the intended changes.
3. Explain that efforts will be made by the training team, by workshop organizers, or by supervisors to visit each participant within three months of completion of the training. The purpose of these visits will be to:
   - Assess the participant's progress in making the desired changes
   - Identify barriers to counseling postabortion clients
   - Provide technical assistance to help overcome these barriers

TRAINING TIP ○○○

It is essential to make specific follow-up plans at the time of the training with participants and their supervisors. Confirm these plans *before* conducting this session (see page 12).

Activity 3: Closing ceremony (20 to 50 minutes, depending on local protocol)

1. Conduct a closing ceremony in a manner appropriate to local customs and observing all necessary protocols.
2. Distribute the certificates of attendance.

Appendixes

Appendix A
Training Outline

Session	Handouts	Participants	Time
1. Opening Session			
A. Opening Ceremony	[none]	All	30 minutes
B. Workshop Introduction	1-A: Workshop Goal and Objectives 1-B: Workshop Schedule	All	50 minutes
2. Values and Attitudes Related to Postabortion Care	2-A: Ambiguous Figure 2-B: Values and Attitudes in PAC	All	1 hour
3. Understanding the Client's Perspective			
A. Developing Case Studies of Postabortion Clients	[none]	Nonphysicians	25 minutes to 1 hour, 30 minutes
B. Confidentiality, Privacy, and Dignity	3-A: Ensuring Clients' Confidentiality, Privacy, and Dignity	All	45 minutes
C. Addressing the Postabortion Client's Feelings		All	1 hour, 35 minutes
D. Gender Issues	3-B: Gender	Nonphysicians	50 minutes
E. Sexuality Issues	3-C: How Do We Learn about Sex? 3-D: Sexuality	Nonphysicians	55 minutes
4. Interpersonal Communication			
A. Two-Way Communication	4-A: One-Way vs. Two-Way Communication	Nonphysicians	30 minutes
B. Verbal and Nonverbal Communication	[none]	Nonphysicians	30 minutes
C. Effective Listening	4-B: Effective Listening	Nonphysicians	35 minutes
D. Asking Open-Ended Questions	4-C: Types of Questions	Nonphysicians	45 minutes
E. Using Simple Language and Visual Aids	4-D: The Female and Male Reproductive Systems 4-E: Anatomy, Physiology, and Pregnancy	Nonphysicians	1 hour, 25 minutes

(continued)

Appendix A (continued)
Training Outline

Session	Handouts	Participants	Time
5. Family Planning Information and Counseling for the Postabortion Client			
A. Rationale	5-A: Simple Answers to Clients' Questions about Postabortion Family Planning	Nonphysicians*	30 minutes
B. Informed Choice	5-B: Contraception, Informed Choice, and Postabortion Care	Nonphysicians	30 minutes
C. Individual Factors	5-C: Individual Factors for Family Planning Counseling during Postabortion Care 5-D: Guidelines for Contraceptive Use, by Clinical Condition 5-E: Guidelines for Selecting Contraception, by Method	Nonphysicians	1 hour, 15 minutes
6. Related Reproductive Health Needs and Other Issues			
A. RTI/STI Information for the Postabortion Client	6-A: Background Information on STIs, HIV, and RTIs 6-B: Sexuality and HIV/STI Risk: Broaching the Subject with Clients	Nonphysicians	1 hour, 10 minutes
B. Referring Clients for Other Services	[none]	Nonphysicians	30 minutes
C. Threatened Abortion	[none]	Nonphysicians	35 minutes
7. Postabortion Counseling			
A. Overview of Postabortion Counseling	7-A: Postabortion Care Counseling 7-B: Counseling the Postabortion Client	Nonphysicians	45 minutes
B. Preprocedure Counseling	7-C: Counseling Guidelines for the Provider: Before the PAC Procedure	Nonphysicians	1 hour, 30 minutes, to 1 hour, 35 minutes
C. Being Supportive during the Procedure	[none]	All	50 to 55 minutes

*Doctors should attend this session if they hold primary responsibility for providing family planning to postabortion clients.

(continued)

Appendix A (continued)
Training Outline

Session	Handouts	Participants	Time
D. Counseling after the Procedure	7-D: Counseling Guidelines for the Provider: After the PAC Procedure 7-E: Postprocedure Information Sheet 7-F: Postabortal Syndrome 7-G: Supportive and Informational Counseling Before, During, and After the Treatment Procedure	Nonphysicians	1 hour to 1 hour, 5 minutes
8. Clinical Practicum	8-A: Counseling Observation Checklist 8-B: Patient Interview Guidelines	All	1/2 day to 1 day
9. Workshop Wrap-Up	[none]	All	55 minutes to 1 hour, 25 minutes

Appendix B
Pretest/Posttest on Postabortion Counseling

1. State the five essential elements of postabortion care (PAC).
    1. _____
    2. _____
    3. _____
    4. _____
    5. _____

2. When does postabortion counseling happen?
    a. Before, during, and after the procedure
    b. Any time you come into contact with the client
    c. When you have identified the client's problem
    d. Both a & b
    e. When you have extra time with nothing else to do

3. Where does postabortion counseling happen?
    a. In a private room with a door and soundproof walls
    b. Anywhere in the service site you come into contact with the client
    c. At a community meeting place
    d. None of the above

4. Give one example of how you can respect a client's privacy when providing postabortion counseling.

5. Two-way communication happens when:
    a. Both client and provider talk
    b. Both client and provider listen
    c. Both a & b
    d. None of the above

6. Give two examples of open-ended questions.
    1. _____
    2. _____

7. Give two signs of effective listening. (How can you tell someone is listening attentively?)
    1. _____
    2. _____

(continued)

Appendix B (continued)
Pretest/Posttest on Postabortion Counseling

8. What is the minimum essential information on family planning that you should tell every postabortion client?
   1. _____
   2. _____
   3. _____

9. List three methods of family planning that can be used safely postabortion.
   1. _____
   2. _____
   3. _____

10. Informed choice means (check *all* answers that are true):
   - ❑ The client has been given full information.
   - ❑ The client cannot leave the service site without choosing a method.
   - ❑ The provider helps the client to make a decision.
   - ❑ Family members motivate the client to choose a particular method.

11. Candidiasis (yeast infection) and bacterial vaginosis are sexually transmitted infections.
   _____ True _____ False

12. What is empathy?

13. Give two examples of problems that require referral, and tell where you would refer the client.
   1. _____
   2. _____

14. Give two examples of how to create a more comfortable environment for counseling.
   1. _____
   2. _____

15. List two warning signs indicating that a woman should seek medical attention after her PAC treatment.
   1. _____
   2. _____

(continued)

Appendix B (continued)
Pretest/Posttest on Postabortion Counseling

16. Define *postabortion counseling*.

17. What key information should you tell every postabortion client about RTIs and STIs?

18. A woman arrives at your site with an incomplete abortion. Use simple language to describe what is happening in her body and how you will treat the problem.

