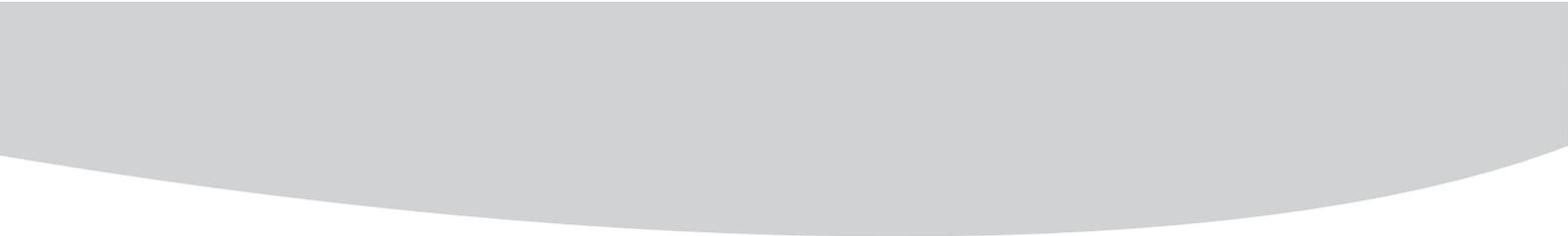


# Volunteer Manual and Training Curriculum

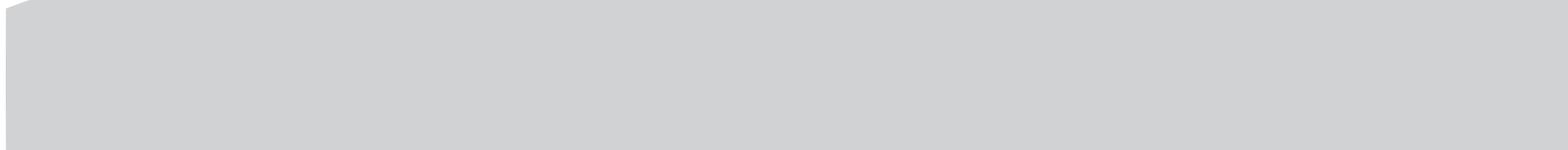
**For Adolescent Sexual and  
Reproductive Health Counselling/Education**



# **Healthy Child Manitoba Office**

**Volunteer Manual & Training Curriculum  
for  
Adolescent Sexual and Reproductive Health  
Counselling/Education**





## INTRODUCTION: THE VOLUNTEER MANUAL, COUNSELLING AND EDUCATION TRAINING CURRICULUM

In 2002, Healthy Child Manitoba Office (HCMO) provided funding to Klinik Community Health Centre (Klinik) to establish a teen clinic at Elmwood High School in Winnipeg. Klinik was selected based on its years of experience providing service to youth and their use of volunteers within their many different program areas. After an initial development and pilot phase, the Elmwood Teen Clinic (ETC) was transferred to the Winnipeg Regional Health Authority (WRHA) for administration by Access River East. Following up on the success of ETC, HCMO provided funding to Mount Carmel Clinic (MCC) in 2005 to begin providing teen clinic services at St. John's High School (SJTC) which opened in September, 2005.

In working together with community partners, it became clear there was a lack of consistency in how teen clinics (HCMO funded and others) were operating in Winnipeg. To support teen clinics, it was determined that a service manual and sexual and reproductive health volunteer training manual based on available evidence, best practice and community experience would be beneficial. In response, HCMO, in partnership with the WRHA and community stakeholders, created these manuals.

In 2006, HCMO began developing this manual, as well as a companion manual, *Teen Clinic Services*, with an advisory and stakeholder committee of community and regional health authority partners. The manuals support the work of existing and future HCMO-funded teen clinics. As well, HCMO has made these documents available for community or regional organizations that may benefit. These manuals are meant to help support existing and future teen clinic programming. As the development of literature and best practices in adolescent health services and teen clinics are evolving, so will the manuals.

This manual is a first step and focuses primarily on Winnipeg clinics. However, much of the information may be useful in northern and rural communities. The manual does not address some of the unique features and challenges of providing adolescent health services in northern and rural communities. The information is general and does not deal with the specific needs of diverse populations. However, the manual represents a collection of the vast knowledge and experience of the advisory committee and stakeholder groups.

HCMO would like to acknowledge the hard work and contribution of the members of the Sexual and Reproductive Health Volunteer Training Manual and Adolescent Health Services Manual Advisory Committee.

- Advisory Committee Member Organizations including:
  - Family Services and Housing
  - Klinik Community Health Centre
  - Manitoba Health
  - Mount Carmel Clinic
  - Nine Circles Community Health Centre
  - Nor'West Co-op Community Health Centre
  - Sexuality Education Resource Centre
  - Winnipeg Regional Health Authority
  - Women's Health Clinic
  - Youville Centre

Their expertise was fundamental in guiding the manual's development. Copies of forms and resources were provided for use in this manual and as a resource to other program planners and service providers. We would like to acknowledge this immense contribution without which this manual would not have been possible.

Additional copies of the manual can be ordered through HCOMO by contacting: 204-945-2785 in Winnipeg or downloaded from HCOMO's website at [www.manitoba.ca/healthychild/](http://www.manitoba.ca/healthychild/).

## LIST OF ACRONYMS

BC – birth control

GLBTT – gay, lesbian, bisexual, two-spirit, transgender

G/P/L – used in recording obstetrical history information. In current practise:

- G – the number of pregnancies, regardless of duration, including the present pregnancy
- P – the number of pregnancies ending after 20 weeks gestation, regardless of whether the infant is born dead or alive and regardless of number of fetuses (ex: twins count as one pregnancy)
- L – number of current living children to whom the woman has given birth

HCMO – Healthy Child Manitoba Office

HIV/AIDS – Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

SRH – sexual and reproductive health

STI – sexually transmitted infection

TA – medical terminology to describe therapeutic abortion

UPP – unplanned pregnancy

WRHA – Winnipeg Regional Health Authority

# Table of contents

Introduction	
Definitions .....	10
Using Volunteers as SRH Counsellors	
Benefits of using volunteers.....	13
Volunteer roles and responsibilities .....	15
Volunteer Management and Co-ordination	
Recruitment and screening.....	19
Orientation and training.....	25
Supervision and support.....	27
Recognition.....	32
Budgeting for program activities .....	34
Resources.....	35
SRH Volunteer Training Curriculum	
Getting started.....	53
Facilitation techniques.....	54
Overview of common participatory exercise .....	59
Preparing for volunteer training.....	64
Typical training session .....	65
Icebreakers and wrap-up activities.....	66
Resources.....	72

## Training Modules

Communication skills.....	75
Working with diversity .....	91
Confidentiality.....	111
Harm reduction.....	125
Volunteer counselling techniques.....	141
Values and sexuality.....	157
Adolescent sexual and reproductive health.....	173
Sexual identity.....	203
Sexual decision making.....	221
Birth control options and safer sex.....	237
Sexually transmitted infections and HIV/AIDS.....	291
Pregnancy options.....	309
References.....	328

# Introduction

This manual supports co-ordinators of volunteers or designated staff in recruitment, screening, training, evaluation and support of teen clinic volunteers based on the standards outlined in the *Canadian Code of Volunteer Involvement*.

*The Canadian Code of Volunteer Involvement* supports the following **values of volunteer involvement**:

- Volunteer involvement is vital to a just and democratic society. It fosters civic responsibility, participation and interaction.
- Volunteer involvement strengthens communities. It promotes change and development by identifying and responding to community needs.
- Volunteer involvement mutually benefits both the volunteer and the organization. It increases the capacity of organizations to accomplish their goals, and provides volunteers with opportunities to develop and contribute.
- Volunteer involvement is based on relationships. It creates opportunities for voluntary organizations to accomplish their goals by engaging and involving volunteers and it allows volunteers to grow and give back to the community in meaningful ways through voluntary organizations.

*The Canadian Code of Volunteer Involvement* supports the following **guiding principles of volunteer involvement**:

- Volunteers have rights. Voluntary organizations recognize that volunteers are a vital human resource and will commit to the appropriate infrastructure to support them. The organization's practices ensure effective volunteer involvement. The organization commits to providing a safe and supportive environment for volunteers.
- Volunteers have responsibilities. Volunteers make a commitment and are accountable to the organization. Volunteers will show respect for beneficiaries and community. Volunteers will act responsibly and with integrity.

This manual is an overview of volunteer co-ordination for new or inexperienced trainers of volunteers and unpaid staff (including co-ordinators of volunteers or their designates) who will be working in adolescent health services (ex: teen clinics). It provides basic information about many of the fundamentals of volunteer management including recruiting, interviewing, evaluating volunteers, etc. It also has a sample curriculum for volunteer training. This manual is not a substitute for professional

training. It can be useful in cases where an agency no longer has the resources to employ a professional co-ordinator of volunteers and needs to have other staff or volunteers do the job.

Before introducing unpaid staff into an adolescent health services program, clinics and agencies must carefully consider the amount of resources required to successfully integrate volunteers into a program and the extent to which these resources are available. While this manual provides support to implement volunteer services into programs, the overall time and energy required both in terms of planning and preparation, recruitment and training and ongoing supervision and support of a volunteer program should not be underestimated. Before initiating any plan to introduce a volunteer component of any kind into a teen clinic, careful and thorough planning and consultation must be done.

This manual will:

- Describe the role of volunteers as sexual and reproductive health counsellors in adolescent health services
- Familiarize program planners and staff with the principles of volunteer management
- Provide a training curriculum to support training of volunteers who will be working in adolescent health services (ex: teen clinics)

Volunteer trainers can choose materials from any area of the curriculum to complement their existing resources. They can also adapt and change the materials to suit their own needs and styles. The first part of the manual presents basic concepts in volunteer management including engaging and working with volunteers over 18 years of age. The second part includes a teen clinic volunteer training curriculum.

 *When you see this symbol:*

Throughout the manual reference is made to sample forms or resources to help you develop or carry out a volunteer program. These forms are located at the back of each section and are designated with a  indicating there's a sample form at the back.

### **Sources:**

The information in this manual has been adapted with permission from various sources:

- AIDS Committee of Toronto (ACT) *National HIV/AIDS Volunteer Training Kit* (download at [www.actoronto.org](http://www.actoronto.org))
- Canadian Federation for Sexual Health (CFSH) *Beyond the Basics: A sourcebook on sexual and reproductive health education*, available through CFSH ([www.cfsh.ca](http://www.cfsh.ca))

# Definitions

**Access:** Programs and services delivered in a way that allows for all Manitobans to take part in programs and receive services all across the province.

**Adolescent:** A person aged 10 to 19; teen refers specifically to adolescents between the ages of 13 and 18.

**Confidentiality:** Making sure there is a system in place to protect the privacy of your health, financial and personal information.

**Cultural responsiveness:** Means people working in service/government agencies will respect each person's needs including culture, race, ethnic background, sexual orientation and faith or religion.

**Determinants of health:** Our levels of health are determined or affected by many things including social and economic factors, physical environment, and individual behavior. It is the combined influence of these factors that determine or affect your health.

**Diversity:** Diversity includes the many differences among people in a society. It includes ethnicity, race, cultural traditions, religious expressions, age, gender, socio-economic status, geography, mental or physical ability and sexual orientation.

**Harm reduction:** Things people can do to reduce harm to themselves and their communities. It includes sharing relevant information, facts and practical material, tools that will help them make informed decisions about how they live. It includes individuals' abilities to protect themselves, families and communities.

**Informed choice:** The provision of accurate and full health information delivered in a clear and understandable manner so as to facilitate informed decision making on the part of the patient.

**PHIA:** *Personal Health Information Act.* Manitoba's provincial act regulating the protection of personal health information. It ensures individuals can find out their own personal health information and have the information kept secure and confidential by those who collect and maintain it. The act can be viewed online at: [www.manitoba.ca/health/phia/index.html](http://www.manitoba.ca/health/phia/index.html).

**Pro-choice:** Pregnant women can expect to be supported in their full range of reproductive rights and freedoms including the right to access safe and legal abortion services.

**Reproductive health:** Women should have complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to her reproductive system.

**Reproductive rights:** Couples and individuals have the right to decide freely and responsibly on the number and spacing of desired children, and to have the information and the means to achieve this. They also have the right to the highest standard of sexual and reproductive health and to make decisions free from any kind of pressure or prejudice.

**Sex positive:** Sexuality is defined as a basic human right, focusing on the life-enhancing aspects of sexuality. It notes the negative aspects, while being non-judgmental and challenges narrow social ideas (ex: the myth that sex=intercourse). It uses inclusive language and avoids stereotyping. It also makes people more aware of the choices involved in sexual decisions (ex: whether or not to be sexual and exactly what being sexual can mean).

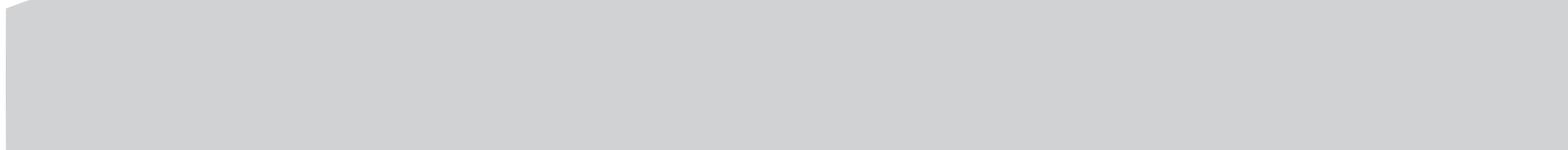
**Sexual Health:** Positive results (ex: self-esteem, respect for self and others, non-exploitive sexual satisfaction, rewarding human relationships, the joy of desired parenthood) are the goal instead of negative results (ex: unintended pregnancy, sexually transmitted infection, sexual coercion).

**Sexuality:** Sexuality includes not only physical and sexual desires, but also identity, social and gender roles and personal relationships with family, peers and partners.

**Teen:** People between the ages of 13 and 18 are considered teens.

**Young people:** The term includes people between 10 and 24 years.

**Youth:** The term includes people between 15 and 24 years.



## **BENEFITS OF USING VOLUNTEERS**

Organizations, individuals and the community as a whole benefit from volunteers. Within a teen clinic, volunteers can fill many roles that contribute to the operations and services offered. The use of volunteers to provide sexual and reproductive health (SRH) education and options counselling has been well established in Winnipeg's teen clinics. There are many benefits to including volunteers within a teen clinic in this capacity and more and more programs are seeking ways to involve volunteers as SRH counsellors. These positive tendencies need to be strengthened.

However, the decision to involve volunteers requires careful planning and consideration. Before involving volunteers as SRH counsellors, it is important that the agency consider all the implications and changes that will be required. The best way to start thinking about volunteer involvement includes a set of fundamental questions about volunteers in the organization overall. An initial internal assessment will ensure staff have the opportunity to reflect on the program's overall purpose and how volunteers can support this. Once an overall vision for volunteer involvement has been agreed upon and a lead staff person identified, planning the volunteer program can begin.

### **Benefits for the organization**

1. Using volunteers involves members of the target population in service delivery. Many of those motivated to volunteer at a teen clinic are young people themselves. Volunteer SRH counselling should only be done by people over 18. In recruiting volunteers, it is important to consider the relative age gap between a counsellor and client. Some young people may benefit from having a young person (ex: between the ages of 18 and 29) providing options counselling. Such volunteers can make young clients feel at ease and may act as role models for young people starting to make choices about their health.
2. Integrating volunteer SRH counsellors into adolescent health services involves members of the community. Teen clinics can provide an opportunity for members of a particular community to become involved in growth and development. Skills gained through volunteering can be carried over to other areas that will benefit the broader community.
3. Volunteers provide opportunities to gain new ideas. An organization will benefit from having young people and community members offer ideas on how best to reach out to youth in their community. This will further lead to additional opportunities to engage and serve the community better.
4. Volunteers can offer valuable feedback on the programs. They can help evaluate programs and provide input into improving services.

5. Volunteers can provide a readily available pool of experienced individuals for hiring in teen clinics or other related programs.
6. Involving volunteers allows the agencies to benefit from people with a diversity of skills and interests.
7. Volunteers can support teen clinic service delivery by providing routine education and information to all clients, allowing teen clinic staff, nurses and physicians more time and opportunity to delve into specific issues and concerns with which clients may be presenting.

Please note: When working with volunteers under the age of 18 there are special considerations that are not addressed within the scope of this manual. For more information on working with volunteers under 18, see Klinik Community Health Centre's Teen Talk Program at [www.klinik.mb.ca/teentalk.htm](http://www.klinik.mb.ca/teentalk.htm).

### **Benefits for the volunteer**

According to the *2000 National Survey of Giving, Volunteering and Participating (NSGVP)* [1] Canadians cited the following as benefits to volunteering:

- More than three quarters (79%) of volunteers said their volunteer activities helped with interpersonal skills, such as understanding people better, motivating others, and dealing with difficult situations.
- Just over two thirds (68%) of volunteers said volunteering helped them develop better communication skills; (63%) reported increased knowledge about issues related to their volunteering.
- Volunteering is often seen as an opportunity to acquire job skills and improve job opportunities. The desire to improve job opportunities is a much more common motivation for volunteering among younger and unemployed volunteers. Over half (55%) of volunteers aged 15 to 24 said they volunteered to improve their job opportunities.
- Individuals may use their volunteer experience to fulfill educational requirements for their fields of study.

### **Volunteers may also benefit by:**

- gaining experience in a field that interests them
- having a chance to meet new people and make friends with other volunteers and staff
- having increased contact with the community

- gaining opportunities to learn from other generations and cultures
- gaining opportunities to develop and exercise new ideas
- the possibility of being hired as paid staff

## **VOLUNTEER ROLES AND RESPONSIBILITIES<sup>1</sup>**

### **Role of volunteers in teen clinic**

The role of volunteer SRH counsellors in adolescent health services should help meet the program's overall vision and objectives. When planning for their roles, it is also important to think of the various ways the program will benefit from using volunteers (ex; building community capacity). Finally, it is important to think about what factors will motivate volunteers to become and to stay involved in the program. Since a key for volunteering includes an opportunity to learn and practise new skills, volunteer jobs should be meaningful, contribute towards professional and personal development and provide volunteers with new knowledge.

While it is important to provide volunteers with worthwhile tasks, it is also essential to safeguard volunteers and staff from the possible abuse of volunteer labour. Volunteers must not be used to displace or replace staff positions. It is unfair to jeopardize staff job security and equally unfair to volunteers to ask them to do, for free, work that people normally get paid for.

All protections and expectations should apply equally to staff and volunteers. Volunteers should be expected to perform their duties responsibly and meet the standards of the job to the best of their abilities. They should also be protected from sexual discrimination and have privacy protection.

### **Ensuring meaningful roles for volunteers:**

Volunteers are best used to perform purposeful, clearly defined tasks, which make use of their individual abilities and foster self-esteem. An appropriate volunteer placement is one in which the tasks listed in the volunteer activity description are:

- related to one another,
- are relevant to current program needs,
- and are specific enough to give volunteers a framework within which to work.

Although some of the tasks that volunteers are asked to do may be similar to those performed by employees, an appropriate volunteer activity differs from a paid position

---

<sup>1</sup>Winnipeg Regional Health Authority, *Volunteer Manager's Handbook*

in the limited range of responsibility given, the number of hours required, and the need for close supervision by a staff person. In such an arrangement, volunteers give their time and expertise and receive satisfaction from learning new skills and exercising areas of personal competence in partnership with teen clinic staff members. By contrast, an inappropriate volunteer placement might ignore the wishes and skills of the volunteer, consist of a grab-bag of menial jobs that no one else wants to do, or actually be a full-time paid position disguised as a volunteer opportunity.

The role of volunteers at teen clinics is to enhance the services provided by:

- conducting SRH counselling/education with clients
- helping with programs/projects
- supporting clients
- linking with community
- providing feedback about services
- promoting programs and services
- participating in community development and education activities

### **Roles and responsibilities of a co-ordinator of volunteers**

An important aspect of good volunteer management is the support and supervision provided by teen clinic staff. Ideally, a co-ordinator of volunteers or designate would be appointed to fill this role on site. Co-ordinators working in a Winnipeg Regional Health Authority (WRHA) affiliated teen clinic site can work with the WRHA volunteer manager who will consult with them and support them in strengthening the volunteer program.

The designated co-ordinator of volunteers works in partnership with staff and affiliated partners and is responsible for the following activities:

- helps in development of new volunteer programs
- ensures there are written activity descriptions for volunteer roles and that the roles are appropriate and safe for volunteers to perform
- manages the recruitment and screening of volunteers
- develops and monitors orientation and training
- develops and monitors feedback for staff and volunteers
- provides ongoing support and recognition to volunteers

- provides training for staff
- establishes ongoing evaluations of the volunteer program
- promotes volunteerism within the organization
- ensures volunteer involvement does not violate workplace collective agreements

### **The role of teen clinic staff**

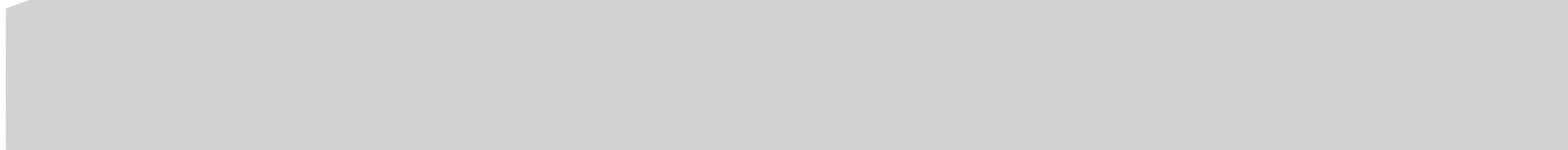
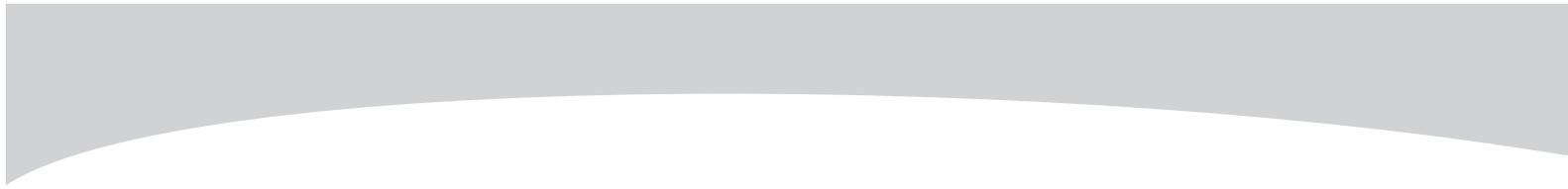
Staff members involved in volunteer program management at teen clinics are encouraged to take advantage of the training and consultation services offered by the WRHA Volunteer Services Program. They may also use training opportunities offered by Volunteer Manitoba and/or the continuing education departments of the universities and community colleges.

When volunteers become members of the teen clinic team they become partners in all the clinic's benefits and responsibilities. Volunteers must agree to follow directions of the staff members with whom they work, and the staff members must train and supervise volunteers in the proper fulfillment of their duties.

The management and supervision of volunteers are important functions for which staff members should receive recognition in their regular staff performance appraisals.

The role of teen clinic staff using volunteers is to:

- assist the co-ordinator of volunteers or designate (or manager, volunteer services if WRHA affiliated) design and develop volunteer placement and activity descriptions
- help screen volunteers
- support orientation and training for new volunteers
- recognize volunteers' contributions
- help evaluate the volunteer program



## RECRUITMENT & SCREENING<sup>1,2</sup>

Recruitment of volunteers for a teen clinic is based on the principles of:

**Management:** Set the long and short-term goals of the recruitment program and set the qualifications, skills and knowledge needed to fill volunteer positions.

**Motivation:** State what you have to offer volunteers and identify the motivational factors that correspond with the volunteer role.

**Marketing:** Choose the most effective way to attract the most diverse and skilled volunteers, keeping in mind the motivational factors of potential volunteers.

---

*From: National HIV/AIDS Volunteer Training kit*

Prospective volunteers should be provided with as much detail as possible about their roles within the clinic. A letter of introduction can be provided to welcome volunteers, describe the training and orientation process (including the number of hours and schedule of training they will be expected to attend). Along with a letter of introduction, additional background information can be given to provide details about the agency, volunteer role and expectations.

A package of information for all new volunteers can include:

- letter of introduction
- training schedule and location
- volunteer contract, detailing expectations of volunteer role and commitment
- volunteer job description
- agency brochure

 *Sample Letter of Introduction*

### Screening Volunteers

Once a volunteer has confirmed that he/she is interested in volunteering, screen to ensure the volunteer will be suited to the roles and expectations required in the job. Initial interviews are conducted to check the qualifications, ability and suitability of the person to perform work on behalf of the organization. Prospective volunteers will be informed in advance that the interview process is designed so both parties can screen each other. The determining factors in the selection, promotion or termination

---

<sup>1</sup>Winnipeg Regional Health Authority, Volunteer Manager's Handbook

<sup>2</sup>AIDS Committee of Toronto, National HIV/AIDS Volunteer Training Kit

of volunteer role or activities may include skill in performance, training, educational background, experience, personal suitability and responsibility.

 **Job descriptions:** Volunteers benefit from detailed job descriptions that provide a clear understanding of the tasks they are asked to complete. Detailed job descriptions help in performance assessments and feedback with supervisors. When volunteers understand their responsibilities and managers can follow up on specifics, both sides benefit. *See example job description at the end of this section.*

#### **Duties of volunteer SRH counsellors:**

1. Attend all volunteer training sessions and do co-counselling as part of the orientation process.
2. Provide non-judgmental information and support to adolescents in the areas of birth control, sexual health and pregnancy options.
3. Carry out pregnancy screening tests and provide results to clients with guidance offered whether pregnancy test is positive or negative.
4. Properly document encounters on the medical chart and stats sheets.
5. Attend volunteer meetings.
6. Stay up to date on new information in the areas of adolescent SRH.

#### **Characteristics of volunteer SRH counsellors:**

1. A positive attitude towards adolescents which affirms that young people are autonomous and capable individuals with the ability to make their own health choices
2. A positive attitude towards adolescent sexuality that recognizes all young people have the right to accurate, non-judgmental information on all issues about SRH and have the right to make their own choices
3. Acceptance and understanding of the principles of informed choice including access to information on the full range of options in language that is clear to the client as well as the opportunity to ask questions and allow clients to make their own decisions free of coercion
4. Reliable
5. Flexible
6. Non-judgmental attitudes

7. Understanding of importance of confidentiality
8. Emotionally stable
9. Strong motivation to help in this field
10. Sense of humour
11. Honest
12. Willingness to deal with explicit sexual language and sensitive sexual topics
13. Knowledge of issues or willingness to learn
14. Self-awareness
15. Life experience
16. Pro-choice: supporting the full and equal reproductive rights of all women, including access to safe, legal, free abortions.

A background check will be necessary for teen clinic volunteers who will have direct contact with clients. Background checks may include police/criminal record checks, child abuse registry screening and/or personal/professional reference checks. While it may seem overly cautious, some young people may be very vulnerable to exploitation and such checks protect the volunteer and the organization as well as the client.

### **Interviewing and selection**

Everyone who applies for a volunteer position has a right to be interviewed in person by the co-ordinator of volunteers or their designate. If the position is to be supervised by a staff person other than the co-ordinator the staff should be involved in the interview. The interview should offer the prospective volunteer the opportunity to learn about the organization and its mission. It is necessary to develop policy that is fully compliant with provincial human rights codes in interviewing and selecting volunteers and other aspects of volunteer management.

It is important that the prospective volunteer knows the opportunity being presented is worthwhile and interesting. At the same time, the purpose of the interview should be clearly stated as an exploratory discussion with no commitments on either side.

### **Preparing for the interview**

- In a warm, personal telephone call, ensure a clear understanding of the time and place for the interview. Arrange for the most suitable location. If you have made the first contact, offer to meet at a place convenient for the volunteer and encourage him or her to visit your organization if possible. Confirm the meeting date and place in a short handwritten note on your organization's stationery. Enclose your organization's brochures. Ensure privacy for the meeting and avoid

interruptions. Alert receptionists and others of your scheduled interview so the prospective volunteer is expected.

- Before the interview, review any material related to the position and, if possible, familiarize yourself with the person's profession, job affiliations, past volunteer involvements, etc.
- Define your objectives for the interview, such as describing the purpose and activities of your organization; outlining the position you are attempting to fill; exploring the volunteer's interests, skills, willingness to volunteer and perceptions of your association; and deciding on the volunteer's availability and general suitability.
- Give consideration to involving another person with the interview. Agree on the areas you each want to cover.

### **During the interview**

- Relax. Put the prospective volunteer at ease because he/she may be nervous.
- Give the interview your full attention.
- Tell him or her this is an opportunity for each of you to explore and ask questions. Try to clarify your expectations and those of the volunteer.
- Do not jump to conclusions when you do not understand. Ask for clarification.
- Listen to what the volunteer says.
- Observe the volunteer. Pay attention to non-verbal clues, including body posture and movement, blushing, coughing, tone of voice, pace of speech, etc.
- Use open and non-directive questions rather than closed questions where possible. Questions that can be answered with either a simple "yes" or "no" are closed and not useful.
- At the end of the interview, summarize any decisions and actions that have been agreed upon to ensure both parties are clear on these. Before thanking the volunteer for coming in, ask if there are any other questions or information required.
- After the interview, write up any necessary notes and tasks for follow-up and ensure the confidentiality of these records.

## Summary of interview procedure and record keeping

On an interview record form, fill in the name of the interviewer; date; name of volunteer; and volunteer's phone number. Review the volunteer's application form. Clarify information on the form with the volunteer. Correct any incorrect/missing information on the form. Ask a selection of non-directive and open-ended questions:

<b>Potential interviewing questions to use:</b>	
Motivation questions	<ul style="list-style-type: none"> <li>• What do you know about our agency?</li> </ul>
	<ul style="list-style-type: none"> <li>• What attracted you to our agency?</li> </ul>
	<ul style="list-style-type: none"> <li>• Is there an aspect of our work that most motivated you to seek to volunteer here?</li> </ul>
	<ul style="list-style-type: none"> <li>• What would you like to get out of volunteering here?</li> </ul>
	<ul style="list-style-type: none"> <li>• What would make you feel like you have been successful?</li> </ul>
Attitude Questions	<ul style="list-style-type: none"> <li>• What have you enjoyed most in previous volunteer work? What have you enjoyed least?</li> </ul>
	<ul style="list-style-type: none"> <li>• What skills do you feel you have to contribute?</li> </ul>
	<ul style="list-style-type: none"> <li>• How do you feel about teenagers?</li> </ul>
	<ul style="list-style-type: none"> <li>• How do you feel about adolescent pregnancy?</li> </ul>
	<ul style="list-style-type: none"> <li>• How do you feel about abortion?</li> </ul>
Interpersonal relations questions	<ul style="list-style-type: none"> <li>• Describe your ideal supervisor. What sort of supervisory style do you prefer?</li> </ul>
	<ul style="list-style-type: none"> <li>• What people do you work best with? Would you rather work on your own, with a group or with a partner? Why?</li> </ul>
	<ul style="list-style-type: none"> <li>• What age groups are you most interested in working with and why? Are there people you feel you would have difficulty working with? Why? What experience have you had working with young people?</li> </ul>
Values questions	<ul style="list-style-type: none"> <li>• What issues are you especially concerned about at the international, national and local levels?</li> </ul>
	<ul style="list-style-type: none"> <li>• What do you do with your leisure time?</li> </ul>

General availability and balance questions	• What is your availability in terms of volunteer time?
	• What else are you doing in your life?
	• How do you balance a busy schedule?
Decision making questions	• What are the most significant decisions that you have made?
	• What process do you employ to make a decision?
Problem solving questions	• How do you deal with anger or conflict?
	• Describe a challenging situation you have encountered and how you dealt with it.
	• What are you like when you learn something new?

In addition to the above questions it is important to screen volunteers for their overall comfort level in discussing sexuality and sexual health topics. The interviewer may wish to provide the volunteer with a list of the topics to be covered in the volunteer training. Highlight that some of the discussion may focus on very sensitive topics (including sexuality, sexual practices and sexual abuse). Volunteers should be asked if they think they may have any difficulty discussing these topics either in training or in providing SRH education/counselling to adolescents. Explore any personal issues or concerns they may have in talking openly about these topics with others.

Discuss the potential volunteer position and check with the volunteer for a match of interests, qualifications and availability. When the interview is over (and the volunteer has left), complete your assessment and make notes about the following areas:

- appearance (if relevant): poised, neat, unkempt
- any potential restrictions or special needs to be accommodated
- reactions to questions: helpful, interested, volunteered information freely, answered questions, evasive, confused
- disposition: outgoing, pleasant, confident, reserved, withdrawn, moody, suspicious, antagonistic
- interpersonal skills: adept at dealing with others, relatively at ease with others, uncomfortable

Record your recommended actions:

- consider for the position
- schedule for second interview
- hold in reserve
- investigate further
- refer elsewhere
- not suitable for agency at this time

Notify the volunteer (by phone or mail) of the organization's decision. Record that you have notified the volunteer: name of volunteer; date and method of notification.

## ORIENTATION AND TRAINING

Research shows that good training increases volunteer productivity. It acts as an incentive to attract people to the organization in the first place and it keeps them there. Access to training and development is a highly regarded form of volunteer recognition.

Through orientation and training you prepare volunteers to perform their roles. All volunteers must receive orientation to their surroundings and training in their work before or during their first time on duty. It is also strongly recommended that staff receive an orientation to the volunteer program. Information about the goals of the volunteer program, the roles of volunteers within the department, and the nature of the relationship between staff and volunteers, will strengthen the staff/volunteer partnership.

### Volunteer orientation content

The volunteer orientation is specifically intended to introduce the new volunteer to the agency itself as well as any relevant policies or procedures that may impact the volunteer in their work. Orientation can be held on an individual or group basis. On an individual basis, the orientation can be tailored to the specific needs of the volunteer. If a number of new volunteers are recruited at the same time, a group orientation can be held.

***The Personal Health Information Act (PHIA)*** refers to Manitoba's provincial act regulating the protection of personal health information. PHIA ensures the rights of individuals to access their own personal health information and the right to have their information kept secure and confidential by those who collect and maintain it. For

more information on PHIA please visit the Manitoba Government's website at [www.gov.mb.ca/health/phia/index.html](http://www.gov.mb.ca/health/phia/index.html)

The orientation should include:

- welcome and introductions to teen clinic staff members
- a brief description and history of the agency and teen clinic
- a tour of the site, including practical information such as the location of coat rack, a place to secure valuables, the supply cupboard, washrooms, emergency exit
- a review of the volunteer handbook (if available) including policies and procedures that are to be followed by all volunteers
- *The Personal Health Information Act (PHIA)* education and signing of a confidentiality pledge form (attach to volunteer's file)

### **Volunteer training**

The training you provide for new volunteers is designed to teach them specific information and skills they need to do their activities. Training is specific to the volunteer role and helps them feel comfortable and prepared for their roles in a teen clinic.

#### **Example: WHC Volunteer Training and Orientation Process.**

The WHC volunteer training process includes a group training session and opportunities to observe and gradually begin counselling clients. Training includes mentoring in which senior volunteers provide the training and support during initial counselling and guide new volunteers towards full counselling status.

1. Training includes 60 hours of volunteer training – group sessions that include discussion, role play and case study.
2. By week three or four, the new volunteer begins sitting in with a current volunteer to observe counselling sessions.
3. Upon completion of training the new volunteer begins a part of the counselling with a senior volunteer. As they become more and more confident they can take on more of the counselling. The senior volunteer provides support and feedback.
4. When he/she feels ready, the new volunteer is evaluated by a senior volunteer who approves him/her for independent counselling. Use feedback forms to ensure he/she is adequately prepared in all areas.
5. After 10 sessions on their own, volunteers are re-evaluated. Evaluations are then done annually.

Volunteers for SRH counselling require extensive training that includes information about all aspects of their roles as a counsellor. This includes training in communication, crisis intervention, cultural responsiveness and core skills on reproductive health and anatomy. This manual includes sample sessions for teaching these and other necessary skills. This training should be integrated into a broader training and orientation process that includes opportunity to observe sessions and practise counselling skills doing individual sessions with a client. The Women's Health Clinic (WHC) has a volunteer training program that (see example) provides an example of the comprehensive training and orientation required to prepare volunteers to be SRH counsellors.

## **SUPERVISION AND SUPPORT**

Providing volunteers with regular supervision and periodic evaluation is important to ensuring their contribution is meaningful - for them and the organization. This is particularly true for young people, who may have little work experience and are seeking (and need) the support and feedback of the organization. Without adequate supervision, volunteers may feel they are unable to meet the needs of the position, or they may find themselves doing things wrong. Nothing could be more discouraging. A negative volunteer experience is bad for the organization and may discourage people from volunteering again.

Supervision provides volunteers with guidance, encouragement, support and on-the-job training. It allows the organization to define the tasks to be done, and to maintain effective working relationships. Volunteers of all ages need to be provided with:

- a clear identification of who is supervising them
- an understanding of how the supervision will be provided
- an opportunity to express their opinions and concerns
- supervision that reflects the job description for the volunteer position and the orientation and training that has been provided

### **Defining expectations**

Supervision includes letting volunteers know what is expected of them. It is important to clearly communicate the agency's expectations to the volunteer. If it can be assumed that no one volunteers to perform poorly then it is necessary to define what doing a good job means.

If agencies place a high level of expectation on volunteers they are more likely to get good results. They should not be afraid to challenge volunteers. Letting volunteers know how much staff and clients are counting on them will help them understand why their work is important and encourage them to give their best.

## Ongoing support

Volunteers who are in high-risk, high-stress jobs, including SRH counselling, need ongoing support. Support meetings provide volunteers who do similar work a chance to talk about their work, especially the feelings their work brings up.

Regularly scheduled meetings with volunteers can be used to:

- share information with volunteers
- discuss questions and concerns
- collect and discuss volunteer reports about their work
- gather feedback on ways to strengthen the program
- provide ongoing education and training
- debrief and discuss challenging client situations
- network with other volunteers
- community building

## Evaluation of volunteers

Informal evaluation goes on almost continuously during a work period, it is necessary to do a regular formal evaluation of the performance of each volunteer. This can be done formally after three months of active volunteer service, and then annually; or before transferring to another volunteer role or leaving the program. Since volunteers do not work for money, work satisfaction is a major factor in keeping a high level of interest and performance. Of equal importance is the need for competent, consistent service from volunteers. Clear evaluation and recognition of the importance of the volunteers can help meet the needs of all concerned.

## Volunteer performance reviews

The volunteer performance review is a mutual way to express appreciation, identify problems and needs, and determine the volunteer's future involvement in a teen clinic. A successful performance review provides an opportunity to communicate with the volunteer. It also allows you to discuss expectations of yourselves and each other. Increasing numbers of volunteers are developing and enhancing their skills through volunteer work. They welcome opportunities to receive constructive feedback and evaluate their work.