Appendix B (continued)
Pretest/Posttest on Postabortion Counseling

Answer Key

1. State the five essential elements of postabortion care (PAC). (5 points)
   - **Community and service-provider partnerships**
   - **Comprehensive counseling**
   - **Treatment of incomplete abortion and potentially life-threatening complications**
   - **Contraceptive and family planning services**
   - **Linkages to reproductive health and other services**

2. When does postabortion counseling happen? (1 point)
   a. Before, during, and after the procedure
   b. Any time you come into contact with the client
   c. When you have identified the client's problem
   d. Both a & b
   e. When you have extra time with nothing else to do

3. Where does postabortion counseling happen? (1 point)
   a. In a private room with a door and soundproof walls
   b. Anywhere in the service site you come into contact with the client
   c. At a community meeting place
   d. None of the above

4. Give one example of how you can respect a client's privacy when providing postabortion counseling. (1 point)
   Possible responses include:
   - **Speaking in a low voice**
   - **Talking to the client in a private room or space (if possible)**
   - **Not sharing the details of her case with others unless necessary**

5. Two-way communication happens when: (1 point)
   a. Both client and provider talk
   b. Both client and provider listen
   c. Both a & b
   d. None of the above

6. Give two examples of open-ended questions. (2 points)
   Possible responses include:
   - **How did you feel when you first found out you were pregnant?**
   - **What did you do after the bleeding started?**
   - **How do you feel now?**
   - **What do you think is going to happen while you are here?**
   - **What concerns do you have?**
   - **What questions or concerns does your husband or partner have about your condition?**
   - **What do you plan to do to protect yourself from getting pregnant again?**
   - **What made you decide to use the same method as your sister/friend/cousin/etc.?**

(continued)

Appendix B (continued)
Pretest/Posttest on Postabortion Counseling

Answer Key

7. Give two signs of effective listening. (How can you tell someone is listening attentively?) (2 points)

Possible responses include:

- **Maintaining eye contact with the speaker (within cultural norms)**
- **Demonstrating interest**
- **Being attentive to the speaker; not doing other tasks at the same time and not interrupting**
- **Asking questions**
- **Showing empathy**
- **Reflecting (i.e., repeating, using your own words to confirm understanding)**
- **Interpreting the feelings and emotions behind what is being said**
- **Integrating what has been said into further discussion**
- **Not talking to other people while listening**
- **Showing a genuine interest in the topic**

8. What is the minimum essential information on family planning that you should tell every postabortion client? (3 points)

1. **That she will be at risk of repeat pregnancy as soon as 11 days after treatment.**
2. **That there are a variety of safe family planning methods that can be used immediately after treatment to avoid pregnancy.**
3. **Where and how to obtain family planning services (at the time of treatment or discharge, or afterward)**

9. List three methods of family planning that can be used safely postabortion. (3 points)

Possible responses include:

- **Condoms**
- **Oral contraceptives (the Pill)**
- **Injectables (DMPA/Depo-Provera or NET-EN)**
- **Norplant implants**
- **Spermicidal foams, jellies, tablets, sponge, or film**
- **Diaphragm or cervical cap**
- **IUD (with certain exceptions)**
- **Tubal ligation (with certain exceptions)**
- **Vasectomy**

10. Informed choice means (check *all* answers that are true): (2 points)

☑ **The client has been given full information.**
❑ The client cannot leave the service site without choosing a method.
☑ **The provider helps the client to make a decision.**
❑ Family members motivate the client to choose a particular method.

(continued)

Appendix B (continued)
Pretest/Posttest on Postabortion Counseling

Answer Key

11. Candidiasis (yeast infection) and bacterial vaginosis are sexually transmitted infections. (1 point)

    False. *(They are RTIs, but they are generally not sexually transmitted.)*

12. What is empathy? (1 point)

    Putting yourself in the client's position and understanding her point of view as if it were your own.

13. Give two examples of problems that require referral, and tell where you would refer the client. (2 points)

    Possible responses include:

    - **Tuberculosis or respiratory infection; referral to other health care providers or specialists**
    - **Loss of an intended pregnancy, or inability to carry a pregnancy to term; referral to an obstetric-gynecologic specialist, or fertility specialist**
    - **Rape, domestic violence, or incest; referral to a rape crisis center, legal services, other social or women's services, or a religious institution**
    - **Inability to afford a family planning method, or limited or insufficient food or money; referral to free or low-cost family planning services, or to social services**
    - **Emotional distress; referral to a psychologist or counselor, or a religious institution**

14. Give two examples of how to create a more comfortable environment for counseling. (2 points)

    Possible responses include:

    - **Make sure the client is ready to talk**
    - **Sit or stand on the same level as the client**
    - **Speak in a low voice**
    - **Shut the door**
    - **Speak in the mother tongue or local language**
    - **Ensure confidentiality**

15. List two warning signs indicating that a woman should seek medical attention after her PAC treatment. (2 points)

    Possible responses include:

    - **Fever**
    - **Dizziness, lightheadedness, or fainting**
    - **Abdominal pain**
    - **Severe cramping**
    - **Nausea, vomiting**
    - **Heavy bleeding (twice as heavy as a normal period)**
    - **Vaginal discharge that smells bad**

(continued)

Appendix B (continued)
Pretest/Posttest on Postabortion Counseling

Answer Key

16. Define *postabortion counseling*. (3 points)

Providing emotional support, information, and help with decision making to clients before, during, and after treatment.

17. What key information should you tell every postabortion client about RTIs and STIs? (3 points)

This depends in part on what three key points the group identified. Likely answers are listed below.

- **Tell the client that she is at risk and how to prevent infection (and to use a dual method if she or her partner has other partners)**
- **Describe the signs and symptoms of RTIs and STIs**
- **Explain where, when, and how the client may seek treatment**

18. A woman arrives at your site with an incomplete abortion. Use simple language to describe what is happening in her body and how you will treat the problem. (2 points)

A possible response might be:

Explain that she was pregnant, but then the pregnancy ended, and now there is tissue left in her "womb," or uterus. The provider will use suction to remove the tissue. This will take ___ minutes [with the time dependent on the method to be used], and she will be given an analgesic beforehand to lessen any discomfort she might feel. Afterward, she can rest for a while and then go home again. (The details will vary, depending on method of treatment.)