### **Benefits of performance reviews:**

- It is a strong statement about the importance of volunteers.
- Both volunteers and the agency are held accountable.
- Volunteers want to be successful and normally respond well to feedback.
- It is an opportunity to express appreciation for the volunteer's efforts and acknowledge accomplishments.
- It enables you and the volunteer to re-negotiate your working agreement for the next time period.
- It provides an opportunity to discuss plans to improve future volunteer performance.
- It allows volunteers to express concerns and leave an unfavourable situation.
- It allows you to share concerns and dismiss the volunteer if the situation requires action.

### **Elements for successful evaluation:**

- Volunteers should be informed of the performance review system when they start their placements.
- Mutuality is the key. It is a time for both the program co-ordinator and the volunteer to share experiences with one another.
- Performance reviews should be based on previously agreed upon standards, the activity description, deadlines, available resources and intervening circumstances.
- The performance review should have no surprises if ongoing supervision and conflict resolution have taken place.
- It is best to gradually include current volunteers who have not previously been reviewed.

### **Identifying and addressing personnel issues**

Occasionally, a volunteer has poor work habits or performance issues that have a bad affect on program delivery. Correcting poor work habits helps the co-ordinator of volunteers, the volunteer and the agency. When working with volunteers, it is important to support a standard of professionalism and show that volunteers can and should be held accountable to those expectations. Dealing with performance issues in a timely manner is important. The agency is liable for the work of volunteers, including mistakes that may cause harm to clients and the teen clinic as a whole. As well, the agency can lose the respect of other volunteers and staff if performance issues are not dealt with. By handling issues in a sensitive, respectful way, the co-ordinator shows respect for the volunteers, the importance of their work and their desire to do good work.

Through regular supervision, problems can be identified when they are small and easily corrected. This should be done in a way that supports volunteers to improve their skills. Often the behaviour that becomes problematic has not been discussed with the volunteer in the first place.

Before taking action, the co-ordinator should carefully consider and specifically identify the problem. Following are some examples of personnel issues that may require intervention:

- actions that affect the volunteer work
- actions that affect the work of others
- actions that violate agency policies or procedures
- actions that become annoying or offensive
- quality and/or quantity of the work does not meet stated expectations
- there is a problem adhering to schedules or deadlines
- the volunteer is taking an excessively long time to develop competency

### **Dealing with performance issues**

Nearly everybody wants to do a good job and wants to be seen as competent in what they do. You can support volunteers by addressing work habit or performance issues.

1. Try to handle problems promptly as they come up. Problems won't disappear if they are ignored; in fact, they are likely to get worse.
2. Before confronting a difficult situation, the co-ordinator of volunteers should make sure to be calm, under control. Be ready to listen to and respond to the volunteer. Try to be as open and honest as possible. Write down key points to help focus and clarify concerns.
3. Serious reprimands should only be discussed in a private one-to-one setting.
4. Investigate and describe what has been observed. Avoid making assumptions or interrupting. It is helpful to have an example of the problem behaviour recorded.
5. Be clear about why the habit is a concern. The most effective way to help a volunteer change a poor work habit is to tell him/her exactly why the habit is a concern.
6. Determine the reasons for the behaviour and take the time to listen.
7. Use the activity description to identify behaviour. Sometimes it is important to separate the individual from the function or activity to make a fair decision.

8. Indicate a shared commitment to finding a solution to the problem. The volunteer should hear: “How can we work together to fix the problem?”
9. Offer support.
10. Agree on a specific plan and arrange for follow-up. This is part of the coaching and recognition that are so important in assuring that problem behaviour doesn't recur and that a solution is being worked on.

### **The decision to terminate a volunteer**

Volunteers can be fired, but the situation should be taken seriously and used as cautiously as if the person were salaried staff. Volunteers, like paid employees, can sue for wrongful dismissal and/or defamation of character.

The degree of corrective action taken with a volunteer should depend on the gravity of the concern, implications for the client's well-being, security of property, and number of previous incidents. Unless the gravity of the concern dictates otherwise, a volunteer should receive at least three oral/written warnings before ending the volunteer's placement.

All corrective measures, including verbal warnings, should be documented on the volunteer's file. This may include verbal and written warnings and if necessary, termination of the volunteer.

Terminating a volunteer is not pleasant. However, failing to correct a bad situation is not fair to other volunteers and staff.

#### **Questions to consider in termination:**

1. Does the volunteer have a current job description?
2. Does the volunteer understand his or her role?
3. Has the volunteer participated in orientation and training?
4. Could the situation be fixed by having the volunteer return to an orientation or training program?
5. Does the volunteer have a designated, accessible supervisor who knows how to supervise volunteers?
6. Have you previously documented the problem in writing; shared it with the volunteer; and discussed ways to avoid the situation in the future? This action would not be appropriate if the volunteer had done something serious.
7. As you have explored the nature of the problem, have you brought all the parties involved in the situation together so all sides of the situation can be examined together?

8. Have you created an action plan to resolve the situation and has the responsible person met with the volunteer as specified in the action plan?
9. Have you involved the appropriate staff in this situation?
10. Have you explored the implications of terminating the volunteer in terms of:
  - a. the life situation of the individual
  - b. the impact of this action on the program and clients
  - c. the impact of inaction on this situation or teen clinic and the clients
11. Have you exhausted all possibilities that would make this action unnecessary?
12. Have you taken steps to minimize or contain the damage that may result from this decision?
13. What organizational support, if any, do you need to act on this decision?

## RECOGNITION

Appropriate, sincere, timely, individual recognition may be the key to the success of a volunteer program. After investing time and effort in creative and energetic volunteer recruitment and training, establishing policies and practices that support and protect volunteers and fostering volunteerism within a teen clinic, it would be a terrible waste to lose volunteers because they feel unappreciated.

While training and supervision are best done in consistent and standard ways, recognition should be customized. Group recognition fails to point out the unique and personal contribution an individual volunteer has made. Everyone is motivated by different factors and, of course, contributes in different ways. When recognizing the contribution of volunteers, it is important to understand what brought them to the organization in the first place. What goals did they set for themselves? What aspects of the organization have they shown the most interest in? What have their successes and challenges been?

Some people get a great deal of satisfaction from being part of an organization. These volunteers enjoy social recognition events where they can spend time with other volunteers. Stress that they are an invaluable part of the team, and that they make the group's work stronger.

Other people are motivated to volunteer to accomplish tasks. Appropriate recognition for these volunteers is to provide tangible evidence of their achievement – an announcement of how many individuals they have counselled or the number of presentations they have made. The goal is to let these volunteers know the affect they are having.

There are also people who enjoy being recognized for their talents and accomplishments. They like being thanked, given gifts, and singled out for achievement. Consider publishing their names in the organization's newsletter or posting certificates in a public place recognizing their achievements. Be sure to get the volunteer's permission to do this ahead of time.

### **Recognition Tips:**

1. Say thanks. It's free, easy and the results can be pure magic.
2. Surprise your volunteers. Deliver some gesture of appreciation they don't expect.
3. Pay personal attention to volunteers. Take some time to get to know what is happening in their lives, and then make an effort to ask them about it the next time you see them.
4. Offer small rewards such as tickets to a movie.
5. Give the volunteer a written testimony from spectators, staff and important people in the community who have noticed their contributions.
6. Host a volunteer party or have a recognition ceremony.
7. Give volunteers a T-shirt or other tangible recognition item.
8. Consider ways to recognize each person publicly within peer group settings and via school and community newspapers, church or synagogue bulletins, etc.
9. Make sure that snacks are always available at volunteer meetings, training sessions, etc.

### **Mentorship**

Another group of volunteers enjoy leadership opportunities. They can be recognized by appointing them to mentorship positions. They can be involved in training new volunteers or can provide input and advice on how to improve the SRH counselling program. These volunteers will excel at helping improve teen clinic services.

## BUDGETING FOR PROGRAM ACTIVITIES

Each of the coordinating functions outlined throughout this section costs the organization. Running a successful volunteer program requires a financial commitment from the agency. When the decision is made to include volunteer SRH counsellors as part of the adolescent health services program, appropriate consideration and planning should be done to ensure volunteer activities are properly budgeted for. The following list provides budget items to include as part of the overall volunteer program:

1. Human resource costs
  - a) salary/benefits of volunteer management staff
  - b) salary/benefits for support staff
2. Operating expenses (ongoing)
  - a) volunteer recruitment/marketing
  - b) volunteer screening and cost of criminal record, child abuse registry and driver/vehicle licensing checks
  - c) volunteer orientation and training
  - d) volunteer recognition
  - e) staff education/ongoing professional development
  - f) telephone/voice mail/cell/pager
  - g) IT maintenance
  - h) volunteer management software licences and support contracts
  - i) rent, heat, lights
  - j) office supplies
  - k) travel – parking and mileage
3. Operating Expenses (one time)
  - a) IT/communication equipment
  - b) office furniture

## RESOURCES

- ✎ Sample letter of introduction
- ✎ Sample volunteer application
- ✎ Sample volunteer SRH counsellor job description
- ✎ Sample volunteer agreement
- ✎ Sample evaluation checklist
- ✎ Sample volunteer evaluation form

## ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH (SRH) COUNSELLOR SAMPLE LETTER OF INTRODUCTION

*(Adapted from Women's Health Clinic — Birth Control Unplanned Pregnancy Counselling Program)*

Greetings:

Thank you for expressing interest in the Adolescent Sexual and Reproductive Health Education/Counselling Program. I am enclosing information we hope will be useful in your decision to volunteer with our clinic.

The next training to become a sexual and reproductive health (SRH) counsellor will be held

---

(DATE)

The volunteer training program places a great emphasis on group participation. We use both small and large group discussions to explore personal views, experiences and provide a social overview on each of the topics addressed. Throughout the whole training program, we will use role playing and case studies to practise the skills and knowledge needed for counselling sessions.

Part of the training program includes a minimum of three observation counselling sessions with trained volunteers. During these sessions, you will observe clients being counselled about SRH options. These sessions are essential to training and will allow you to see how the theory and technical information is incorporated into a counselling session.

After the training program, you will be counselling with trained volunteer counsellors. You will counsel with another volunteer counsellor until you are approved to counsel on your own. This process takes approximately eight weeks.

Because the role of counsellors at this clinic require clients to feel safe and secure, we do a pre-employment security check on all volunteers and staff. Volunteers are requested to submit to a criminal record check and child abuse registry check before they begin their volunteer work. Information about the security checks will be given during the screening interview.

You will be trained to work from a client-centred counselling model. This non-judgmental counselling approach empowers clients to make informed choices. As a counsellor, you will provide clients with the information and support they will need to make decisions about a variety of SRH issues.

Your counselling work will involve, for the most part, individual counselling sessions, although at times, our clients will bring along a partner, friend or parent. A typical birth control session involves discussion about birth control methods, how to use them and where to get them. In the context of birth control, you will also address prevention of sexually transmitted infections (STI), including HIV/AIDS; as well as relationship and sexuality issues. During pregnancy options counselling sessions, you will help clients discuss their feelings about pregnancy, relationship/sexuality issues and their feelings and thoughts about the options available. In keeping with the agency's pro-choice policy, we will provide all the information, referrals and support they need to decide to either continue with the pregnancy/and parent, choose adoption or have an abortion.

### **How much time will I be volunteering?**

Volunteers of the SRH counselling program volunteer approximately 15 to 18 hours a month. The volunteer commitment includes:

After completion of the training program you will be expected to do a three-hour shift each week and any additional follow-up phone calls that are necessary (approximately 1/2 hour per week).

Approximately eight to nine times per year there is a two-hour volunteer meeting and training session held in the evening. This provides us with a forum to get together to discuss current counselling issues and procedures and update new information. You are expected to attend at least 50 per cent of scheduled volunteer meetings.

We request a one-year commitment from volunteers. Your one-year commitment begins when the training program is completed.

If you are interested in participating in the volunteer training program to become a SRH counsellor, or have further questions please feel free to contact us. An initial interview is required before the training to discuss in more detail the various aspects of the volunteer counselling program. You will receive a reminder letter before the next training session with the start date and when to call to set up an interview.

We appreciate your interest in our volunteer program and look forward to meeting you!

Sincerely,

# SAMPLE VOLUNTEER APPLICATION FORM

(Adapted from Winnipeg Regional Health Authority Volunteer Services)

Date: \_\_\_\_\_

Mr.  Ms.  Mrs.  Miss

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. No. \_\_\_\_\_

City/Town: \_\_\_\_\_

Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Email: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Business \_\_\_\_\_ Other (cell/fax): \_\_\_\_\_

I prefer to receive calls at:  Home  Business Best **Time:** \_\_\_\_\_

Are you 18 years of age or older?  yes  no

**Education:** Formal education is *not* required to be a volunteer. We welcome experience of all kinds!

	Name of school	Course of study	Start/end dates
High School			
Post secondary – college/university			
Professional training			
Trade or business			
Other			

Are you receiving credit for your volunteer work?  yes  no

Required number of hours \_\_\_\_\_ By when? \_\_\_\_\_

What school or organization do you require the hours for? \_\_\_\_\_

### Employment History

Company name/Employer	Your job title	From (M/Y)	To (M/Y)	Status (full or part-time, retired)

**Your volunteer work.** Please list organizations in your community that you're involved with including community clubs, schools, religious organizations, professional associations, non-profit organizations, sporting organizations, etc.

Organization	Your responsibilities	From (M/Y)	To (M/Y)	Reason for leaving

Have you ever applied to volunteer with this organization before?  yes  no

When? \_\_\_\_\_

**Is there a specific volunteer role that you are interested in? If yes, please describe:**

\_\_\_\_\_

\_\_\_\_\_

**Check  the community area(s) or location(s) where you would prefer to volunteer:**

- |   |  |                                     |
|---|--|-------------------------------------|
| <input type="checkbox"/> St. James / Assiniboia | <input type="checkbox"/> St. Boniface  | <input type="checkbox"/> St. Vital  |
| <input type="checkbox"/> Assiniboine South      | <input type="checkbox"/> River East    | <input type="checkbox"/> Ranscona   |
| <input type="checkbox"/> Fort Garry             | <input type="checkbox"/> River Heights | <input type="checkbox"/> Seven Oaks |
| <input type="checkbox"/> Inkster                | <input type="checkbox"/> Point Douglas | <input type="checkbox"/> Downtown   |

Other/specific location \_\_\_\_\_

**Check  your reasons for volunteering.**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Academic credit            | <input type="checkbox"/> Learn new skills      | <input type="checkbox"/> Practise English skills          |
| <input type="checkbox"/> Confirmation requirement   | <input type="checkbox"/> Help others           | <input type="checkbox"/> Referred by medical professional |
| <input type="checkbox"/> Employment experience      | <input type="checkbox"/> Improve health care   | <input type="checkbox"/> Stay active and involved         |
| <input type="checkbox"/> Explore careers            | <input type="checkbox"/> Social interaction    | <input type="checkbox"/> Increase self esteem             |
| <input type="checkbox"/> Relative/friend volunteers | <input type="checkbox"/> Other (specify) _____ |   |

**Check  how you found out about our volunteer program.**

- |   |  |  |                                    |
|---|--|--|------------------------------------|
| <input type="checkbox"/> Physician              | <input type="checkbox"/> School                        | <input type="checkbox"/> TV                          | <input type="checkbox"/> Community |
| <input type="checkbox"/> Newspaper              | <input type="checkbox"/> Volunteer centre              | <input type="checkbox"/> Volunteer                   | <input type="checkbox"/> Radio     |
| <input type="checkbox"/> WRHA newsletter        | <input type="checkbox"/> Referral organization         | <input type="checkbox"/> Previously a patient/client |                                    |
| <input type="checkbox"/> Poster/brochure/flyer  | <input type="checkbox"/> Recruitment/information booth |  |                                    |
| <input type="checkbox"/> Employee of WRHA       | <input type="checkbox"/> Internet                      | <input type="checkbox"/> Relative/friend             |                                    |
| <input type="checkbox"/> Previously a volunteer | <input type="checkbox"/> Other (specify) _____         |  |                                    |

Please check  the preferred time period(s) that you are available to volunteer FOR THE NEXT THREE MONTHS. **Please specify the times you would arrive for your shift and have to leave.**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	<input type="checkbox"/>						
Morning	<input type="checkbox"/>						
Afternoon	<input type="checkbox"/>						
Evening	<input type="checkbox"/>						

How many times per week would you like to volunteer?

- one shift    2-3 shifts    4 or more

Are you interested in volunteering for special projects or events?  yes    no

Are there times of the year you are not available to volunteer? (ex: vacation) \_\_\_\_\_

**Who would you like us to contact in case of an emergency?**

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

## References

Please list **three current** references such as past /present employers, teachers/ instructors, youth group leaders, colleagues or a supervisor from a volunteer experience. We **do not accept** family members or personal friends as references **unless you were employed by them**. We **do accept** signed reference letters that are current and on the organization's letterhead.

Name	Organization	How do you know this person?	Phone No. Day/Evening	Fax No.
1.				
2.				
3.				

I hereby authorize \_\_\_\_\_ to contact the named references about my suitability as a volunteer. I hereby release \_\_\_\_\_ from all liability for any damage from releasing this information. I further authorize \_\_\_\_\_ to keep this information in their records and release and absolve them from all liability that may otherwise accrue from their keeping this information and using it for their purpose. **Disclaimer:** It is the policy of this organization to screen all prospective volunteers. While we try to place every prospective volunteer, management reserves the right to reject applicants who do not meet our requirements and/or placement criteria.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

## What to expect when you apply to become a volunteer

### STEP 1 • APPLYING

- Applying to volunteer is much like applying for a job. We take many factors into consideration before accepting volunteers. Because we take our responsibility for clients/patients seriously, we screen all applicants thoroughly. Completing your application as thoroughly as possible will help us assess your suitability for volunteering in a teen clinic.
- When you complete the application be sure to provide three current references with correct phone numbers.

### STEP 2 • THE INTERVIEW

- Once our office receives your application, a staff member will call you to arrange a date and time for an interview.
- The interview is one of our ways of finding out more about you and your interests.
- During the interview, feel free to ask any questions you may have about volunteering.
- We will also discuss expectations of volunteers and the importance of confidentiality.

### STEP 3: • SCREENING

- After your interview, a staff member will contact your references.
- Depending on the volunteer roles you are interested in, a criminal record check and/or a child abuse registry check may be required. You will be notified of any required checks during your interview.

### STEP 4 • TRAINING AND ORIENTATION

- If a successful match is made between your skills and abilities and our organization's requirements, you will be offered a volunteer position. If you decide to accept, you will be enrolled in volunteer training.
- If you are a student getting credit hours for your volunteering, it is your responsibility to track your hours to ensure you are meeting your school's hour requirements.

# ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH (SRH) COUNSELLOR VOLUNTEER JOB DESCRIPTION

*(Adapted from Women's Health Clinic – Birth Control Unplanned Pregnancy Counselling Program)*

## **Duties and responsibilities:**

1. to provide non-judgmental information and support and an opportunity for clients to discuss their options and make a decision about birth control, safer sex or pregnancy options
2. to ensure pregnancy tests are done and results provided to client
3. to make appropriate referrals and be an advocate for the client when required
4. to conduct follow-up phone calls to pregnant clients when appropriate
5. to read the communication log, appointment book and check mail slots regularly
6. to stay updated on agency's policies and procedures
7. to keep adequate records (ex: medical charts, stat sheets)
8. to get own replacement when unable to make a shift (exception is when the volunteer is too ill to make phone calls)
9. to keep work area tidy

## **Skills and qualities:**

1. mature, empathetic, compassionate and non-judgmental
2. genuine concern for people
3. flexible in approach to people
4. capable of identifying and coping with own feelings and able to support others to do the same
5. able to support agency's pro-choice policies and harm reduction approach to health care and counselling
6. willing to work with adolescents

### **Training and supervision:**

1. approximately 60 hours required for volunteer training
2. commitment to work for one year (which includes one three-hour shift per week) and attending 50 per cent of the scheduled volunteer meetings
3. pre-employment security checks, which includes criminal record check and child abuse registry check

### **Supervision:**

Volunteers are directly responsible to the co-ordinator of volunteers and will receive ongoing supervision and evaluation from both the core volunteers and co-ordinator.

### **Evaluation:**

Volunteers will be evaluated after the initial 10 clients seen in counselling and then annually.

### **Termination:**

If a volunteer decides to leave the program after the initial one-year commitment, he/she must notify the co-ordinator of volunteers as soon as possible.

# ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH VOLUNTEER SAMPLE VOLUNTEER AGREEMENT

*(Adapted from Women's Health Clinic – Birth Control Unplanned Pregnancy Counselling Program)*

Welcome to the teen clinic SRH counselling program. We rely on the help of our volunteers. We appreciate your participation and hope your work with us is fulfilling and helpful in your personal growth.

To best serve the needs of our clients, it is important that you be responsible and maintain the trust we have put in you. Therefore, we ask you to consider the directives below:

1. I will keep all client and agency information confidential.
2. I will work one shift per week (approximately three hours). This includes making appropriate referrals and client follow-up phone calls (approximately 30 to 60 minutes per week) for at least one year. The one-year commitment begins when training program ends.
3. I will attend at least 50 per cent of the scheduled two-hour volunteer meetings and training held for the SRH counselling program.
4. I will be responsible for finding my own replacement if I am unable to come to my regular shift and will notify my supervisor. An exception to finding a replacement is when the volunteer is too ill to make phone calls.
5. I will undergo a pre-employment security check, which includes a criminal record check and child abuse registry check, before I begin my volunteer work.
6. If I do not fulfill these commitments, I am aware that my status as a volunteer will be reviewed.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

# ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH VOLUNTEER COUNSELLING EVALUATION CHECKLIST

*(Adapted from Women's Health Clinic – Birth Control Unplanned Pregnancy  
Counselling Program)*

This form is for feedback on newly trained volunteers and for yearly volunteer evaluations.

When observing the counselling session, the observer considers the following areas:

- Does the counsellor address agency policies and philosophy at the beginning of the session?
- Does the counsellor establish a comfortable atmosphere for the client? (ex: openness, approachable, supportive).
- Is the attitude toward client empathetic, respectful, genuine, non-judgmental? Does the counsellor check out the client's perceptions?
- Is there good use of communication skills? (ex: open-ended statements, perception checks, attending behaviour, non-verbal communication, comfort with silence)
- Is there exploring problems, summarizing, focusing, exploring balance between addressing both feeling and information in the counselling sessions?
- Does the counsellor address support available to the client? (ex: family, partner, peers, etc.)
- Does the counsellor explore spiritual/cultural/religious issues (if applicable)?
- Does the counsellor have a good working knowledge of the counselling model and process? (ex: identifying feelings, resources and alternatives, contracting, wrap-up)
- Does the counsellor address relationship and sexuality issues with the client?
- Does the counsellor address HIV and STI prevention information and safer sex practises?
- Does the counsellor have a good working knowledge of birth control information?
- Does the counsellor address a birth control plan with the client?
- Does the counsellor provide appropriate resource materials to the client?
- Does the counsellor discuss opportunities for follow-up?

- Does the counsellor have a good working knowledge of therapeutic abortion procedures and after-care instructions?
- Does the counsellor address various steps in the TA referral process?
- Is the counsellor aware of referral procedures when dealing with the various options available for clients continuing with pregnancy, both parenting and adoption? Does the counsellor know where in the clinic the information can be found?
- Does the counsellor have a good working knowledge of charting procedures?

\_\_\_\_\_  
Volunteer  
(First and last name)

\_\_\_\_\_  
Observer  
(First and last name)

\_\_\_\_\_  
Date

Able to counsel independently for:  birth control  pregnancy options

# ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH VOLUNTEER SRH VOLUNTEER EVALUATION FORM

*(Adapted from Women's Health Clinic – Birth Control Unplanned Pregnancy Counselling Program)*

The evaluation process involves self-evaluation by the volunteer filling out this form. Bring the completed form to the evaluation counselling session. The evaluation session is done with a volunteer observer.

Volunteer: \_\_\_\_\_

Date of birth control counselling session: \_\_\_\_\_

Observer: \_\_\_\_\_

Date of pregnancy options counselling session: \_\_\_\_\_

Review for:  after 10 clients       yearly

## Section A:

The following questions are to be completed by the volunteer. Answer the following questions about yourself. Circle the most appropriate number.

1. In your SRH education/counselling, how confident do you feel about your ability to:

	Not very confident		Very confident	
identify the client's feelings	1	2	3	4
explore client concerns and issues	1	2	3	4
explore options and resources	1	2	3	4
contract and wrap-up	1	2	3	4
balance discussion between feelings and information	1	2	3	4

2. How comfortable / satisfied are you with:

	Not very confident		Very confident	
communication skills	1	2	3	4
use of open-ended questions	1	2	3	4
non-verbal communication (dealing with silence)	1	2	3	4

	Not very confident		Very confident	
ability to check out perceptions	1	2	3	4
paraphrasing and summarizing	1	2	3	4
attitudes:				
ability to be empathetic/compassionate	1	2	3	4
ability to be respectful	1	2	3	4
ability to be non-judgmental	1	2	3	4

What would help you improve your skills/attitudes? \_\_\_\_\_

---



---

3. How comfortable are you with your working knowledge of the STI/HIV prevention information you discuss in an education/counselling session?

Not comfortable Very comfortable

1 2 3 4

What would help you develop your skills in this area? \_\_\_\_\_

---



---

4. How comfortable are you discussing various sexual practises (ex: oral sex, anal sex) and strategies to reduce the harm/risk of high risk sexual activities?

Not comfortable Very comfortable

1 2 3 4

What would help you increase your comfort in this area? \_\_\_\_\_

---



---

5. How often do you offer your client the opportunity for follow up in counselling?

Not often Frequently

1 2 3 4

What are your reasons for not offering your client follow up? \_\_\_\_\_

---



---

6. How aware are you of community resources and the appropriate referral process?

Not aware

Very aware

1

2

3

4

What would help you develop your skills in this area? \_\_\_\_\_

---

---

7. How satisfied are you with your ability to carry out the various SRH education/ counselling procedures such as charting, what to do with a completed chart, internal referral to counselling, etc.?

Not satisfied

Very satisfied

1

2

3

4

Suggestions for improvement? \_\_\_\_\_

---

---

8. Do you feel you are receiving the support/help you need from:

other volunteers

yes  no

clinic staff

yes  no

co-ordinator of volunteers

yes  no

Suggestions for improvement: \_\_\_\_\_

---

---

9. Do you feel you have enough opportunity to debrief your SRH counselling sessions?  yes  no

Suggestions for improvement: \_\_\_\_\_

---

---

10. How often do you attend agency training sessions?

Never

Frequently

1

2

3

4

Are they useful?  yes  no

Any comments or suggestions: \_\_\_\_\_

---

---

11. How satisfied are you with your volunteer experience?

Not satisfied

Very satisfied

1

2

3

4

Suggestions for improvement? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Section B:

Self evaluation. Please list your strengths and areas for improvement for SRH counselling.

Strengths – Birth control counselling	Areas for improvement – Birth control counselling

Strengths – Pregnancy options counselling	Areas for improvement – Pregnancy options counselling

**Observer feedback:**

After the session has been completed, please have the observer complete the following sections.

<b>Strengths</b> – Birth control counselling	<b>Areas for improvement</b> – Birth control counselling

<b>Strengths</b> – Pregnancy options counselling	<b>Areas for improvement</b> – Pregnancy options counselling

After completing and signing this form, please return it to the co-ordinator of volunteers.

Signatures:

\_\_\_\_\_

Volunteer

\_\_\_\_\_

Observer

## GETTING STARTED

The following sections present information to help organizations plan and train for adolescent sexual and reproductive health (SRH) volunteers. For volunteers to feel confident in their roles as health educators and counsellors, it is important to provide them with the core skills needed to carry out their roles effectively. The following sections offer a complete training curriculum that can be conducted in a group setting.

### Using the curriculum

The curriculum has 10 modules. Each covers specific skills or topics, starting with core skills that are commonly required by any SRH volunteer and continuing on to information on various aspects of adolescent SRH. All volunteers who will be involved in providing health education or counselling should be offered core skills training. This includes information on important aspects such as communication, diversity, confidentiality and counselling skills. The remaining modules may be combined or adapted to accommodate the agency's needs and timelines.

### Adolescent SRH volunteer training modules

- Core skills
  - communication skills
  - working with diversity
  - confidentiality
  - harm reduction
  - volunteer counselling techniques
  - crisis intervention
- values and sexuality
- adolescence and reproductive health
- sexual identity
- sexual decision making
- dating violence
- contraception
- pregnancy options counselling
- sexually transmitted infections (STI) and HIV/AIDS

## FACILITATION TECHNIQUES<sup>1</sup>

This section presents a brief overview of some training concepts and techniques. In particular, it has information to consider for training adult volunteers (18 years and older). It is intended for use by trainers who have little or no previous experience and is not in any way intended as a definitive course in instructional theory. Some of these suggestions may help facilitators' technique with their training sessions.

*Volunteer training participants are often motivated by the need to:*

- achieve practical goals
- achieve personal satisfaction
- gain new knowledge
- achieve formal educational goals
- socialize with others or escape from everyday routine
- achieve societal goals

*Training participants usually like to:*

- Apply what they learn shortly after learning it. They are pragmatic and goal-oriented.
- Learn concepts and principles in addition to facts. They want to see the whole picture and have tools they can use to apply their learning to new and different situations.
- Help set goals and objectives. They are self-directed.
- Receive feedback so they can evaluate themselves. They want to know how they are doing.
- Be valued for their knowledge and past experiences.
- Make good use of their time. They are busy people who do not have time to waste.

Some common principles when training adults include:

- Emphasize discussion and interactive learning. Avoid lecturing.
- Make content and materials closely fit the student's needs.
- Use interactive methods (case studies, role-playing, etc.) to help participants learn by using their own experience and the experiences of others.

---

<sup>1</sup>AIDS Committee of Toronto, *National HIV/AIDS Volunteer Training Kit*

- Allow plenty of time to process the learning activities.
- Include opportunities for participants to apply their learning to real-life situations.
- Use demonstrations to show both how to do something and how **not to do it**.
- Learning is aided by using hands on practice rather than lectures.

## Adult learning principles

Adult students are partners with the facilitator in the learning. Participants should actively influence the learning agenda as much as possible. In designing training programs, trainers should acknowledge that participants are capable of taking responsibility for their own learning and, where appropriate, incorporate self-directed learning activities in the course design.

People learn best when they are treated with respect. Throughout the training process, it is important to encourage questions while affirming the experience of the participants. A safe environment that is informal and personal supports learning and sharing. Sessions should take advantage of any opportunity to promote getting acquainted and interpersonal connections with other participants. Using small groups throughout the training helps participants develop trust and confidence.

The abilities of adult students are important in deciding what can be learned and how long it will take. Trainers should know their audiences. Consider the complexity of the learning and the time the participants need to be successful. This affects the order of presentation materials to be delivered. Points presented at the beginning and end of the message are remembered better than those in the middle. If four points are to be discussed, the two most important points should be presented first and last. The ability to retain information should also be considered. For example, the rate of forgetting tends to be very rapid immediately after learning, so repeat the training message. It usually takes a lot of repetition in a session to overcome rapid forgetting. Repetition of identical materials is often as effective in helping memory as repeating the same story with variations.

A message is more easily learned and accepted if it does not interfere with earlier habits. A training theme that draws on prior experiences of the participants will help. The mere repetition of a situation does not necessarily lead to learning. Two things are necessary: belonging and satisfaction. Belonging means that the elements to be learned must seem to belong together and must show some form of relationship or sequence. Satisfaction is found in real or symbolic rewards, rather than annoying consequences.

### *Creating a positive learning environment*

A creative environment:

- creates curiosity so that participants will want to pay attention
- holds participants' attention
- helps participants feel good about mastering material and learning new skills
- makes sure that material is perceived as useful
- helps participants feel confident by creating mutual trust

Studies in memory retention indicate that people retain:

- 10 percent of what they read
- 20 percent of what they hear
- 30 percent of what they see
- 50 percent of what they see and hear
- 70 percent of what they say
- 90 percent of what they say and do

### **Learning Objectives**

#### *Cognitive (thinking) objectives*

Cognitive objectives describe what changes are intended in knowledge. These objectives are described as lower or higher level cognitive objectives.

Lower-level cognitive objectives include:

- fact: accumulation of pieces of information
- comprehension: understanding those pieces of information

Higher level cognitive objectives include:

- application: being able to use the information
- analysis: being able to separate the information into smaller pieces
- synthesis: being able to put pieces of the information together to form a new idea
- evaluation: being able to assign worth, value or significance to the information

### *Attitude objectives*

Attitude objectives define what participants are intended to feel, value or believe. They address low, medium or high levels of change.

### *Skill objectives*

Skill objectives describe changes in performance. These are sometimes called behaviour or psychomotor objectives.

## **Matching learning objectives to instructional techniques**

To determine the ideal instructional technique for a particular learning objective, consider the desired result.

<b>If the learning objective is:</b>	<b>Use:</b>
fact	lecture
comprehension	lecture
application	activity
analysis	group discussion
synthesis	group discussion
evaluation	group discussion
skills building	demonstration and student practise

Students cannot achieve higher-level cognitive objectives unless lower levels have been met. An idea cannot be understood if basic facts are not known and understood. Analysis or synthesis cannot occur without knowing and understanding the facts and being able to use or apply them. Students cannot evaluate information if they cannot analyze and synthesize it.

It may be necessary to add a lecture to an activity. Begin with a lecture to make sure the participants know and understand the material. Then, in a group discussion or simulation exercise, provide an opportunity to apply, analyze, synthesize and evaluate the information.

*A comparison of instructional techniques*

Technique	Characteristics	Primary Objective
Lecture	<ul style="list-style-type: none"> <li>• one-way communication</li> <li>• speedy</li> <li>• orderly exact coverage</li> <li>• total instructor control</li> <li>• no deviation from subject</li> </ul>	<ul style="list-style-type: none"> <li>• fact mastery of pre-selected material</li> </ul>
Lecture/discussion • discussion follows a lecture or is permitted throughout	<ul style="list-style-type: none"> <li>• one-way, two way</li> <li>• orderly coverage</li> <li>• controlled deviation from lecture</li> <li>• high instructor control</li> <li>• slower than lecture</li> <li>• questions and disagreements encouraged</li> </ul>	<ul style="list-style-type: none"> <li>• fact mastery of pre-selected plus additional material</li> <li>• development of logical reasoning ability and critical attitude</li> <li>• control of individual involvement</li> </ul>
Demonstration with narrative	<ul style="list-style-type: none"> <li>• one-way, two-way communication</li> <li>• orderly coverage plus physical performance</li> <li>• high instructor control</li> <li>• errors immediately seen and corrected</li> <li>• can be adjusted to learning speed of participants</li> <li>• follow-up desired</li> </ul>	<ul style="list-style-type: none"> <li>• mastery of physical task or routine mental or visual techniques</li> <li>• establishment of good staff/volunteer and peer working relationships</li> </ul>
Cased (decision-making, illustrative, group analysis)	<ul style="list-style-type: none"> <li>• multi-way communication</li> <li>• build around situational setting</li> <li>• medium to low instructor control</li> <li>• emphasizes explicit definition of problems and issues</li> <li>• slow</li> <li>• involves questions, disagreement, emotional involvement</li> </ul>	<ul style="list-style-type: none"> <li>• logical reasoning ability and critical attitude</li> <li>• problems</li> <li>• recognition of areas of information gap</li> <li>• development of individual and group decision-making ability</li> <li>• development of perception and empathy</li> <li>• communication of ideas to others</li> </ul>

Technique	Characteristics	Primary Objective
Role Play <ul style="list-style-type: none"> <li>participants become actors in a sequence of activities that are followed by discussion</li> </ul>	<ul style="list-style-type: none"> <li>multi-way communication; partially controlled</li> <li>realism depends on skill of actors</li> <li>low instructor control</li> <li>encourages emotional involvement in the situational setting</li> <li>slow</li> </ul>	<ul style="list-style-type: none"> <li>development of perception and empathy.</li> </ul>
Incident process <ul style="list-style-type: none"> <li>one incident or some limited information is introduced</li> <li>the participants then use questions to uncover additional relevant information</li> </ul>	<ul style="list-style-type: none"> <li>two-way communication</li> <li>partially controlled</li> <li>questioning attitude</li> <li>slow</li> </ul>	<ul style="list-style-type: none"> <li>Teaches importance and difficulty in obtaining material</li> <li>teaches orderly, logical decision making.</li> </ul>

### *Introducing an exercise*

Never lead an exercise cold. Always practise with a large group of peers to iron out wrinkles and avoid surprises. You may find a crucial piece was left out or the instructions are too confusing. Alternatively, you may feel uncomfortable facilitating a particular exercise. Find this out during a trial run and, if necessary, find one you're more comfortable with. Allow participants the option of participating or not - no one wants to feel coerced. Don't pressure people to tell how they feel. Give crystal clear instructions: "This is what you'll do." "This is where you'll go." "This is how we'll debrief at the end." Many adult students need to know the entire process before they can comfortably participate in it.

## **OVERVIEW OF COMMON PARTICIPATORY EXERCISES**

### **Processing**

Participants may use small groups to discuss the emotional (or other) effects of an exercise. Discuss responses with participants in the large group (the whole group is also sometimes called the plenary). Focus on strategies and what to do with the emotions. Beware of a cute and clever style. Participants may get offended or misunderstand you. Acknowledge input by recording thoughts and feelings on flipcharts and discussing.

## **Debriefing**

Review the purpose of the exercise. Sum up participants' experiences. Thank them for their participation. Discuss how the exercise can be used or modified in other situations. Whenever possible, be flexible, confident and maintain a high energy level.

## **Demonstrations**

Use demonstration and practice to address skill objectives. In this method, participants are provided with opportunities to observe, practise and perform.

## **Group discussion**

Know the general topic well and have a list of possible issues in mind. Define the topic so that it is clear and real. Use common experiences from the world of the participants. Act as a facilitator, listen to others, encourage and recognize contributions and provide a summary or conclusion. Ask questions and encourage participants to ask questions while inviting participants to answer questions.

To stimulate discussion: describe a problem or present a case or initiate a simulation exercise or role play. Always think about creating an environment that encourages group discussion. This includes showing your own self-awareness and personal openness. Respond to comments in a non-judgmental way without implying agreement with every view expressed. Try to create an overall atmosphere of mutual respect and trust. Demonstrate comfort with participants from different backgrounds and with different abilities. Try to challenge participants without being intimidating or threatening. Remain alert and pay attention to the process and content of the discussion.

Throughout the discussion, be aware of what is not being said by observing body language, silences and signals of group discomfort. This is one component of active listening.