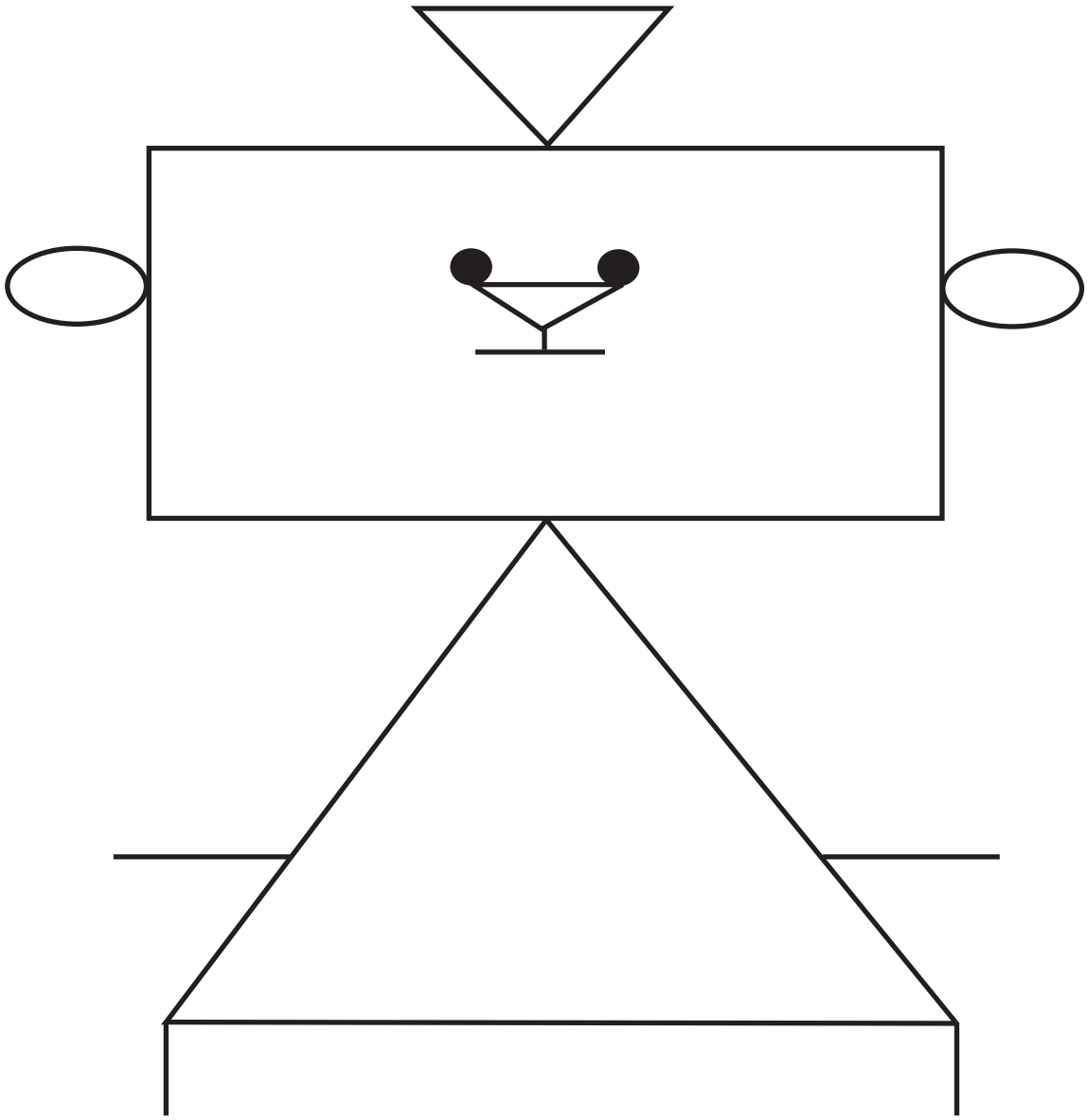
Appendix C
Transparencies and Activity Materials

You may wish to make transparencies and/or photocopies of the following items prior to the training. If an overhead projector is not available, prepare flipcharts to display during the training.

Appendix C
Transparency 2-A: Ambiguous Figure

Source: Boring, E. G. 1930. A new ambiguous figure. *American Journal of Psychology* July:444.

Appendix C
Transparency 4-A: Sample Diagram



Appendix C
Transparency 5-A

Minimum Essential Information about Family Planning for the Postabortion Client

✓ That she will be at risk of repeat pregnancy as soon as 11 days after treatment

✓ That there are a variety of safe family planning methods she can use immediately after treatment to avoid pregnancy

✓ Where and how to obtain family planning services (either at the time of treatment or after discharge)

Appendix C
Transparency 5-B

Family Planning Information and Counseling for the Postabortion Client

"A woman who has an [induced] abortion signals a very clear wish not to be pregnant [at this time]. A woman who seeks an abortion in a country where abortion is not legally [or safely] available…may do so at significant risk to her life. That so many women who seek abortions overcome formidable social, legal, and personal obstacles is a testament to their will to discontinue an unwanted pregnancy. Yet little attention has been paid to reaching these women with information and services that can help prevent future pregnancies. As a result, the cycle of risk, unwanted pregnancy, and abortion may remain unbroken."

Adapted from: Neamatalla, G. S., and Verme, C. S. 1995. Postabortion women: Factors influencing their family planning options. *AVSC Working Paper* No. 9. New York: AVSC International.

Appendix C
Transparency 6-A

Sample Case Study 1: Daisy

Daisy is a 17-year-old high school graduate, the eldest sibling, and the hope of her parents to help her two younger brothers and three sisters through school. She was disowned by her parents when they discovered that she had spent a night with her boyfriend, Ronnie. As a result, she was forced to live with Ronnie, who is still a high school student. Ronnie's parents are now burdened with an additional dependent, which Daisy senses. When Daisy missed her monthly period and noticed spotting a few days later, she didn't bother to tell Ronnie and his family, thinking that it was just her delayed menses. The spotting progressed to bleeding, with lower abdominal cramps. She had to change sanitary napkins more frequently than she had during her previous menses. This prompted her to tell Ronnie's mother about her condition. Thus, she was brought to the hospital.

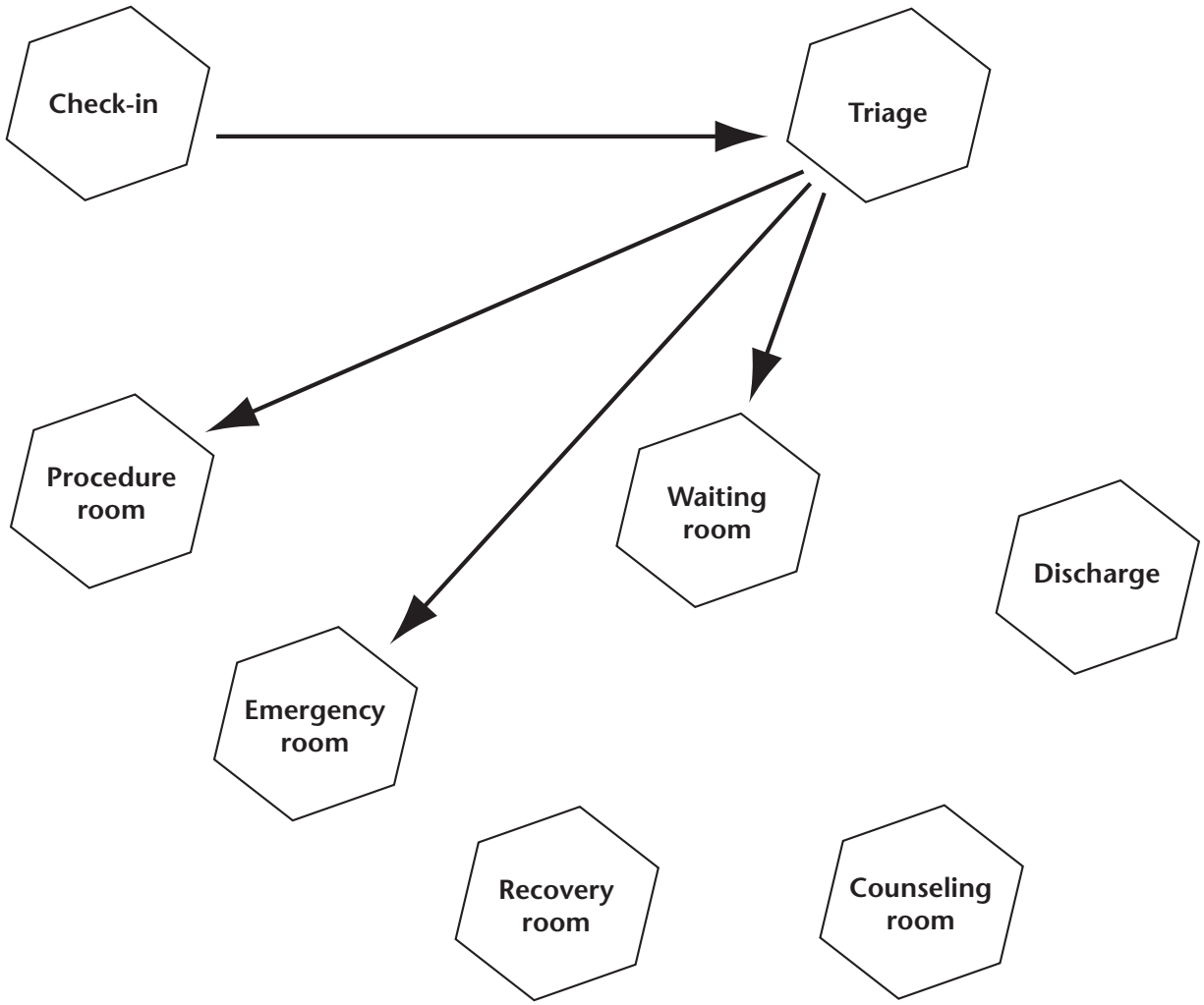
Appendix C
Transparency 6-B

Sample Case Study 2: Diana

Diana is a 23-year-old high school dropout now on her sixth pregnancy and is married to Jaime, a construction worker. The couple has five daughters, and they live with Jaime's parents. Diana and Jaime hope that the sixth baby will be a boy. Despite financial difficulties, they are excited to be having another child. One day, Diana went to visit her mother in a nearby town after doing her routine household chores. When she arrived home, she noticed some light spotting, which she believed was the result of her travel, but she did not tell Jaime about the bleeding. The next day, just after Jaime left for work, Diana had more vaginal spotting. She went to the hospital with her mother-in-law. She was afraid of losing the baby, of being a financial burden to her in-laws, and of not keeping her partner. She was also afraid of losing the harmonious relationship with her in-laws and felt guilty for not doing the best for her baby.

Appendix C
Transparency 7-A

Sample "Map" for Case-Study Client Walk-Through of PAC Services (incomplete)



Appendix C
Transparency 7-B

General Requirements of Pain Control
(During Uterine Evacuation with an Awake Client)

- A procedure room that is quiet and nonthreatening
- Health care workers who are calm, friendly, gentle, and unhurried
- Continuous attention to the client from the medical team
- A clear explanation of what to expect before the procedure, what is happening during the treatment, and what, if any, discomfort she may expect to feel
- A competent, efficient, and well-trained team of providers who communicate well with the client

Adapted from: Margolis, A., Leonard, A. H., and Yordy, L. 1993. Pain control for treatment of incomplete abortion with MVA. *Advances in Abortion Care* 3(1):1–8.

(continued)

Appendix C
Transparency 8-A

Sample Postabortion Counseling Checklist

Preprocedure (Plus Information on the Procedure [D&C or MVA])

Information to Be Gathered	Responses/Data Collected
Demographic ■ Which data to gather will depend on the country context	
Chief complaint(s) ■ What ■ Since when ■ Duration ■ Character ■ Associated signs/symptoms	
Questions to ask ■ How did the bleeding start? ■ Was something done to start the bleeding? ■ Aside from blood, have you passed meaty material through the vagina? ■ Do you have pain? Where? When did it start? How bad is it? ■ Have you had fever? Chills? ■ Have you felt weak? Have you fainted? Have you collapsed?	
Medical history ■ Diabetes ■ Hypertension ■ Tuberculosis ■ New growths ■ Others	
Obstetric-gynecologic/menstrual history ■ Date of last menstrual period ■ Duration and character of menses ■ Parity ■ Gravidity ■ Abortions ■ Number of living children	

(continued)

Appendix C
Transparency 8-A (continued)

Sample Postabortion Counseling Checklist

Preprocedure (Plus Information on the Procedure [D&C or MVA])

Information to Be Gathered	Responses/Data Collected
Information to be given to the client ■ Overall physical condition ■ Results of physical and pelvic examinations and laboratory tests ■ Time frame for treatment ■ Need for referral and transport to another facility ■ Procedures to be done, as well as risks and benefits ■ Explanation of how D&C or MVA is done (steps, effects of drugs used, possible examination, expected feelings, procedure room set-up description, consent), as well as expected length of hospital stay ■ Referral/vehicle for transport	
Ask the client for any questions and answer appropriately	
Explore the client's needs and feelings about her situation/future plans	

(continued)

Appendix C
Transparency 8-A (continued)

Sample Postabortion Counseling Checklist

Postprocedure

Steps	Notes
Explore the client's feelings, questions, and concerns after the procedure; provide support and encouragement	
Remind the client of possible side effects, risks, and warning signs; she should return if warning signs occur	
Tell the client how to take care of herself at home	
Give the client written postprocedure information	
Remind the client of the importance of follow-up	
Discuss/describe/provide available contraceptive methods, as appropriate	
Discuss RTIs/STIs: ■ Signs and symptoms ■ Why and how to prevent ■ Where to go for services	
Assess the need for additional counseling and/or referral for other reproductive needs or nonmedical issues: ■ Medical ■ Social ■ Economic	

General notes:

Appendix D
Sample Case Studies

The following case studies can be used as examples for Session 3, Part A; additionally, if there is not sufficient time to develop original case studies, the participants may adapt some of these cases to fit their local reality. All names and cases are fictional.

Case Study 1: Pembeley

Pembeley is a 28-year-old nurse. She is single and lives in an upper-middle-class neighborhood with her family. Pembeley got pregnant with Nabile, a pharmaceutical sales representative who calls on the private hospital where she works as a nurse. Pembeley told Nabile that she was pregnant and that she had decided to keep the baby, regardless of whether he would be involved in raising the child. At 10 weeks' gestation, Pembeley had a spontaneous abortion, and she went to a local public hospital with heavy bleeding. Because she was unmarried, the providers in the hospital assumed she had induced the abortion and made her wait several hours for treatment, performing her procedure only after attending to all of the other women seeking care on that day. She was rebuked for her immoral behavior and carelessness, and for getting pregnant as a single woman. When Pembeley requested birth control pills, the nurses told her that she'd have to visit the family planning clinic next door during its regular operating hours, but they also warned that the clinic did not routinely provide methods to unmarried women.

Case Study 2: Paloma

Paloma is a 20-year-old high school graduate who works as a salesgirl in a department store. She had been living with her boyfriend in his parents' home for more than a year when she found out that she was two months pregnant. The couple were happy about her pregnancy, but Paloma was hesitant to tell her boyfriend's family about it, anticipating some kind of reprimand from his mother, who had been telling them that they should go on their own by this time. One night, Paloma's boyfriend came home drunk and started a fight with her. He accidentally hit her abdomen during the fight, and later that night she felt severe crampy pains in her lower abdomen. Moderately profuse vaginal bleeding followed, which frightened her. Early the following morning, feeling weak, she went to the hospital alone, as her boyfriend was still asleep. At the hospital, she could not understand why the doctor and the nurse did not seem to believe her story, as they told her to admit that she had done something else to get rid of her baby. Why would she do that? She stared at them in disbelief, feeling numb for the loss of her baby. After about an hour, she was brought into a room where she was told she would be treated. She felt scared of how these unfriendly people would treat her, and she was afraid to tell them she had only a small amount of money. Paloma had never felt so alone as she did now.