### **Tips for leaders of group discussions**

- If a person's non-verbal cues indicate disagreement with what another person is saying, ask for his/her point of view.
- If a person tells an irrelevant story, ask others if they can relate it to what is being discussed.
- After asking a question, tolerate silence while others are thinking. Facilitators should not answer their own questions.

- Share in the learning process. Let the participants know when their discussion has broadened the facilitator's knowledge.
- Group discussion can help deal with negative attitudes. Peer pressure can often instigate attitude change.
- Use a summary statement to close a discussion.
- Participants should be aware of the goals for the session and encouraged to share attitudes, feelings and ideas about it. A wide variety of attitudes, feelings and ideas will be expressed; differences should be accepted as legitimate and valuable.
- Participants should be aware of the elements of the group process and should understand the meaning of shared leadership.

## Role playing

When role playing, participants step out of their own characters and assume the role of someone else in a defined situation. The result should not be pre-planned. The effect of each role player's behaviour in that situation should be analyzed in relation to the overall objective or goal of the exercise.

- Participants should have time to plan their roles.
- Participation should be voluntary. Some adults absolutely hate role playing. These people should be encouraged to join in, but never forced to participate.
- Volunteers should assume their roles in front of the group. "They step out of their roles when the others give them applause; or when they rejoin the group, remove their name tags, and assume their own identity."
- Role playing should continue only as long as needed to establish the situation and illustrate the behaviour to be analyzed by participants and observers.
- All group members should share their feelings and observations with each other about the roles.

## Case study

An alternative to role playing in which participants are provided with a scenario is a case study to review and discuss. Rather than acting out roles, participants are asked to work together to identify a suitable response, solution or approach to the case study problem or issue.

## **Fishbowl**

Part of the group sits in the front or middle of the room and discusses a specific topic while the rest of the group observes and listens silently. The discussion should have a time limit.

At the end of the time, all group members analyze and evaluate the discussion. If desired, the process can be repeated with another portion of the group.

### **Tips for using flipcharts**

- Use flipcharts to note questions, highlight points of discussion, sketch diagrams and list input from participants.
- Flipchart pages can be torn off and taped on the wall to save for later discussion.
- Check visibility from the back of the room.
- Keep words simple and print or write neatly.

## **Brainstorming**

This technique is used to generate as many different ideas as possible on a specific topic within a given time limit, usually five to ten minutes. All group members are challenged to think of as many ideas as possible. As fast as ideas are voiced, they are recorded by the facilitator without comment by any members of the group. At the end of the time period, the group goes back over the ideas to sort them and discuss.

## **Eliciting**

This technique involves drawing information out of participants using guided, pointed questions. It is different than brainstorming because when eliciting, the facilitator usually knows the outcome and tries to get participants to discover it for themselves. Eliciting requires very skillful use of questions.

## **Simulations**

A simulation is a model of reality focusing on particular aspects to bring new insights. Simulations may take the form of games or other activities that imitate a real situation. Simulations usually allow participants to cognitively and emotionally experience the interrelatedness between various elements of a situation or issue. Simulations can be very structured and complicated or very informal, depending upon the intent.

They should always be led by someone experienced, who understands their dynamics and underlying goals. Simulations can easily reinforce existing stereotypes and myths if not handled carefully.

## **Lecture**

When using lecture (didactic) presentations, do not present too many points. Six major points are probably enough for half an hour. Before starting, explain when questions should be asked: any time, at the end, at certain intervals, etc. Introduce the topic by specifying what will be presented, how long it will take and how you will proceed with it. This helps participants anticipate events, prepare for change in pace or technique and direct their energies accordingly. Summarize the content both at the beginning and the end. During the lecture, pause occasionally to give listeners a chance to catch up and summarize for themselves. Careful use of visual aids can help support points. Handouts should be provided either before or after the presentation. If you're giving the handouts after the lecture, tell them so they'll listen to you instead of taking notes.

Mix activities so participants are alternately passive (sitting, hearing, seeing) and active (problem-solving, writing, constructing, discussing, moving, walking, speaking).

Present new material in a logical sequence, step-by-step, relating it to familiar and known material (such as readings, previous discussions, participants' own experience, etc.). Keep changing the pace; move around; speak from the different areas of the room; use gestures and body movement to support what you are saying; and change the tone of your voice. Pauses and moments of silence can be used for reflection, questions, concentration, etc.

Use the following guidelines for good lectures:

- Know the subject thoroughly.
- Explain the purposes, objectives and relevance of the subject.
- Follow an organized and logical sequence.
- Maintain eye contact with participants.
- Speak clearly and with appropriate vocabulary.
- Illustrate the main points with appropriate examples.
- Allow opportunities for participants' questions and opinions.
- Use appropriate audio-visual materials.
- Repeat main points during the lecture.
- Summarize main points while closing.

## PREPARING FOR VOLUNTEER TRAINING

Preparing to offer SHR volunteer training requires planning and co-ordination. Once volunteers have been selected and the training has been scheduled, it is up to the lead facilitator to make all the arrangements to ensure that the training proceeds smoothly.

Taking care of as many advance details as possible will help ensure sessions go smoothly.

### **Space:**

- Training should be held in a central, accessible location.
- Make sure all participants are aware of the location as well as any other information, such as where to park.
- Make sure there are washrooms nearby that are wheelchair accessible.
- Set up the room according to your own preferences. Most commonly, participants are seated in a circle to ease conversation and interaction.

### **Materials:**

- Have light snacks and beverages available at every training session.
- Review your agenda and consider ahead of time what equipment is required for the session including flipcharts and paper, markers, masking tape, name tags, paper, pens, copies of handouts and presentations, LCD projector for electronic presentations, etc.

### **Guest speakers or presenters:**

- If you invite guest speakers, be sure you talk to them ahead of time to co-ordinate the session together.
- Clearly specify how much time they will have to cover the topic, what you hope participants will get out of it, how many participants will be present, etc.
- Have a thank-you card or small gift to present to the guest speaker after the session.

### **Evaluations:**

- Each session should include an opportunity for participants to evaluate the session itself.
- Evaluation can be done verbally and in writing. Verbal evaluations should take place at the end of the session with all participants being given opportunity to provide their feedback or feelings about the session.

- Not all participants will be comfortable giving feedback verbally. Written anonymous evaluations allow participants to provide their feedback privately.
- Evaluation forms should be brief. Only ask questions you want answered and that you are prepared to do something about.
- Evaluations should be reviewed after each session and used to adapt further training sessions as appropriate.

### Evaluation Form

## TYPICAL TRAINING SESSION

The following is a suggested format that should be adapted by facilitators to suit their personal preferences and/or styles. Activities and length of time will vary depending on topic, size of group etc.

- welcome and introductions
- beginning exercise (check-in or ice breaker)
- review day's agenda
- activity and/or discussion
- break
- activity and/or discussion
- debrief topic
- wrap up exercise (check-out or closing activity)
- evaluations

### *Using beginning and wrap-up exercises*

Beginning and wrap-up exercises are designed to provide a structured opening and closing to the training session. Beginning exercises are designed to allow participants to get to know each other better both at the very beginning of the training and as the group forms over time. As well, opening activities help put participants into the training frame of mind. Participants will be coming to the training from very different and often busy lives (work, school, family). A common beginning activity brings them together to the common goal.

The same thing applies to the closing or wrap-up exercises. Wrap-up exercises help participants wind down before leaving. They help provide closure to a training session. Some of the training modules include specific ending exercises that are geared to

wrap up the content of the module and not necessarily as a personal “wind down” for participants. It is important that participants have an opportunity, after completing the module to reconnect with each other and prepare to return to their normal lives.

*A word about timing:*

Beginning and closing exercises should be relatively brief. However, there may be times when participants want or need to share a lot of information with the group. Whether it be at the start of the session or at the end of a particularly difficult or personal session, participants may require additional time to debrief. It is up to the facilitator to assess each circumstance and determine what is best in terms of the needs of the entire group.

If there is a particular individual who seems to need more time to share, the facilitator may need to spend some time with that person one-on-one to ensure he or she is being heard without taking time away from the rest of the group.

## **ICEBREAKERS<sup>1</sup>**

The following is a series of general icebreakers. Most are designed as introductory exercises to help participants get to know each other or to feel more comfortable before beginning in-depth training.

### **Class list**

Objectives:

to learn names and begin to create a comfortable climate for working/learning

#### **Materials:**

pieces of card or sheets of paper

pens

#### **Timing :**

10 minutes

#### **Method:**

Give out pieces of paper and pens. Ask each person to create a class list: this is done by going up and greeting every other member of the group in turn, exchanging names (and perhaps where they come from) and writing their names (and any other information collected) on the sheet.

---

<sup>1</sup> AIDS Committee of Toronto, *National HIV/AIDS Volunteer Training Kit*

## **Eman**

### **Objectives:**

to encourage self-disclosure in a light-hearted and unusual way

### **Materials:**

pieces of paper  
pens

### **Timing:**

15 to 30 minutes (depends on number of participants)

### **Method:**

Give out pieces of paper and pens. Ask each person to write down their first name backwards (example: Joe = Eoj; Karen = Nerak; etc.) Ask all the participants in turn to introduce themselves to the rest of the group by making up a meaning for their name as it reads backwards (example: "I'm Linda. My name backwards is Adnil. This means that I'm like a sheep, but only in the evening.")

## **Introductions**

### **Objectives:**

to help participants get acquainted with each other and to help facilitators get to know the members of the group

### **Materials:**

none

### **Timing:**

15 to 30 minutes (depends on number of participants)

### **Method:**

Ask participants to pair off and spend about 10 minutes (five minutes for each partner) talking about themselves or listening to their partners. Ask them to return to the full group, and ask each person in turn to introduce his/her partner to the whole group.

## **My name**

### **Objectives:**

To introduce group members

### **Materials:**

none

### **Timing:**

15 to 30 minutes (depending on number of participants)

**Method:**

Start by telling the group your name and say something about it (example: how you came to be given your name; how you feel about your name; if you have a nickname and if so, what is it and why were you given it; if you have ever thought of changing your name and, if so, why; etc.) ask each member of the group to do or say something similar about their names. With a very large group, this exercise could be done with people divided into smaller groups.

**Personal name sheet****Objectives:**

To get to know other participants and to encourage self-disclosure

**Materials:**

Flipchart paper and markers  
Sample name sheet for demonstration

**Timing:**

30 minutes

**Method:**

Give each person a sheet of flipchart paper and a marker. Ask them to design a personal name sheet by writing their names in the centre of the sheets and then dividing the rest of the sheets into four squares (by drawing a line down the centre and a line through the middle so you end up with four squares). In each of the four squares, have each person record a) something they enjoy doing b) something they are good at c) something they want to learn about d) a pleasant memory (or substitute any topic you choose as long as it is casual and not heavy). Ask them to try to draw, rather than write, in each square (the intention is to try to convey the four topics in a creative and personal way). When everyone is finished, post the sheets on the wall and have everyone introduce themselves to the whole group using their name sheets.

Note: the facilitator should model a name sheet at the beginning (or have one prepared ahead of time to show).

**Scavenger hunt****Objectives:**

To learn about people in the group

**Materials:**

copies of a sheet of paper with a set of “characteristics” (see below)  
make enough copies for all participants

**Timing:**

15 to 30 minutes

**Method:**

Hand out sheets with questions/statements and tell participants their task is to find participants who have the characteristics on the sheet. Tell them they have to get one person to write his/her name beside each of the characteristics and that a name can only be used once. The goal is to fill as much of the sheet with as many different names as possible.

Characteristics to print on the sheets could include: a) someone who has a birthday in January b) someone who has travelled to another country c) someone who was born in another country d) someone who has a partner/significant other e) someone who has children f) someone who was born in the city/town where you are conducting the training g) someone who doesn't know how to drive a car h) someone who has volunteered before i) someone who has seen/read a current movie/book (write in a topical name), etc.

Note: the characteristics should be general enough that some of the people will actually have done such things but not so common that every person will have.

## WRAP-UPS<sup>1</sup>

The way a session ends is as important as the way it starts. If participants have been working in small groups, they need an opportunity to come back together and hear what others have been doing. It is also important that people go away aware of what they have learned. Here are some suggestions for rounding off or winding down a training session.

### One thing I am taking away

**Objectives:**

Have participants share what they have learned.

**Materials:**

none

---

<sup>1</sup> AIDS Committee of Toronto, *National HIV/AIDS Volunteer Training Kit*

**Timing:**

15 - 30 minutes (depending on number of participants).

**Method:**

Have each person in the group share what he/she has learned during the session or something they are going to take away with them.

**What next?****Objectives:**

Have participants identify how they will use what they have learned.

**Materials:**

flipchart and markers.

**Timing:**

15 - 30 minutes (depending on number of participants).

**Method:**

Ask participants to consider what they have gained from the session. Ask them to identify their next steps personally and professionally and the support they will need to do them. It may be most appropriate to leave this unstructured or you may want to put a series of questions on a flipchart.

**What do I have?****Objectives:**

to have participants reflect on their skills and learning needs

**Materials:**

none

**Timing:**

30 minutes

**Method:**

Ask participants to spend a few minutes thinking about two questions: “What knowledge, skills and abilities do I already have that will help me in this area of my work?” and “What knowledge, skills and abilities do I want to develop to do my job more effectively?” Ask participants to choose a partner and take 10 minutes each to discuss their responses. Bring the whole group together and discuss responses or have each person in turn talk about his/her individual response.

## **You gave the group and me**

### **Objectives:**

to acknowledge the contributions and strengths of each participant

### **Materials:**

none

### **Timing:**

15 - 30 minutes (depending on size of the group)

### **Method:**

The participants are instructed to stand in a circle. The facilitator explains the feedback process: participants are asked to briefly talk about how they felt about another person - things they admired or liked or enjoyed about that person's contributions to the training. The facilitator stipulates that all feedback comments are to be phrased in this way: "You gave the group and you gave me..." The person receiving feedback may respond in whatever way he/she wants. Then, one person steps into the centre of the circle and chooses someone to face feedback; then the person in the centre turns and faces another individual and again receives feedback. This process is repeated until all of the people in the circle have given feedback to the person in the centre. Each person takes a turn in the centre of the circle until everyone has received feedback.

## **Training review**

### **Objectives:**

to review what participants have learned in the training

### **Materials:**

flipchart and markers

### **Timing:**

20 minutes

### **Method:**

This wrap-up is used to review what participants have learned and experienced during the training. Place flipchart paper around the room. Give markers to each participant. Ask them to get into pairs. Have each pair use their piece of flipchart paper to record the ideas, feelings, processes, activities, interactions, etc. that happened during the training. Ask them to try to record whatever happened in whatever manner they choose (chronological, topic area, ideas versus feelings, etc.) After they are done, have the whole group take some time to move around the room and read or look at what everyone has recorded. Bring the group together and ask each pair to talk about what they have written. Encourage the group to discuss whether they agree with the pair's records or not. Review the training by using the participants' own reflections.

## RESOURCES

 *Evaluation Form*

## Volunteer Training Session Evaluation Form

Your feedback is very important to help us know if we are doing a good job. We would appreciate if you could take a few minutes to share your opinions on this session. Do not write your name on the form. Thank you.

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

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

For each of the following, please check off the best response:

Session	Excellent content	Good	Needs Improvement	Not applicable
1. Covered useful material	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Was relevant to my needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Was easy to understand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Visual aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Handouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Presentation	Excellent content	Good	Needs Improvement	Not applicable
6. Presenters' knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Presenters' communication style	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Responded well to questions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. The workshop increased my knowledge and skills on the topic.

Strongly Agree       Agree       Disagree       Strongly Disagree

10. Overall, how would you rate this workshop?

Excellent       Good       Fair       Poor

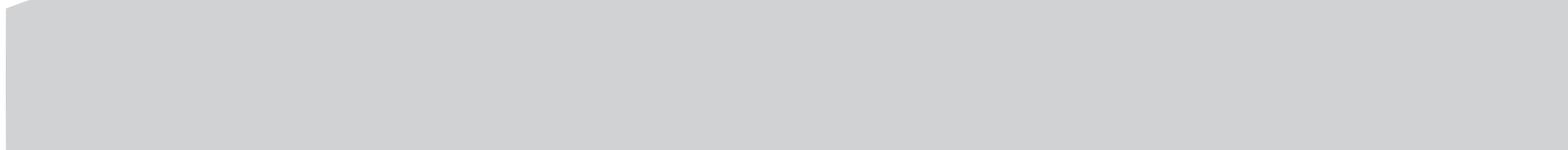
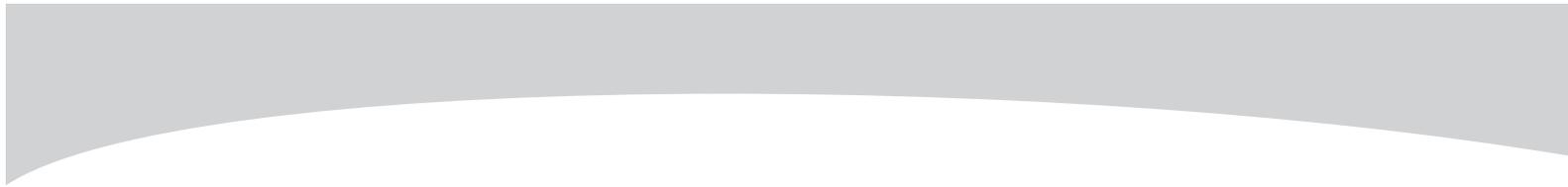
11. How could this training session be improved? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Thank you! Please leave this form in the envelope provided.*



## MODULE ONE

# COMMUNICATION SKILLS

*This module is adapted from the AIDS Committee of Toronto, National HIV/AIDS Volunteer Training Kit*

### **Session objectives:**

- recognize difficulties with effective communication
- become familiar with the ideas of active listening
- develop awareness of non-verbal behaviours
- recognize ineffective listening
- recognize how abstraction affects communication
- become familiar with the communication technique of congruent sending
- practise communication skills

### **Agenda:**

1. opening activity, icebreaker or go-around (10 minutes)
2. chain communication (20 minutes)
3. active listening (15 minutes)
4. eavesdropping (20 minutes)
5. barriers to effective communication (15 minutes)
6. words and meanings (20 minutes)
7. break (10 minutes)
8. congruent sending (15 minutes)
9. role play (45 minutes)
10. closing activity or discussion and evaluations (15 minutes)

Total Time: three hours

## CHAIN COMMUNICATION

**Objective:** Participants will learn to recognize some of the difficulties with effective communication.

**Structure:** large group activity

**Time:** 20 minutes

**Materials:** pen and paper

### Procedure:

1. **Say:** “We’re going to do a brief activity about listening to get right into the topic of communication skills. Some of you may have done this before. I’d like someone to volunteer to come over here and I’m going to whisper some information very quietly so no one can hear what I’m saying. I then want that person to select someone else to come over and whisper what I told them to the next person. Then, the next person will do the same thing with another person and so on. When we’re at the second last person, I’d like the last person to bring a piece of paper and pen with them and write down what they are told. Then, we’ll compare that information with the actual information I started with. Can I have a volunteer, please?”
2. **Whisper** to the volunteer: “I want you to go to the nearest grocery store and buy me some apples, broccoli, cheese, french fries, green grapes and kleenex.”
3. **Say** “OK. I’d like you to select someone and whisper to them exactly what I just whispered to you.”
4. **Go around** until all participants have taken a turn. Remind the last person to write down what they hear.
5. **Ask** the last person to read out what they wrote. Then, read out the list you originally whispered.
6. **Discuss** the activity briefly by asking:
  - Did the final list differ substantially from the initial one?
  - If so, why do you feel this happened?
  - Can you pinpoint any areas of breakdown in communication?
  - Was there anything that made the information easier to remember?
  - Was there anything that made it difficult to remember?
  - Was memory the only factor involved here or was there something else going on?

## ACTIVE LISTENING

**Objective:** Participants will become familiar with the idea of active listening.

**Structure:** lecture and discussion

**Time:** 15 minutes

**Materials:** copies of handout: *Active Listening Techniques*, copies of handout: *Active Listening Checklist*, flipchart, markers

### Procedure:

1. **Introduce** the topic by asking participants to explain what they believe is meant by the term “active listening”. Record responses on flipchart.
2. **Explain** that active listening is a way of responding to someone by trying to understand not merely what the person is saying but what he/she is feeling. Active listening involves techniques that demonstrate what they are saying deserves to be heard. It encourages people to feel comfortable enough to continue talking about difficult issues. Another term for active listening is reflective listening. The key is that you are actively giving something back to the other person (reflecting) to encourage him/her to express feelings and thoughts deeply and honestly.
3. **Distribute** handout: *Active Listening Techniques* and handout: *Active Listening Checklist*.
4. **Review** the information on the handout: *Active Listening Techniques*. As you read the information to participants (or have members of the group read the handout) ask participants to think about ways they might practise active listening in their day to day lives.
5. **Review** handout: *Active Listening Checklist*. **Discuss** why participants feel it might be important to practise active listening in a counselling session.

## ACTIVE LISTENING TECHNIQUES

Technique	Description
Attend	Clear your mind and really pay attention to what the other person is trying to tell you; stop rehearsing what you will say in response; do not interrupt, offer advice or give suggestions; do not bring up similar feelings and problems from your own experience; what may be appropriate in a counselling session, such as offering suggestions or options, is not part of active listening. Active listening is focused on helping the person to talk and feel.
Empathize	Try to put yourself in the other peoples shoes to understand what they are saying and how they feel; ask yourself (and not the other person) questions to evoke empathy. Example: "If I were in this situation, how would I feel?" or "Have I been in a situation like that myself?"
Non-verbal communication	Use attending and observing behaviour to encourage people to verbalize their ideas or feelings freely; the physical things you can do to show people you are interested and that they have your full attention include eye contact, comfortable distance, posture (facing and leaning toward the person), tone of voice, gestures and alertness; a person who is sending you a message with body language needs to know this message has been received. Example: "You seem to be upset." or "You appear angry."
Clarify	Get at additional facts to better understand what is being said; help the person explore all sides of a problem - example: "How did you react when this happened?" or "Is this the problem as you see it now?"

Restate (paraphrase)	Check out your assumptions by repeating, in your own words, the main thoughts and ideas that the person has expressed. This shows that you are listening and that you understand what is being said. It allows you to check the meaning and interpretation of what you have heard; it does not mean that you agree or disagree with the content. Example: “As I understand it, your plan is...” or “So what you’re telling me is...”
Encourage	Convey interest and prompt the person to continue talking; use neutral words and avoid disagreeing or agreeing. Example: “Can you tell me more about?” or “I see what you’re saying.”
Reflect	Show you understand how the person feels about what he/she is saying; help the person evaluate and/or clarify what he/she is feeling. Example: “It sounds like you feel...” “Do you feel that...”
Use prompts	Let the person know you would like more information by using prompts such as nonverbal reinforcers (a smile, a nod, etc.) or silence. One of the most effective ways to get people to talk is for you to say nothing; use brief prompt phrases to elicit more information. Example: “And then what happened?” or “What did you say to that?”
Ask open-ended questions	Phrase questions so that the person will give you meaningful information; try not to ask questions that can be answered by “yes” or “no.” Example: “Tell me how you feel about...” or “Please explain that to me.”
Summarize	Put all the information together – the facts and the feelings – to ensure the person has given you all the information, to serve as a springboard for further discussion and to give the person a chance to correct or add anything. Effective summarizing involves statements that are short, to the point and that do not add any new content, meaning or interpretations to what the person has said. Example: “These are the main ideas you have expressed...” or “This is how I understand what you have said...”
Validate	Acknowledge the person’s worth, efforts and feelings. Example: “It must have been difficult to do that.” or “You’ve really worked hard to solve this problem.”

## ACTIVE LISTENING CHECKLIST

- Stop talking.
- Empathize with the person.
- Concentrate on what the person is saying.
- Look at the person.
- Smile and gesture appropriately.
- Try to leave your emotions behind.
- Get rid of distractions.
- Ask questions.
- Listen for what is not said.
- Listen to how something is said.
- Avoid making assumptions.
- Avoid classifying the person.
- Avoid hasty judgments.

## EAVESDROPPING

**Objective:** Participants will develop awareness of non-verbal behaviours.

**Structure:** large group activity

**Time:** 20 minutes

**Materials:** flipchart, markers

### Procedure:

1. **Ask** for two volunteers. **Say:** “I want the two volunteers to go across the room and have a conversation for about three to five minutes. Try to discuss something that is meaningful to both of you. Talk in very low voices. The rest of us are not supposed to be able to hear you. If we can hear you, I’ll clap my hands and that will be a signal to lower your voices. If you could take your chairs over to the corner of the room, I’ll tell the others what I want them to do and then I’ll let you know when to begin.”
2. **Have** the volunteers move to a distant part of the room. Make sure that they are both still visible to everyone. **Say:** “The rest of us are going to eavesdrop on the conversation that these two people are having. However, since we won’t be able to hear them, we’ll have to use other means for guessing what they are discussing. Observe them closely. Look at their non-verbal behaviour and body language. Try to guess what they are talking about. OK. The two volunteers can begin talking.”
3. **Allow** the two volunteers to talk for three to five minutes.
4. **Say:** “OK. The time is up. Thank you both. You can stay there for a moment. I now want the rest of you to take a piece of paper and write down what you think the two volunteers were talking about. Just take a couple of minutes and quickly record what you think their conversation might have been about based on your observation of their body language.” Give participants time to write down their observations.
5. **Have** the volunteers rejoin the group and ask everyone to read out what they wrote down. Have participants read out their observations. Then ask the two volunteers to tell the group what they were actually talking about.
6. **Discuss** the exercise asking:
  - What non-verbal behaviours and body language cues did you note as the basis for your guesses about the topic of conversation?
  - Who guessed correctly and why?

- Who was wrong and why?
- How did the conversing people choose their topic?
- How did it feel to know that others were eavesdropping on the conversation?
- What have you learned about non-verbal behaviour and body language?

## BARRIERS TO EFFECTIVE COMMUNICATION

**Objective:** Participants will learn to recognize barriers to effective listening.

**Structure:** large group discussion

**Time:** 15 minutes

**Materials:** copies of handout: *Barriers to Effective Communication*, flipchart, markers

### Procedure:

1. **Ask** participants to give examples of poor or negative communication (ex: checking a watch, giving orders like “You should.”). List the examples on the flipchart. **Ask** participants how they feel when somebody they are having a conversation with does these things.
2. **Distribute** handout: *Barriers to effective communication*. Review the information on the flipchart. Ask participants if they have any additional examples.
3. **Ask:**
  - What is the effect on a client of ineffective communication?

## BARRIERS TO EFFECTIVE COMMUNICATION

Ineffective listening involves a failure to distinguish times when an opinion or advice is needed and times when the person is not expecting you to do anything except understand his/her words and feelings. Ineffective listening involves a failure to listen long enough or with sufficient understanding of the person's feelings to really understand their issues and concerns.

*ordering or demanding*

example: "You must try to do this." or "You have to stop doing that."

*warning or threatening*

example: "You had better do this." or "If you don't do that, then..."

*admonishing or moralizing*

example: "You really should have done this." or "That wasn't very nice to have done that."

*persuading or arguing or lecturing*

example: "Do you realize that..." or "The facts are actually..."

*advising or providing answers*

example: "Why don't you..." or "Let me suggest..."

*criticizing or blaming or disagreeing*

example: "You aren't thinking about this properly." or "Don't you think you should try to stop doing that?"

*inappropriate praising or agreeing*

example: "You handled that just the way I told you to." or "That would be the right thing to do."

*sympathizing or reassuring*

example: "Don't worry." or "You'll feel better."

*probing or inappropriate questioning*

example: "Why did you do that?" or "What did you say that for?"

*interpreting or diagnosing*

example: "What you need is..." or "Your problem is..."

*diverting or avoiding*

example: “We can discuss that later.” or “That reminds me of...”

*kidding or using sarcasm*

example: “My elderly aunt said the same thing!” or “When did you last read a newspaper?”

*empty reassurances*

example: “I wouldn’t worry about it.” or “Everything will be fine.”

*rejecting*

example: “Let’s not discuss that.” or “I don’t want to hear about that.”

*disapproving*

example: “Was that really wise?” or “I don’t like that kind of behaviour.”

*defending*

example: “That hospital has a fine reputation.” or “No one here would lie to you.”

*diminishing expressed feelings*

example: “Everyone feels like that sometimes.” or “It’s always darkest before the dawn.”

*using clichés*

example: “It’s for your own good.” or “Keep your chin up.”

## WORDS AND MEANINGS

**Objective:** Participants will learn to recognize how abstraction affects communication.

**Structure:** small and large group discussion

**Time:** 20 minutes

**Materials:** flipchart

### Procedure:

1. **Write** the following words on the flipchart paper:

healthy

ill

problem

anxiety

fear

sexuality

2. **Have** participants get into groups of three. Assign one word at random to each group. If there are more than 18 participants, assign the same words to more than one group. Have the groups define their words. Definitions can be a one-word synonym or a phrase or whatever the group thinks appropriate. Give participants a couple of minutes to define the word.

3. **Write** the following words on a flipchart while the groups are working. Write them exactly as they appear below.

Possession – Abstract

Pet

Animal

Cat

Siamese

Seal point – Concrete

4. After groups have had some time to write their definitions stop them and ask them to consider the words on the flipchart. **Explain** that words can be abstract or concrete. Abstract means that they represent ideas. Concrete means that they represent real things.

In the example on the flipchart, begin with the concrete at the bottom. A seal point is a particular type of Siamese cat with specific colours. A Siamese is a breed of cat. A cat is a common domesticated animal. All three of these words are very concrete. They describe a specific thing - a feline creature - in varying degrees of particularity. The word “animal” becomes more abstract. It’s a classification that represents non-human creatures. The word “pet” is even more abstract. It’s an idea indicating an animal that we own. The word “possession” is even more abstract as it represents anything that someone can own. When you say “cat,” you can picture a specific concrete thing. When you say “possession,” you know what it means as a concept, but without more information, you don’t know what the person is referring to (a car? a house? a pet?). **To communicate effectively, it’s important to clearly distinguish between abstract and concrete words. The more concrete you are, the more clearly understood you will be. Being concrete when you speak is an important communication technique to use when working with clients.**

5. **Ask** participants to now define the word they were given – but this time, try to define it as concretely as possible. If the original definition seems thoroughly concrete, have them try a different word. Give each group five minutes to prepare a definition.
6. **Have** participants work on the activity. Monitor and answer questions or help, but do not provide definitions. **Have** each group in turn share the more concrete definition with the larger group.
7. **Discuss** the concept of concrete by asking questions such as:
  - Were most of the definitions abstract at the beginning?
  - If so, how did this fact affect the similarity of definitions?
  - How did trying to make definitions more concrete affect their degrees of similarity?
  - Were some words more difficult to make concrete than others?
  - If so, how do you account for that?
  - What does this experience suggest about where meaning lies?
  - How can you communicate your meaning more clearly to another person?

## CONGRUENT SENDING

**Objective:** Participants will become familiar with the communication technique of congruent sending.

**Structure:** large group discussion

**Time:** 15 minutes

**Materials:** copies of handout: *Congruent Sending*, flipchart and markers

### Procedure:

1. **Distribute** handout: *Congruent Sending*.
2. **Give** participants five minutes to read the handout to themselves. Allow participants to ask any questions they may have about the information on the handout.
3. **Discuss** the concept of congruent sending by asking questions such as:
  - Has anybody had an experience relying on this communication technique? Can you describe it?
  - Was it effective? Why or why not?
  - What would make this communication technique difficult or challenging?
  - What would make it simpler to use?
  - How can this be applied in a counselling situation?

## CONGRUENT SENDING

Congruent sending is an aspect of active listening. “Congruent” means “coinciding exactly” – when two things suitably fit together. People talking about their problems need someone to listen actively and to respond in a manner that is congruent, or that fits, with what they are saying and how they are feeling. They do not need judgment or misunderstanding. Congruent sending is a technique to help avoid judgment and misunderstanding.

Congruent sending consists of:

- ownership of feelings
- sending feelings: “I hear what you’re saying. You sound angry.”  
*instead of sending evaluations: “You get nasty when you’re mad! I’m signing you up for anger management classes.”*
- Describing: “I really get annoyed when you borrow my book and don’t return it.”  
*Rather than evaluating: “I get really annoyed when you’re so inconsiderate.”*

A simple formula for congruent sending is

(a) “I’m” + (b) feeling word + (c) behavioral description

(a) = ownership of feelings (“I” statement)

(b) = sending emotions (feeling word)

(c) = describing, not judging (describe behaviour)

Congruent sending encourages you to be a great deal more open and direct with your feelings. The result is that people learn to trust you. Your openness also encourages openness in others. In addition, by owning your feelings and avoiding judging, you can minimize defensiveness while dealing directly with problems.

## ROLE PLAY

**Objective:** Participants will practise communication skills.

**Structure:** small and large group activity

**Time:** 45 minutes

**Materials:** flipchart, markers

**Note:** Some participants may be reluctant to take part in role playing. An alternative would be to prepare scenarios ahead of time and have each pair work together to identify possible solutions or approaches.

### Procedure:

1. **Divide** participants into pairs. **Ask** each pair to work together to come up with a realistic dialogue between a teen clinic client wanting information about your services and a SRH counsellor. One participant will play the client and the other will be the SRH counsellor. After they have developed a very brief dialogue, (a couple of minutes) they will perform it in front of the whole group. The client's dialogue should be as vague as possible at the beginning. The volunteer's role is to use some of the communication skills covered earlier in the session - active listening, being concrete, congruent sending - to assess the client as clearly as possible. The volunteer is trying to learn what it is that the client really wants. **Have** each group work out a specific problem that the client has and develop a dialogue. They can write down their dialogue. **Give** them 15 minutes to develop the dialogue.
2. **Have** the pairs in turn present their dialogues to the large group. Time them and if they run over a couple of minutes, politely stop them and ask for the next pair to begin. **Ask** for some feedback on any of the dialogues or any comments about the exercise. **Elicit** feedback and comments and discuss briefly.

## MODULE TWO

# WORKING WITH DIVERSITY

*This module has been adapted from the AIDS Committee of Toronto, National HIV/AIDS Volunteer Training Kit.*

### **Session Objectives:**

- Recognize the nature of oppression.
- Recognize definitions, terms and labels that influence responses to diversity.
- Examine ethnic, racial, social and cultural identity and the similarities and/or differences in experiences based on that identity.
- Identify underlying fears and ignorance behind discrimination.
- Examine methods of dealing with discrimination.
- Practise dealing with discrimination.

### **Agenda:**

1. opening activity, icebreaker or discussion (10 minutes)
2. tree of oppression (15 minutes)
3. labels: definitions and terms (30 minutes)
4. identity: personal awareness inventory (20 minutes )
5. discrimination (20 minutes)
6. break (10 minutes)
7. strategies for being culturally responsive (20 minutes)
8. action plans (30 minutes)
9. closing activity or discussion and evaluations (15 minutes)

Total Time: three hours

## TREE OF OPPRESSION

**Objective:** Participants will recognize the nature of oppression.

**Structure:** small group activity and large group discussion

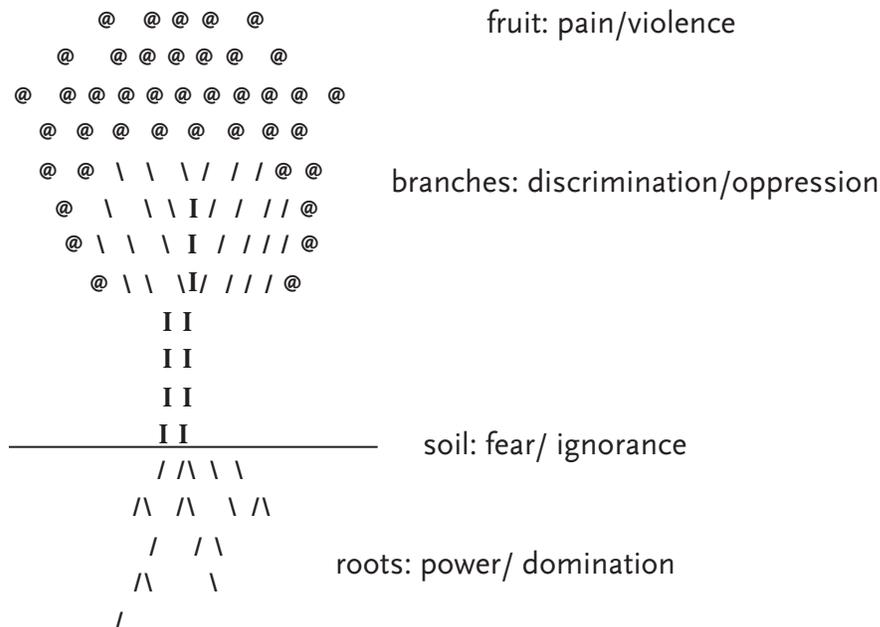
**Time:** 15 minutes

**Materials:** copies of handout: *Tree of Oppression*, flipchart, markers

### Procedure:

1. Before you begin, **draw** the diagram below (with the words) on a flipchart. (See handout for a representation)

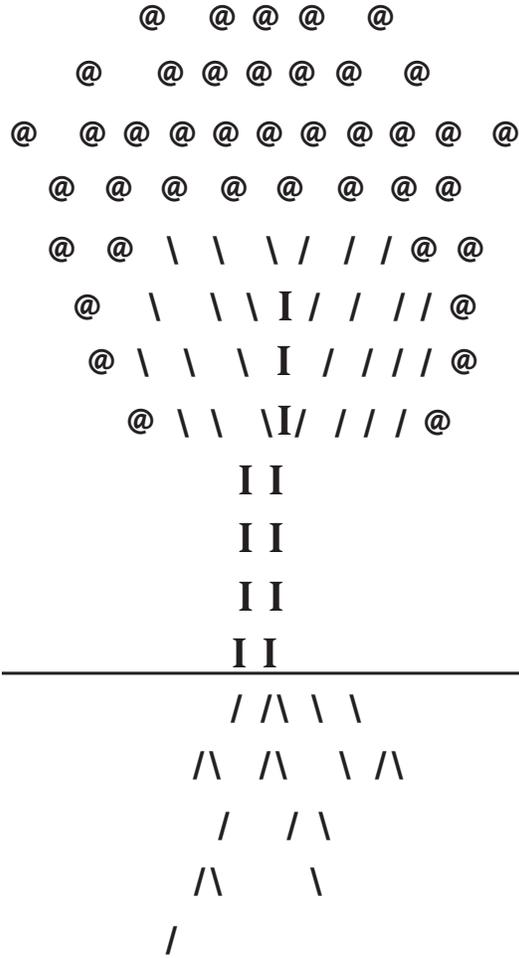
#### Tree of oppression



2. **Distribute** handout: *Tree of Oppression*. **Explain** that the roots of oppression are power and domination. The soil in which oppression flourishes is fear and ignorance. The branches are the different forms of oppression and discrimination. The fruit of this tree is pain and violence.

3. **Have** participants work with a partner and come up with some examples for each of the four parts of the tree. Ask participants to think of a couple of examples of power – who is oppressing who and why? Name some forms of discrimination and write them near the branches. Think about some effects of discrimination and write examples beside the fruit. Think about fear and ignorance. What issues are people afraid of that make them discriminate?
4. After groups have had an opportunity to work on their handouts and discuss, **ask** for a pair of volunteers to come up to the flipchart and talk about examples they came up with for the branches – **the forms of oppression**. Have participants write the key words on to the flipchart as they present. **Have** other pairs come up and present their examples for the three other areas and discuss.
5. **Say:** “Different forms of oppression are distinct, as reflected by their positions on different branches, and yet they are fed by the same soil, share common roots and have similar results.”

# TREE OF OPPRESSION



fruit: pain/violence

branches: discrimination/oppression

soil: fear/ignorance

roots: power/domination

## LABELS – DEFINITIONS AND TERMS

**Objective:** Participants will recognize definitions, terms and labels that influence responses to diversity.

**Structure:** small group activity and large group discussion

**Time:** 30 minutes

**Materials:** copies of handouts: *Definitions and Terms, Labels, Suggestions for Using Appropriate Language*, flipchart, markers

**Note:** Throughout this session the facilitator should be aware that participants may be coming to the session with their own personal experiences of being labeled. Be conscious of how the exercise may effect those who have had personal experiences with discrimination in the past. Spend time debriefing either with the entire group or one-on-one as needed at the end of the activity.

### Procedure:

1. **Read** the following paragraphs to the group:

It is important for people to be able to name the multiple sources of their oppression before they can begin to challenge this oppression. It's also important to begin to make links between various kinds of oppression. Various kinds of oppression often share similar characteristics. They are all part of the overall structure of domination at the personal, societal and institutional levels. People use stereotypes of the oppressed group to justify continuing the oppression. There is a cycle of socialization about this oppression. Whether we are a member of an oppressed group or not, we are socialized to accept the existing beliefs about that group.

Oppression continues because of our co-operation in its continuation – by not paying attention to it, not confronting it or not considering it important. By understanding the similarities between the different types of oppression, we may be able to reflect on personal situations of discrimination, empathize with other types of oppression that we have not experienced and begin to work to challenge oppression.

2. **Ask** the group what a label is. **Explain** that the terms we choose to use when describing people – or groups of people – can have very powerful effects. Appropriate terminology is viewed by some people as an important indicator of respect for and belief in the dignity and worth of individuals and groups. Even unintentional slights are noticed and may be interpreted as an indication of

insensitivity, disrespect or even hostility. Self-identification is often an important step in community awareness and growth. However, not all terms are accepted even by people within the same group.

3. **Distribute** handouts: *Definitions and Terms and Labels*. **Divide** participants into groups of four. Have groups look through the handout: *Labels* and divide the words into positive names and negative labels. Groups can add words to the list if they wish. While dividing up the list, have participants think about and note why they find some terms to be negative or offensive and why they think the positive ones are OK. Give groups 15 minutes to work.
4. After 15 minutes stop participants and **ask** them to discuss responses to the list of terms and labels. Have participants tell the group why they reacted to some of the words on the list and how they sorted them into positive or negative.
5. **Distribute** handout: *Suggestions for Using Appropriate Language*. Ask for volunteers to read out the suggestions on the handout to the group. After the list has been read out, ask participants if they have any questions and discuss as a group.

## DEFINITIONS AND TERMS

### Prejudice

- an unfavourable opinion or feeling formed beforehand or without knowledge, thought or reason
- any preconceived opinion or feeling, either favourable or unfavourable
- unreasonable feelings, opinions or attitudes, especially of a hostile nature, directed against a racial, religious or national group
- negative personal behaviour that discriminates against individuals of such a group

### Bias

- a mental leaning or inclination
- partiality

### Bigotry

- holding blindly and intolerantly to a particular creed, opinion, etc.
- being narrow-minded and intolerant

### Discrimination

- differential treatment of an individual on the basis of the individual's actual or presumed membership in or association with some class or group of people, rather than on the basis of personal merit

- differential treatment of an individual or group on the basis of:
  - ancestry, including colour and perceived race
  - nationality or national origin
  - ethnic background or origin
  - religion or creed, or religious belief, religious association or religious activity
  - age
  - sex, including pregnancy, the possibility of pregnancy, or circumstances related to pregnancy
  - gender-determined characteristics or circumstances
  - sexual orientation
  - marital or family status
  - source of income
  - political belief, political association or political activity
  - physical or mental disability or related characteristics or circumstances
  - failure to make reasonable accommodation for the special needs of any individual or group, if those special needs are based upon any characteristic listed above

**LABELS**

people of colour  
 non-whites  
 coloured people  
 Black people  
 black  
 brown  
 yellow  
 red  
 white  
 Negroes  
 Orientals  
 Caucasians  
 Negroid race  
 Mongoloid race  
 Caucasoid race  
 Anglo-Saxon  
 w.a.s.p. (white Anglo-Saxon Protestant)  
 Asians  
 South Asians  
 East Indians  
 mulatto  
 mixed-race person  
 bi-racial  
 middle-eastern person  
 Arab  
 Muslim  
 physically-challenged  
 disabled  
 handicapped  
 blind  
 visually-impaired  
 hard of hearing  
 deaf  
 hearing impaired  
 mentally-challenged  
 mentally handicapped  
 mentally retarded  
 developmentally delayed  
 developmentally disabled  
 Aboriginal people  
 Inuit people  
 First Nation  
 Indians  
 natives  
 Two-spirit  
 Eskimos  
 Jewish people  
 Jews  
 Hebrews  
 Afro-Canadians  
 ethnic minority  
 multicultural people  
 ethnics  
 third world people  
 mainstream groups  
 normal  
 world majority people  
 queer women of colour  
 lesbian  
 gay  
 homosexual  
 dykes  
 fags  
 queers  
 homos  
 bisexual  
 transsexual  
 two-spirited people of the First Nation  
 hyphenated-Canadian (African-Canadian, Chinese-Canadian, etc.)  
 person of (Polish, Korean, Italian, etc.) extraction  
 person of (Polish, Korean, Italian, etc.) heritage  
 Latino  
 Hispanic  
 Spanish-speaking people

## **SUGGESTIONS FOR USING APPROPRIATE LANGUAGE**

1. Ask friends, co-workers, clients or social contacts how they want to be addressed. This is the surest way to learn what term or phrase is appropriate.
2. Use inclusive language (“us” or “Canadians”) and avoid words or labels that exclude people (“them,” “those people”).
3. Never use obsolete, clinical, quasi-scientific terms (“Caucasoid race”).
4. Learn and use terms preferred by the listener.
5. Use words that identify group similarities (“people of colour”) instead of those which are based on differences (“non-whites”).
6. Avoid paternalistic phrases (“our Chinese community”) and quaint but offensive terms (“of the Jewish persuasion”).
7. Avoid all demeaning slang and derogatory terms.

## IDENTITY: PERSONAL AWARENESS INVENTORY

**Objective:** Participants will examine ethnic, racial and cultural identity and the similarities and/or differences in experiences based on that identity.

**Structure:** individual activity and large group discussion

**Time:** 20 minutes

**Materials:** copies of handout: *Identity – Personal Awareness Inventory*, flipchart, markers

### Procedure:

1. **Distribute** handout: *Personal Awareness Inventory*. **Have** participants work individually and complete the exercise on the handout. Give participants 10 minutes.
2. **Have** participants discuss their responses to the exercise. Record any key points on a flipchart.

## IDENTITY: PERSONAL AWARENESS INVENTORY

Here are some categories that people frequently use to identify themselves. How do you define yourself? Do you define yourself using any of these categories:

- religion
- economic group
- ethnic group
- racial group
- gender and sexuality group
- nationality
- other

Using the categories (or any other information you choose), write a brief identity statement: "I am a..." \_\_\_\_\_

---

---

Using your identity statement, briefly answer these questions:

a) I was first aware of being (identity statement) when... \_\_\_\_\_

---

---

b) I am most aware of being (identity statement) when... \_\_\_\_\_

---

---

c) For me, being (identity statement) means... \_\_\_\_\_

---

---

d) Because of being (identity statement), I have experienced the following forms of discrimination... \_\_\_\_\_

---

---

## DISCRIMINATION – FEAR AND IGNORANCE

**Objective:** Participants will identify underlying fears and ignorance behind discrimination.

**Structure:** small and large group activity

**Time:** 20 minutes

**Materials:** copies of handout: *Discrimination – Fear and Ignorance*, flipchart, markers

### Procedure:

1. **Distribute** handout: *Discrimination – Fear and Ignorance*. **Read** the following paragraph to participants:

Discrimination often has its origins in fear and ignorance. People often hold discriminatory attitudes because they have hidden fears or are in pain about something they associate with a specific group. They may be afraid of losing something of value they believe the other group may take from them. Or they may be in pain about perceived unfairness to themselves which they believe the other group is responsible for. To challenge oppression, this underlying fear and pain has to be located and validated. This fear or pain is genuine and needs to be acknowledged. It's the person's ignorance of the link between their fears or pain and their discriminatory attitudes that is the problem to be worked on. One method for working on this involves reframing the person's discriminatory attitude to identify and rationally examine the hidden reasons for these attitudes.

2. **Ask** participants to work with a partner and complete the exercise on the handout. Give groups 15 minutes to complete the activity. **Discuss** as a large group, the definitions of the problems and the challenges to the attitudes that the groups came up with. **Have** pairs provide their responses to each situation. Record any key points on a flipchart.

## DISCRIMINATION (FEAR AND IGNORANCE)

Examine the following discriminatory complaints to

- locate the underlying fear or pain
- acknowledge the fear or pain
- reframe the complaint to address the discrimination

### example of discriminatory complaint:

“They’re all on welfare.”

- underlying fear or pain  
“I work hard. My parents worked hard. So much of our hard work goes to support others.”
- acknowledge the fear or pain  
“It must take a lot of strength to work so hard.”
- reframe the complaint  
“Has anyone in your family ever needed financial help? How did you decide whether they should get help or not? Was it based on their behaviour, their customs, the way they looked? What would you do if you needed financial help and the government said you couldn’t get it because of your ethnic group? Do you think that would be fair to you?”

### i) discriminatory complaint

“They’re all violent. They’re all criminals. They all come here and sell drugs and shoot people.”

- underlying fear or pain \_\_\_\_\_
- acknowledge the fear or pain \_\_\_\_\_
- reframe the complaint \_\_\_\_\_

### ii) discriminatory complaint

“They’re all promiscuous. All they do is have sex. They spread disease because they have hundreds of partners.”

- underlying fear or pain \_\_\_\_\_
- acknowledge the fear or pain \_\_\_\_\_
- reframe the complaint \_\_\_\_\_

### **iii) discriminatory complaint (client speaking)**

“They stick to their own kind. They don’t mix with anyone else. They keep their money to themselves and won’t speak English.”

- a) underlying fear or pain \_\_\_\_\_
- b) acknowledge the fear or pain \_\_\_\_\_
- c) reframe the complaint \_\_\_\_\_

## STRATEGIES FOR BEING CULTURALLY RESPONSIVE

**Objective:** Participants will examine methods for working from a culturally responsive perspective.

**Structure:** large group discussion

**Time:** 20 minutes

**Materials:** copies of handout: *Strategies for being Culturally Responsive*, flipchart, markers

### Procedure:

1. **Ask** participants to share some strategies for being culturally responsive. Record key points on a flipchart.
2. **Distribute** handout: *Strategies for being Culturally Responsive*. Review handout with participants while providing the information below to highlight each point.
  - Distinguish misunderstanding from prejudice  
When inter-group conflicts arise, be prepared to distinguish between what is simply a misunderstanding and what is prejudicial. Misunderstandings are clarified by giving people insights that broaden their awareness. This is very different from prejudice, which is often malicious and unfounded.
  - Challenge prejudices  
Challenge prejudices by stimulating some discussion about the issue with group members. An alternate approach is to provide them with scenarios that show different points of view.
  - Learn about cultural customs  
Misunderstandings, whether they are based on linguistic, racial or cultural differences, can be damaging. For example, a male may take the hand of an Asian woman with the intent of showing his concern for her comfort or well-being. However, in some communities, touching strangers (even handshakes) is considered an unacceptable liberty. This is a case of a cultural misunderstanding; learn about cultural customs to avoid such misunderstandings.
  - Acknowledge discomfort  
Interact with clients in a way that is comfortable to them. Listen and watch closely for non-verbal indicators of stress, discomfort or confusion. If you feel you have made someone feel uncomfortable, acknowledge it by providing an appropriate apology.

- **Be empathetic**  
Put yourself in someone else's position. If someone says he/she is afraid of someone with HIV/AIDS, express your understanding of the fear of the disease, but deal with the misunderstanding of the routes of transmission or whatever issue is creating the fear.
- **Be non-judgmental**  
Encourage people to express their concerns. This does not mean that you cannot challenge values or ideas that people have. Just use a positive approach and ask why the person feels this way; follow his/her logic and try to get the person to examine the value.
- **Avoid cultural stereotyping**  
Every individual combines the general characteristics and tendencies of his/her culture with his/her own perceptions, values, attitudes, stereotypes and prejudices. Do not generalize.
- **Listen to others**  
Intercultural communication requires two-way communication. Let people define their needs and in response, find ways to handle their concerns. Paraphrase and reflect on the ideas and suggestions they have raised.
- **Find common ground**  
Personalize your knowledge and perceptions. When you talk about your own feelings, ideas and experiences, people may be able to identify with you and relate their personal experience with your own.
- **Get to know other cultures**  
Familiarize yourself with the terms, values, traditions and belief systems of various communities with whom you work. Find out about day-to-day aspects (food, music, customs, etc.) of cultures other than your own. Buy publications, listen to radio or television programs and shop at businesses that are owned by other ethnic, racial or cultural groups.
- **Examine organizational practices**  
Be aware of values and assumptions that are inherent in your organization and need to be challenged. When doing education work, ask yourself whether your educational materials (posters, brochures, videos, etc.) are culturally diverse and are available in an understandable language that is sensitive to the values of your audience.

- Practise zero tolerance

Interrupt racist remarks and jokes as they happen. Challenge racism and other forms of discrimination whenever and wherever you encounter them by pointing out the discriminatory implications of assumptions that come up in everyday conversations with people.

## **STRATEGIES FOR BEING CULTURALLY RESPONSIVE**

- Distinguish misunderstanding from prejudice.
- Challenge prejudices.
- Learn about cultural customs.
- Acknowledge discomfort.
- Be empathetic.
- Be non-judgmental.
- Avoid cultural stereotyping.
- Listen to others.
- Find common ground.
- Get to know other cultures.
- Examine organizational practices.
- Practise zero tolerance.

## ACTION PLAN

**Objective:** Participants will practise being culturally responsive.

**Structure:** small group and large group discussion

**Time:** 30 minutes

**Materials:** copies of handout: *Action Plan*, flipchart, markers

### Procedure:

1. **Distribute** handout: *Action Plan*. Divide participants into groups of four. Ask participants to take 15 minutes and work in their small groups to come up with action plans to address the situation in the scenario in a culturally responsive manner.

### **Scenario:**

A recent client survey has shown that many of the clients attending the teen clinic are Asian and people of colour. When they were surveyed, most of the clients responded they did not feel that the teen clinic was sensitive to their cultural needs but they had nowhere else to go. However, the respondents did not identify any specific ideas for making the teen clinic more sensitive. Despite the fact that there is a high demand for volunteer positions at your organization, most of the SRH counsellors in the program are white. Also, all of the staff at the teen clinic are white. Previous efforts to recruit more staff or volunteers who are people of colour have not been successful. The agency has asked the committee to develop an action plan to make the teen clinic more culturally responsive to the client population.

2. After 15 minutes **ask** participants to share some of the ideas they have come up with. **Have** each group briefly discuss their solutions. Encourage brief comments and feedback about the solutions.

## ACTION PLAN

You are working on a teen clinic planning committee. Your committee has been asked to formulate a plan for making the teen clinic more culturally responsive. Work with your group to write an action plan that will address the issues raised in the following scenario. Use the suggestions below to help write your plan.

### Scenario

A recent client survey has shown that many of the clients at the teen clinic are Asian youth and young people of colour. When they were surveyed most of the clients responded that they did not feel that the teen clinic was sensitive to their cultural needs but they had nowhere else to go. However, the respondents did not identify any specific ideas for making the teen clinic more sensitive. Despite the fact that there is a high demand for volunteer positions at your organization, most of the SRH counsellors in the program are white. Also, all of the staff at the teen clinic are white. Previous efforts to recruit more staff or volunteers who are people of colour have not been successful. The agency has asked the committee to develop an action plan to make the teen clinic more culturally responsive to the client population.

### Action plan suggestions

1. Clearly identify the problem.
2. What are your specific goals?
3. What resources (people, materials, etc.) do you need?
4. What risks might be involved?
5. What resistance might you encounter?
6. What support do you have?
7. How will you determine that the issue has been addressed?

## MODULE THREE

# CONFIDENTIALITY

*This module has been adapted from the AIDS Committee of Toronto, National HIV/AIDS Volunteer Training Kit*

### **Session Objectives:**

- Become familiar with the concept of confidentiality.
- Develop sensitivity to issues of confidentiality.
- Develop personal confidentiality guidelines related to SRH.
- Understand and clarify comfort levels with confidentiality policy guidelines.
- Recognize breaches of confidentiality and create responses to those breaches.

### **Agenda:**

1. opening activity, icebreaker or discussion (10 minutes)
2. broken promises (20 minutes)
3. what is confidentiality (15 minutes)
4. developing personal confidentiality guidelines (30 minutes)
5. break (10 minutes)
6. examining confidentiality policy guidelines (60 minutes)
7. breaches of confidentiality (20 minutes)
8. closing activity or discussion and evaluations (15 minutes)

Total Time: three hours

## BROKEN PROMISES

**Objective:** Participants will develop sensitivity to the issues of confidentiality.

**Structure:** small group and large group discussion

**Time:** 20 minutes

**Materials:** copies of handout: *Broken Promises*, flipchart, markers

### Procedure:

1. **Distribute** handout: *Broken Promises*. Divide participants into pairs. Ask each pair to spend 10 minutes answering the questions with their partners. **Discuss** briefly how participants felt about breaking and keeping promises.

## **BROKEN PROMISES**

Think about a promise that was made to you by someone and was not kept.  
Answer the following questions.

- i) What was the promise that was broken?
  
- ii) How did you feel about the promise being broken?
  
- iii) What did you feel about the person who broke the promise?
  
- iv) Did you work out what you were going to say or do to this person?
  
- v) What did you actually say or do?
  
- vi) If you did not say or do what you intended, what stopped you?
  
- vii) If you did do what you intended, what difference did this make to how you felt about the broken promise and the person who broke it?

## WHAT IS CONFIDENTIALITY?

**Objective:** Participants will become familiar with the concept of confidentiality.

**Structure:** large group discussion

**Time:** 15 minutes

**Materials:** copies of handout: *What is Confidentiality?*, flipchart, markers

### Procedure:

1. **Ask** participants “What is confidentiality?” **Ask** participants to respond and record key points on a flipchart.
2. **Share** the following definition of confidentiality:
  - an assurance of mind or firm belief in the trustworthiness of another or in the truth and reality of a fact, trust or reliance – someone or something in which trust is placed
  - something told in secret or a private communication
  - the belief that another will keep a secret; assurance of secrecy
3. **Distribute** handout: *What is Confidentiality?* and review with participants. Ask then why it is important, when working with adolescents to ensure we always respect their confidentiality. **Discuss.**

## WHAT IS CONFIDENTIALITY?

### Definitions of “confidence” and “confidentiality”

- an assurance of mind or firm belief in the trustworthiness of another or in the truth and reality of a fact; trust; reliance
- someone or something in which trust is placed
- something told in secret; a private communication
- the belief that another will keep a secret; assurance of secrecy

### The need for confidentiality

Ensuring confidentiality is a legal, professional and moral responsibility of all people associated with a teen clinic. The legal obligation for confidentiality is based on the principle that a person’s medical history is private and any information that connects a client’s identity to a diagnosis is confidential. The professional obligation for confidentiality extends the right of privacy to a client’s family and friends. It also involves sharing only authorized information with the client network. The right to confidentiality extends to young people and should be respected as much as with adult clients.

It’s important for volunteers working at a teen clinic to pay strict attention to clients’ privacy rights. We must all be careful to preserve clients’ confidentiality. Discretion must be exercised in identifying clients outside the organization. Extreme care must be taken in distribution of personal information obtained through activities at the organization. Confidential information should not be discussed outside the organization. You might talk in generalities about what you are doing and about the clients, volunteers and staff with whom you interact, but nothing that identifies a specific person or any details. This helps everyone to experience the organization as a secure environment.

## DEVELOPING PERSONAL CONFIDENTIALITY GUIDELINES

**Objective:** Participants will develop personal confidentiality guidelines related to adolescent health services.

**Structure:** individual, small group and large group activity

**Time:** 30 minutes

**Materials:** copies of handouts: *Confidentiality Rights and Responsibilities*, *Confidentiality Guidelines Activity*, flipchart, markers

### Procedure:

1. **Ask** participants: “How do you decide whether or not something is confidential?” **Ask** participants to respond and record key points on a flipchart.
2. **Distribute** handout: *Developing Personal Confidentiality Guidelines*. Ask participants to spend five minutes and individually respond to the questions on the handout.
3. After five minutes, **have** participants form groups of four and discuss their responses. Then, have each group work together to develop brief guidelines about confidentiality using the handout *Confidentiality Guidelines Activity*. Give each group five minutes to identify at least four confidentiality guidelines.
4. **Discuss** briefly each group’s responses with the large group. Record key points on a flipchart.

## **CONFIDENTIALITY RIGHTS AND RESPONSIBILITIES**

1. Imagine that you have just learned that you have a sexually transmitted infection (STI). How would you respond? What are your feelings?
2. Who would you tell? Why?
3. Who would you want to make sure doesn't know? Why?
4. Under what conditions would you want people to know?
5. Under what circumstances would you want to know if a friend or someone you work with had an STI? Why?

## CONFIDENTIALITY GUIDELINES ACTIVITY

Work in a small group and develop guidelines for safeguarding confidentiality about adolescent sexual and reproductive health. Develop at least four brief guidelines.

Think about the following questions:

What issues or concerns did you identify that relate to confidentiality and sexual and reproductive health?

What concerns may be unique to adolescents?

What guidelines could be developed that would safeguard these concerns?

Who do these guidelines serve and why?

How can these guidelines be used at personal and group levels?

## EXAMINING CLINIC CONFIDENTIALITY GUIDELINES

<b>Objective:</b>	Participants will understand and clarify their comfort level with confidentiality policy guidelines.
<b>Structure:</b>	small group and large group activity
<b>Time:</b>	60 minutes
<b>Materials:</b>	copies of handout: <i>Confidentiality Policy Guidelines</i> , flipchart, markers

### Procedure:

1. **Distribute** handout: *Confidentiality Policy Guidelines*. Divide participants into pairs and have them review each of the policy guidelines and agree on their comfort level with each guideline. Give participants 30 minutes to thoroughly examine the guidelines and complete the exercise.
2. After 30 minutes, **discuss** by asking the following questions:
  - What was your comfort level on each guideline? (Record answers on flipchart.)
  - Are there any surprises?
  - Which guidelines are we the most uncomfortable with?
  - How can volunteers and others support one another in dealing with confidentiality issues and questions?

## CONFIDENTIALITY POLICY GUIDELINES

- A) **Sharing personal health information**  
No personal health information about clients should be shared with anybody else without their consent. This includes minors under 18 years of age. Parents of minors are not entitled to have access to their child's personal health information.
- B) **Discussing confidential information with fellow volunteers**  
It is not acceptable to discuss any confidential information you might have with any other volunteer at the organization. Not all volunteers have access to confidential information.
- C) **All personal information is confidential**  
It is never acceptable to presume that any personal information about any staff member, board member, volunteer, client or general member is common knowledge. This includes marital or relational status (married to, divorced from, or dating), sexual orientation (heterosexuality, homosexuality, bisexuality), medical information (HIV status, hemophiliac, diabetic), or any other personal information. Regardless of your experience of any individual's comfort with the common knowledge of any of their personal information, this should never be repeated to anyone without that person's written consent.
- D) **Confidentiality restrictions apply even after you've left the organization**  
A confidentiality policy is strictly maintained, even after a volunteer leaves. Confidentiality extends not only for the time you are volunteering, but continues indefinitely once you leave the organization.
- E) **Do not discuss confidential information with family or friends**  
It is never acceptable to discuss any confidential information with your family or friends. Information about a client, even if not specified by the client, should not be told to the volunteer's family members, partners or friends.
- F) **No public discussion or identification of confidential information**  
Volunteers should avoid discussing contacts, clients' names, and circumstances in elevators, restaurants, movie theatres, lunchrooms, etc. Volunteers should be careful about greeting clients in a public place and not reveal to others that they are clients of a teen clinic.
- G) **Clients may withhold any identifying information**  
Representatives of the organization must respect the right of clients not to offer identifying information if they choose. Representatives will not ask for identifying information unless it is necessary for service delivery.

## CONFIDENTIALITY POLICY GUIDELINES

How comfortable do you feel in following these guidelines?

Comfort scale rating

1 = very uncomfortable

2 = somewhat uncomfortable

3 = neutral

4 = somewhat comfortable

5 = completely comfortable

Based on your personal and professional experiences, what feelings, questions or issues does this guideline raise? Circle the most appropriate number on the scale

A) Do not share personal health information.

*Comfort rating*

Very uncomfortable

Completely comfortable

1

2

3

4

5

Based on your personal and professional experiences, what feelings, questions or issues does this guideline raise?

B) Do not discuss confidential information with fellow volunteers.

*Comfort rating*

Very uncomfortable

Completely comfortable

1

2

3

4

5

Based on your personal and professional experiences, what feelings, questions or issues does this guideline raise?

- C) All personal information is confidential.

*Comfort rating*

Very uncomfortable

Completely comfortable

1

2

3

4

5

Based on your personal and professional experiences, what feelings, questions or issues does this guideline raise?

- D) Confidentiality restrictions apply even after you've left the organization.

*Comfort rating*

Very uncomfortable

Completely comfortable

1

2

3

4

5

Based on your personal and professional experiences, what feelings, questions or issues does this guideline raise?

- E) Do not discuss confidential information with family or friends.

*Comfort rating*

Very uncomfortable

Completely comfortable

1

2

3

4

5

Based on your personal and professional experiences, what feelings, questions or issues does this guideline raise?

- F) Do not discuss or identify confidential information in public.

*Comfort rating*

Very uncomfortable

Completely comfortable

1

2

3

4

5

Based on your personal and professional experiences, what feelings, questions or issues does this guideline raise?

- G) Clients may withhold any identifying information they choose.

*Comfort rating*

Very uncomfortable

Completely comfortable

1

2

3

4

5

Based on your personal and professional experiences, what feelings, questions or issues does this guideline raise?

## BREACHES OF CONFIDENTIALITY

**Objective:** Participants will recognize breaches of confidentiality and create responses to them.

**Structure:** small group and large group activity

**Time:** 20 minutes

**Materials:** paper and pens, flipchart, markers

### Procedure:

1. **Divide** participants into groups of three. Give each group 10 minutes to create a scenario in which confidentiality has been breached and write it down.
2. When groups have created a scenario, **have them exchange** scenarios so that each group has another group's scenario. Have groups create a brief response to the breach and how they would deal with the situation.
3. **Have** each group read out the scenario they were given and then discuss their responses. Discuss key points as they come up.

## MODULE FOUR

# HARM REDUCTION

*This module has been adapted from the Manitoba Harm Reduction Network, What does Harm Reduction Mean to Me, My Work and My Community Training Curriculum.*

### **Session objectives:**

- understand the meaning and principles of harm reduction
- to examine values and attitudes about harm reduction in the participant's lives and work

### **Agenda:**

1. opening activity, icebreaker or discussion (10 minutes)
2. harm reduction values and attitudes (30 minutes)
3. what is harm reduction (30 minutes)
4. break (10 minutes)
5. harm reduction issues in SRH counselling (40 minutes)
6. defining harms (20 minutes)
7. harm reduction and the provider-client relationship (20 minutes)
8. closing activity, discussion and evaluations (20 minutes)

Total Time: three hours

For more information, resources or support on harm reduction, contact the Manitoba Harm Reduction Network at [www.harmreductionnetwork.mb.ca](http://www.harmreductionnetwork.mb.ca).

## HARM REDUCTION VALUES AND ATTITUDES

**Objective:** Participants will have an opportunity to examine their values, beliefs and attitudes about harm reduction.

**Structure:** large group activity

**Time:** 30 minutes

**Materials:** paper, pens, flipchart, markers, signs: Agree, Disagree, Unsure

### Procedure:

1. **Give** participants the following instructions:
  - You will notice that I have posted three signs around the room: Agree, Disagree, Unsure.
  - I will read a number of statements and after you have heard each one, I will ask you to position yourself under the poster that best describes how you feel about what you heard.
  - In your smaller group, discuss why you positioned yourself there. Share your feelings, views and opinions.
  - Ask for one spokesperson to share your findings for each statement.
2. **Examples of statements** to be read. Or feel free to create your own based on your audience.
  - Harm reduction encourages drug users to continue using.
  - Harm reduction is a new practice that has been developed to talk to clients about substance use and sexual behaviour.
  - Harm reduction is based on allowing clients the right to make choices that work for them.
  - A harm reduction approach is at one end of the continuum of service provision while abstinence programming is on the other.
  - Harm reduction allows participants to glamorize their substance use or any other harmful behaviour they are engaged in.
  - Education and advocacy are cornerstones to a harm reduction approach.
  - Harm reduction doesn't really help people.

3. After the last statement is processed, **ask** the participants to return to their seats and **debrief** the activity by asking the following questions:
  - How was this activity for you?
  - What are these statements examples of?
  - How did it feel to hear opinions or views that are different from your own?
  - What does this activity tell you about people and their reactions to certain statements?
  - How does this relate to our work as a SRH counsellor?

## WHAT IS HARM REDUCTION?

**Objective:** Participants will create a definition of harm reduction and then tailor this definition to appropriate populations.

**Structure:** large group discussion

**Time:** 30 minutes

**Materials:** flipchart, markers, handout: *Principles of Harm Reduction*

### Procedure:

1. **Ask** participants: “What does harm reduction look like?” or “What are some things that you do in your work that could be defined as harm reduction?” Brainstorm some ideas and record them on a piece of flipchart paper. If you are only getting responses such as “needle exchange,” you might suggest other possibilities, such as reducing substance use or changing the route of administration. You might point out that harm reduction can also be applied to a variety of health issues such as sexual decision-making, parenting, pregnancy, etc.
2. **Ask** the group to develop one or two-sentences defining harm reduction that the group can agree on. If the group is large, break it up into a smaller groups. Following are examples of some good working definitions:
  - a. Harm reduction focuses on supporting people as they attempt to make any positive change.
  - b. Harm reduction must be client-centered, which means that any harm reduction steps must be defined and prioritized by the client.
3. **Record** the group’s definition of harm reduction on a newsprint sheet and post it or go around the room and ask groups what they came up with. Try to agree and record it on a piece of flipchart paper.
4. **Ask** participants how they would revise or expand the definition of harm reduction for HIV, hepatitis and sexually transmitted infections. To stimulate discussion, suggest:
  - a. strategies to reduce the harm or risk of transmitting STI’s or HIV or becoming re-infected with a STI or HIV
  - b. strategies to reduce the risk of more rapid STI or HIV progression as a result of substance use

5. **Write** the group's adapted definitions on a sheet of flipchart paper and then post it.
6. **Distribute handout:** *Principles of Harm Reduction* and introduce the following key point:
  - a. Harm reduction includes techniques and programs that support our work with people who take risks.

## PRINCIPLES OF HARM REDUCTION

### **Humanistic:**

- recognizes the intrinsic value and dignity of all human beings
- does not judge individuals on the basis of their individual behaviour
- accepts that moral condemnation leads to isolation of people and communities and is counterproductive
- seeks to enhance social and health programs, disease prevention and education, while minimizing repressive and punitive measures
- expects accessible, flexible, culturally responsive and non-judgmental services for all
- recognizes the rights and abilities of individuals in making their own choices

### **Pragmatic:**

- accepts risk-taking as normal human behaviour
- risk minimization occurs when people make choices that reduce the possibility of harm, rather than the total elimination of harm or risk
- identifies a range of risks related to sexually transmitted infection (STI) and bloodborne infection and the context in which they occur
- encourages people to start “where they’re at” to protect themselves and their partners

### **Focus on harm:**

- challenges the harmful social policies and their consequences, including misrepresentation of communities and misinformation about risk-taking behaviour

### **Evaluate impact:**

- contributes to the safety and well being of the community
- recognizes diversity within the community or communities, accepting that there is no one homogenous group
- demands that individuals and communities affected be directly involved in organization of strategies for harm reduction

### **Deal with priority issues:**

- recognizes the right for comprehensive, non-judgmental medical and social services and the fulfillment of the basic needs of all individuals and communities
- supports the development and provision of accessible harm reduction tools and information

## HARM REDUCTION ISSUES IN SRH COUNSELLING/EDUCATION

**Objective:** Participants will understand how to use the principles of harm reduction to support their clients' efforts to reduce harms.

**Structure:** small and large group discussion

**Time:** 40 minutes

**Materials:** flipchart, markers, handout: *Harm Reduction Issues in SRH Counselling*

### Procedure:

1. **Divide** participants into groups of three and give each a copy of *Harm Reduction Issues in SRH Counselling/Education*. Go over the questions with the large group and answer any questions participants may have. Once groups understand the questions, have each group spend 10 to 15 minutes discussing and responding to the questions in their small groups.
2. **Bring groups back together**, and have one person from each group present the responses. Allow time for discussion and clarification.
3. **Emphasize** that harm is what the client says it is, not what we think it is. We are trying to move away from encouraging people to review harm with clients, but rather to ask clients to identify these for themselves and then be able to express their own needs for reducing harm. This technique can help us better understand the challenges in each individual client's own life and help focus on the risk behaviour that is most important to that client.

**Note:** With a small group this activity can be done as a single group brainstorming activity. Write each question on a flipchart and have the participants answer the questions.



(c) to society

medical:

legal:

personal:

3. In your role as a SRH counsellor, what can you do to address the situation?

4. What impact will this approach have?

5. What barriers or obstacles will make it difficult to address the situation?

## DEFINING HARM

**Objective:** Participants will increase understanding of the unique harms encountered by people.

**Structure:** large group activity

**Time:** 20 minutes

**Materials:** flipchart, markers

### Procedure:

1. **Note:** This session can be adapted to best suit your audience. The primary purpose is to allow participants to learn more about their client's lives and identify how personal values and judgment can affect a healthy client-counsellor relationship.
2. Before you begin, **write** on a flipchart: "Do Client's Have the Right to...?" and the following questions underneath:
  - a. make decisions about what risks they are willing to take
  - b. use substances during pregnancy
  - c. intimacy
  - d. be sexually active
  - e. have competent and sensitive medical care
  - f. withhold STI or HIV status from others
  - g. use drugs, drink alcohol, smoke
3. Start by acknowledging that our beliefs and feelings about the potential harm of certain behaviour may lead us to make judgments about the people who engage in such behaviour. These judgments may be a barrier to practising harm reduction.
4. **Ask** participants to think about the unique harms their clients might face. How does it differ from the harm faced by others (ex: adolescents engaging in risky or unprotected sexual activity)?
5. **Ask** participants to think about the teens they'll be working with. Ask about the kinds of images and messages about youth that might influence people's ideas about young people and risk taking? How might these images make young people feel? How might they affect young people's abilities to reduce risk to themselves and others?

6. **Discuss** participants' responses and attitudes to each statement on the flipchart. **Explain** the role values and opinions may play in our responses to each statement. What impact might these values, opinions and beliefs have upon the work we do with clients?
7. **Ask** participants how their values and opinions might create barriers in their work. Ask them to brainstorm ways to overcome these barriers. Discuss the benefits, from a harm reduction perspective of addressing the values and opinions that may undermine our relationships with clients.

## HARM REDUCTION AND THE PROVIDER-CLIENT RELATIONSHIP

**Objective:** Participants will review the ways in which harm reduction may affect counsellor-client relationships and identify ways they can incorporate harm reduction skills into their work.

**Structure:** large group activity

**Time:** 20 minutes

**Materials:** flipchart, markers, handouts: *Support Role in a Harm Reduction Framework*, *Individual Outcomes in a Harm Reduction Approach*

### Procedure:

1. Before you begin, **write** “Skills we use” on a flipchart.
2. **Ask** participants to name some of the effective skills they use with clients. Write down their responses. **Review** the list and add any skills the participants have not mentioned including:
  - creating and supporting options
  - asking open-ended questions
  - reaching and supporting clients “where they’re at”
3. **Remind** participants that harm reduction involves the use of diverse strategies and skills. **Distribute** handout: *Support Role in a Harm Reduction Framework* and review it with the group.
4. **Explain** that there are three key aspects to harm reduction relationships. Acknowledge that some participants may already fully integrate them in their relationships with clients, while others may have incorporated only some aspects. In the harm reduction relationship, the counselor is not seen as the expert but as a consultant who can clarify information for the client and offer options. The client is responsible for the success of harm reduction efforts.
5. **Ask** participants what they feel may be the potential benefits to the client when a harm reduction approach is used. **Distribute** handout: *Individual Outcomes in a Harm Reduction Approach* and highlight any points on the handout that may not have been identified by the group.

## SUPPORT ROLE IN A HARM REDUCTION FRAMEWORK

A harm reduction approach offers the client:

- a safe, supportive environment
- clear indication of harm
- clear boundaries
- knowledge of themselves

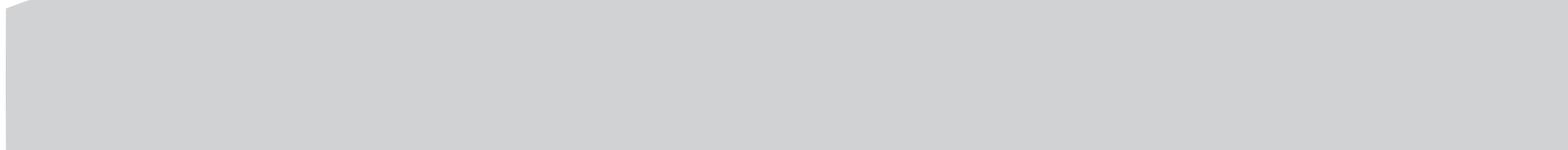
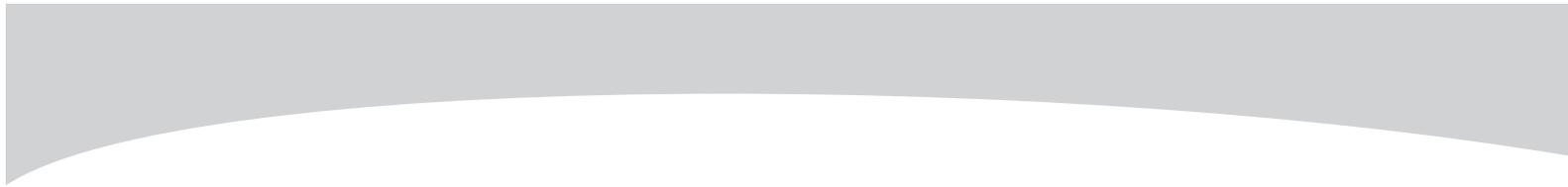
Harm reduction redefines the relationship between the counsellor and client so that:

- The client decides what (if anything) to change and when the change will happen.
- The counsellor offers information and is a consultant.
- The counsellor offers and supports a **range** of options for positive change.