(continued)

Appendix D (continued)
Sample Case Studies

Case Study 3: Sylvia

Sylvia is a 34-year-old widow with three children. When her husband died two years ago, Sylvia began working six days a week at a clothing factory, and her income just barely supports her children and herself. This year, Sylvia started a relationship with a man in her village, and their plan was to marry in a year's time, once they have saved enough money to acquire a home for the entire family. They hope to have a child together one day, but they cannot afford one for at least another two or three years. When Sylvia got pregnant, she obtained misoprostol* from her co-worker at the factory, who instructed Sylvia to insert four tablets into her vagina to stop the pregnancy. Three days later, Sylvia went alone to the district hospital with heavy bleeding. Her condition was incomplete abortion, but during her assessment the attending physician found remnants of the misoprostol tablets in her vagina. She was not counseled before treatment or during the procedure. The providers who treated her displayed scornful attitudes, because they believed she was immoral for having induced an abortion and for having sexual relations as a widowed woman. Sylvia had hoped to request a DMPA injection from the hospital, but she was left feeling so ashamed by the time of discharge that she couldn't bear any further humiliation; therefore, she departed the hospital as quickly as possible, without any method of family planning to prevent future unwanted pregnancies.

*Misoprostol is a prostaglandin E_1 analog indicated for the prevention and treatment of gastric and duodenal ulcers resulting from long-term use of nonsteroidal anti-inflammatory drugs. As a result of its abortifacient properties, women may depend on the off-label use of misoprostol to terminate their pregnancies.

Case Study 4: Patricia

Patricia is a 45-year-old woman married to a farmer. Patricia's husband has a history of violence and drinking, and he often forces her to have sex when he is drunk. They have 13 children, and the family makes just enough money to survive. Patricia has never used a family planning method, but she intended to undergo tubal ligation several times. Most recently, she missed her menstruation for two months but assumed that this was the result of early menopause. When she experienced mild hypogastric pain and vaginal spotting, she consulted a local health clinic and learned that she was pregnant. She was given medications and was advised to have bed rest at home. Patricia did not want any more children, and she did not inform her husband of the pregnancy. She attempted to cause a miscarriage by carrying around a heavy bucket of water for several hours, which eventually led to moderate vaginal bleeding. She went directly to the hospital, where her bleeding worsened. She was conscious and reasonably calm, but in mild pain. After examination, the doctor told Patricia that she would have to undergo dilation and curettage. Familiar with the procedure, she got frightened that her husband might get mad about her inability to work during the postsurgery recovery period.

(continued)

Appendix D (continued)
Sample Case Studies

Case Study 5: Claudine

Claudine is a 17-year-old single college student who comes from a middle-class family. As the eldest in the family, she was expected to support her brothers and sisters after she finished her studies. She got pregnant for the first time with her boyfriend, who was also a student and was not ready to raise a family. Fearing that her parents would not let her continue her studies if they learned of her pregnancy, Claudine went to a quack to obtain an abortion. Severe abdominal pain and a fever prompted her mother to bring her to the local hospital a few days later. She was taken to the nontrauma area of the emergency room and prepared for uterine evacuation, but no one told Claudine what would happen to her during treatment. In the meantime, her mother was informed of her condition by hospital staff.

Case Study 6: Marisol

Marisol is 43 years old and the mother of six children. She lives in a lower-middle-class rural area, and in addition to her work as a wife and a mother, she does much of the work to maintain the family farm. Marisol has had eight pregnancies, one of which aborted spontaneously and one of which was a stillbirth. At this point in her life, she does not wish to have any more children, but she has never used any method of family planning. Marisol became pregnant for the ninth time and consulted her husband for advice. He recommended that she obtain an abortion from a traditional birth attendant (TBA) in their community. Marisol visited the TBA and received a vigorous massage intended to terminate the pregnancy. When she began to bleed heavily, Marisol returned to the TBA for help but was instructed to go to the hospital instead. At the hospital, the providers would not treat her until she confessed to inducing an abortion. The doctors and nurses chastised her for murdering an unborn child and threatened to report her to the local authorities. No one ever talked to her about how to avoid becoming pregnant again in the future.

Case Study 7: Susan

Susan is 37 years old and is married to Theo, a military man. She is a college graduate and has no children but is on her second pregnancy. She works long days as a cashier in a restaurant, six days a week. Susan and Theo have been married for five years, and they were excited to learn of the pregnancy. With Theo away on fieldwork, Susan was always left alone at home. One night when she was on her way home from work, she experienced moderate abdominal pain followed by moderate vaginal bleeding. She went immediately to the hospital, where she was brought directly to the emergency room. She was crying and feeling worried because she was alone and did not have any money on hand. When a physical examination was done, the doctor noted vulvar lesions and a greenish vaginal discharge. The doctor found out her cervix was open and meaty tissue was found in the vagina. She was diagnosed to have had an abortion.

(continued)

Appendix D (continued)
Sample Case Studies

Case Study 8: Anna

Anna is a 35-year-old woman who works abroad for the majority of the year. She is married to a fisherman and has four children. After being on home leave for three months, Anna was due to return to her work abroad in two weeks. When she discovered that she was pregnant, she visited a midwife, who inserted a catheter into her uterus. The midwife told Anna that she would have an abortion in three days' time. The vaginal bleeding and abdominal pain began three days after Anna visited the midwife. She also had a fever and felt very weak. Anna then told her husband about the abortion, and he scolded her and called her a murderer before taking her to the hospital. Anna asked the doctors if she was dying and blamed her husband for refusing to wear a condom. She verbalized her anger at the midwife and repeatedly asked if she would be released soon, to return to work at her overseas job. The doctor told her that she would have to undergo a uterine evacuation using MVA, and she was terrified. Anna hoped that she would at least be asleep during the procedure so that she would not have to endure any more pain.

Case Study 9: Nicole

Nicole is 23 years old and single, with one child. She lives independently and goes out with "sugar daddies," who give her money and gifts in exchange for sex. Nicole has never used contraception and has a history of STIs. After she missed her menses for two months, Nicole took misoprostol* (two tablets orally and two vaginally). Alarmed that she was still bleeding four days later and feeling very weak, she went to the hospital and demanded to be attended to immediately. The doctor found on exam that her cervix was open and her vagina contained clotted blood and placental tissue. The doctor told her that she would have to undergo a uterine evacuation. She verbalized her fear of the procedure, lamented getting pregnant, and began to weep openly. The nurse preparing her for treatment scolded Nicole for the irresponsible and immoral behavior that resulted in her pregnancy.

*Misoprostol is a prostaglandin E_1 analog indicated for the prevention and treatment of gastric and duodenal ulcers resulting from long-term use of nonsteroidal anti-inflammatory drugs. As a result of its abortifacient properties, women may depend on the off-label use of misoprostol to terminate their pregnancies.

(continued)

Appendix D (continued)
Sample Case Studies

Case Study 10: Anupa

Anupa is a 17-year-old student living in a rural area. She has no children but would like to raise a family in two or three years. Anupa and her boyfriend were using natural family planning; they did not have intercourse during the days when they thought she was not fertile. When Anupa got pregnant, she and her boyfriend concluded that they were not prepared to have a baby yet. Although abortion is legally available in her country, Anupa had heard rumors that in the public clinic all abortion clients are forced to accept permanent or long-term family planning methods. To avoid this risk, Anupa consulted a traditional healer in her village. The healer gave Anupa an herbal drink and then inserted sticks into her vagina. Anupa was in tremendous pain both during and after the procedure, and after four days of bleeding, severe cramping, and fever she finally went to a government clinic for care. The clinic agreed to treat her on the condition that she would accept an IUD, and in desperation Anupa concurred with this requirement. By the time she was seen by a provider, Anupa's complications and infection were very advanced.

Case Study 11: Rose

Rose is a 46-year-old housewife who found out that she was three months pregnant only a year after she had had her eighth child. She did not know she was pregnant until she had a pregnancy test at the health center, since her menses has not returned after her last delivery. The midwife assigned in their area gave her some condoms, but there were times her husband did not like to use them. Her pregnancy worried her, as her husband's pay was barely enough for their family. Also, her eldest daughter, who is 17, had just given birth two months ago, and Rose felt ashamed to be pregnant again when she was already a grandmother. She decided to go to a traditional healer, who inserted a catheter into her uterus. The traditional healer assured her everything would be fine. For three days, Rose stayed in bed bleeding silently. She was forced to tell her husband what she had done when she developed high-grade fever and chills. Her husband rushed her to the hospital, where she had to undergo a hysterectomy because of uterine lacerations and infection. She was angry with the traditional healer for telling her everything would be fine, when in fact she almost died. She felt better after a week and was relieved that her problems were over, although she continued to feel pangs of guilt whenever she saw her husband looking sad and quiet.

(continued)

Appendix D (continued)
Sample Case Studies

Case Study 12: Fen

Fen is a 26-year-old housewife with two children. Fen's husband is a carpenter who works away from home during the week and comes home every weekend. Fen has already missed three periods and realized that she is pregnant. A few days ago, she felt abdominal pain. Later that day, the pain became worse and she began to have vaginal bleeding. Fen asked her mother to watch the children so she could go to the hospital. At the hospital, the doctor did an ultrasound and told Fen that she needed to undergo uterine evacuation. Fen did not understand what this meant, and she felt even more worried because her husband was not around and did not know about her condition. The following day, the husband arrived from work worried and confused that his wife was in the hospital. Meanwhile, Fen learned from the nurses that she had lost her pregnancy, and she began to feel depressed and lonely.

Case Study 13: Lerma

Lerma is a 21-year-old unemployed high school graduate. She has one child and has been married for three days to a rickshaw driver. Lerma has missed her menstruation for two months. Two days prior to her wedding, she had some vaginal bleeding that she thought was her menstruation. Eight hours later she had hypogastric pain that prompted her to consult a doctor. Her husband and mother accompanied her to the hospital. On the same day an ultrasound was done, and Lerma was told that she was two months pregnant and that the baby could not be saved. The couple accepted the news with mixed feelings—excitement and sadness at the same time. The doctors told Lerma that she would have to have uterine evacuation using MVA. The thought of losing her baby and waiting for the procedure made her nervous, anxious, and afraid. She also feared that she might not be able to carry a future pregnancy to term after this surgery.

Case Study 14: Diana

Diana is a 23-year-old high school dropout now on her sixth pregnancy and is married to Jaime, a construction worker. The couple has five daughters, and they live with Jaime's parents. Diana and Jaime hope that the sixth baby will be a boy. Despite financial difficulties, they are excited to be having another child. One day, Diana went to visit her mother in a nearby town after doing her routine household chores. When she arrived home, she noticed some light spotting, which she believed was the result of her travel, but she did not tell Jaime about the bleeding. The next day, just after Jaime left for work, Diana had more vaginal spotting. She went to the hospital with her mother-in-law. She was afraid of losing the baby, of being a financial burden to her in-laws, and of not keeping her partner. She was also afraid of losing the harmonious relationship with her in-laws and felt guilty for not doing the best for her baby.

(continued)

Appendix D (continued)
Sample Case Studies

Case Study 15: Mia

Mia is a 30-year-old married housewife. She is a high school graduate, and her husband is a factory worker. They have two children. Mia's last pregnancy was eight months ago. She delivered at a government hospital, where a nurse told Mia that she was protected from pregnancy as long as she was completely breastfeeding her baby and that she should come back for family planning when she stopped breastfeeding. One month ago, Mia went to the outpatient department of the same hospital, and after her check-up she learned that she was pregnant. She could not believe the news, because the nurse had said that breastfeeding would protect against pregnancy. Mia wanted another baby, but not so soon. Three days afterward, she visited a traditional healer to terminate the pregnancy. That evening she experienced abdominal cramping and vaginal bleeding. Her husband brought her to the emergency room, and after examination the doctor told Mia that she was having an abortion, for which an MVA procedure would be done. She started crying and saying repeatedly that she did not want to harm her baby, but that it was too soon to have another pregnancy. Her husband tried to comfort her, but nothing he said could lessen her feelings of guilt.

Case Study 16: Annabel

Annabel is a 24-year-old escort at the local expatriate club, and she fell in love with a handsome American diplomat who frequented the establishment. They lived together at the diplomat's plush condominium for about three months. Annabel was happy with her life and felt even more elated when she became pregnant. She thought that the pregnancy was her chance to hold onto her boyfriend. Then when she started to have vaginal spotting, Annabel's boyfriend took her to the hospital, where the doctor explained that she was experiencing threatened abortion. She felt sad, and feared that she might lose both her baby and her boyfriend.

Case Study 17: Rita

Rita is a 23-year-old married woman and works as a nurse in a government hospital. She and her husband live with the husband's family. Rita missed her menstruation and suspected that she was pregnant, but she did not have time to get antenatal care because she was constantly busy between her job and her housework. Rita was two months pregnant when after a very tiring shift at the hospital she noticed blood in her underwear. Rita told her husband about it, and her husband shared this information with his mother-in-law. Rita took the advice of her mother, who told her to take time off from work to avoid losing the pregnancy. Once the bleeding stopped, Rita returned to work, and then she began to bleed again, this time profusely. Rita was admitted to the hospital and a D&C was performed. She was advised by the doctor to rest and postpone another pregnancy for a while. The doctor also informed Rita that her next pregnancy would require serious management. Rita's husband and mother-in-law were saddened by the news, and Rita blamed herself for not following her mother-in-law's advice.

(continued)

Appendix D (continued)
Sample Case Studies

Case Study 18: Nasim

Nasim is a 22-year-old single woman working as an employee in an export processing plant in a small village. She comes from an urban middle-class family, and her parents are very religious. Unknown to the parents, she was living with her married boyfriend while living in the village and working at the plant. Nasim does not use any form of contraception and engages in unprotected sex with her boyfriend. When Nasim learned that she was pregnant, she was happy about the news but feared how her parents would react. Her boyfriend did not welcome the news of her pregnancy and suggested that she terminate it. Nasim was angry with her boyfriend for not giving her the support she expected. On one of her trips to the city, she bought some herbs reputed to make her menstruation return. She drank the concoction regularly while visiting her family, and two weeks afterward she noticed some spotting on her underwear. The bleeding continued, accompanied by abdominal pain. She became apprehensive but was afraid to tell her parents about her problem. When Nasim could no longer bear the pain, she asked to be brought to the family doctor, still ambulatory and coherent, and she underwent curettage. Her parents were furious when they learned of her condition and threatened to disinherit or disown her. Nasim was angry and frustrated but had no one to talk to. She was angry with her boyfriend for not being there when she needed him most, angry with her parents for not understanding her, and most of all angry with herself for her own behavior that brought about this situation.