## **INDIVIDUAL OUTCOMES IN A HARM REDUCTION APPROACH**

A harm reduction approach:

- restores individual dignity, self-esteem and a sense of value
- increases a sense of control
- reaffirms that everyone has a choice
- improves the range of options
- provides a safe place
- develops a sense of partnership
- restores future vision and hope
- gives the individual a voice
- acknowledges that every person is an expert in his/her own life



## MODULE FIVE

# VOLUNTEER COUNSELLING TECHNIQUES

*This module has been adapted from the AIDS Committee of Toronto, National HIV/AIDS Volunteer Training Kit.*

### **Session objectives:**

- examine the meaning of peer counselling
- examine issues and reference material that affects counselling
- understand the focus of counselling
- understand basic counselling skills
- examine questions in a counselling context
- examine a process for counselling
- understand problem solving approaches
- practise counselling

### **Agenda:**

1. opening activity, icebreaker or discussion (10 minutes)
2. what peer counseling is (30 minutes)
3. aims of the counselling session (30 minutes)
4. break (10 minutes)
5. counselling skills (45 minutes)
6. practise counselling (60 minutes)
7. closing activity, discussion and evaluations (20 minutes)

Total Time: 3.5 hours

## WHAT IS PEER COUNSELLING?

**Objective:** Participants will examine the meaning of peer counselling.

**Structure:** small group and large group activity

**Time:** 30 minutes

**Materials:** copies of handout: *What is Peer Counselling*, paper, pens, flipchart, markers

### Procedure:

1. **Divide** participants into groups of three. Give each group 15 minutes to develop a brief definition of peer counselling. After 15 minutes, **have each group provide their definitions**. Record key points on a flipchart.
2. **Distribute** handout: *What is Peer Counselling*. **Review** handout with participants and respond to any comments or questions as they arise.

## WHAT IS PEER COUNSELLING?

Peer counselling is a method and a philosophy. The basic premise is that most people are capable of solving their own problems if given a chance. The role of the peer counsellor is not to solve peoples' problems for them, but to help them find their own solutions. By using active listening and other skills, counsellors help clients clarify their thoughts and feelings and explore various options or solutions.

Peer counsellors don't tell people what they should do. They don't give advice. They don't interpret or diagnose, because peer counsellors are not professionals. Peer counsellors don't assume they can know what a person is thinking or feeling better than the person themselves.

Feelings are crucial and the most important aspect of counselling. Feelings are the root of most problems. Our culture encourages people to be good at thinking about their problems, but discourages them from becoming aware of feelings. It's important to become more aware of your own feelings, so you can recognize and explore feelings of others.

## AIMS OF THE COUNSELLING SESSION

**Objective:** Participants will understand the focus of SRH counselling.

**Structure:** large group activity

**Time:** 30 minutes

**Materials:** copies of handout: *Counselling Techniques*, paper, pens, flipchart, markers

### Procedure:

1. **Brainstorm** by asking participants to list the goals of a SRH counselling session. Record responses on flipchart. Refer to the list below to ensure all points have been covered.

*SRH counselling sessions should provide an opportunity to:*

- talk to another person
  - listen to what is said and note what is not said
  - identify concerns and help the person manage them
  - provide information about birth control, STI, HIV or pregnancy options
  - assess the psychological and emotional impact of these concerns on the person
  - assure the person his/her views have been heard
  - help the person make informed decisions
  - identify the person's previous ways of coping and develop new methods, if necessary
  - encourage the person to make decisions and manage his/her life as circumstances permit
2. **Distribute** handout: *Counselling Techniques*, review with participants and respond to questions and comments as they arise.

## COUNSELLING TECHNIQUES

### Aims of the session

Each session should provide an opportunity to:

- talk to another person
- listen to what is said and note what is not said
- identify concerns and help the person manage them
- provide information about Birth Control, STI, HIV or pregnancy options
- assess the psychological and emotional impact of these concerns on the person
- assure the person that their views have been heard
- help the person make informed decisions
- identify the person's previous ways of coping and develop new methods for this if necessary
- encourage the person to make decisions and manage their life as circumstances permit

### How to achieve the aims of counselling

#### Objectives should be small, limited and attainable

Counsellors can feel overwhelmed by the problems a person brings to a session. This causes uncertainty and lack of confidence, which is easily conveyed to the client who may then feel even more anxious. It's very important to have specific and realizable objectives for each session so that progress can be made and a goal achieved. This might include merely listening to the person's story or identifying problems where specialized help might be required. If the objectives are clear and attainable, the client may be able to manage their difficulties better.

#### The counsellor should lead the session

The counsellor takes the lead in setting up the session, defining its purpose and guiding the conversation. The content of the session – what is said – addresses the most pressing concerns of the client. At the end of the session, the client should feel that he/she has had an opportunity to talk, explore concerns and develop a strategy for dealing with some of them. Listening to the client is a crucial part of counselling. Assessment needs to be thorough and ongoing.

### **Anxiety needs to be reduced to manageable proportions**

Helping clients manage anxiety can help them to make decisions and cope better with their situations and their problems. After the counsellor has heard and assessed the client's problems, the first major intervention may be to help him/her develop a plan for coping with them. As soon as a plan has been developed, it's possible to explore the client's reaction to some anticipated fears and concerns. Practical management of problems must be dealt with immediately to reduce anxiety.

### **Dependency should be avoided**

Sometimes, counsellors are tempted to help by trying to solve the client's problems. This can make the client overly dependent on the counsellor, which may cause helplessness or anger. Many people have had some form of trauma in their lives, such as the death of someone close or being unemployed or becoming ill, and probably had the capacity to cope without professional help. The counsellor should try to understand how the client has managed situations in the past and how these experiences could be used to deal with the present situation. It's important to help clients realize they have the capacity to manage problems on their own. This allows them to retain a sense of control over their own life.

### **The person's own way of coping has to be respected**

Some people may be in denial about whatever is happening in their lives. Counsellors should respect this as a way of coping - no matter how irrational it might seem. Counsellors should be careful when confronting people who use denial as a coping mechanism. Sometimes, denial needs to be challenged. Other times, if challenged at the wrong time or in the wrong manner, clients might become very anxious, depressed, suicidal or totally dependent on the counsellor.

### **Boundaries need to be set**

The counsellor must clearly state the limits of what can possibly be achieved in the sessions. Confusion over what can and cannot be expected can hurt the relationship between the counsellor and client. If counsellors offer what they cannot really provide, they'll ultimately let the client down. For example, an offer such as "You can contact me any time," has to be backed up by a workable plan, and the client must also be told who to contact in case the counsellor is not available. Professional boundaries must be respected, otherwise clients become too dependent on counsellors and come to believe they cannot cope on their own.

### **Assumptions should not be made**

It is wise to take nothing for granted and not to make assumptions about the client's level of knowledge, concerns, values and possible reactions, or how to behave in relationships. Making assumptions stops free discussion and exploration of the true nature of the person's worries.

## COUNSELLING SKILLS

**Objective:** Participants will understand basic counselling skills.

**Structure:** small and large group activity

**Time:** 45 minutes

**Materials:** copies of handouts: *The Eight Rules of Counselling, Counselling Techniques – Statements, Using Questions in a Counselling Setting* (handout on page 152), paper, pens, flipchart, markers

### Procedure:

1. **Distribute** handout: *The Eight Rules of Counselling*. Review handout with the group and respond to any comments or questions as they arise.
2. Divide participants into pairs and **Distribute** handout: *Counselling Techniques – Statements*. Ask participants to work together to develop a response to each of the three statements on the handout using the techniques discussed. Give participants 15 minutes to complete the activity.
3. After 15 minutes, **have each pair share** their responses. Discuss each statement briefly by asking for feedback and comments from the rest of the group.

## THE EIGHT RULES OF COUNSELLING

### The eight rules of counselling

- i) be non-judgmental
- ii) be empathetic
- iii) don't give advice
- iv) don't ask why?
- v) don't take responsibility for the client's problems
- vi) don't interpret
- vii) stick with the "here and now"
- viii) deal with feelings first

### Counselling skills

#### 1. *Non-verbal and minimal verbal attending*

This skill is the foundation on which all the other skills are based. Sometimes called the art of listening with your mouth closed, these skills will help you to be a more effective and empathetic listener. Non-verbal attending includes:

- eye contact
- body posture
- concerned facial expression and tone
- verbal following (don't jump topics)
- minimal verbal encouragement (use brief statements)
- head nodding

#### 2. *Open questions*

Open questions encourage clients to talk without being defensive. Open questions encourage clients to explore their thoughts and feelings and work out solutions to their problems. Open questions include:

- how? or what?
- clarification and elaboration

- working with feelings
- problem solving

### 3. *Paraphrasing*

To accurately paraphrase what someone is saying, you must be able to accurately listen. A good paraphrase helps clients clarify what they are saying and demonstrates you are understanding them. Practising this skill will show how hard it is to really listen to someone. Paraphrasing includes:

- summing up the essence of what a person said
- brief and tentative statements (without interpreting)
- checking perceptions (“Is that how you see it?”)
- clarifying (“What do you mean by ‘x’?”)
- conveying empathy (“You’re expressing a lot of pain.”)

### 4. *Examining feelings*

The essence of counselling involves exploring clients feelings. Use open questions, reflections of stated or implied feelings and other skills. Counsellors should encourage clients to get in touch with their feelings. Sometimes the feelings are the problem and sometimes the problem is behind the feelings. Examining feelings includes:

- getting at the feelings
- asking feeling questions and getting feeling answers
- paraphrasing spoken feelings
- reflecting unspoken feelings
- defining and clarifying feelings
- acknowledging and taking responsibility for feelings
- dealing with feelings

### 5. *Summarizing*

This set of skills helps tie together the counselling session and gives the client a clear image of what has been discussed. Summarizing includes offering the person a large paraphrase that captures the essence of what has been said during the session. It puts the session into a logical and usable order. Summarizing is a wrap-up of the session which helps the person digest what has just taken place.



- b) paraphrase
- c) question to elicit feelings
- d) summarize

**Statement 3**

“I like to have a lot of different sexual partners without using condoms. I don’t care if I get any diseases.”

- a) open question
- b) paraphrase
- c) question to elicit feelings
- d) summarize

## USING QUESTIONS IN A COUNSELLING SETTING (CIRCULARITY)

- Questions are used to gather information about interactions, patterns of behaviour or relationships and beliefs. This information is used to link people to each other and to ideas and feelings that are not often overtly expressed.
- “Circularity” is achieved by the use of sequential questions. A wide range of questions can be asked that have the overall effect of helping people talk about difficult issues and see their situations differently. Ways of coping with and adjusting to circumstances can then be addressed.
- Questions can challenge a client’s ideas and views. Each question is designed to gather information about one aspect of a situation or concern. The use of multiple questions helps develop a more complete view of the situation or concern, but questions should not lead to a simple “yes” or “no” answer, because that ends, rather than opens up, the conversation.
- Questions might address issues such as relationships; difficult situations for prevention; knowledge about sexually transmitted infections (STIs) and HIV/AIDS; and their impact on any other person. There are a number of different types of questions that can be used.

## Types of questions

1. *Linear*
  - “How do you feel?”
2. *Difference*
  - “Is it more or less stressful for you to know ...”
3. *Circular*
  - “How do you imagine it would affect your relationship with them if your parents knew you were here?”
  - “If I were to ask your partner what his/her view would be, what do you imagine he/she would say?”
4. *Hypothetical/future-oriented*
  - “If you chose to continue the pregnancy how would your life change?”

## Striving towards neutrality

- All attempts on the part of the counsellor to preserve a professional relationship and to resist being distracted by any information given by the client can help the counsellor be more neutral and effective. Neutrality may be achieved if the counsellor respects any view or position that the client may take. It's probable the counsellor will have some feeling about what is discussed in the session, but how the counsellor responds to these feelings is another matter.
- Too many comments designed to comfort and identify with the person may change the definition from a professional relationship to one of friendship. Statements such as: “Oh gosh! How awful for you! I know just what it is to feel like that!” make assumptions about how others feel. Being too friendly defines the relationship in a way that might be difficult to reverse if there are conflicts or issues that require objective distance from the counsellor.
- The counsellor should not have any preconceived ideas about what is best for the client or what decisions he/she should make.
- Complete neutrality can never be achieved in counseling, but the following guidelines may help achieve balance: being in control of the session without aligning with or supporting any particular person or any view presented; asking many questions and being interested in the views of people and their contacts; and using a neutral tone of voice.
- Using a neutral, enquiring tone of voice conveys respect for whatever is said. The counsellor is then less likely to influence what the client talks about. To help keep the session focused and to be as neutral and objective as possible, the counsellor might include a colleague, such as a nurse or a doctor, in the session. The person who is not actively interviewing can help the counsellor be more objective. In

addition, he/she may also challenge the views of the counsellor, which, in turn, may increase the number of ideas and possibilities that can emerge from the session.

### **Self-evaluation questions for counsellors**

Here is a list of some questions counsellors might ask themselves when reviewing a session. The answers may guide counsellors' thoughts about how to plan the direction of future sessions.

- What is the problem?
- How is it defined and by whom?
- What does the client expect of me in relation to the problem?
- Why does this problem appear at this time?
- Who else is implicated?
- What would happen if the situation deteriorated?
- Why is the person telling me this?
- How is the person telling me this?
- Who else is the person telling?
- Who else should the person be telling?
- How can I best deal with the issue?
- What is the worst possible consequence of what the person is telling me?
- How do I feel about it?
- What is the explicit or implicit message?
- What are the settings in which all this takes place?
- What needs to be done to bring about a change?
- How does the person view me at present?
- What behaviour tells me that this is how the person feels?
- If my colleagues were here, what might they advise me to do?

## PRACTISE COUNSELLING

**Objective:** Participants will practise the counselling skills learned in the session.

**Structure:** role play and large group discussion

**Time:** 60 minutes

**Materials:** copies of scenarios, paper, pens, flipchart, markers

### Procedure:

1. **Divide** participants into pairs. Provide each pair with a copy of one of the three scenarios and have them spend 25 minutes developing a way to role play between a client and counsellor that addresses the scenario they have been given.
2. **Have** each group role play the scenarios. **Debrief** each scenario by asking participants for feedback and discussion after each group presents.

## **SCENARIOS FOR COUNSELLING PRACTISE ROLE PLAYS**

### **Scenario 1**

A 15-year-old client has come to the teen clinic for the first time. She has just started a new relationship with her boyfriend. They are not yet sexually active, but she is concerned about birth control if they start having sex. She is very concerned about her parents finding out and is very shy and reluctant to answer any of your questions. She says she would just like to use the pill.

### **Scenario 2**

A 17-year-old woman has recently broken up with her boyfriend and is now pregnant. Her parents are very strict; have forbidden her to date; and don't know about her past relationship. She does not want an abortion but wants to continue the pregnancy. However, she is very afraid of how her parents will react.

### **Scenario 3**

A 21-year-old male has come to the teen clinic for STI testing. He is very concerned about HIV and would like information on HIV and STI prevention.

## MODULE SIX

# VALUES AND SEXUALITY

*This module has been adapted from the Canadian Federation of Sexual Health, Beyond the Basics; A Sourcebook on Sexuality and Reproductive Health.*

### **Session objectives:**

- Define and explore personal values about relationships and sexuality.
- Demonstrate the range of sexual values among individuals.
- Understand how sexual values influence decision making.

### **Agenda:**

1. opening activity, icebreaker or discussion (10 minutes)
2. defining personal values (30 minutes)
3. values auction (30 minutes)
4. break (10 minutes)
5. values voting (35 minutes)
6. sexual violence (30 minutes)
7. values and sexuality (20 minutes)
8. closing activity or discussion and evaluations (15 minutes)

Total Time: three hours

## DEFINING PERSONAL VALUES AND DEMOCRATIC VALUES HOW DO THEY APPLY TO OUR SEXUALITY?

**Objective:** Participants will define personal and democratic values and examine how they can be applied to sexuality issues.

**Structure:** large group discussion

**Time:** 30 minutes

**Materials:** flipchart, markers

### Procedure:

1. **Write** a definition of personal values - things or qualities a person thinks are important – on the flipchart.
2. **Write** a definition of democratic values – agreed upon principles or concepts that are promoted in Canadian society – on the flipchart.
3. **Ask** participants to give some examples of personal values (ex: loyalty, intelligence, dedication, attractiveness, etc.) and democratic values (ex: fairness, equality, justice, respect for others, etc.) Note: there may be some overlap between personal and democratic values.
4. **Ask** participants to discuss where they learn their personal and democratic values (ex: family, media, religion, friends).
5. **Point out** that, since we all learn our values from different sources, different people will have different values. In a democratic society like Canada, people respect everybody's right to have his/her own values. However, to live together in a free and fair society, we use basic democratic values like equality, justice, responsibility and respect as guidelines for how our society is organized and how people treat each other.
6. **Ask** participants to give examples of how democratic values such as honesty, equality, respect and responsibility apply to sexuality and interpersonal relationships. Following are some examples:
  - being honest about your feelings (ex: not deceiving a person about your feelings to get something from them)

- having an equal relationship (ex: giving each person in a relationship an equal say in decisions about the relationship, including sexual behaviour)
  - respecting the rights of others (ex: treating everybody with equal fairness whether they are male, female, gay, lesbian, heterosexual, bisexual etc.; respecting the right of a partner to say no to sex)
  - taking responsibility for myself and others (ex: always using condoms if I have sex)
7. **Conclude** the discussion by suggesting that participants can keep these ideas about personal values and democratic values in mind as the group moves on to explore choices, relationships and behaviour related to sexuality and sexual health.

## VALUES AUCTION

**Objective:** Participants will prioritize their values.

**Structure:** large group activity

**Time:** 30 minutes

**Materials:** *Values for Auction* list, play money, flipchart, markers, index cards

### Procedure:

1. **Before the session** write the list of *Values for Auction* on the flipchart.
2. **Introduce** *Values for Auction* by explaining that you have a list of values that are important to some people. Read the values you have posted on the flipchart and ask participants to add others.
3. **Explain** the auction process. Give each participant \$300 in play money. Tell the group you are going to auction off the values on the list. Give the following instructions:
  - Use your money to buy the values most important to you.
  - You must bid at least \$20 or a multiple of \$20 for each bid.
  - Once you have spent your \$300, you are out of the auction.
4. **Open the bidding.** Award each value to the highest bidder by giving her/him the index card with the value written on it. Record the amount paid for each value on the flipchart. After the auction, identify the values that received the highest bids.
5. **Lead a discussion**, using the following questions as a guide:
  - How did you decide which values to bid on?
  - What value did you really want that you were not able to buy? Point out that in the real world, people can have any values they want because values are not for sale.
  - What were the top five values?
  - Which values seemed less important?
  - Which of these values would you want to pass on to your children? What process would you use to teach your children your values? How were your values communicated to you as a child?

6. **Conclude** by pointing out how understanding our values and what's important to us is an integral part of decision making and fostering healthy behaviour.

### **Values For Auction**

1. being a good friend to others
2. being well liked and popular
3. being good looking
4. having a well-toned, fit body
5. being honest
6. having money and nice clothes
7. being with someone I love
8. saving sex until marriage or a lifetime commitment
9. respecting others in relationships
10. feeling good about myself
11. being comfortable with my sexual orientation (gay, bisexual, heterosexual)
12. accepting people who are different from me
13. having a close relationship with my family
14. practising my religion or spirituality
15. having the freedom to make my own decisions
16. enjoying lifelong health
17. giving back to the community/helping others
18. fighting to right the wrongs in our society

## VALUES VOTING

**Objective:** Participants will explore their values regarding relationships and sexuality.

**Structure:** large group activity

**Time:** 35 minutes

**Materials:** *Values Statements* list, three signs: AGREE, DISAGREE, NEUTRAL, masking tape

### Procedure:

1. **Post** the three signs around the room leaving enough space for participants to gather beneath them.
2. **Choose** six to eight of the statements from the Values Statements list.
3. **Explain** the exercise is designed to explore personal values, and give the following directions:
  - “I will read several statements to you, one at a time. Most of the statements are about relationships, dating and sexual behaviour.”
  - “Go and stand under the sign that represents your response to the statement: **AGREE, NEUTRAL, DISAGREE.**”
  - “When everyone is standing where they want to be, I’ll ask volunteers to explain their positions.”

Note: If participants are all standing under one sign, explore the position that is not expressed. If necessary, give some of the beliefs from that point of view. Tell participants that they can benefit from being exposed to all points of view and will be better prepared to respond when someone challenges their values.

4. **Read** the first statement and ask everyone to take a position under a sign. Ask volunteers to explain why they have chosen to stand where they are. Congratulate those willing to stand alone.
5. When the first statement has been fully discussed, go on to the next one. Pacing is important. Don’t drag out the discussion; make sure most points of view have been heard.
6. End with these **discussion questions**:
  - How easy was it to vote on these values?
  - Which statements were the hardest for you? Why?

- If your parents or partner voted on these statements, would their votes be similar to, or different from, those of this group?
  - What happens when your values are different from those of your client?
  - What is one thing you learned about your own values from this activity?
  - What did you learn about the values in this group?
7. **Conclude** by pointing out how understanding our values, even when they differ from the majority, is an integral part of decision making and fostering healthy behaviour. As health counsellors, it is important for us to be aware of our values and how they may affect us in our role.

### Values Statements

1. Most young people, 13 or younger, are too young to date.
2. Women who dress in sexy or provocative clothing are asking to be sexually harassed.
3. Gay, lesbian and bisexual teenagers should be allowed to take their same-sex partners to school dances and other social functions.
4. It's okay for two people of different races to date.
5. Using birth control is primarily the responsibility of the woman in a relationship.
6. Men only need to use condoms when they're having sex with someone who has had many sexual partners.
7. It is irresponsible for a person to have sex without using protection from pregnancy and STIs.
8. Having sex with someone you don't really care about is wrong.
9. A girl who carries condoms in her purse is probably "easy."
10. Choosing not to have sex is the best choice for teenagers.
11. Adolescents are too young to decide how to deal with pregnancy on their own.
12. Teenagers are too young to be good parents.
13. There should be more restrictions on sexual images, language and soliciting on the Internet.
14. Women who continue to have multiple abortions are irresponsible.

## EXPLORING ATTITUDES ABOUT SEXUAL VIOLENCE

**Objective:** Participants will identify their attitudes concerning sexual violence.

**Structure:** large group

**Time:** 30 minutes

**Materials:** handouts: *Is it All Right...?*, *The Rape of Mr. Smith*

### Procedure:

1. **Distribute** the *Is it All Right...?* handout. Explain that the questions are about rape and that respondents answered for themselves, not as they thought their friends would.
2. **Ask** what attitudes are reflected in this handout. Responses should include:
  - Sexual violence is okay in certain situations.
  - If someone behaves in a certain way (dresses sexily, turns a partner on, doesn't pay for expenses, or is drinking), they are perceived to be asking for it, and can be blamed for the sexual violence that happens to them.
3. **Ask** how these attitudes increase sexual violence. Responses should include:
  - The message, "Sexual violence is always wrong." is not clearly delivered if we: excuse violence in certain situations; believe that it is to be expected; and blame the survivor for the violent behaviour that occurred. If we make excuses and exceptions for violence, we are allowing and supporting it.
4. **Explain** that you want to look at a different type of violation and at the issue of blame.
5. Have two volunteers **read** *The Rape of Mr. Smith* aloud.
6. **Ask** participants what the point of the story was and how it relates to sexual violence. Responses should include:
  - Blaming the victim of a robbery for getting robbed is absurd. It is not absurd in our culture, however, to blame the person who was raped for the rape, or to blame the person who was sexually violated in other ways for the sexual violence.
7. **Ask** participants how we develop our attitudes about what is right and wrong behaviour. Point out that some of the ideas of how to behave and what to expect in a relationship are hurtful and others are helpful.

8. **Give** some examples of messages or ideas we get about how to behave and what behaviour to expect from others that would harm a relationship. Some ideas are:
  - We expect that conflicts will be resolved with violence.
  - We are taught we don't need to talk about sexual intimacy: people should just know what their partners want.
9. **Ask** participants if they can think of other behaviours to add to the list.
10. **Conclude** by pointing out:
  - Sexual violence occurs, in part, because of some of the messages in our society, about how we are to behave and what we are to expect from each other in a relationship.
  - We are all susceptible to those messages. It is important to be aware of what they are, and which ones will lead to a relationship that will be in the best interest of both people involved.
  - Promoting healthy sexual relationships for young people and adults can help change some of those messages into ones that promote relationships based on mutual respect-not exploitation.

## IS IT ALL RIGHT...

These are the results of a survey conducted by Jacqueline Goodchilds of the University of California, Los Angeles. She asked high school students:

*“Is it all right if a male holds a female down and physically forces her to engage in intercourse if ...”*

Conditions	Percentage of “yes” responses	
	Males	Females
1. He spent a lot of money on her?	39%	12%
2. He is so turned on he thinks he can't stop?	36%	21%
3. She has had sex with other guys?	39%	18%
4. She is stoned or drunk?	39%	18%
5. She lets him touch her above the waist?	39%	28%
6. She is going to have sex with him and then changes her mind?	54%	31%
7. She has led him on?	54%	26%
8. She gets him excited sexually?	51%	42%
9. They have dated for a long time?	43%	32%

## THE RAPE OF MR. SMITH

**In the following situation, a lawyer asks questions of a hold-up survivor.**

“Mr. Smith, you were held up at gunpoint on the corner of First and Main?”

“Yes.”

“Did you struggle with the robber?”

“No.”

“Why not?”

“He was armed.”

“Then you made a conscious decision to comply with his demands rather than resist?”

“Yes.”

“Did you scream? Cry out?”

“No, I was afraid.”

“I see. Have you ever been held up before?”

“No.”

“Have you ever given money away?”

“Yes, of course.”

“And you did so willingly?”

“What are you getting at?”

“Well, let’s put it like this, Mr. Smith. You’ve given money away in the past. In fact, you have quite a reputation for giving your money to charity. How can we be sure that you weren’t trying to have your money taken from you by force?”

“Listen, if I wanted -”

“Never mind. What time did this hold-up take place, Mr. Smith?”

“About 11:00 p.m.”

“You were out on the street at 11:00 p.m.? Doing what?”

“Just walking.”

“Just walking? You know that it’s dangerous being out on the street that late at night. Weren’t you aware that you could have been held up?”

“I hadn’t thought about it.”

“What were you wearing at the time, Mr. Smith?”

“Let’s see ... a suit. Yes, a suit.”

“An expensive suit?”

“Well, yes. I’m a successful lawyer, you know.”

“In other words, Mr. Smith, you were walking around the streets late at night in a suit that practically advertised the fact that you might be a good target for some easy money, isn’t that so? I mean, if we didn’t know better, Mr. Smith, we might even think that you were asking for this to happen, mightn’t we?”

## VALUES AND SEXUALITY

**Objective:** Participants will compare their own values related to sexuality with those of their family and friends.

**Structure:** individual and large group discussion

**Time:** 20 minutes

**Material:** handout: *Values/Moral Values and Sexuality*

### Procedure:

1. **Make** the following points:
  - Thinking about our values about sexuality can help us make important decisions we may face in our lives.
  - In making decisions about sexuality, we are often influenced by important people in our lives, like family and friends.
  - This questionnaire is designed to help us identify our own perspectives and those of others who may be important to us.
2. **Distribute** the *Values/Moral Values and Sexuality* handout. Tell participants their answers are confidential and you will not be collecting them.
3. Allow sufficient time for participants to complete the handout.
4. **Conclude** by asking participants if there were statements where they put different responses for themselves, their close family, or friends. Briefly discuss how decisions about sexuality issues can be complicated and how important it is to think carefully about our values. The more comfortable and aware we are of our own values about sexuality, the more prepared we are to discuss them in a counselling setting.

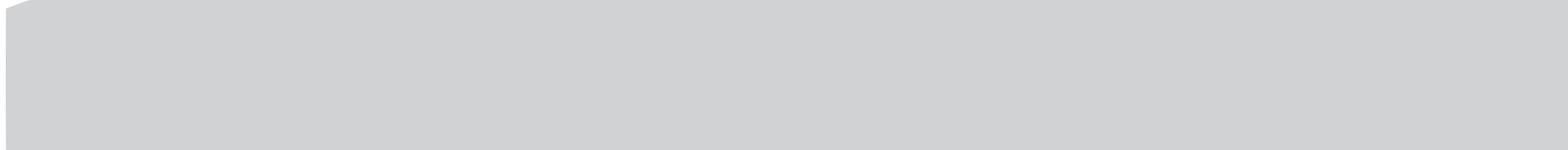
## VALUES/MORAL VALUES AND SEXUALITY QUESTIONNAIRE

**Directions:** Use a check mark to indicate agreement with the statement.

Statement	I Agree	My Family Agrees	My Friends Agree
Having sex before marriage/ life time commitment is wrong.			
It is important for teenagers to know how to use birth control and practise safer sex (use condoms).			
My religion should play an important role in how I make decisions about sexual behaviour.			
The most important thing about sex is having fun.			
It's important to be in love with your partner before you have sex with him/her.			
If two people are sexually attracted to each other, that's all that is needed to have a good relationship.			
Honesty and respect are essential to a good relationship.			
People who are gay or lesbian deserve as much respect as anybody else.			
There is too much pressure put on teenagers to have sex.			

<b>Statement</b>	<b>I Agree</b>	<b>My Family Agrees</b>	<b>My Friends Agree</b>
Most teenagers would be better off waiting until they are older before having sex.			
It's OK to masturbate.			
It's OK for a pregnant teenager to get an abortion, if that's what she decides is best for her.			

After completing this exercise, I learned:



## MODULE SEVEN

# ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

*This module has been adapted from the Canadian Federation of Sexual Health, Beyond the Basics; A Sourcebook on Sexuality and Reproductive Health.*

### **Session objectives:**

- Identify and describe the SRH concerns of adolescents.
- Develop the skills to talk about reproductive and sexual health issues with adolescents.

### **Agenda:**

1. opening activity, icebreaker or discussion (15 minutes)
2. common adolescent health concerns (30 minutes)
3. reproductive health issues question/answer match (30 minutes)
4. break (10 minutes)
5. youth bill of rights (40 minutes)
6. counselling teenagers - guidelines (40 minutes)
7. closing activity or discussion and evaluations (15 minutes)

Total Time: three hours

## COMMON CONCERNS BRAINSTORMING

**Objective:** Participants will identify and describe the reproductive health concerns of adolescents and build skills to talk about reproductive health issues.

**Structure:** large group discussion

**Time:** 30 minutes

**Materials:** handouts: *It's the Truth: The Facts About Sexual and Reproductive Health Care for Males and Females, Adolescent Health Services, Youth Crisis and Information Lines*, flipchart, markers.

### Procedure:

1. **Tell** the group the session will address concerns that many teens have about their sexual and reproductive health. Write MALE CONCERNS on flipchart and ask the group to brainstorm common concerns, worries, or questions that many males have about the sexual parts of their bodies. Repeat for FEMALE CONCERNS. Point out which concerns have to do with sexual health, sexual responsiveness and sexual attractiveness.
2. **Discussion** questions:
  - Is there a difference of focus between male and female concerns? If so, why?
  - Where can young people go for help for a sexual health concern/problem?
3. **Distribute handouts:** *It's The Truth: The Facts about Personal Sexual and Reproductive Health Care for Males and Females*. Ask participants to read through the lists and see if the handouts address any of the concerns they listed. Discuss any questions.
4. **Conclude** by pointing out how important it is for young people to have accurate information on reproductive health to navigate the health care system and to maintain good sexual health through adolescence and into adulthood.

### Extension:

**Ask** participants to list community resources (sexual health clinics, STI/HIV testing sites, hotline phone numbers, public health department, etc.).

**Distribute handout:** *Adolescent Health Services and Youth Crisis and Information Lines*. These lists will be useful for future reference.

## IT'S THE TRUTH: THE FACTS ABOUT PERSONAL SEXUAL AND REPRODUCTIVE HEALTH CARE FOR ADOLESCENT FEMALES

It is **common** for adolescent females to:

- be at a different stage of physical development from peers of the same age
- have one breast slightly larger or differently shaped
- have breast swelling and tenderness just before their periods
- have cramps before and/or during their periods
- have nipples that turn in instead of sticking out or hair around the nipples
- have some natural, healthy, genital odour
- have genital hair of a different colour from hair on other parts of their bodies
- have a regular menstrual cycle length between 21 and 40 days
- have irregular periods
- have wetness in the vaginal area when sexually aroused
- masturbate occasionally, frequently, or not at all (with no resulting physical harm)
- have varying amounts of clear to cloudy discharge from the vagina, as part of their monthly cycle or with antibiotics, birth control pills, or pregnancy
- have their hymens stretched during routine physical activities like gymnastics (therefore not a clue to virginity)
- have labia, breast, nipples of various sizes, shapes, skin tones

It is **uncommon** but **possible** for adolescent females to get

- cysts in the breast
- breast cancer
- cervical or uterine cancer
- ovarian cysts (sac or cavity of abnormal character containing fluid which may occur in the ovaries)
- uterine fibroids (non-cancerous tumour of muscular and fibrous tissues which may develop in the wall of the uterus)

**Signs** of possible **problems** for adolescent females include:

1. Pain:
  - general pelvic pain
  - pain, burning and/or itching while urinating
  - pain during intercourse
2. Change in menstrual cycle:
  - suddenly irregular periods
  - unusually late period
  - unusual cramps
  - cramps with no period
3. Change in body:
  - more frequent urination
  - lump, growth or a sore on genitals
  - unusually heavy or smelly vaginal discharge
  - changes in appearance of nipples
  - a lump in the breast that wasn't there before
  - discharge from nipple or discharge with blood or pus in it

**Prevent** problems by:

- having a yearly pap test if sexually active or age 18 to 20 and haven't had one before
- doing a self breast exam at the same time each month
- tracking menstrual cycles
- keeping the outside of the vagina clean and dry
- avoiding perfumed or scented soaps, douches, tampons, sanitary napkins, sprays, or bath bubbles and oils
- wearing cotton underpants and pantyhose with a cotton-lined crotch
- not wearing clothes or pyjamas that are too tight in the crotch and thighs
- sleeping without underwear
- if having intercourse, using condoms to prevent sexually transmitted infections (STIs), contraception to avoid unintended pregnancy, and water-based lubricant if needed
- getting tested for STIs if had intercourse without a condom

## IT'S THE TRUTH: THE FACTS ABOUT PERSONAL SEXUAL AND REPRODUCTIVE HEALTH CARE FOR ADOLESCENT MALES

It is **common** for adolescent males to:

- be at a different stage of physical development from peers of the same age
- have one testicle larger and lower hanging than the other
- have their testicles hang closer to, or further from, the body, depending upon temperature changes, stress, or sexual arousal
- be normal with either a circumcised or uncircumcised penis
- have a whitish, cheesy substance (smegma) under the foreskin, if uncircumcised
- have a pimple or hairs on the penis
- have genital hair of different colour from hair on other parts of their bodies
- have some natural, healthy genital odour
- have frequent erections, sometimes due to sexual arousal, stress or general excitement, and sometimes for no apparent reason
- wake up in the morning with an erection
- sometimes lose an erection during intercourse
- masturbate occasionally, frequently, or not at all (with no resulting physical harm)
- have erections without ejaculating
- have wet dreams (nocturnal emissions)
- have a flaccid (limp) penis length of under five inches
- believe, incorrectly, that penis size is crucial to proper sexual functioning
- have an ache in the testicles (“blue balls”) after prolonged sexual arousal (which will go away by itself or can be relieved through masturbation)
- have breast swelling during puberty which disappears after puberty ends
- have some breast tenderness, or a sore spot under one or both nipples

It is **uncommon** but **possible** for adolescent males to:

- get breast cancer
- get testicular cancer
- have hernias
- have foreskin stick to the penis (uncircumcised male)

**Signs** of possible **problems** for adolescent males include:

1. Pain:
  - pain, burning and/or itching while urinating
  - sharp pain in testicles that lasts more than a few minutes
  - moderate pain in testicle or groin that lasts more than a day or two
  - persistent itching around testicles, inside thighs, or in anal area
2. Change in body:
  - more frequent urinating
  - coloured or smelly discharge from end of penis
  - discharge from the nipple
  - lump, growth, or sore in testicles or other part of genitals

**Prevent** problems by

- having regular check-ups
- doing a monthly testicle exam
- examining genitals for sores, unusual lumps
- keeping genitals clean and dry
- not wearing tight jeans or pants
- if having intercourse, using condoms to prevent sexually transmitted infections (STIs) and unintended pregnancy and using waterbased lubricant if needed
- getting tested for STIs if had intercourse without a condom

## ADOLESCENT HEALTH SERVICES

(Source: Klinik Community Health Centre, Teen Talk)

### Community Health Clinics in Winnipeg

For low-cost/free birth control, pregnancy testing, pregnancy options counselling, STI/HIV testing, and Emergency Contraception Pill (also called the morning after pill) ALWAYS PHONE AHEAD!!

<b>Klinik</b> • 870 Portage Ave. – Teen Klinik (drop in) Mon. 4:30–8pm (closed long weekends)	784-4090
<b>Elmwood Teen Clinic</b> • 505 Chalmers – Teen Clinic (drop in) Tues. 4–8pm	in person
<b>Women’s Health Clinic</b> • 3rd Floor 419 Graham Ave.-Teen Clinic (drop in) Thurs.3–8pm	947-1517
<b>Mount Carmel Clinic</b> • 886 Main St. – Teen Clinic (drop in) Sat. 12-4 (closed long weekends)	582-2311
<b>HSC Children’s Hospital</b> • 840 Sherbrook – Teen Clinic Tues./Thurs. 1–4 (prefer appt.)	787-2664
<b>Nor’West Co-Op</b> • 103-61 Tyndall – Teen Clinic (drop in) Wed. 3:30–5:30pm	940-2020
<b>Youville St.Vital</b> • 6-845 Dakota StVital – Teen Clinic (drop-in) Tues. 4–7pm	255-4840
<b>Nine Circles</b> • 705 Broadway – Wed. 1–7pm (drop in) for HIV/AIDS & Hepatitis C testing	940-6000

### Drop in Services

<b>Street Connections</b> • Get free condoms, needles, and referrals. <b>Call for van hours</b>	981-0742
<b>MacDonald Youth Services</b> • 161 Mayfair – Counselling, overnight shelter, free condoms	477-1804
<b>Ndinawe</b> • 370 Flora Ave. – Safe shelter for youth on the street and runaways – 24 hrs	586-2588
<b>Ma Mawi</b> • 94 McGregor St. – Community drop-in with lots of youth groups and programs	925-0300

### Pregnancy Options Resources

<b>Child &amp; Family Services (CFS)</b> • 222 Provencher – Adoption Intake & Family support	944-4288
<b>Healthy Baby</b> • Resources, programs & support for pregnant & parenting teens	945-1301
<b>Adolescent Parent Centre</b> • 136 Cecil Ave. – School for pregnant or parenting teens	775-5440

For abortion info and referrals go to any of the Teen Clinics, or the Health Science Centre

### Dating Violence Resources

<b>Klinik Drop-In Counselling Program</b> • 545 Broadway – Mon + Wed 12–7. Fri + Sat 12–4	784 4067
<b>Child &amp; Family Services Intake Line</b> • 835 Portage Ave. – Mon–Fri 8:30–4:30	944-4200
<b>CFS After hours line</b>	944-4050

## Other Resources

<b>VOICES, Manitoba Youth in Care</b> • 929 Main St. – Resources and peer support	982-4956
<b>Addictions Foundation of Manitoba</b> • 200 Osborne N. – Counselling and support groups	944-6235
<b>Youth Mobile Crisis System</b> • Counseling over the phone & they can come to your home (for youth within Winnipeg city limits)	949-4777
<b>Adolescent Mental Health Centralized Intake</b> • 848 William Mental health program, no referral needed	958-9660
<b>Youth Employment Service</b> • 294 Portage Ave. Suite 614 – Assists with employment	987-8601
<b>Partners</b> • 510 Selkirk Ave. – Provides employment & community supports	945-0447 or 1-800-883-0398

## YOUTH CRISIS AND INFORMATION LINES

*(Source: Klinik Community Health Centre)*

**Klinik Crisis Line • 1-888-322-3019  
786-8686 (24 hours)**

provides counselling, support and information for people in crisis or distress

**Klinik Sexual Assault Crisis Line • 1-888-292-7565  
786-8631 (24 hours)**

for counselling, information, support and advocacy around sexual assault

**Facts of Life Line • 1-800-432-1957 • 947-9222  
(Tuesday & Thursday Noon-4:00 pm)**

provides confidential, anonymous & non-judgmental information about sexuality, birth control, relationships, AIDS, STIs, pregnancy options and anything else to do with sexuality

**Gay, Lesbian, Bi-Sexual and Transgender Info Line  
• 1-888-399-0005 • 284-5208 (7:30 - 10 pm)**

provides appropriate support, referrals and information to individuals around the issues of sexual orientation, gender identity, homosexuality and bisexuality

**Health Links • 1-888-315-9257 • 788-8200  
(24 hours)**

for information and referral services on health related matters, staffed by registered nurses to assist health professionals and the public

**AIDS/STI Info Line • 1-800-782-2437 • 945-2437  
(M-F 8:30 am - 8 pm)**

for information and/or free literature on HIV/AIDS and other sexually transmitted infections

**Kids Help Phone • 1-800-668-6868 (24 hours)**

a Canada wide service providing information and support to youth

**Resource Assistance for Youth (RAY)**

**1-800-668-4663 • 783-5617 (24 hours)**

helps youth access services and/or return to their families

**Children's Advocate • 1-800-263-7146 •**

**945-1364 (M-F 8:30 am - 4:30 pm)**

**(24 hour voice mail)**

responding to complaints or concerns from youth who are involved in the child welfare system

**Low Income Intermediary Project • 956-2677**

**(9-5 Weekdays)**

support and advocacy for people in poverty or on a low income (single parents, welfare assistance)

## REPRODUCTIVE HEALTH ISSUES QUESTION/ANSWER MATCH

**Objective:** Participants will identify and describe the reproductive health concerns of adolescents and build skills to talk about reproductive health issues.

**Structure:** large group activity

**Time:** 30 minutes

**Materials:** reproductive health question and answer cards educator resource, participant resource

### Procedure:

1. **Tell participants** they're going to have a chance to find answers to common questions about reproductive and sexual health problems.
2. **Distribute** one question or answer card to each participant. (Store question and answer cards in pairs until you know the number needed for your group. Shuffle the order of the question and answer cards before you begin the activity.)
3. **Explain** that they each have either a question card or an answer card. Their job is to find the person in the room holding the best match to their own card. Demonstrate by doing an example with one participant.
4. **Tell participants** they will have five minutes to find their match and they should remain with their match until the activity is completed.
5. **After everyone has found a match**, ask each pair to read their question and answer to the group, one at a time. If the group believes the match is accurate, the pair sits down and the entire group adds information or asks questions about that issue. If someone questions the accuracy of the match, ask that pair to move to a specified section of the room until all of the pairs have reported.
6. **When all of the pairs have read their cards**, have participants with the questionable matches reread their cards, and others suggest the correct match for any that were paired incorrectly.
7. **Conclude** with the following questions:
  - What did you learn from doing this activity?
  - How might young people feel about talking to somebody about these issues?
  - How might you help increase their comfort level with this topic?
  - What other sexual or reproductive health issues would you like to know about?

## REPRODUCTIVE HEALTH ISSUES QUESTION/ANSWER MATCH

1. What are some reasons a woman might get a pelvic exam?
  - She has a change in usual vaginal discharge.
  - She's 18 to 20 and hasn't had one before.
  - It's been a year since she's had one.
2. How often should a man examine his testicles?
  - once a month
3. How often should a woman examine her breasts?
  - once a month
4. What is the name of the special instrument health care providers use for a female pelvic exam?
  - a speculum
5. What percent of infected males know they have gonorrhoea because they have symptoms?
  - about 85 per cent
6. What percent of infected females know they have chlamydia because they have symptoms?
  - about 15 per cent
7. What are some signs or symptoms people might have if they have a sexually transmitted infection?
  - discharge from penis/ vagina
  - painful sores
  - pain or burning with urination
8. What are some early signs of pregnancy?
  - missing a menstrual period (or period much lighter than usual)
  - sore breasts
  - nausea or upset stomach
9. Who has to give someone under the age of 18 permission to have a sexual health exam or a test for a sexually transmitted infection?
  - nobody

10. What are some ways a health professional checks to find out if a person has a sexually transmitted infection?
  - visual exam of genital area
  - swab/culture lab test
  - exam of cells under microscope
  - blood test
  - urine test
11. What factors increase a female's chances of getting pelvic inflammatory disease, which may limit her ability to become pregnant in the future?
  - having been infected with gonorrhoea
  - having many different partners
  - beginning intercourse before age 18
12. What factors increase a female's risk of getting cervical cancer?
  - smoking
  - beginning intercourse before age 18
  - infection with HPV (Human Papilloma Virus)
  - infection with HIV
13. What health benefits besides pregnancy prevention can condoms provide?
  - reduced risk of cervical cancer
  - reduced risk of acquiring a sexually transmitted infection
14. Women between the ages of 15 and 24 account for approximately what percentage of all positive Chlamydia cases?
  - 40 per cent
15. What percentage of young people aged 15 to 19 in Manitoba smoke tobacco?
  - 20 per cent
16. What is considered to be Canada's most common sexually transmitted infection?
  - human papilloma virus (HPV)
17. When might a health care provider be forced to contact a minor's parent or guardian?
  - only in a medical emergency when the patient needs additional specialized care
18. What are some reasons why some teens don't go to a health care provider?
  - embarrassed
  - partner doesn't want them to go
  - afraid family will find out

## REPRODUCTIVE HEALTH QUESTION AND ANSWER CARDS

### QUESTIONS

1. What are some reasons a woman might get a pelvic exam?	10. What are some ways a health professional checks to find if a person has a sexually transmitted infection?
2. How often should a man examine his testicles?	11. What factors increase a female's chances of getting pelvic inflammatory disease, which may limit her ability to become pregnant in the future?
3. How often should a woman examine her breasts?	12. What factors increase a female's risk of getting cervical cancer?
4. What is the name of the special instrument health care providers use for a female pelvic exam?	13. What health benefits besides pregnancy prevention can condoms provide?
5. What percentage of infected males know they have gonorrhoea because they have symptoms?	14. Women between the ages of 15 and 24 account for approximately what percentage of all positive chlamydia cases?
6. What percentage of infected females know they have chlamydia because they have symptoms?	15. What percentage of young people aged 15 to 19 in Manitoba smoke tobacco?
7. What are some signs or symptoms people might have if they have a sexually transmitted infection?	16. What is considered to be Canada's most common sexually transmitted infection (STI)?
8. What are some early signs of pregnancy?	17. When might a health care provider be forced to contact a minor's parent or guardian?
9. Who has to give someone under the age of 18 permission to have a sexual health exam or a test for a sexually transmitted infection?	18. What are some reasons why some teens don't go to a health care provider?

## REPRODUCTIVE HEALTH QUESTION AND ANSWER CARDS

### ANSWERS

<ul style="list-style-type: none"> <li>• She has a change in usual vaginal discharge.</li> <li>• She's 18 to 20 and hasn't had one before.</li> </ul>	<ul style="list-style-type: none"> <li>• once a month</li> </ul>
<ul style="list-style-type: none"> <li>• once a month</li> </ul>	<ul style="list-style-type: none"> <li>• a speculum</li> </ul>
<ul style="list-style-type: none"> <li>• about 85 per cent</li> </ul>	<ul style="list-style-type: none"> <li>• about 15 per cent</li> </ul>
<ul style="list-style-type: none"> <li>• discharge from penis/ vagina</li> <li>• painful sore</li> <li>• pain or burning with urination</li> </ul>	<ul style="list-style-type: none"> <li>• missing a menstrual period (or period much lighter than usual)</li> <li>• sore breasts</li> <li>• nausea or upset stomach</li> </ul>
<ul style="list-style-type: none"> <li>• nobody</li> </ul>	<ul style="list-style-type: none"> <li>• visual exam of genital area</li> <li>• swab/culture lab test</li> <li>• exam of cells under microscope</li> <li>• blood test</li> <li>• urine test</li> </ul>
<ul style="list-style-type: none"> <li>• having been infected with gonorrhoea</li> <li>• having many different partners</li> <li>• beginning intercourse before age 18</li> </ul>	<ul style="list-style-type: none"> <li>• smoking</li> <li>• beginning intercourse before age 18</li> <li>• infection with HPV (Human Papilloma Virus)</li> <li>• infection with HIV</li> </ul>
<ul style="list-style-type: none"> <li>• reduced risk of cervical cancer</li> <li>• reduced risk of acquiring a sexually transmitted infection</li> </ul>	<ul style="list-style-type: none"> <li>• 40% per cent</li> </ul>
<ul style="list-style-type: none"> <li>• 20 per cent</li> </ul>	<ul style="list-style-type: none"> <li>• human papilloma virus (HPV)</li> </ul>
<ul style="list-style-type: none"> <li>• only in the event of a medical emergency when the patient needs additional specialized care</li> </ul>	<ul style="list-style-type: none"> <li>• embarrassed</li> <li>• partner doesn't want them to go</li> <li>• afraid family will find out</li> </ul>

## YOUTH BILL OF RIGHTS

**Objective:** Participants will identify and discuss the reproductive and sexual health rights of young people.

**Structure:** small group activity and large group discussion

**Time:** 40 minutes

**Materials:** handout: *Youth Bill of Rights*, flipchart, markers

### Procedure:

1. **Ask** participants to divide into groups of three or four people. Instruct each group to spend 10 minutes creating a *Youth Bill of Rights* on sexual and reproductive health. Give an example of a right such as, the right to accurate health information. Give each group paper and markers to record their lists.
2. After 10 minutes, have each group **present their lists** to the large group.
3. **Ask** the groups if there are any rights they would add to the lists presented. Are there any rights they feel don't belong on the list? Discuss.
4. **Handout:** *Youth Bill of Rights*. **Read** the list out to the group. **Ask:**
  - How different are these rights from the list the group created?
  - Why is it important to identify youth's rights?
  - How might these rights be communicated to young people coming here for help?

## YOUTH BILL OF RIGHTS

As a young person needing health care:

- You have the right to receive treatment without discrimination on the basis of race, ethnicity, religion, gender, gender identity, disability, or sexual orientation.
- You have the right to receive respect and positive, caring treatment.
- You have the right to ask questions. You have a right to ask for clarification and to receive explanations of tests, treatments, treatment options and all aspects of your care.
- You have the right to receive confidential and affordable care. Your provider should assure you that the information you share is confidential and will not be told to a parent or guardian unless you give permission. If the health care provider does not guarantee your confidentiality, you have the right to find one who will.
- You have the right to care regardless of your ability to pay.
- You have the right to accurate, uncensored information.
- You have the right to demand youth-friendly services that are flexible and culturally appropriate.
- You have the right to non-judgmental health care. Your health care provider should not make assumptions about your behavior.
- You have the right to disclose your sexual identity, gender identity and sexual activities. This information may help your health care provider understand what types of tests, referral and health information you need.
- You have the right to say “no” to care and to learn about the effect this may have on your health.
- You have the right to change health care providers at any time and for any reason. You also have the right to a second opinion.

## GUIDELINES FOR COUNSELLING

**Objective:** Review general guidelines for counselling teens on sexual and reproductive health.

**Structure:** lecture and discussion

**Time:** 40 minutes

**Materials:** handout: *Counselling Teenagers – Guidelines*

### Procedure:

1. **Review** the handout: *Counselling Teenagers* before the session. **Make notes** or summarize the information into a presentation.
2. **Present** the information in the *Counselling Teenagers* handout to the group. (Keep the presentation to a maximum of 20 minutes). Invite participants to ask any questions they may have and respond to questions.
3. **Invite** participants to share any concerns or apprehensions they may have about counselling teenagers about sexual and reproductive health. **Brainstorm** ideas to help them address these apprehensions.
4. **Distribute** handout: *Counselling Teenagers* and ask participants to keep the guidelines for future reference. Tell participants if they have any questions, they should see you after the session or at the next training.

## COUNSELLING TEENAGERS

*(Adapted from Women's Health Clinic, Birth Control and Unplanned Pregnancy Counselling Program)*

### **Confidentiality:**

A client's need for confidentiality and privacy should always be respected. The exception to this policy is if the client is being sexually or physically abused and requires being reported to Child and Family Services.

### **Informed Choice:**

All information on birth control methods and pregnancy options and referrals is provided. We do not hold back any information we have.

### **Birth Control:**

We assist teens with their choice of birth control, providing them with whatever method they choose. (Exception to this is that, for medical reasons, she is not appropriate for her choice of birth control.) No parental consent is required.

### **Therapeutic Abortions:**

We help teens with their choice of pregnancy options, including how to obtain therapeutic abortions in Canada or U.S. In Manitoba, the need for parental consent is up to the discretion of the practitioner. Refer all minors to a community health centre for further counselling or help as required.

### **Physical and Sexual Abuse:**

In Manitoba, if a minor (under 18) tells you she/he has been physically or sexually abused, you are legally obligated to report this to Child and Family Services.

Reporting would be done, ideally, in co-operation with client and practitioner or paid counselling staff.

## CONFIDENTIALITY

Most teens have questions and concerns (although not always expressed) about the confidentiality of the services. Example:

- Will we call their parents?

- Will their parents find out if there is a claim against their MHSC number?

There is only one exception to the confidentiality issue for those under 18 years – if the issue is sexual abuse. In this situation, we are required by law to involve others.

## **INFORMED CHOICE**

Discuss with the teen, the policy that all clients interested in birth control see a counsellor to discuss the various methods, advantages, disadvantages, etc. This allows all clients to make informed decisions about their method of birth control.

Tell them that when all clients come for pregnancy options counselling, all of the options are explored. This is to ensure informed decisions.

*Suggestions:* “I just wanted you to know that whatever birth control method (or pregnancy option) you want, you will get. I am not trying to change your mind, but it is our policy ... just to ensure that you are making a choice based upon all of the information.”

## **SEXUALITY**

There are many conflicting attitudes about sex, which we learn from society, parents and peers.

During a counselling session with teens, the counsellor should always check in with the client to see how he/she is feeling about being sexually active and issues related to sexuality and relationships.

Reassure teens that sexuality is a normal part of human behaviour. It is important that we feel comfortable with our sexuality. Often this is difficult if:

- We are being pressured to have sex which we are not ready for or don't want to.
- There are conflicts with parents' morals and parental expectations.
- There are conflicts with religion and the cultural context of the client's life.
- We are having sex to fit in with the crowd.

The counselling session should allow time to discuss these feelings and offer support where needed. The following are examples of questions that can help in discussion:

- How are they feeling about being sexually active? Is it fun/enjoyable?
- Was it a comfortable decision for them?
- Did they and their partners discuss their feelings about becoming sexually active?
- Was it a decision because of peer pressure, (ex: fear of losing partner)?
- If they don't feel like sex, do they have the confidence and control to say “no”?

- If so, how do their partners accept this?
- What are their relationships like with their parents or guardians?
- Can they discuss sexuality issues with their parents or guardians?
- How would their parents or guardians react if they found birth control?
- Who can they talk to about sexuality and relationship issues?

## RELATIONSHIPS

### 1. With Parents

It is important in both sexual and reproductive health counselling to encourage adolescent clients to talk with their parents or guardians whenever possible. It is especially important with pregnancy options because of the possible need to get parental consent before having an abortion with some practitioners in Manitoba, or if she decides to continue her pregnancy.

Telling parents or guardians about a pregnancy may be one of the hardest things young women may have to do. The SRH counsellor should try to provide them with personal support and help them prepare for telling their parents. Be sure that they understand time is a factor.

If they feel they cannot or do not want to tell them alone, offer some suggestions:

- perhaps their partner could be there
- perhaps they have a brother or sister, aunt or other close relative or friend of the family who they feel close to that can be there for support
- Health Sciences Centre: Pregnancy Counselling Clinic has a social worker who is willing to become involved with young people and help them tell their parents or guardians. Clients must give permission before the social workers can talk to the parents.

Have them contact you as soon as they have told their parents or guardians and they have some time to discuss the situation. Again, be sure they are aware of the time element involved.

Often, once clients have told their parents/guardians about the pregnancy, they will return to the clinic. They can get additional counselling to discuss resources, referral processes, procedures, follow-up care, etc. In any counselling session, when parents or guardians or partners come with the clients, try to speak with the clients alone. Explain to the parents or partners that it is the clinic's policy to spend some time with the

client alone. Have them wait in the front reception area. It is up to you when you want to see the client alone. Some prefer the beginning, others the end of the counselling session. The purpose of this is to make sure the decision is hers and that she is not being pressured into a decision by her parents or partner. She may also feel easier about answering questions about her feelings with her parents or partner not in the room.

If a woman does not want an abortion, but feels her parents or partner will force her to have one, assure her that no one can force her. It is her body, and must be her decision. If her parents or partner threaten to kick her out of the house, or make life difficult for her if she doesn't have an abortion, then the parents may need to be referred for counselling. If you are not comfortable with this, please contact the coordinator of volunteers or another staff person.

## **2. With Partner**

When discussing teens' relationships with their partners, it is important to check if they are being coerced or pressured into sexual activity. As part of Canada's law on child sexual abuse it is recognized that adolescents, as part of their normal development, may engage in some sexual exploration. To allow for this, the law states that it is not a crime for two adolescents who are close in age to agree to sexual activity. The consent of both teens is, of course, essential. Children under 12 are never considered able to consent to sexual activity. Children 12 or older, but under 14, are deemed unable to consent to sexual acts except where their sexual partner is under 16 and is less than two years older than they are.

Regardless of the difference in age, it is very important to check out clients' relationships with their partners for possible abuse. See section on Abuse for more information.

## **ABUSE**

Every counselling/education session should provide the opportunity to discuss emotional and physical abuse and sexual assault, including coercive sex (date / acquaintance rape).

It is important for SRH counsellors to acknowledge that they are not adequately trained and experienced enough to provide long-term counselling in this area. They do have enough knowledge and ability to identify and acknowledge these areas, provide immediate support and empathy, acknowledge clients' strength for confiding in somebody and sharing their experiences, and to make appropriate referrals.

Following are some examples of questions which can be used for discussion and checking in about abuse:

- How are things at home?
- What is your relationship like with your parents or guardians?
- Are you treated well at home?
- Do your parents or guardians come down heavy on you?
- Do you have a lot of friends?
- Are your parents or guardians strict? In what ways?
- If you do something they disapprove of, how do they/you handle the situation?
- Have you ever had sex with someone you didn't want to?
- Are you comfortable saying "no" to sexual intercourse or any other sexual practises you do not want to be involved with?
- How does that person react when you say no?

The Manitoba Guidelines on Identifying and Reporting Child Abuse (available online at [www.pacca.mb.ca/pdf/revised\\_guidelines\\_on\\_identifying\\_and\\_reporting.pdf](http://www.pacca.mb.ca/pdf/revised_guidelines_on_identifying_and_reporting.pdf)) are primarily intended for abuse within the family unit (father, mother, brother, sister, aunt, uncle, etc.). They do include Third Party Assault (minors involved with an adult). The guidelines state that if a minor tells us he/she is being abused, we are legally responsible to report this information to Child and Family Services who will, if deemed necessary, contact the police.

This responsibility raises an issue within the clinic's confidentiality policy. A young person may feel secure within the session to confide in you because you have told them at the beginning of the counselling/education session that everything discussed within the session remains confidential. If they do confide in you and you inform them (which you must do) that you have to contact Child and Family Services, the client may feel betrayed again. Emphasize for the client your concern for their safety and that the clinic will support them during this difficult time.

During the session if you suspect abuse and the client is not opening up to you, it is important that, with gentleness and directness, you address the presence of possible abuse with the client. Continue talking to build trust within the counselling/education session. Hopefully, as the session goes on, the client will feel more comfortable about disclosing abuse. In the majority of situations, clients want to be directly asked about abuse, even if this is difficult to do for both the client and the SRH counsellor.

You can focus on the issue of abuse and reinforce to her/him in a general way that:

- NO ONE ever deserves to be abused.
- ANYONE being abused is not to blame.
- The person being abused is not responsible for the abuser's actions.
- The person being abused does not have to put up with the abuse.
- Abuse is a criminal act.

Anyone acknowledging to you that they have been abused should be seen by a practitioner if they are being seen at the teen clinic. They will want to document any cuts, scrapes, scars, bruises, etc.

If a client does acknowledge to you that he/she is being abused, acknowledge his/her strength for confiding in you and provide a lot of support and empathy. When it is appropriate, within the session, contact Child and Family Services. Reporting to Child and Family Services should not be done by the SRH counsellor without first consulting with the co-ordinator of volunteers, a practitioner, or a social worker. If possible, allow them to be in the room with you when you are making the phone call or allow them to make the phone call. This way they are less likely to feel that something is happening behind their back which they have no control over. Depending on the situation, a social worker may come to the clinic or will arrange to contact the client as soon as possible. This contact can be done at school if the client wishes.

### **Abuse in Teen/Youth Dating Relationships**

One definition of abuse is “the use of physical, verbal, or emotional force to control and maintain power by intimidating someone over a period of time.” This is unfortunately quite common in teen relationships, and should be checked for in counselling situations. Some indicators you can listen for as your client talks about their partners are:

- Are they jealous or possessive?
- Do they let the client have friends?
- Do they check up on the client?
- Do they not accept breaking up?
- Do they have a bad temper, or a history of fighting?
- Do they come from an abusive background?

If it becomes clear the client is in an abusive relationship, assure him/her that he/she is not at fault. Remind him/her that that no one has the right to abuse him/her. (See general section on Abuse and Teens above)

You should assess the clients' safety, and help develop a safety plan, if necessary. Encourage clients to tell their parents or guardians or someone else they trust about the situation. They will need other supports, regardless of whether they choose to leave the relationship or not.

Tell the client about the availability of counselling and other relevant community resources.

## **Sexual Assault**

Ask clients who they told about the sexual assault and discuss what support, if any, they have had. If they are willing, discuss feelings about the experience. Provide a lot of support and empathy; validate their feelings and their strengths for sharing the experience.

Deal with their immediate responses and feelings and encourage them to make contact with Klinik for 24-hour crisis support, or another agency for more in-depth counselling. Counselling can help direct their anger, regain self-control and strong self-image and rid themselves of any guilt feelings they may be experiencing. It is important that sexual assault survivors realize and believe that it is not their fault and that no one ever deserves to be sexually assaulted.

## **Date/Acquaintance Rape**

This form of abuse is more widespread than acknowledged by the media. Although not limited to the teen dating scene, young people seem to be at higher risk. Date/acquaintance rape could include lies, subtle threats, false promises, or deliberate deceptions. It takes place when one person pressures another into sex against their better judgment through emotional blackmail.

Examples:                    “If you loved me, you’d do it.”  
                                      “I’ll love you forever if ...”

Often, after sexual intercourse under these circumstances, the person feels betrayed, degraded, humiliated and lacking in control.

It is important to check in with clients during the session about date/acquaintance rape and sexual assault. Ask them if they have ever had an experience where they were not interested in sex and stated so, but were nagged, made to feel guilty, etc., until they gave in. If so, discuss how they felt afterwards. Did they confront their partners about their feelings? How have they prepared themselves to handle the situation if and when it arises again?

It is very important that we feel good about ourselves and have control over our bodies and feelings. Feelings of self-worth can be tarnished and, without someone to talk to, unresolved.

## **ANATOMY AND REPRODUCTION**

All clients should be given information on anatomy and reproduction. Even though clients may say they have learned it in school, it is still important to review basic female and male anatomy and reproduction so clients become familiar with their own body and menstrual cycle and can more easily understand the successful use of birth control. Anatomy and reproduction is also essential when discussing the abortion procedure. You may find it useful to use the diagrams made available in the counselling rooms.

## **SEXUALLY TRANSMITTED INFECTIONS (STI)**

Many people delay seeking medical attention if they think they may have an STI because of the social stigma associated with it (ex: “Nice girls don’t get STIs”).

When talking about STIs with clients, let them know STIs are very common. If you are sexually active in anything but a totally monogamous relationship, there is a good chance of contracting a STI.

If clients think they have a STI, they should seek medical attention as soon as possible. A practitioner can test for the presence of STIs.

If clients think they have a STI they should refrain from sexual intercourse until they have been tested and treated.

SRH counselling/education is a good opportunity to discuss HIV (and other STIs); transmission and prevention. Be sure to ask clients what they know about HIV and whether they have any concerns they would like to share with you.

### **Most Common STI Symptoms**

- vaginal discharge different than normal - could be green, yellow or foul smelling
- vaginal itching
- painful urination
- burning during urination
- frequent urination
- mild to severe abdominal pain

## When to Seek Medical Attention

- if any of the symptoms listed above are present
- if a partner tells them they suspect or have been diagnosed with a STI
- if they have multiple sexual partners, they should be checked more frequently for the presence of a STI (perhaps once every two to three months)

## General Information

- A person can get an STI more than once. Because they may have had chlamydia does not mean they are immune to getting it again.
- It is possible to have two separate STIs at the same time. The treatment of one does not necessarily mean the cure of the other.
- The choice of birth control can help prevent a STI. The male condom and female condom provide protection against most STIs.
- *The Public Health Act* requires health personnel to report all cases of syphilis, gonorrhoea, chlamydia and HIV.
- A public health worker will contact anyone who tests positive for syphilis, gonorrhoea, chlamydia and HIV. They will want to be sure that all partners are notified, tested and treated.
- Contact workers claim to do their work discretely and confidentially.
- If a person does not go for testing/treatment:
  - They put their health at risk.
  - They continue to spread STIs or HIV to other sexual partners.
  - They can be arrested and taken to a clinic for testing. (This would only occur if all attempts to have the person come in were exhausted and ignored)

## BIRTH CONTROL (BC)

Encourage clients to talk about their past experiences with birth control, their concerns and frustrations, and what change or method they are considering.

The most popular choice of BC with young people is birth control pills and condoms. Usually, more time is spent on these two methods, however, the other methods should be discussed, albeit briefly, if time permits. Explain that although other methods may not be their choice now, they should know about them if their needs change. Knowing about other possible BC methods is important if clients are not suitable candidates for

their chosen method of BC (ex: the Pill). The exception to covering all BC methods is if a client is currently on the pill and is at the teen clinic to get it free or low cost. In this case, address the limitations of the pill and ensure you have a safe sex discussion.

It is very important to reassure teens at the beginning of the counselling session that the counselling session is confidential and that things discussed in the session remain with the clinic (where legally possible). No one can phone in and receive information about them. Also, assure them that their parents should not know there has been a claim on their MHSC number for the services of a practitioner.

It is also a good idea to mention that BC is available at the teen clinic and, if necessary, they can make an appointment to see a practitioner. It is not uncommon for teens to feel anxious that we may not provide them with BC.

By explaining all of the above at the beginning of the counselling session, teens should feel more at ease and less threatened about the SRH counselling session.

After the sessions, clients may see the practitioner for BC. They can wait if they have the time, return on another teen clinic day, or make an appointment to come another time. For teen clinic, an internal examination is not usually done on the same night as counselling is done. The client is given one month of pills if they are sexually active, or several packs of pills if they are not sexually active. The practitioners would rather wait until the client has become sexually active to do the internal because the pelvic examination tends to be less painful. After the first or second month, the teen is asked to come in for a complete check-up.

## **PELVIC EXAM/PAP SMEAR**

The majority of teens have never had a pap/pelvic exam and are understandably nervous at the thought. SRH counsellors should take time to explain a pap/pelvic exam and reassure them. Let teens know the exam should be painless. If however, they are very tense, it could be more uncomfortable.

### **Procedure for a Pap/Pelvic Exam**

- A warm speculum is inserted into the vagina. (Show her the speculum.)
- The “bill” is clamped open. This spreads open the walls of the vagina and allows the practitioner to see the cervix.
- The practitioner will insert long Q-Tip type swabs and remove cells from the surface of the cervix. They will do this three or four times. One swab is to detect abnormal changes in the cervical cells (pap test). Other swabs are for STI checks.
- The cells are placed on a glass slide and sent to the lab to be examined.

- The speculum is removed and the practitioner will perform an internal pelvic examination. This is done by inserting the middle gloved finger into the vagina and feeling the cervix, uterus, fallopian tubes and ovaries.

Discuss the importance of having an annual pap/pelvic exam:

*Pap Smear:* Detects early changes in the cervical cells.

*Swabs to detect STIs:* Teen clinic practitioners routinely check for STIs in an annual check-up. Some private physicians do not.

*Pelvic Exam:* This is to check that there are no abnormalities within the reproductive organs such as ovarian cysts.

## **CONTINUING PREGNANCY**

### **Parenting**

If a minor plans to continue with her pregnancy and keep the baby, Child and Family Services will become involved with her and her family. They are notified by the hospital when she delivers the baby. The teen may want to contact Child and Family Services earlier in the pregnancy. The agency's role is to discuss her resources, living arrangements, financial arrangements and provide support and additional resources if necessary.

### **Adoption**

Suggested questions:

- How do you feel about adoption?
- How do you think your parents and friends will respond to your decision?
- How do you think you will feel when the baby is born?
- What kind of support and resources do you see yourself having?

If she is considering adoption, she can contact Child and Family Services to discuss the process and her concerns. Talking with them in no way means she is obligated to sign papers and make a quick decision. When discussing places to stay during her pregnancy, offer her information on Villa Rosa in Winnipeg.

## **Continuing/Parenting:**

The following issues need to be addressed in a counselling session to help the teen with her decision-making process:

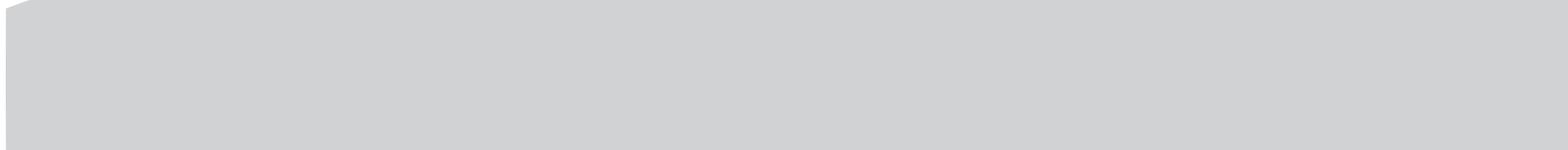
- What were her plans for the future/education before she found out she was pregnant? How will these plans have to change?
- How does she plan to support herself and the baby financially? Can she live at home with the baby? Will she want to?
- How does she perceive her social life changing? How does she feel about these changes?
- What are her plans for continuing her education?
- Will she be parenting alone?

## **Abortion**

- What are her feelings about abortion?
- Do her religious and abortion views conflict?
- Who would support her decision? (parents, boyfriend)
- How does she think she will feel following the abortion?
- Why does she feel abortion would be the best decision?

## **General Information on Abortion and Minors**

In some instances in Manitoba, a person under the age of 18 may require parental consent to have an abortion. Consent requirements for minors are up to the discretion of the practitioner providing the abortion. Minors seeking an abortion should be referred to a community health centre that can facilitate a referral for the minor, regardless of whether or not she has told her parents or guardians about the pregnancy.



## MODULE EIGHT

# SEXUAL IDENTITY

*This module has been adapted from the Canadian Federation of Sexual Health, Beyond the Basics: A Sourcebook on Sexuality and Reproductive Health.*

### **Session Objectives:**

- Identify and explore gender stereotypes and gender equality.
- Explain how sexuality develops and changes throughout the lifespan.
- Describe media portrayals of sexuality.
- Examine sexual orientation.

### **Agenda:**

1. opening activity, discussion or icebreaker (10 minutes)
2. the porcupine game (20 minutes)
3. sexuality through the lifespan (40 minutes)
4. visualization (30 minutes)
5. break (10 minutes)
6. relationships Questionnaire (20 minutes)
7. toward understanding that some of us are gay or lesbian (35 minutes)
8. closing activity or discussion and evaluations (15 minutes)

Total Time: three hours

## THE PORCUPINE GAME

**Objective:** Participants will identify aspects of sexual identity that are most important to them.

**Structure:** large group

**Time:** 20 minutes

**Materials:** Flipchart, markers

### Procedure:

1. **Draw** a circle on the board and label it “sexual identity”. Define sexual identity as how we feel and express ourselves as sexual beings.

Point out that:

- We are all sexual beings, whether we have sex or not.
- Our sexual identity is formed by a number of factors.

2. **Ask** participants to identify these factors. Draw a spoke from the circle for each definition. You may need to give a few examples to get the ball rolling and/or provide definitions for the following factors:

- sex
- gender
- sexual orientation
- culture
- age
- disability (physical, developmental)
- religion
- experiences
- media
- relationships
- biology
- values
- feelings
- social skills

- thoughts/fantasies
  - reproductive decisions
  - sexual health
3. **Ask** participants to think about which factor is the most important aspect of their sexual identity, and which is least important (some can be equally important). Ask them to think about why one is more important than another.
  4. **Ask** the following questions:
    - Which spoke is the most important to you? Least?
    - Do you think your spokes will change over time? Why or why not?
  5. **Conclude** by informing participants that everyone has a unique set of “spokes” that make up everybody’s sexual identity. This identity is fluid and changes over time as people grow, develop, make new friends and change their levels of sexual involvement.

## SEXUALITY THROUGH THE LIFESPAN

**Objective:** Participants will explore how sexuality develops and changes throughout life, from birth to death.

**Structure:** small group

**Time:** 40 minutes

**Materials:** handouts: *Human Sexuality Is...*, and *Sexuality Through the Lifespan*, flipchart, markers

### Procedure:

1. **Introduce** the activity by pointing out how in today's society, when people use the word "sex" they are usually referring to vaginal intercourse.
  - As young people internalize this message, they may feel pressured to experience intercourse as an affirmation of their sexuality.
  - This lesson is structured to heighten awareness of sexuality, including gender identity, gender role behaviour, interpersonal relationships and family life. All are an intrinsic part of every person's life.
  - By examining ways humans express their sexuality throughout their lives, participants can broaden their understanding of their own and other's sexual experiences.
2. **Ask** participants:
  - What questions do young children ask about sex?
  - What play activities do young children create, to find out about their sexuality?
  - What are young children curious about regarding sexuality?
3. **Divide** the participants into small groups and distribute both handouts. The groups should work to agree in completing the assignment.
4. **Review** the handouts with the entire group.
5. **Conclude** the activity with a discussion based on the following questions:
  - What stage are adolescents in? How does sexuality in adolescence compare with sexuality in other stages of the lifespan?
  - How is sexuality in childhood similar to sexuality in old age? How is it different?

- Describe some forms of sexual activity that do not involve intercourse (ex: mutual masturbation, oral sex). What are some of the reasons people choose these activities rather than intercourse?
- What would help people develop positive attitudes about their own sexuality?
- What aspects of human sexuality would be the same or different if a person were gay or lesbian? Physically or developmentally disabled?
- What is common in all age groups (ex: love, affection, etc.)?

# HUMAN SEXUALITY IS...

**Directions:** Human beings are sexual from birth to death. Sexuality, however, changes throughout the lifespan as a person grows and develops. Place a check in the column that indicates the times in the lifespan that each of the following needs or behaviours might occur.