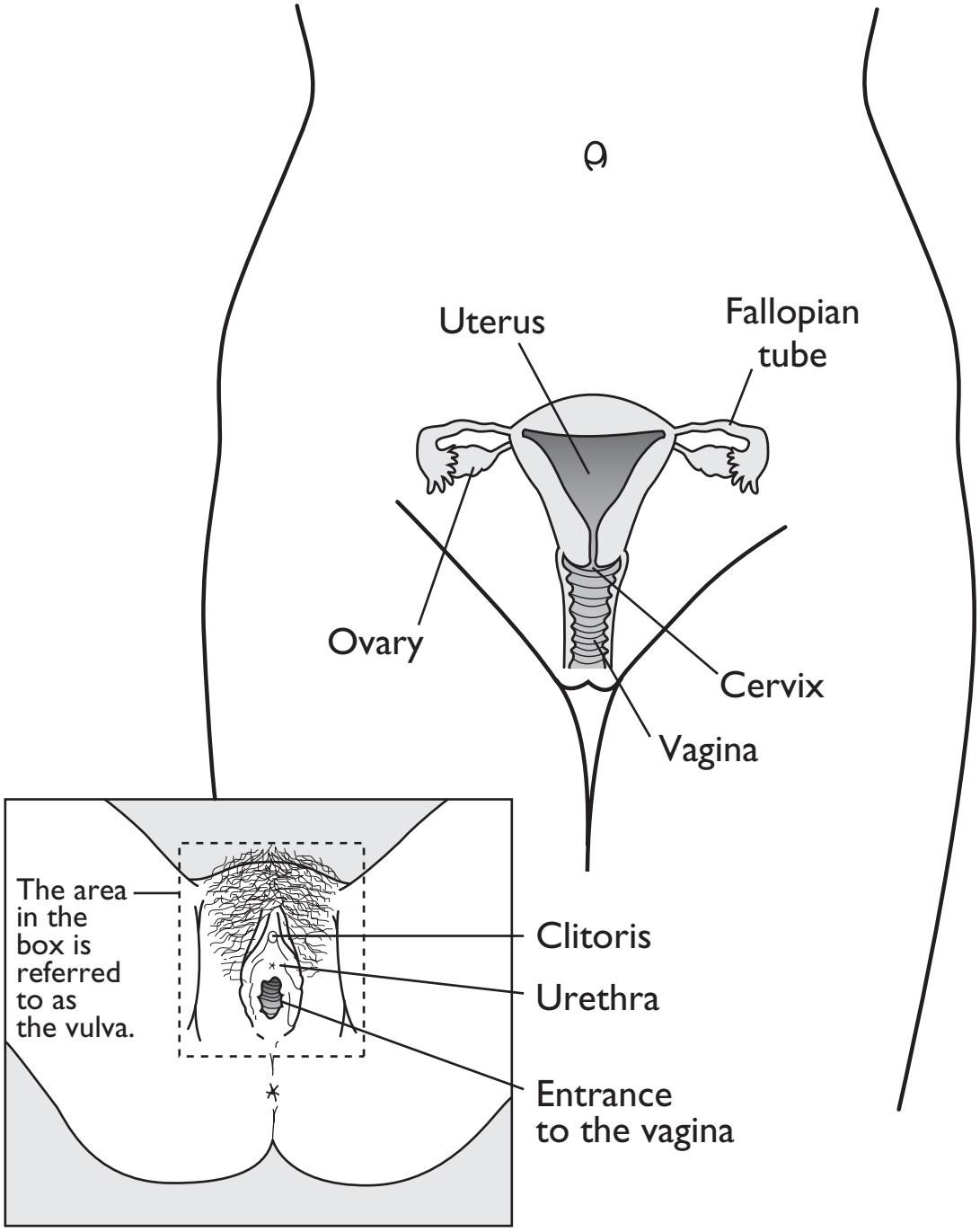
Case Study 19: Leah

Leah is a 37-year-old clerk in a local store, married to a security guard. They have one 4-year-old daughter, whom Leah carries on her way home from work each day. When Leah's menstruation was two months late, she went to the clinic for a pregnancy test. The test was positive, and the whole family was very happy. The couple planned to have this pregnancy because Leah was getting older, and they believed that this was a lucky year. One night Leah noticed a spot of blood on her underwear. She was a bit alarmed but managed to rest that night. The next morning she felt mild hypogastric pain and had moderate vaginal bleeding. She left her daughter with a neighbor and went directly to the hospital by herself. After the exam, the doctor informed her that an emergency D&C would need to be done. Leah cried, fearing the procedure and her husband's reaction. After treatment, she was brought to the ward, and her husband arrived three hours later. Leah was even more frightened when she saw him.

Source: The case studies for Sylvia, Pembeley, Anupa, and Marisol were taken from Tabbutt-Henry, J., and Graff, K. 2002. *Counseling the postabortion woman: Client-provider communication in postabortion care.* Draft. New York: EngenderHealth; all others were adapted from stories developed by staff from EngenderHealth's Philippines program.