Human Sexuality Is...	Early Childhood Birth-3 years	Late Childhood 4-8	Early Adolescence 9-11	Adolescence 12-18	Young adult 19-30	Adult 30-45	Adult 46-64	Adult 65+
Love								
Touch and affection								
Sense of being male or female								
Curiosity about body difference								
Need for friends								
Males: erection								
Females: lubrication of vagina								
Possibility of orgasm								
Possibility of masturbation								
Menstruation								
Sperm production								
Awareness of sexual attraction to others								
Possibility of sexual intercourse								
Possibility of other sexual activity (kissing, petting, etc.)								
Possibility of pregnancy or impregnating								
Possibility of contraception and safe sex decisions								
Possibility of becoming pregnant								
Flirting								
Possibility of ending a relationship								
Need for independence								

## **SEXUALITY THROUGH THE LIFESPAN**

### **EARLY CHILDHOOD (Birth-3Years)**

- Learns about love and trust through touching and holding
- Sucking (need for oral satisfaction)
- Boys: erections of penis
- Girls: vaginal lubrication
- Gender identity develops (child knows “I am a boy” or “I am a girl”)
- Sex role conditioning (boys and girls are treated differently)
- Exploration of own body (hands, feet, genitals, etc.)
- Toilet training
- Possibility of orgasm
- Curiosity about differences between boys’ and girls’ bodies
- Curiosity about parents’ bodies

### **LATE CHILDHOOD (4-8 Years)**

- Childhood sexual play (ex: doctor)
- Sex role learning: how to behave like a boy or girl
- Learns sex words: “bathroom vocabulary”
- Asks questions about pregnancy and birth
- Begins to distinguish acceptable and not acceptable behaviour
- Possibility of masturbation
- Becomes modest about own body
- Media influences understanding of male/female family roles

### **EARLY ADOLESCENCE (9-11 Years)**

- Puberty begins (growth of genitals, breast development, etc.)
- Possibility of masturbation
- Closeness of same sex friends
- Possibility of body exploration with others

## **ADOLESCENCE (12-18 Years)**

- Puberty changes occur
- Menstruation or sperm production
- Possibility of masturbation
- Pleasure from kissing and petting
- Greater awareness of being sexually attracted to others
- Possibility of sexual activity
- Possibility of pregnancy or impregnating
- Possibility of contraception and safer-sex decisions
- Strong need for independence

## **YOUNG ADULTHOOD (19-30 Years)**

- Possibility of sexual activity
- Possibility of mate selection
- Decision-making about partnerships, marriage, family life, and careers
- Possibility of masturbation
- Possibility of pregnancy, impregnating, childbirth, and parenting
- Possibility of contraception and safer-sex decisions
- Possibility of ending a relationship

## **ADULT (31-45 Years)**

- Possibility of mate selection
- Maintaining relationships (sexual and non-sexual)
- Possibility of masturbation
- Possibility of parenting responsibilities (sex education of own children)
- Possibility of pregnancy, impregnating and childbirth
- Decision-making about contraception and safer sex
- Possibility of grandparenting
- Possibility of ending a relationship

### **ADULT (46-64 Years)**

- Menopause
- Possibility of grandparenting
- Possibility of sexual activity
- Possibility of mate selection
- Possibility of masturbation
- Possibility of contraception and “safer-sex” decisions
- Possibility of divorce or death of a loved one

### **ADULT (65 to death)**

- Body still responds sexually, but more slowly
- Possibility of grandparenting
- Need for physical affection
- Possibility of sexual activity
- Possibility of masturbation
- Possibility of mate selection
- Possibility of death of a loved one

## VISUALIZATION

**Objective:** Participants will discuss and challenge heterosexual privilege.

**Structure:** large group

**Time:** 30 minutes

**Materials:** handout: *Visualization Story*

### Procedure:

1. **Ask** participants to relax and listen to the story.
2. **Read** the story from the handout.
3. **Ask** participants to take a few moments to think about the story.
4. **Facilitate** a discussion:
  - What is your response to the story?
  - Was this real?
  - What did you think or feel while listening to the story?
5. **Conclude** by pointing out that gay, lesbian, and bisexual people face certain challenges in our society. We should respect all people and where possible, lend our support.

## Visualization Story

It is a beautiful spring morning as you awake. You take a shower, dress and sit down to your breakfast. You glance outside and enjoy the tulips and daffodils that are finally starting to grow. It is a work day, but unlike any other because today, for one day in your life, you are a heterosexual person living in a gay world-and you are the minority.

You don't feel any different, and you wonder how your day will go. You glance at a magazine and listen to the radio. It's almost time to go to work, but wait... a magazine ad catches your eye. Two women models hold each other, sensuously displaying bathrobes on sale for half price. The cartoon on the opposite page tells of a funny mishap in a family of two men and their dog.

You listen again to the radio playing a catchy song about the love between two women and the distance that keeps them apart. The doorbell rings and you grab your coat. Your carpool has arrived and it's time to leave for work.

On the way to work, your friends are talking about their latest same-sex love interests. It seems normal: no one is surprised and the conversation continues. You would like to tell your friends about what you did this weekend and about the cute opposite sex person that you met, but now you are kind of afraid of how your friends will react.

When you arrive at work, you go to make yourself some coffee in the lunch room. Around the table a group of your co-workers are laughing as a joke about heterosexuals is shared. You leave, wishing you could have told them to "shut up." On your way to your staff meeting, a group of guys purposefully bump into you, and they tell you they hate heterosexuals and that you had better stay out of their way.

You make your way to your meeting and take a seat. Your boss has decided to have a team building activity. This morning everybody will be talking about how they balance their work life with their personal relationships. Everybody is talking about their relationships with their same sex partners. You don't feel that you can share with your group about your heterosexual relationship and you feel like you are being forced to lie. You look out the window as the bright spring day continues...

## RELATIONSHIPS QUESTIONNAIRE

**Objective:** Participants will examine heterosexism.

**Structure:** individual activity followed by large group discussion

**Time:** 20 minutes

**Materials:** handout: *Relationships Questionnaire*

### Procedure:

1. **Distribute** the handout.
2. After participants have had sufficient time to complete it, **conclude** the activity with a discussion based on the following questions:
  - What was it like for you to complete the questionnaire?
  - What would it be like for a gay, lesbian, or bisexual person to answer this questionnaire?
  - Would a gay, lesbian, or bisexual person answer yes to many of these questions?
  - How would a gay, lesbian, or bisexual person feel?
  - How are gay, lesbian, and bisexual relationships sometimes difficult?

## RELATIONSHIPS QUESTIONNAIRE

Write “yes” or “no” at the end of each statement.

1. I can talk freely about my family life and important relationships to friends at school, work, church, etc.
2. My partner and I can go shopping together pretty well assured that we will not be harassed.
3. I can kiss my partner farewell at the bus stop, confident that onlookers will either ignore us or smile understandingly.
4. I can be pretty sure that our neighbours will be friendly or at least neutral.
5. Our families and church community are delighted to celebrate with us the gift of love and commitment.
6. I can walk into any bookstore, sure that I will find books that reflect my relationship experiences.
7. When my partner is seriously ill, I know I will be admitted to the intensive care unit to visit him/her.
8. The books I read contain stories and pictures of relationships like ours.
9. I can find appropriate cards for my partner, to celebrate special occasions like anniversaries.
10. I grew up thinking my loves and friendships were healthy and normal.
11. If I experience violence on the street, it will not be because I am holding hands with my partner.
12. I have always known there are people in the world like me.

## TOWARD UNDERSTANDING THAT SOME OF US ARE GAY OR LESBIAN

**Objective:** Participants will evaluate the messages received about homosexuality.

**Structure:** individual and small group activity

**Time:** 35 minutes

**Materials:** handout: *Toward Understanding That Some of us are Gay or Lesbian*

### Procedure:

#### Background Notes

As many as 10 per cent of people are lesbian, gay, or bisexual and about 30 per cent of us have a same-sex experience at some time in our lives.

Gay, lesbian and bisexual youth are at particular risk in this society. They are surrounded by images and references that imply the normality of heterosexuality and the unacceptability, even sinfulness, of their own feelings and identity. Even human sexuality instruction may reinforce their alienation by presenting information that overwhelmingly assumes heterosexuality.

Studies have shown that sexual orientation issues were a concern of 30 per cent of youth who have committed suicide. There is often little help for young people who are, or who think they may be, homosexual.

This activity attempts to sensitize participants to the difficulties society imposes on lesbian and gay youth and provides participants who are lesbian, gay or bisexual with suggestions for finding support. It is important to be conscious of the fact that there are gay, lesbian, bisexual or questioning participants in your group.

1. **Distribute** *Toward Understanding Some of Us are Gay or Lesbian* handout.
2. **Tell** participants to complete each statement by filling in the corresponding blank spaces. Explain that this is a personal exercise and that they should refrain from asking other participants about their responses. **All responses are private.**
3. **Allow** participants sufficient time to write their answers before proceeding. Suggest that they answer quickly, writing the first ideas that come to their minds. This is a good way to get in touch with their feelings.

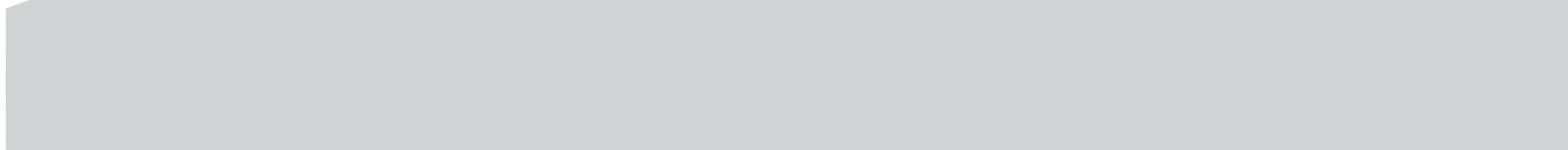
4. Once they have completed all the questions randomly, **divide** the large group into groups of four. Tell participants they will have about 10 minutes to discuss any part of the exercise they choose.
5. **Remind** them that:
  - No one has to talk unless they want to.
  - Everyone should have a chance to speak.
  - They should actively listen to each other.
6. **Bring** the groups together and write, “I learned that...” on the board. Ask participants to turn their handout sheets over and write down three things they have learned from the handout and/ or from talking with others afterwards. Ask for volunteers to read one of their “I learned” statements. Explain that the responses will not be discussed, only listened to.
7. **Conclude** by asking participants for suggestions as to how youth who are lesbian or gay can get support. List these suggestions on the board. Ask participants which of these resources they think would be most helpful and why.

## TOWARD UNDERSTANDING THAT SOME OF US ARE GAY OR LESBIAN

Complete each of the following statements. Do not take a long time to think about your answer; try to write the first thing that comes to your mind.

1. Three words or ideas I associate with:
  - a) homosexuality:
  
  - b) heterosexuality:
  
  - c) bisexuality:
  
2. Three messages I learned about:
  - a) homosexuality:
  
  - b) heterosexuality:
  
  - c) bisexuality:
  
3. Three concerns I would have if someone told me they were:
  - a) lesbian:
  
  - b) gay:
  
  - c) bisexual:
  
  - d) heterosexual:

4. Three ways life is different for people who are:
  - a) lesbian:
  - b) gay:
  - c) bisexual:
  - d) heterosexual:
  
5. Three ways the following youth can get support:
  - a) homosexual:
  - b) heterosexual:
  - c) bisexual



## MODULE NINE

# SEXUAL DECISION MAKING

*This module has been adapted from the Canadian Federation of Sexual Health, Beyond the Basics; A Sourcebook on Sexuality and Reproductive Health.*

### **Session Objectives:**

- Identify healthy and unhealthy relationships.
- Demonstrate assertive communication skills.
- Learn to apply decision making skills in counselling.

### **Agenda:**

1. opening activity, discussion or icebreaker (10 minutes)
2. healthy relationships comparison (15 minutes)
3. healthy relationship statements (30 minutes)
4. dear expert (30 minutes)
5. break (10 minutes)
6. sexual decision making case studies (30 minutes)
7. being assertive (40 minutes)
8. closing activity or discussion and evaluations (15 minutes)

Total Time: three hours

## HEALTHY RELATIONSHIPS COMPARISON

**Objective:** Participants will define a healthy and unhealthy relationship.

**Structure:** large group and small group activity

**Time:** 15 minutes

**Materials:** flipchart, markers

### Procedure:

1. Depending on the size of the group, **divide** it into two or four equal groups.
2. **Assign** one group the topic of “healthy relationships” and the other group “unhealthy relationships.”
3. Give each group five minutes to **brainstorm** as many characteristics of their subject as possible.
4. **Have** each group present its list, either written on the board or on taped up flipchart papers. After all of one subject has been presented, let anyone else contribute to the list until there is a list for “healthy” and another for “unhealthy” relationships. Leave these lists up on the walls for the rest of the session.

### Sample List:

#### Healthy Relationships

- happiness
- trust
- love
- affection
- equality
- mutual respect
- friendship
- laughter
- common interests
- support
- fair fights
- acceptance
- empathy
- comfort
- kindness
- acceptance
- strong self-esteem of both partners
- humour
- fun
- can be yourself
- no fear of partner
- still independent people
- honesty
- communicate well
- faithfulness

## Unhealthy Relationships

- no trust
  - no respect
  - jealousy
  - abuse-emotional, physical
  - bad/no communication
  - low self-esteem
  - power issues
  - based only on physical attraction
  - unfair fights
  - partner tries to change you
  - lies
  - manipulation-mental, sexual
  - lack of understanding
  - no fun
  - fear
5. **Lead** a discussion by asking:
- How do you feel in a healthy relationship?
  - How do you feel in an unhealthy relationship?
  - Why do people sometimes stay in unhealthy relationships?
  - What can you do if you know someone is in an unhealthy relationship?
  - Who can help them?
  - What are some ways to end an unhealthy relationship?
6. **Conclude** the activity by pointing out how important it is to recognize the qualities of both healthy and unhealthy relationships. In counseling, this will help us work with our clients to develop and negotiate satisfying and meaningful relationships.

## HEALTHY RELATIONSHIPS STATEMENTS

**Objective:** Participants will identify the myths and facts surrounding relationships.

**Structure:** large group

**Time:** 30 minutes

**Materials:** three signs: Agree, Disagree, and Unsure, masking tape, flipchart, markers

### Procedure:

1. Before the activity begins, **paste** the three signs on different walls within the room.
2. **Read out** one statement from the list below. Have participants walk towards the sign that describes how they feel-agree, disagree, unsure. This activity can be modified so that seated participants hold up signs. Use different coloured signs to make tabulating easier. Alternatively, have participants respond as though they were teenagers.
3. **Ask** them to explain why they feel this way. Try to bring up relevant points with each statement.
4. Continue by **reading** another statement. They don't have to be done in any particular order, and if the points relating to the statement have already been discussed, skip that statement and move on. Choose the ones that are most appropriate to your group.
5. **Conclude** by pointing out that young people are exposed to a lot of stereotypes and misinformation about sex and relationships. It is important to challenge these messages to develop healthy relationships and positive self-esteem.

### Statements

1. **Most young people are having sex.**
  - Most young people are not having sex: it just seems like it.
  - What is the influence of the media? (people lie, etc.)
  - Why do people have sex? (popularity, love, insecurity, etc.)
  - Why don't people have sex? (religion, readiness, values, etc.)
  - Why shouldn't people be made to feel they have to do something just because everyone else seems to be?

2. **A girl who has sex with several different partners is easy but a guy is a player.**
  - Is this double standard fair?
  - How do girls see each other? How do guys see each other?
  - How can we stop double standards?
3. **Young women have sex to get their partner to love them.**
  - Is this because they have poor self-esteem? With a healthy self-esteem, you know someone loves you for who you are not how far you go.
  - What can you do to boost your self-esteem?
  - Will sex make someone love you?
4. **Young people feel social pressure to be sexually involved in some way.**
  - Where does it come from? (ex: media, peers)?
  - Is it effective?
  - How is this pressure dealt with/resisted?
  - What are the self esteem issues?
5. **Everybody has to put up with a certain amount of disrespect in a relationship.**
  - What are the self esteem issues?
  - What are the abuse issues? (physical, verbal, emotional, sexual).
  - Where do you draw the line?
  - What is disrespect?
  - What do you do if a client is in an abusive relationship?
6. **It's easier to have sex than to talk about it with your partner.**
  - Why do women go one step further because they are too embarrassed to talk about it (ex: kissing to petting)?
  - Why is it difficult to talk about? (Sex is considered a taboo subject-not often talked about at home, therefore not used to talking about it).
  - How important are communication skills?
7. **Dating someone is better than dating no one.**
  - What are the self esteem issues?
  - Why is it important to love and value yourself for who you are and not for whom you're with?
8. **S/he wouldn't be so jealous if s/he didn't really love me.**
  - What are the trust, respect issues?
  - What are the abuse issues?
  - What is love?

**9. It is possible to confuse love and infatuation.**

- What is the difference?
- What are signs of infatuation? Love?
- Is infatuation healthy?
- Can you date someone even if you don't love him or her?

**10. The only way to show love is through intercourse.**

- abstinence
- intimacy
- alternatives (ex: mutual masturbation, oral sex, etc.)

## DEAR EXPERT

**Objective:** Participants will identify sexual decision-making issues.

**Structure:** small group

**Time:** 30 minutes

**Materials:** handout: *Dear Expert*, flipchart, markers

### Procedure:

1. **Introduce** the activity by pointing out how difficult and important it is to decide whether or not to start, or continue, a sexual relationship.
2. **Divide** participants into seven groups.
3. **Assign** each small group one of the *Dear Expert* letters from the handout.
4. **Give** participants enough time to write a response.
5. Bring the groups back together, and **ask** one volunteer from each to read the letter and another volunteer to read the response. Do this with each of the seven groups. Use your answer key to add to the discussion or to correct any misconceptions.
6. As a group, **discuss**:
  - What are the best reasons not to have sex?
  - Reasons to have sex?
7. **Conclude** by pointing out how important it is to use our personal beliefs, values and previous relationships when making decisions about sex.

## DEAR EXPERT

### 1. Dear Expert:

Pat and I have been dating for four months. Pat is really wonderful and really wants to have sex with me, but I'm just not sure. How do I know if I'm ready?

**feelings for Pat**

**personal values (ex : cultural, religious)**

**alternatives to intercourse**

**looking back: will you feel good about decision?**

**prepared to take responsibility with birth control and STI prevention**

### 2. Dear Expert:

I just had sex for the first time last weekend. Sam is really wonderful, but I kind of regret having sex. I don't know if I want to continue a sexual relationship. But now that I've done it, I guess there is no going back. What should I do?

**just because you said yes once does not mean you have to say yes again**

**freedom to say yes or no**

**important to communicate concerns to Sam**

**alternatives to intercourse**

### 3. Dear Expert:

My boyfriend and I started going out a few months ago. Our relationship is great, but he always wants to hold my hand and kiss me when we're in public, and I don't feel comfortable with that. What should I do?

**important to do what's right for you**

**important to talk to each other**

### 4. Dear Expert:

I've been going out with Sue for 10 months. She always threatens to break up with me if I don't have sex with her. Sometimes I don't feel like it. I tried to talk to her about it, but she just won't listen. I'm worried she'll spread nasty rumours about me. What should I do?

**abuse issues**

**freedom to say yes or no**

**important to get support from trusted friend/adult**

**may need to end relationship**

5. **Dear Expert:**

Robin and I have been together for over a year. We really care about each other and enjoy spending time together. We haven't had sex, and we both feel good about that decision. But everyone assumes that we've had sex and even make jokes and comments about it. There's just so much pressure-it seems like everyone is doing it, so maybe we should, too. What should I do?

**freedom to say yes or no**

**not everyone is having sex, although it may seem like it**

**don't feel you have to do something just because everyone else seems to be**

6. **Dear Expert:**

Chris and I have been going out for over six months. I really care about and want to be close to Chris. But there are parts of my body that I really hate, and I'm afraid that once he sees me naked, he won't want me. What should I do?

**Self-esteem and body image issues**

**try talking to Chris or someone else you trust about concerns**

**take things slowly**

7. **Dear Expert:**

My boyfriend and I really care about each other and we're getting really serious. We both want to have sex and want to be safe, but we're too embarrassed to buy condoms. What should we do?

**buy them together**

**go to a sexual health clinic/youth centre (youth friendly) to get them for free**

**ask someone else to buy them for you**

**reconsider having sex**

## DEAR EXPERT

**1. Dear Expert:**

Pat and I have been dating for four months. Pat is really wonderful and really wants to have sex with me, but I'm just not sure. How do I know if I'm ready?

**2. Dear Expert:**

I just had sex for the first time last weekend. Sam is really wonderful, but I kind of regret having sex. I don't know if I want to continue a sexual relationship. But now that I've done it, I guess there is no going back. What should I do?

**3. Dear Expert:**

My boyfriend and I started going out a few months ago. Our relationship is great, but he always wants to hold my hand and kiss me when we're in public, and I don't feel comfortable with that. What should I do?

**4. Dear Expert:**

I've been going out with Sue for 10 months. She always threatens to break up with me if I don't have sex with her. Sometimes I don't feel like it. I tried to talk to her about it, but she just won't listen. I'm worried she'll spread nasty rumours about me. What should I do?

**5. Dear Expert:**

Robin and I have been together for over a year. We really care about each other and enjoy spending time together. We haven't had sex, and we both feel good about that decision. But everyone assumes that we've had sex and even make jokes and comments about it. There's just so much pressure-it seems like everyone is doing it, so maybe we should, too. What should I do?

**6. Dear Expert:**

Chris and I have been going out for over six months. We've been talking lately about having sex and I think I'm ready. I really care about and want to be close to Chris. But there are parts of my body that I really hate and I'm afraid that once he sees me naked, he won't want me. What should I do?

**7. Dear Expert:**

My boyfriend and I really care about each other and we're getting really serious. We both want to have sex and want to be safe, but we're too embarrassed to buy condoms. What should we do?

## SEXUAL DECISION MAKING CASE STUDIES

**Objective:** Participants will identify circumstances that would make having sex a risky choice and ways to reduce risk.

**Structure:** Large group

**Time:** 30 minutes

**Materials:** flipchart, markers

### Procedure:

1. **Read** the following case study to your group:

*Ann is 17 years old. The summer after graduation, Ann was offered a job at a hotel outside of town. She took the job, even though it meant being away from her family and friends for three months. At the hotel, Ann felt lonely. The other girls had worked at the hotel for several summers and seemed to be in a clique that excluded her. Then Ann met James. He was a really hot lifeguard and all of the girls wanted his attention. James became really interested in Ann and asked her out.*

*Suddenly, the other girls paid attention to Ann. They included her in their activities and pumped her for information about James. Ann wanted to be popular, so she decided to go out with James. Everyone would think she were nuts if she didn't. James very quickly began to pressure Ann to have sex with him. He even made it clear he wouldn't keep dating her if she refused. One night, after drinking beer and getting high on marijuana, James walked Ann back to the hotel and asked if he could go up to her room with her.*

2. **Ask** your group:

- Ann needs to decide if she is ready to have a sexual relationship with James or not. Following are some things to consider:
- pressure (from James, from friends)
- wanting to be popular, to belong
- alcohol, drug use
- attracted to James
- looking back: will she feel good about her decision?
- STI protection
- pregnancy prevention
- alternatives to intercourse

3. **Ask** the group if, in this case, sex would be a good choice. What can Ann do to reduce her risk in this situation?
4. Next, **read** the following revised case study:

*Ann is 17 years old. The summer after graduation, Ann was offered a job at a hotel outside of town. She took the job, even though it meant being away from her family and friends for three months.*

*At first, Ann felt lonely. Although the other girls had worked at the hotel over several summers and seemed to be in a clique, Ann persisted and eventually made a couple of friends. One evening, Ann met James. He was a really hot lifeguard and all of the girls wanted his attention. James became really interested in Ann and asked her out. James was really nice and spent a lot of time with her. James taught Ann how to swim and Ann taught James how to play tennis. They took long walks together and talked about everything. They were inseparable and seemed very happy.*

*At one point during the summer, Ann and James started talking about having sex. They wanted to demonstrate their love for each other. They both agreed that if they were to have sex, they should use condoms in order to protect each other from pregnancy and STIs.*
5. **Ask** your group:

Factors Ann and James should consider when deciding whether or not to have sex (sample list follows)?

  - good communication skills
  - equal relationship
  - sharing relationship (both contribute)
  - pleasure
  - love
  - STI, pregnancy prevention
  - possible virginity
6. **Ask** the group if, they feel that in this case, sex would be a good choice. Do they feel comfortable with the idea of Ann and James having sex at all? Why or why not?
7. **Conclude** by pointing out how difficult and important a decision it is for young people to decide about having sex. Whether they are deciding for the first time ever or with a new partner, there are several factors that are important to consider. Our role as SRH counsellors is to identify some of these factors and provide the information. They need to make their own informed decision regardless of how we feel about the choices they make.

## BEING ASSERTIVE

**Objective:** Participants will identify ways in which people can express their feelings directly.

**Structure:** large group and small group activity

**Time:** 40 minutes

**Materials:** handout: *Being Assertive*, flipchart, markers

### Procedure:

1. **Introduce** the activity by pointing out that communication is a basic component of relationships. Communication is the exchange of thoughts, ideas, or feelings between two or more people.
2. **Point out** that we communicate verbally (talking or writing) and non-verbally (posture, facial expression). Listening is also an important part of communicating.
3. It is important that we all learn to communicate directly with each other. Typically, there are three ways of communicating:

#### Passive:

- Give in and saying yes when you don't want to.
- Put others' feelings and concerns before yours.
- Keep your concerns to yourself.

#### Aggressive:

- Dominate others.
- Put yourself first, at the expense of others.
- Use threats or force.

#### Assertive:

- Stand up for your rights without denying other people theirs.
  - Respect yourself and others.
  - Ask for what you want in a straightforward manner.
4. To develop an assertive style of communication, it is important to make eye contact (without staring) and to speak in a clear, firm voice. The use of "I" messages is also helpful:

I feel \_\_\_\_\_ when \_\_\_\_\_ and I want \_\_\_\_\_.

For example:

Situation – A friend is making fun of the way I’m talking.

Response – I feel **upset** when **I’m made fun of** and I want **you to stop**.

5. For some situations, it is helpful for people to practise what they are going to say, ahead of time. It is also helpful to think about how the other person might respond, and how to react to that response. Thinking and planning ahead helps build confidence.
6. **Distribute** the *Being Assertive* handout. Ask participants to imagine they are giving advice to a client who is in this situation, or that they are young people themselves and to develop appropriate assertive responses. Give participants sufficient time to fill in their responses. Ask volunteers to share their answers.
7. **Instruct** participants to form pairs. Ask each pair to role-play one of the situations from the handout (or to make up their own). Role playing can be performed in front of the entire group.
8. **Conclude** by pointing out that developing an assertive style of communication, which includes using “I” messages and compromise, is an important skill for young people to learn. Clients can be encouraged to use this skill to foster healthy relationships, decision making and self-esteem.

## BEING ASSERTIVE

**Directions:** Imagine you are a young person in this situation. Write an assertive response for each situation.

1. Your friend tells you to “shut up” during an argument.  
**I don't like it when you speak to me that way. It makes me feel as though you don't care about me.**
2. You want to tell your best friend that you are gay.  
**There's something I need to tell you, but I'm worried about how you might react. I'm gay.**
3. You are starting to worry that a friend likes you in a romantic way, but you do not feel the same way.  
**This is really hard for me to talk about, but I'm getting the feeling that you want to be more than just friends. I really like being friends with you, but I'm not attracted to you in that way.**
4. Your parents have been arguing a lot lately, and the situation is upsetting you.  
**I feel upset and worried when I see you arguing so often. Can we talk about the situation?**
5. Your boyfriend/girlfriend tells you that s/he wants to have sex, but you don't want to.  
**I'm just not ready for sex. I don't feel like having sex tonight. Can we just hug/kiss/touch each other instead?**
6. You need to tell your boyfriend/girlfriend that you have chlamydia.  
**I have something important to tell you, but I'm really worried that you will get upset. I just got some test results back from the doctor, and it turns out I have chlamydia.**
7. Your boyfriend/girlfriend refuses to use condoms.  
**I always use condoms. Using condoms is really important to me. Condoms can be fun. Let me show you... Let's go buy some together.**
8. You have decided to break up with your boyfriend/girlfriend.  
**You know that I care about you a lot, but I think the time has come for us to break up.**

## BEING ASSERTIVE

**Directions:** Imagine you are a young person in this situation. Write an assertive response for each situation.

1. Your friend tells you to “shut up” during an argument.
2. You want to tell your best friend that you are gay.
3. You are starting to worry that a friend likes you in a romantic way but you do not feel the same way.
4. Your parents have been arguing a lot lately and the situation is upsetting you.
5. Your boyfriend/girlfriend tells you that s/he wants to have sex, but you don't want to.
6. You need to tell your boyfriend/girlfriend that you have chlamydia.
7. Your boyfriend/girlfriend refuses to use condoms.
8. You have decided to break up with your boyfriend/girlfriend.

## MODULE TEN

# BIRTH CONTROL AND SAFER SEX

*This module has been adapted from the Canadian Federation of Sexual Health, Beyond the Basics; A Sourcebook on Sexuality and Reproductive Health.*

### **Session Objectives:**

- Learn the various methods of birth control and safer sex options.
- Review a typical birth control counselling session.
- Become comfortable doing birth control and safer sex counselling with adolescents.

### **Agenda:**

1. opening activity, icebreaker or discussion (10 minutes)
2. methods of pregnancy prevention quiz (20 minutes)
3. flipchart questions for methods of pregnancy prevention (40 minutes)
4. demonstrate how to use a condom (25 minutes)
5. break (10 minutes)
6. birth control counselling guidelines (60 minutes)
7. closing activity or discussion and evaluations (15 minutes)

Total Time: three hours

## METHODS OF PREGNANCY PREVENTION QUIZ

**Objective:** Participants will identify effective methods of pregnancy and STI prevention.

**Structure:** individual

**Time:** 20 minutes

**Materials:** handout: *Methods of Pregnancy and STI Prevention*, flipchart, markers

### Procedure:

**Distribute** handout: *Methods of Pregnancy and STI Prevention* to participants and give them time to complete the quiz individually. Review answers as a large group.

- 1. If you are under 16 years of age, you need parental consent to obtain birth control pills.**  
FALSE. There is no minimum age to prescribe contraception and youth are under no legal obligation to inform their parents that they are being prescribed/using contraception.
- 2. Condoms can be used with water-based lubricants.**  
TRUE. Oil or petroleum based lubricants (ex: Vaseline or hand lotion) cause condoms to break.
- 3. Spermicides, when used alone, are an effective method of birth control.**  
FALSE. However, spermicides, when used with condoms, are 98 per cent effective.
- 4. Oral contraceptives (the birth control pill) should be taken at the same time every day.**  
TRUE. For best results, the pill should be taken at the same time every day.
- 5. Women must receive Depo-Provera injections every six months.**  
FALSE. Women must receive Depo-Provera injections every three months.
- 6. Spermicides are an effective protection against the AIDS virus.**  
FALSE. Condoms provide the best protection against HIV. The only 100 per cent effective way to avoid HIV is to abstain from high-risk activities.

- 7. It is possible for a woman to become pregnant if she has vaginal intercourse during her period.**

TRUE. It is unlikely that a woman would become pregnant during her period. However, some women with shorter menstrual cycles ovulate earlier than day 14, and sperm can survive four to seven days inside a woman's body.
- 8. Air must be squeezed out of the tip of the condom before putting it on.**

TRUE. This reduces the chance of it breaking or tearing.
- 9. Non-lubricated condoms work best for oral sex.**

TRUE. Lubricated condoms have a medicinal taste, non-lubricated do not.
- 10. Withdrawal is an effective method of birth control.**

FALSE. Withdrawal is not a reliable method.
- 11. Emergency contraception (the Morning After Pill) can be taken up to five days after unprotected vaginal intercourse.**

TRUE. However, the earlier a woman takes emergency contraception, the more effective it is.
- 12. Douching is an effective method of birth control.**

FALSE. Douching is not effective at all.
- 13. A condom can be used more than once.**

FALSE. A condom can only be used once and should be discarded after use.
- 14. Abstinence is 100 per cent effective in the prevention of STIs and pregnancy.**

TRUE. However, if having vaginal or anal intercourse, it is important to use condoms each and every time, especially if doubled up with the pill, spermicides, or Depo-Provera.
- 15. A prescription for a vaginal ring can be obtained from a physician.**

TRUE. A physician at a clinic or physician's office must prescribe the vaginal ring.
- 16. The patch can be worn for up to one year.**

FALSE. The patch can only be worn a week at a time and changed each week for three weeks (the fourth week is patch-free allowing a period to occur.)
- 17. Birth control is not a guy's responsibility because he's not the one who could get pregnant.**

FALSE. Guys should also know about all methods of birth control and disease prevention so they can support their partner's effective use of a method and reduce the risk of STIs and unintended pregnancy.

## METHODS OF PREGNANCY PREVENTION

True or false...

1. \_\_\_\_\_ If you are under 16 years of age, you need parental consent to obtain birth control pills.
2. \_\_\_\_\_ Condoms can be used with water-based lubricants.
3. \_\_\_\_\_ Spermicides, when used alone, are an effective method of birth control.
4. \_\_\_\_\_ Oral contraceptives (the birth control pill) should be taken at the same time every day.
5. \_\_\_\_\_ Women must receive Depo-Provera injections every six months.
6. \_\_\_\_\_ Spermicides are an effective protection against the AIDS virus.
7. \_\_\_\_\_ It is possible for a woman to become pregnant if she has vaginal intercourse during her period.
8. \_\_\_\_\_ Air must be squeezed out of the tip of the condom before putting it on.
9. \_\_\_\_\_ Non-lubricated condoms work best for oral sex.
10. \_\_\_\_\_ Withdrawal is an effective method of birth control.
11. \_\_\_\_\_ Emergency contraception (the morning after pill) can be taken up to five days after unprotected vaginal intercourse.
12. \_\_\_\_\_ Douching is an effective method of birth control.
13. \_\_\_\_\_ A condom can be used more than once.
14. \_\_\_\_\_ Abstinence is 100 per cent effective in the prevention of sexually transmitted infections (STIs) and pregnancy.
15. \_\_\_\_\_ A prescription for a vaginal ring can be obtained from a physician.
16. \_\_\_\_\_ The patch can be worn for up to one year.
17. \_\_\_\_\_ Birth control is not a guy's responsibility because he's not the one who could get pregnant.

## FLIPCHART QUESTIONS FOR METHODS OF PREGNANCY PREVENTION

**Objective:** Participants will describe various methods of pregnancy prevention.

**Structure:** small group

**Time:** 40 minutes

**Materials:** flipchart paper, markers, tape, samples of various methods of contraception for participants to examine, brochures or fact sheets on birth control methods downloaded from the Sexuality Education Resource Centre at [www.serc.mb.ca](http://www.serc.mb.ca)

### Procedure:

1. **Prepare** six sheets of flipchart paper by listing a different method of pregnancy prevention at the top of each one. List the questions participants will be answering as well. Be sure the sheets can be read from a distance, and leave enough space for participants to record their answers. (The answer key that follows lists methods you may want to discuss with your group, questions to include on the flipchart paper, and basic information about each method to share with the group).
2. **Tape** flipchart paper up at various points in the room. Place the appropriate sample method nearby.
3. **Divide** the participants into groups and assign each to a method. Ask them to answer the questions and record their answers on the sheet. If participants are really stumped, you can give them some written information for guidance (Note: you can download a series of fact sheets from the Sexuality Education Resource Centre's website [www.serc.mb.ca](http://www.serc.mb.ca) or call to have hard copies sent to you).
4. **Circulate** between the groups to keep them on task, asking them leading questions and giving information.
5. Once participants have completed the questions, **review** each method with them, by following the answer key. You may wish to have each group report their findings. Remember, the answer key will not provide all information about each method. The goal of this activity is to introduce participants to the different methods of pregnancy prevention available (particularly those young people most commonly use), and to let them know about community resources. For more information about the methods, consult the fact sheets.

5. **Conclude** by asking the following question:
- Which methods do you think are most effective for young people and why? (abstinence/postponing intercourse, oral contraceptives/Depo-Provera/the patch/vaginal ring [used with condoms], condoms, and emergency contraception [for emergencies only]).
  - When counselling teens about contraception, what do you think would be the key messages to provide them with?

## What You Should Know About ...

# Reproductive & Sexual Rights

See Glossary section for definitions of underlined words.

### What are my Reproductive and Sexual Rights?

In Canada, you have the right to make decisions about your body. You have the right to:

- Decide whether or not to have children, when to have children, and how many children to have
- Choose a birth control method that is right for you
- Receive sexual and reproductive health care services
- Receive information about sexual and reproductive health
- Choose your partner
- Agree whether or not to have sexual relations
- Decide when to have sex or not
- Choose whether or not to marry
- Protect yourself and your partner from sexually transmitted infections/HIV
- Choose your own doctor.

### What are my rights when seeing a doctor?

It's important to feel comfortable with your doctor. You have the right to:

- Spend enough time to talk about your health care needs
- Be treated with respect
- Ask questions and get answers that you understand. Write your questions down on a piece of paper and take it with you.
- Have someone with you for the whole appointment, including the physical exam
- Make decisions about your health care without anyone else knowing about it
- Change doctors.

### What can I do if I don't want to have children (get pregnant) now?

If you decide not to have children:

- You can decide not to have sex
- You can decide to have sex and use birth control.

### Where can I get more information?

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

### Glossary:

**Birth Control** – The different ways of preventing pregnancy.

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## What You Should Know About ...

# Sexual Reproduction

See Glossary section for definitions of underlined words.

### How does the reproductive system work?

1. Every month a woman's body gets ready to get pregnant. An egg (ovum) from one of the ovaries starts to mature. The lining of the uterus thickens.
2. When the egg is ripe, it bursts out of the ovary. This is called ovulation. The egg travels up the fallopian tube toward the uterus.
3. This is the time when a woman is "fertile" (when she could get pregnant).
4. When the man ejaculates during intercourse, millions of sperm are released in the vagina.
5. If a sperm joins with the egg, the egg is called a "fertilized egg".
6. The fertilized egg then travels down the tube to the uterus and attaches itself to the wall of the uterus.
7. The fertilized egg will need the thick lining of the uterus for nourishment (food) and will start to grow into an embryo, then a fetus.
8. A baby is ready to be born 40 weeks from the last menstrual period.
9. If the egg is not fertilized, the thick lining of the uterus is not needed. The body gets rid of this lining. It passes out through the cervix and then the vagina. This is called menstruation or "having your period".

### How does a woman know when she's fertile?

During the "fertile" time, a woman may notice that her vaginal discharge is clear and slippery. This mucus helps sperm travel up into the uterus. A woman may not be aware of when she is fertile.

### Does the man have to ejaculate for the woman to get pregnant?

Even before ejaculation, when the penis gets erect (hard), the small amount of wetness on the tip of the penis contains thousands of sperm. This small amount is enough to get a woman pregnant. This is called pre-ejaculatory fluid or pre "cum".

### Is there a safe time to have sex and not get pregnant?

- Sperm can remain in a woman's body for several days after sexual intercourse. Even if you do not have intercourse during the "fertile time" there can still be sperm present to fertilize the egg.
- Not all women have the same cycle. They may not know when they are ovulating and some women ovulate more than once in each month. So, there is never a safe time to have sex if you don't want to get pregnant. Use birth control.

### Does a woman have to have sex or have a baby if she doesn't want to?

No. Find out about REPRODUCTIVE AND SEXUAL RIGHTS and birth control.

### Where can I get more information?

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

## **Glossary:**

**Birth Control** – The different ways of preventing pregnancy.

**Cervix** – The lower part of the uterus that opens into the vagina. It is also called the “neck of the uterus”.

**Discharge** – The release of any substance from anywhere on the body.

**Ejaculate/Ejaculation** – The release of semen from the penis. “Ejaculate” is also known as “come” or “cum” (street language).

**Embryo** – A word for the early stage of development of a baby, from the time of conception to the end of the second month of pregnancy.

**Fallopian Tube** – Two tubes, one leading from each ovary, to the uterus. This is where an ovum (egg cell) may be fertilized by a sperm cell.

**Menstruation** – The “monthly” discharge of blood from the uterus in females after puberty. Also known as a woman’s “period”.