Appendix E
The Female and Male Reproductive Systems

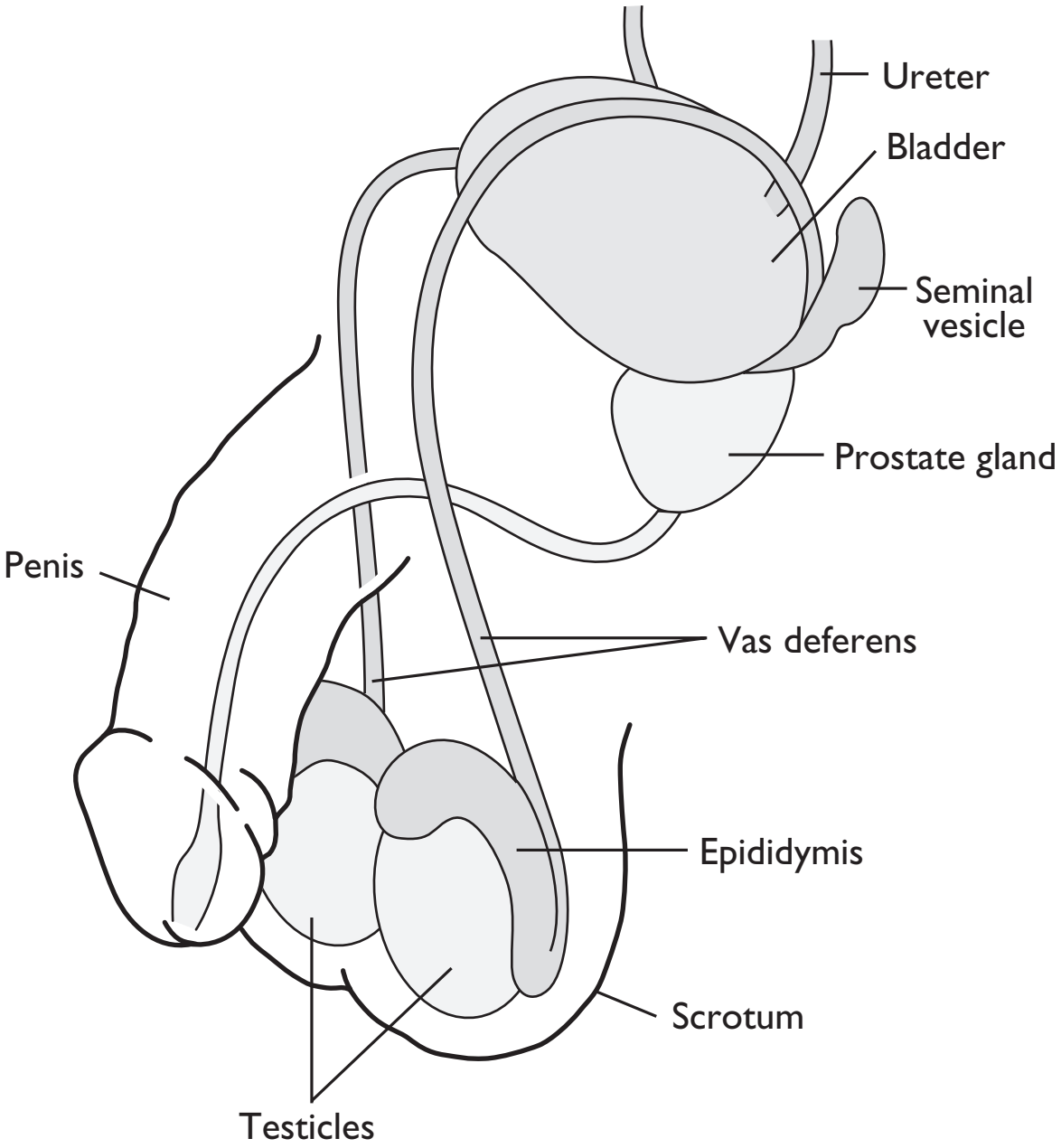
The Female Reproductive System



Adapted from: AVSC International. 1995. *Family planning counseling: A curriculum prototype*. New York.

Appendix E (continued)
The Female and Male Reproductive Systems

The Male Reproductive System



Adapted from: AVSC International. 1995. *Family planning counseling: A curriculum prototype*. New York.

Appendix F
Additional Trainer's Resources

Leonard, A. H., and Ladipo, O. A. 1994. Post-abortion family planning: Factors in individual choice of contraceptive methods. *Advances in Abortion Care* 4(2):1–4.

Margolis, A., Leonard, A. H., and Yordy, L. 1993. Pain control for treatment of incomplete abortion with MVA. *Advances in Abortion Care* 3(1):1–8.

Neamatalla, G. S., and Verme, C. S. 1995. Postabortion women: Factors influencing their family planning options. *AVSC Working Paper* No. 9. New York: AVSC International.

Salter, C., Johnson, H. B., and Hengen, N. 1997. Care for postabortion complications: Saving women's lives. *Population Reports*, series L, no. 10. Baltimore: Johns Hopkins University, Population Information Program.

Winkler, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium.

Wolf, M., and Benson, J. 1994. Meeting women's needs for post-abortion family planning: Report of a Bellagio Technical Working Group, Bellagio, Italy, February 1–5, 1993. *International Journal of Gynecology and Obstetrics* 45 (Suppl).

World Health Organization (WHO). 1995. Information and counselling for the patient. In *Complications of abortion: Technical and managerial guidelines for prevention and treatment.* Geneva, pp. 71–76.

Appendix G
Sample Client-Education Material

This material can be used as a guide for developing local-language client-education materials. Review it before use, and modify the content slightly, as needed, to fit your local setting.

Source: The text from this sample material was translated and adapted from a brochure developed by EngenderHealth's Dominican Republic program.

Front Cover

AFTER LOSING A PREGNANCY,
YOU NEED TO TAKE CARE OF YOURSELF

Inside: Page 1

The loss of a pregnancy can affect you physically and emotionally. To recover, it is important to:

- Seek and receive support from the health care staff at the service site.
- Have support from your partner.
- Have support from your family or from people close to you.
- Practice good hygiene. (Wash your genitals well at least twice a day.)
- Eat well. (Eat according to your normal diet and drink enough liquids.)
- Use only those medications that were prescribed to you in the hospital, until you finish the full treatment.
- Initiate sexual relations only after the bleeding has stopped and when you feel comfortable. (One of the most important parts of care for you right now is to protect yourself against unwanted pregnancy. Use a method of family planning until you and your partner both decide that you are prepared for a new pregnancy.)

Inside: Page 2

To prevent future pregnancies, choose a family planning method. When you leave the hospital, you can use:

- *The IUD:* The intrauterine device (IUD) is a method for temporary use, shaped like a "T," that is placed inside the uterus or womb to prevent pregnancies. If you decide to use it, it offers you up to 10 years of protection.
- *Injectables:* An injectable such as Depo-Provera is a temporary method for women. You get an injection every three months.
- *Norplant implants:* Norplant implants are a temporary method for women. Two or six little tubes are placed under the skin of your arm. It offers you at least five years of protection.
- *The Pill:* This is a temporary method for women. To protect against unwanted pregnancy, you take one pill every day at the same time.
- *Tubal ligation or vasectomy:* These are permanent family planning methods for women or men who already have their desired number of children. The procedure can be done at any time that you or your partner decide.

(continued)

Appendix G (continued)
Sample Client-Education Material

Inside: Page 2 (continued)

When you decide to have sexual relations, you can use:

- *The condom:* The condom is a temporary method for a couple to use during sexual relations to prevent pregnancy and the transmission of sexually transmitted infections (STIs), including HIV.
- *Foaming tablets, sponges, and foam:* These are temporary methods. You just need to put one of them into your vagina before sexual relations to avoid pregnancy.

Health care staff can help you and your partner choose the most appropriate method and can address your concerns about family planning or other health issues.

Back Cover

You should return to the hospital:

- For a follow-up visit on _____ (date), or
- If you experience one or more of the following symptoms:
  - Heavy bleeding
  - Vaginal secretions or bleeding with a foul odor
  - Fever
  - Dizziness
  - Severe cramps
  - Severe abdominal pain (below the belly button)
  - Severe and frequent headaches

Remember:

- You have the right to ask for and receive information from the health care staff.
- You should return to the hospital for a check-up, or immediately if you have one or more of the symptoms listed above.
- Unsafe abortions affect your health and can even cause death.
- The condom is a method that protects you from pregnancy and from STIs, including HIV.
- You can use the family planning methods presented here immediately after losing a pregnancy or when you decide to have sexual relations.

Appendix H
Workshop Evaluation Form

Instructions: For each item, check the box that best reflects your opinion. Your honest responses will help us improve future trainings. Your comments are also welcome.

Name (optional): _____

1. The objectives of the training were:
   - ❑ Very clear
   - ❑ Clear
   - ❑ Not clear

   Comments: _____

   _____

   _____

2. The objectives of the training were:
   - ❑ Completely met
   - ❑ Mostly met
   - ❑ Insufficiently met

   Comments: _____

   _____

   _____

3. The length of the training was:
   - ❑ Too long
   - ❑ Adequate
   - ❑ Too short

   Comments: _____

   _____

   _____

(continued)

Appendix H (continued)
Workshop Evaluation Form

4. The workshop content maintained my interest:

- ❑ All of the time
- ❑ Most of the time
- ❑ Some of the time

Comments: _____

_____

_____

5. The material presented in the course was:

- ❑ Almost all new to me
- ❑ Mostly new to me
- ❑ Mostly known to me

Comments: _____

_____

_____

6. The skills I acquired are:

- ❑ Directly applicable to my everyday work
- ❑ Somewhat applicable to my everyday work
- ❑ Not very applicable to my everyday work

Comments: _____

_____

_____

7. The training facilities were:

- ❑ Very satisfactory
- ❑ Somewhat satisfactory
- ❑ Unsatisfactory

Comments: _____

_____

_____