**Ovaries** – The female organs that store and release egg cells and produce the hormones estrogen and progesterone.

**Ovulation** – The release of an egg (ovum) from an ovary.

**Penis** – The external male sex organ, used for urination (peeing) and sexual intercourse.

**Semen** – The white fluid that comes out of the penis when a man ejaculates.

**Sperm** – The male reproductive cell; carried out of the penis in the semen during ejaculation.

**Uterus** – A pear-shaped, hollow organ with muscular walls. The fetus grows in the uterus. The uterus is also called the “womb”.

**Vagina** – The muscular tube inside a woman’s body where the menstrual blood comes out from the uterus, where a baby comes out from the uterus during childbirth, and where a penis can go in for vaginal intercourse.

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## Abstinence: Postponing sexual intercourse

---

Having sex is a big decision, and a lot of teens decide to wait.

Think about how you will know if you are ready to have sex.

### Ask yourself...

- How does having sex fit with my beliefs?
- Do I feel pressured?
- Do I have to 'prove' that I love my partner?
- How might having sex change the way I feel about myself?
- Do I believe that this will be a pleasurable experience for me?
- Will sex change my relationship?
- Do I feel comfortable with my body and how it works?
- Can I talk honestly with my partner about my feelings?
- How would I feel if other people knew I was having sex?
- Am I ready for this?

Talk it over with someone you trust.

If you are not ready for sex, then abstinence is the choice for you. You decide what you are comfortable doing with your partner. Some activities you may consider are holding hands, kissing, massage, going for walks, talking, hugging, tickling, writing letters, body rubbing or touching, or kissing. You decide. Talk it over with your partner.

By choosing to have no sexual contact, you will avoid pregnancy and sexually transmitted infections. If you are engaging in some sexual contact, you can be safe from pregnancy and STIs by keeping semen and vaginal fluids totally away from a partner's vagina, anus and mouth; and by avoiding the skin to skin contact that could spread herpes or genital warts (HPV).

**For more information, go to [Deciding About Sex](#).**

Sexuality Education Resource Centre  
Reviewed 2007

## What You Should Know About ...

# Birth Control Methods

### How do birth control methods work?

Birth control methods work in one of several ways:

- by stopping the woman's ovaries from releasing an ovum (egg)
- by preventing the man's sperm and the woman's egg from meeting
- by thinning the lining of the uterus so that the fertilized egg doesn't stick to it.

### How do I decide what birth control method to use?

You can answer the following questions to help you decide which method(s) to use:

- How does the method work?
- Do I need to see a doctor to get it?
- How well does the method work to prevent pregnancy?
- Does the method help prevent sexually transmitted infections (STIs)?
- What are the advantages and disadvantages of the method?
- Is there anything about the method that will discourage me from using it correctly?
- Do I have any health problems that I need to think about when choosing a method?
- Does the provincial health care plan pay for it? If not, can I afford the cost?
- Will my partner pay for part of the cost?
- What are my birth control needs at this time in my life? How do I feel about an unplanned pregnancy?
- How often do I have sex? Will I remember to have my method with me every time I have sex?
- Can I talk to my partner about birth control? Will my partner support my choice?
- Do I use drugs (including alcohol) that might cause me to take risks?
- Am I opposed to any methods because of personal beliefs?

### What kinds of birth control are there?

There are many different methods of birth control. Some do not require a doctor's prescription. You can buy them at a pharmacy (drugstore) or large grocery store:

- Male condom
- Female condom
- Spermicides
- Contraceptive sponge
- Cervical barriers.

You must see your doctor for other methods of birth control:

- The Pill
- The Patch
- Diaphragm
- Injection (Depo-provera)
- IUD
- Vaginal Ring
- Tubal Ligation
- Vasectomy.

### Where can I get more information?

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## What You Should Know About ...

See Glossary section for definitions of underlined words.

# Male Condoms

### What is a condom?

- A condom is a latex rubber pouch. It fits over the penis during sexual intercourse.

### How does the condom work?

- The condom is a barrier. It stops sperm from getting into the vagina, anus, or mouth during vaginal, anal or oral sex. It will prevent pregnancy 85-97% of the time.

### Can the condom protect me from STIs and HIV?

- Yes. The condom offers protection against most sexually transmitted infections (STIs) including HIV. The female condom is the only other method of birth control that will do this.
- The condom may not protect you against the viruses that causes genital warts or herpes, if they are on parts of the skin not covered by a condom.

### What kind of condom should I use?

- Use latex or polyurethane condoms. They will protect you from most sexually transmitted infections (STIs) and HIV.
- Use lubricated latex condoms with a reservoir tip. Lubricated condoms offer better protection because they go on your penis and into the vagina or anus more easily. Non-lubricated condoms are good for oral sex.
- There are also condoms that come in different colours, flavours, sizes and textures (feel). Read the label to make sure they offer protection from STIs and pregnancy.

### Where can I buy condoms?

- You can buy condoms at drug stores, some supermarkets and convenience stores, and washroom vending machines.
- *Make sure that the packages say that the condom will protect you against pregnancy and sexually transmitted infections.*
- Your community clinic may give you low-cost or free condoms.

### How do I use a condom?

Important: Make sure to put a condom on the erect (hard) penis before you have any contact with your partner's vagina, anus or mouth. This will prevent pregnancy and sexually transmitted infections.

1. Carefully unwrap the condom package and take out the condom.
2. You can put a drop of water-based lubricant inside the tip of the condom.
3. Make sure the "ring" of the condom is on the outside so that the condom will roll easily down the penis.
4. If you are not circumcised, pull back your foreskin before you put on the condom.
5. Pinch the reservoir tip at the top of the condom to remove all the air. Otherwise the semen will have no place to go.
6. Pinch the tip with one hand (with your index finger, middle finger and the thumb). Then roll the condom all the way down the erect (hard) penis with the other hand. If you like, you can ask your partner to do this part. You can put water-based lubricant on the outside of the condom.
7. If you can't roll the condom down, the "ring" may be inside. Throw the condom away and use a new one.
8. After you ejaculate, hold on to the condom and pull out from your partner. If you leave your penis inside until it is soft, the condom will leak. If you continue having sex and the condom is full of ejaculate or "cum", the condom may break.
9. Take the condom off away from your partner's vagina or anus.
10. Check to see if there were any tears or holes. Throw the condom away in the trash can. Do not flush condoms down the toilet.

### **What if the condom leaks or breaks?**

See a health care provider as soon as possible for emergency contraception.

### **Can I reuse a condom?**

No. You must use a new condom every time you ejaculate or have sex. Never reuse a condom.

### **What are some other things to remember?**

- Practice using a condom a few times before you have sexual intercourse for the first time. It is easy to use a condom once you learn how.
- Always check the expiry date on the condom package or box. Don't use them if they are past their expiry date.
- Be careful not to tear the condom when opening the package.
- Store condoms in a cool dry place, like a handbag, drawer or loose pocket. Sunlight and heat can break down the latex in the condoms. For this reason, don't keep them in the glove compartment in your car, a back pocket or your wallet.
- Add water-based lubricants to the inside and outside of the condom to increase sexual pleasure. Also, condoms are less likely to break if you put a drop of water based lubricant on the outside of the condom.
- Use water-based lubricants only. Never use oil based lubricants like vaseline, cooking oil, margarine, hand cream or baby oil. They can break down latex condoms.

### **Where can I get more information?**

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

**If this method fails, and if you don't want to get pregnant, see a health care provider or pharmacist for emergency contraception as soon as you can.**

### **Glossary:**

**Anus** – The opening to the rectum (in the bum).

**Emergency Contraception** – A method used to avoid pregnancy after sex, because a birth control method failed or was not used.

**Ejaculate/Ejaculation** – The release of semen from the penis. "Ejaculate" is also known as "come" or "cum" (street language.)

**Penis** – The external male sex organ, used for urination (peeing) and sexual intercourse.

**Vagina** – The muscular tube inside a woman's body where the menstrual blood comes out from the uterus, where a baby comes out from the uterus during childbirth, and where a penis can go in for vaginal intercourse.

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## What You Should Know About ...

See Glossary section for definitions of underlined words.

# Female Condoms

### What is a female condom?

- A female condom is a soft, loose-fitting polyurethane (synthetic rubber or latex free) pouch.
- It has two flexible rings. The smaller ring fits inside the vagina and covers the cervix. The larger ring hangs outside the vagina and covers the vulva.
- The inside of the condom is lubricated.

### How does the female condom work?

- The condom is a barrier. It stops sperm from getting into the woman's cervix during sexual intercourse. The female condom will prevent pregnancy 79-95% of the time.

### Can the female condom protect me from STIs and HIV?

- Yes. The condom offers protection against most sexually transmitted infections (STIs) including HIV.
- You need to use condoms every time you have sexual intercourse.
- It is the only method used by a woman that can protect you from pregnancy and STIs.
- It offers more protection from genital warts and herpes than the male condom, because it covers more of the genital area.

### Where can I get the female condom?

- You can get the female condom at most drug stores and from some community health clinics.
- The female condom costs a lot more than male condoms. If cost is a problem, talk with your health care provider.

### How do I use the female condom?

1. To put the female condom in, pinch the smaller ring at the closed end of the condom between your thumb and middle finger. Put the condom in as far as it will go. Make sure the condom does not twist and that the outer ring is hanging outside the vagina.
2. Put a drop of water-based lubricant either on the tip of your partner's penis or at the opening of the female condom. This helps prevent bunching up and slipping. It may also make using the condom more comfortable. A small bottle of lubricant comes with the box of female condoms.
3. Be sure to guide the penis inside the female condom. The condom twists easily. Sometimes the penis goes in next to the condom instead of inside the condom.
4. Do not use male and female condoms at the same time.
5. After the man has ejaculated, lie down to take out the female condom. Squeeze and twist the outer ring. Doing this prevents sperm from leaking out. Do this before standing up.
6. Pull the female condom out gently. Throw it away in the trash can. Do not flush the condom down the toilet.
7. The female condom can be used for anal (bum) sex as well. Remove the ring on the closed end and insert the condom into the anus. The outer ring will hang out.

### What if the female condom leaks or breaks?

See a health care provider as soon as possible for emergency contraception.

### **Can I reuse a female condom?**

No. You must use a new condom every time you have sex. Never reuse a condom.

### **Where can I get more information?**

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

**If this method fails, and if you don't want to get pregnant, see a health care provider or pharmacist for emergency contraception as soon as you can.**

### **Glossary:**

**Cervix** – The lower part of the uterus that opens into the vagina. It is also called the “neck of the uterus”.

**Emergency Contraception** – A method used to avoid pregnancy after sex, because a birth control method failed or was not used.

**Ejaculate/Ejaculation** – The release of semen from the penis. “Ejaculate” is also known as “come” or “cum” (street language).

**Genitals** – The external sex organs (vulva on a female and penis and scrotum on a male). Often referred to as “private parts”.

**Vagina** – The muscular tube inside a woman’s body where the menstrual blood comes out from the uterus, where a baby comes out from the uterus during childbirth, and where a penis can go in for vaginal intercourse.

**Vulva** – The external female sex organs (genitals) of a woman.

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## What You Should Know About ...

See Glossary section for definitions of underlined words.

# The Birth Control Pill

### What is a birth control pill?

- The birth control pill (the Pill) is taken orally (by mouth) to prevent pregnancy.
- It contains man-made hormones similar to the natural hormones that already exist in your body.

### How does the Pill work?

- The Pill prevents your ovaries from releasing an ovum (egg) each month.
- The Pill makes the cervical mucus thicker. This makes it harder for sperm to get into the uterus.
- The lining of the uterus gets thinner so it is harder for a fertilized egg to stick to the uterus. Even if an egg is released and fertilized, it will not continue to grow.

### Does the Pill protect me from STIs and HIV?

- **No.** The Pill does not protect you against sexually transmitted infections (STIs).
- Always use a latex or polyurethane condom when you have sex. This will reduce your risk of getting an STI or HIV infection.

### Where can I get the Pill?

You can get the pill from:

- your health care provider
- a teen clinic
- a walk-in clinic
- a community health clinic.

### How do I use the Pill?

Your health care provider will tell you when and how to start the Pill.

Birth control pills come in packs of 21 or 28. The first 21 pills in both types of packs contain hormones. In the 28 pack, the last 7 pills don't contain hormones. They are only there to help you to remember to take a pill every day.

- When you first start taking the pill, use a back up method for 7 days if you started taking the pill during your period. If you are starting your first pack when you are not having a period, use a back up method of birth control for 14 days.
- Take 1 pill every day at the same time of day.
- Take the pill orally (swallow it).
- Follow the directions on the package to take the pills in the correct order.
- Finish the package.
- If you have a 21 pack, start a new pack of pills after the 7 days off.
- If you have a 28 pack, start a new pack of pills when the last pack is finished.

You will get your period during the 7 days off (if you are taking the 21 pack) or while you are taking the last 7 pills of the 28 pack. It may not start immediately.

If you are taking the 21 pack, you cannot get pregnant during the week you are not taking the pills, unless you have not taken your pills correctly.

This information is about combined hormonal pills (with estrogen and progestin). The progestin-only pill is different. Talk to your health care provider if you have questions about using a pill that does not contain estrogen.

### **Will the Pill affect my period?**

- The birth control pill should make your period regular.
- You may not bleed as much, or have as many cramps.

### **Does anything stop the Pill from working?**

- Throwing up or having diarrhea one to four hours after you take your pill may flush the Pill from your body. This may mean the Pill will not work. **Be sure to use another method of birth control (e.g., condom) for the rest of your pill package.**
- Some drugs that you take can stop the Pill from working. **If you take any drugs, tell your doctor or pharmacist that you are on the Pill. While you are taking these drugs, continue taking the Pill but use another birth control method as well.**

### **How effective is the Pill?**

- The Pill prevents pregnancy 97-99% of the time.
- It is very effective when you take one every day at the same time.

### **Are there any side effects?**

#### **Minor side-effects**

When you begin taking the Pill you may feel some minor side effects. These are not dangerous. If they are very uncomfortable or last longer than a few months, talk to your doctor.

Some *common* minor side effects include:

- nausea (sometimes taking the Pill with food or before bedtime helps get rid of nausea)
- sore breasts
- bleeding between periods
- very light or missed periods.

Some *uncommon* minor side effects include:

- headaches
- mood swings or depression
- weight change
- less interest in sex
- acne (pimples)
- increased hair growth.

#### **Serious side-effects...**

A very small number of women suffer more serious side-effects. These include heart attacks, strokes, blood clots in veins, high blood pressure, gallbladder disease, liver tumors, and migraine headaches.

**See a doctor immediately if you have...**

- abdominal pain (severe)
- chest pain (severe), or breathing problems
- headache (severe), dizziness
- weakness or numbness in any part of your body
- eye problems (vision loss or blurring)
- speech problems
- severe leg pain (calf or thigh)
- jaundice (yellow skin).

Your health care provider will help you decide if you should take the Pill.

**What if I miss a Pill?**

*If you miss one pill in the first 7 days of your pack:*

- Take it as soon as you remember it. Take your next pill at your regular time. It is okay to take two together if you do not remember until the next day.
- Use condoms for 7 days and continue taking your pills.
- If you forget to take a pill, you may start to bleed (spotting). This is normal. Continue taking your pills.
- Consider calling your health care provider to discuss taking emergency contraception (EC). You can also get EC right away at a pharmacy. The sooner EC is taken, the more effective it will be.

*If you miss one pill in the day 8 – 21 section in your pack:*

- Take a pill right away and then take the next pill at your regular time.
- Continue your pack of pills.

*If you miss two or more pills or are late starting a new pack:*

- Call your health care provider to discuss taking emergency contraception and how to start a new pack of pills.
- Use condoms and another back up method of birth control.

Some women will initially feel nauseated on the pill, but vomiting is rare. If you vomit within one hour of taking a pill, you must take another pill. The pill may not be absorbed if you have persistent vomiting or diarrhea. Use condoms until your symptoms are gone **and** until you have been on a new pack of pills for one week. Call your health care provider if you have any questions.

**What if I miss my period?**

- Sometimes you can miss a period even if you have taken all your pills the right way. This can be a normal side-effect of the Pill or you **might** be pregnant. Keep taking your pills and have a pregnancy test to find out whether or not you are pregnant.
- If you miss periods often, talk to your health care provider.
- If you have missed any pills and miss a period, have a pregnancy test done right away.

**Is the Pill safe for all women to use?**

- No. Ask your health care provider if it is right for you. Tell him/her about any medical problems.
- Smoking while taking the Pill increases the chance of serious side effects.

### **Remember...**

- The Pill is most effective when you **take one every day at the same time**.
- To help you remember, combine taking the Pill with something else you do every day at the same time, such as going to bed, eating a meal, or brushing your teeth.
- The Pill does not work right away. Use another birth control method such as condoms with foam, sponge, or diaphragm for the first week or two weeks (see 'How Do I Use the Pill?').
- The Pill protects against pregnancy but does not protect against STIs.
- The Pill does not protect against pregnancy once you stop taking it.

### **Where can I get more information?**

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).
- From the following website: [www.sexualityandu.ca](http://www.sexualityandu.ca).

**If this method fails, and if you don't want to get pregnant, see a health care provider or pharmacist for emergency contraception as soon as you can.**

### **Glossary:**

**Cervical mucus** – The fluid produced by the cervix. The mucus changes in amount and consistency at different times of the menstrual cycle. Around the time of ovulation, the mucus is clear and slippery.

**Emergency Contraception** – A method used to avoid pregnancy after sex, because a birth control method failed or was not used.

**Ovaries** – The female organs that store and release egg cells and produce the hormones estrogen and progesterone.

**Uterus** – A pear-shaped, hollow organ with muscular walls. The fetus grows in the uterus. The uterus is also called the "womb".

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## What You Should Know About ...

See Glossary section for definitions of underlined words.

# Cervical Barriers

### What are cervical barriers?

- There are now three different types of cervical barriers. They replace the former “cervical cap”.
- The three types are the FemCap, the Lea’s Shield, and the Oves Contraceptive Cap.
- They are all available without a prescription. The Oves Cap is disposable (throw it out after use).
- They are all made of silicone rubber.

### How do they work?

- They are barriers. They stop the sperm from meeting the egg by covering the cervix. Use spermicide with the cervical barriers.
- The FemCap will prevent pregnancy 86%-93% of the time. The Lea’s Shield about 91% of the time. The Oves Cap about 96% of the time, when used properly. These products are new, so it is hard to find accurate information about the effectiveness.
- The FemCap and Oves Cap come in three different sizes (depending if you have been pregnant and/or given birth). The Lea’s Shield is only available in one size, which should fit all women.
- Use the cervical barriers every time you have sexual intercourse.

### How do I use the cervical barriers?

- Read the instruction booklets that come with these barriers.
- You must put spermicide on the barriers before you put them in.
- Put the barriers in your vagina, covering your cervix, before you have sexual intercourse.
- Use an applicator to put more spermicidal jelly into your vagina if you are having intercourse more than once. Do not remove the barriers, because that would let the sperm in. You don’t need to put in more spermicide with the Oves Cap (even for another act of intercourse).
- If you find this too messy, use condoms for repeated intercourse while the barriers are in place.
- Leave the barriers in the vagina for 6-8 hours after the last time you had sex. This is so the spermicide has time to kill the sperm. Do not douche, or take a bath during this time. You can take a shower.
- It is safe to leave the FemCap and Lea’s Shield in for 48 hours, the Oves Cap for 72 hours.
- All three types of cervical barriers have a loop attached to help you to remove them.

### How do I care for cervical barriers?

- The Oves Cap should be thrown out after it is used.
- The FemCap and Lea’s Shield should be washed with mild soap and water.
- Dry them carefully and put them back in their container.

### Do cervical barriers protect me from STIs and HIV?

- No. Always use a latex or a female condom when you have sex to reduce the risk of getting an STI (sexually transmitted infection) or HIV.

### **Are there any side effects to cervical barriers?**

- A very few women will get Toxic Shock Syndrome.
- Some women may be allergic to the spermicide. It may cause skin irritation. Tiny tears in the skin will increase the risk of getting sexually transmitted infections such as HIV.

### **Where do I get cervical barriers?**

- You do not need a prescription for the cervical barriers.
- The easiest way to get them is to order them online at [www.ladytobaby.com](http://www.ladytobaby.com).
- Once you have received the cervical barrier, you can take it with you to a health care professional for help on how to insert it.

### **Where can I get more information?**

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

**If this method fails, and if you don't want to get pregnant, see a health care provider or pharmacist for emergency contraception as soon as you can.**

### **Glossary:**

**Cervix** – The lower part of the uterus that opens into the vagina. It is also called the “neck of the uterus”.

**Emergency Contraception** – A method used to avoid pregnancy after sex, because a birth control method failed or was not used.

**Spermicide** – A product containing chemical that kills sperms. It comes in jellies, foam, suppositories, and film (a thin plastic-like square sheet).

**Toxic Shock Syndrome** – An infection that is caused by bacteria. It is a rare infection associated with the use of tampons.

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## What You Should Know About ...

See Glossary section for definitions of underlined words.

# Depo-provera

### What is depo-provera?

- Depo-provera is a hormone given by injection (a needle).
- Each injection protects against pregnancy for three months.
- The injection is usually given in the buttocks, thigh or upper arm by a health care provider.

### How does it work?

- Depo-provera releases a hormone (progesterone). This hormone stops your ovaries from releasing an ovum (egg) each month. If there is no egg, you cannot get pregnant.
- It also makes the mucus in the cervix thicker. This makes it harder for sperm to get into the cervix.
- It also changes the lining of the uterus so it is harder for a fertilized egg to attach to the uterus.
- Depo-provera will prevent pregnancy more than 99% of the time.
- It gives you protection against pregnancy for 12 weeks.

### How soon does it start working?

- When you have the depo-provera injection within the first five days of your menstrual cycle, it works 24 hours after the injection.
- When you have the depo-provera injection **after** the first five days of your menstrual cycle, it works after 14 days
- When the depo-provera injection is given to a woman after she has given birth, or had a miscarriage or an abortion, it works immediately.

### Does it protect me from STIs and HIV?

- **NO.** Always use a latex condom or a female condom when you have sex to reduce the risk of getting an STI (sexually transmitted infection) or HIV infection.

### How often do I have the injection?

- You have the injection once every 10-12 weeks (four times a year).
- You must remember to have the injection on schedule.
- Depo-Provera does not protect against pregnancy when you are late for your injection.

### What if I forget or can't come on time to get my three-month injection?

- You must get your injection within 10-12 weeks of the last one. If you wait longer than 13 weeks, you should have a pregnancy test done before your next injection.
- You should also use another form of birth control for 2 weeks after a late injection.

### Are there side effects?

- There is slightly greater risk of osteoporosis from taking depo-provera.
- Some women using this method have bleeding between periods, heavy periods or no periods at all.
- Other common side effects include breast tenderness, increased appetite, mood changes, headache or dizziness, and a decrease in sex drive.
- You cannot stop the effects of depo-provera immediately. The side effects are likely to last until the drug has totally worn off.
- It takes an average of 6-10 months for your fertility to return after you have stopped using the drug.

**Studies have shown that women who have used depo-provera for a long time have a slight decrease in the calcium in their bones. This can contribute to the development of a condition called osteoporosis. Exercise, enough calcium (1000mg/day), and not smoking can prevent osteoporosis for all women.**

### **Where can I get depo-provera?**

- You can get depo-provera from your health care provider.
- Talk to your health care provider if cost is a problem for you.

### **Before I start to use depo-provera, what will the health care provider need to know?**

The health care provider needs to know if:

- You are pregnant or think you are pregnant
- You have a liver disease, heart problems, seizures, diabetes or asthma
- You have migraine headaches or depression
- You are using any medication including contraceptives
- You have any allergies
- You have experienced heavy vaginal bleeding
- You have lumps, swelling or tenderness in your breasts
- You have any medical conditions or illness
- You have had a Pap test, and if so, when was your last Pap test.

If you have any questions or concerns regarding any of these health conditions, you should talk to a health care provider.

Note: Taking depo-provera increases the risk of osteoporosis. However, talk to your health care provider about risks versus the benefits of this contraceptive.

### **Where can I get more information?**

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

**Important: If you did not take the depo-provera on time and did not use another form of birth control method during sex, see a health care provider or pharmacist for emergency contraception.**

### **Glossary:**

**Cervix** – The lower part of the uterus that opens into the vagina. It is also called the “neck of the uterus”.

**Emergency Contraception** – A method used to avoid pregnancy after sex, because a birth control method failed or was not used.

**Menstrual Cycle** – The length of time between the 1<sup>st</sup> day of a woman’s menstruation (period) in one month and the 1<sup>st</sup> day of her menstruation the next month (measured in days).

**Osteoporosis and Depo-provera** – The increased risk of thinning bones (osteoporosis) for women who have used depo-provera (hormonal injection). Adequate intake of calcium and vitamin D, weight-bearing activity, and avoiding cigarette smoking may help to prevent osteoporosis. Individuals at increased risk include:

- women who don’t have their recommended daily amount of calcium
- very athletic women who do not have a period
- women who have been pregnant numerous times
- women with certain medical conditions.

Depo-provera is one of the very effective forms of birth control. Do not stop this form of birth control without talking to your health care provider. Be informed about your choice. Be educated and choose birth control that is right for you.

**Pap Test** – A test in which a sample of cells from the cervix are removed to check for any changes in the cervix. Treating early changes may prevent cancer of the cervix.

**Uterus** – A pear-shaped, hollow organ with muscular walls. The fetus grows in the uterus. The uterus is also called the “womb”.

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## What You Should Know About ...

# Diaphragms

See Glossary section for definitions of underlined words.

### What is a diaphragm?

- The diaphragm is a shallow dome-shaped soft rubber cup. It has a flexible rim.
- Your health care provider will measure your vagina to see what size diaphragm you need.

### How does it work?

- The diaphragm is a barrier. It stops the egg from meeting the sperm by covering the cervix. Use spermicide with the diaphragm.
- The diaphragm will prevent pregnancy 84-94% of the time.
- You need to use it every time you have sexual intercourse.

### How do I use the diaphragm?

- Ask your doctor or nurse to show you how to put it in properly.
- Put about a teaspoon of spermicidal jelly around the rim and in the centre of the diaphragm.
- Put the diaphragm in your vagina before you have sexual intercourse (up to 6 hours before sex).
- Use an applicator to put more spermicidal jelly into your vagina if you wait more than one hour between inserting the diaphragm and having vaginal intercourse.
- Use an applicator to put more spermicidal jelly into your vagina if you are having intercourse more than once. Do not remove the diaphragm, because that would let the sperm in.
- If you find this too messy, use condoms for repeated intercourse while the diaphragm is in place.
- Leave the diaphragm in the vagina for 6-8 hours after the last intercourse. This is so the spermicide has time to kill the sperm. Do not douche, or take a bath during this time. Showers are okay. It is safe to leave it in for up to 24 hours, but not longer.
- To remove the diaphragm, hook your finger around the rim and pull.

### How do I care for the diaphragm?

- Wash it with mild soap and water.
- Check for holes by holding it up to the light or running water into it.
- Dry it carefully and put it back into its container.

### When will I need a new diaphragm?

You may need a new diaphragm:

- If you lose or gain 10 to 15 pounds
- After having a baby, miscarriage or an abortion
- After any kind of abdominal surgery
- If it feels uncomfortable
- After one year of use or follow the manufacturer's instruction.

### **Does a diaphragm protect me from STIs and HIV?**

- No. Always use a latex condom or female condom when you have sex to reduce the risk of getting an STI (sexually transmitted infection) or HIV infection.

### **Are there any side effects to a diaphragm?**

- A very few women will get Toxic Shock Syndrome or urinary tract (bladder) infection.
- Some women may be allergic to the spermicide. It may cause skin irritation. Tiny tears in the skin will increase the risk of getting sexually transmitted infections such as HIV.

### **Where do I get a diaphragm?**

- You need a doctor's prescription for a diaphragm.

### **Where can I get more information?**

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

**If this method fails, and if you don't want to get pregnant, see a health care provider or pharmacist for emergency contraception as soon as you can.**

### **Glossary:**

**Cervix** – The lower part of the uterus that opens into the vagina. It is also called the “neck of the uterus”.

**Emergency Contraception** – A method used to avoid pregnancy after sex, because a birth control method failed or was not used.

**Spermicide** – A product containing chemical that kills sperms. It comes in jellies, foam, suppositories, and film (a thin plastic-like square sheet).

**Toxic Shock Syndrome** – An infection that is caused by bacteria. It is a rare infection associated with the use of tampons.

**Vagina** – The muscular tube inside a woman's body where the menstrual blood comes out from the uterus, where a baby comes out from the uterus during childbirth, and where a penis can go in for vaginal intercourse.

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## What You Should Know About ...

# IUS - Intra-Uterine System (Mirena)

See Glossary section for definitions of underlined words.

### What is an IUS (Mirena)?

- An IUS is a small piece of plastic that a doctor or nurse can insert into your uterus to prevent pregnancy.
- It is T-shaped with a cylindrical reservoir that slowly releases the hormone progestin into the lining of the uterus. This can prevent pregnancy for up to 5 years.
- It prevents pregnancy 99.9% of the time. It is about as effective as tying your tubes.

### Where can I get an IUS?

- See a doctor to get a prescription.
- It can be expensive. If cost is a problem, talk to your health care provider.

### How do I use an IUS?

- A doctor or nurse will examine you to check for pregnancy or any infections.
- A doctor or nurse will do a pelvic exam (internal exam). S/he will insert a speculum (instrument) into your vagina to see your cervix and wash it with an antiseptic solution.
- Next, s/he will insert an IUS into your uterus. This may be uncomfortable so you may want to ask for pain pills ahead of time.
- The doctor or nurse will leave the two plastic strings that hang down through the cervix into the vagina. The threads or strings are very thin and do not hang outside the body. You may want to check the strings from time to time to make sure it is still in place.

### What do I do if I want my IUS taken out?

- You must see a doctor or nurse. Do not try to take an IUS out by yourself.

### Does an IUS protect me from STIs or HIV?

- No. Always use a latex condom or female condom when you have sex. This will reduce the risk of getting an STI (sexually transmitted infection) or HIV infection.

### Are there side effects?

*Minor side effects include:*

- Some discomfort when the IUS is put in
- Irregular bleeding for the first three to six months
- No period after one year of use for some women.

*Serious side effects are rare, but include:*

- Ectopic pregnancy
- Pelvic Inflammatory Disease (PID).

### **What else do I need to know?**

- If you get a sexually transmitted infection with an IUS in place, you may get PID. You may not be able to have children as a result.
- Contact your health care provider at once if you have any signs of infections, such as fever, chills, unusual discharge or foul smelling discharge

### **What do I do if my IUS comes out?**

- Call your health care provider and use another kind of contraceptive such as condoms.

### **Where can I get more information?**

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

**If your IUS comes out, and if you don't want to get pregnant, see a health care provider or pharmacist for emergency contraception as soon as you can.**

### **Glossary:**

**Cervix** – The lower part of the uterus that opens into the vagina. It is also called the “neck of the uterus”.

**Ectopic pregnancy** – A pregnancy which starts to grow outside the uterus – in one of the fallopian tubes (the tube leading from the ovary to the uterus).

**Emergency Contraception** – A method used to avoid pregnancy after sex, because a birth control method failed or was not used.

**Pelvic inflammatory diseases (PID)** – An infection of the uterus, the fallopian tubes or ovaries, which is caused by bacteria. It can lead to infertility if left untreated. Early treatment of PID is the most effective way to prevent infertility and other complications.

**Uterus** – A pear-shaped, hollow organ with muscular walls. The fetus grows in the uterus. The uterus is also called the “womb”.

**Vagina** – The muscular tube inside a woman's body where the menstrual blood comes out from the uterus, where a baby comes out from the uterus during childbirth, and where a penis can go in for vaginal intercourse.

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## What You Should Know About ...

# IUD - Intra-Uterine Device

See Glossary section for definitions of underlined words.

### What is an IUD?

- a small piece of plastic that a doctor or nurse inserts into your uterus to prevent pregnancy.
- The most common IUD is T-shaped with a copper wire.

### How does it work?

- The IUD makes the mucus thick so the sperm can't get into the uterus.
- The IUD creates an environment that is unfriendly to sperm and egg cells.
- The copper in the wire of the IUD destroys sperm.
- The IUD will prevent pregnancy 99% of the time.
- The IUD can stay in place for up to 5 years.

### Where can I get an IUD?

1. See a doctor who will prescribe an IUD.
2. Take the prescription to the drugstore to be filled.
3. Go back to the doctor to put in the IUD.

Some doctors or community clinics have a supply of IUDs in their offices. The IUD can be expensive. Talk to your health care provider if cost is a problem.

### How do I use an IUD?

- A doctor or nurse will examine you to check for pregnancy or any infections.
- A doctor or nurse will do a pelvic exam (internal exam). She/he will insert a speculum (instrument) into your vagina to see your cervix and wash it with an antiseptic solution.
- Next, she/he will insert an IUD into your uterus through the vagina.
- Then she/he will leave the two very thin plastic threads or strings that hang down through the cervix into the vagina. The threads or strings do not hang outside the body.
- You may want to check the strings once in a while to make sure they are still there.

### When should I start using an IUD?

- An IUD can be inserted at any time. Some doctors or nurses prefer to insert them during your period.

### Does an IUD protect me from STIs and HIV?

- **NO.** Always use a latex condom or female condom when you have sex to reduce the risk of getting an STI (sexually transmitted infection) or HIV infection.

### Are there any side effects?

Some *common side effects* are:

- Cramping and discomfort when the doctor puts in the IUD. Ask for pain pills ahead of time
- Heavier and more painful periods
- Expulsion. The IUD falls out.

A few women have *serious side effects*. These are:

- Infections\* (including Pelvic Inflammatory Disease)
- Ectopic pregnancy
- Infertility (not able to have children). This could happen if you get an infection and it is not treated.

**Call your doctor now if you have:**

- Heavy or continuous bleeding
- Fever/ chills
- An unusual smell coming from your vagina which may be a sign of infection
- Unusual or foul smelling discharge
- Severe backache
- Severe cramps.

If the IUD is not right for you, talk to your health care provider about IUS or “Mirena”.

### **What do I do if I want my IUD taken out?**

- If you want to have your IUD taken out, you must see a doctor or nurse. Do not try to take an IUD out by yourself.

### **What do I do if my IUD comes out?**

- Call your health care provider and use another kind of contraceptive such as condoms.

### **Where can I get more information?**

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

**If your IUD comes out, and if you don't want to get pregnant, see a health care provider or pharmacist for emergency contraception as soon as you can.**

#### **\*Infections**

If you get a sexually transmitted infection with an IUD in place, there is a greater chance of getting pelvic inflammatory disease (PID). PID could cause damage to your reproductive organs. You may not be able to have children as a result. So, if you have any signs of infection, such as fever, chills, unusual discharge or foul smelling discharge, you need to contact your health care provider as soon as possible. You need to receive treatment to prevent the infection from developing into PID.

See next page for glossary

## **Glossary:**

**Cervix** – The lower part of the uterus that opens into the vagina. It is also called the “neck of the uterus”.

**Ectopic pregnancy** – A pregnancy which starts to grow outside the uterus – in one of the fallopian tubes.

**Emergency Contraception** – A method used to avoid pregnancy after sex, because a birth control method failed or was not used.

**Pelvic inflammatory diseases (PID)** – An infection of the uterus, the fallopian tubes or ovaries, which is caused by bacteria. It can lead to infertility if left untreated. Early treatment of PID is the most effective way to prevent infertility and other complications

**Sperm** – The male reproductive cell; carried out of the penis in the semen during ejaculation

**Vagina** – The muscular tube inside a woman’s body where the menstrual blood comes out from the uterus, where a baby comes out from the uterus during childbirth, and where a penis can go in for vaginal intercourse.

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## What You Should Know About ...

See Glossary section for definitions of underlined words.

# The Contraceptive Patch (Ortho Evra)

### What is the Contraceptive Patch?

- The Contraceptive Patch is a small, smooth, beige, square patch placed on the skin.
- It contains man-made hormones similar to the natural hormones that already exist in your body.
- It is similar to the Birth Control Pill, except the hormones enter through the skin, not through the mouth.

### How does the Patch work?

- The Patch prevents your ovaries from releasing an ovum (egg) each month.
- The Patch makes the cervical mucus thicker. This makes it harder for sperm to get into the uterus.
- It changes the lining of the uterus. The lining of the uterus gets thinner so it is harder for a fertilized egg to stick to the uterus. Even if an egg is released and fertilized, it should not develop.
- The Patch prevents pregnancy 92-99% of the time.

### How do I use the Patch?

- Place the Patch on the buttocks, abdomen, upper body (front or back, not the breast), or upper outer arm.
- Wear a new Patch every week for 3 weeks in a row. Wear it in a different place each week.
- Always change the Patch on the same day of the week.
- Do not wear the Patch on the 4th week (the Patch-free week). This is the time you get your period.
- Wear a new Patch on the same day of the 5th week to start a new cycle.
- You can wear the Patch while swimming, doing exercise, taking a shower or bath, or during hot and humid weather.

### How soon does it start working?

- If you start the Patch on the first day of your period, it works immediately. If not, it starts working within 7-14 days.
- Use another method of birth control (condoms and foam or sponge) until it starts working.

### Does the Patch protect me from STIs and HIV?

- No. Always use a latex condom or a female condom when you have sex to reduce the risk of getting an STI (sexually transmitted infection) or HIV infection.

### Are there any side effects?

You may feel some minor side effects. If they are very uncomfortable or last longer than a few months, talk to your doctor. Minor side effects include:

- irregular bleeding
- nausea
- headaches

- breast discomfort
- skin irritation at patch site
- menstrual cramps
- upper respiratory infection
- depression or sadness.

### **Is the Patch safe for all women to use?**

Ask your health care provider if it is right for you. Tell him/her about any medical problems. The patch may not be right for you if:

- you smoke, especially if you are 35 or older
- you are breastfeeding
- you weigh more than 198 pounds (it may not be as effective)
- you have a family history of breast cancer
- you have had heart disease, serious liver disease, diabetes, blood clots, or high blood pressure.

### **Where can I get the Patch?**

You can get the Patch from:

- your health care provider
- a teen clinic
- a walk-in clinic
- a community health clinic.

### **Where can I get more information?**

- From your health care provider, community health clinic, or public health nurse
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

**If this method fails, and if you don't want to get pregnant, see a health care provider or pharmacist for emergency contraception as soon as you can.**

### **Glossary:**

**Cervical mucus** – The fluid produced by the cervix. The mucus changes in amount and consistency at different times of the menstrual cycle. Around the time of ovulation, the mucus is clear and slippery.

**Emergency Contraception** – A method used to avoid pregnancy after sex, because a birth control method failed or was not used.

**Uterus** – A pear-shaped, hollow organ with muscular walls. The fetus grows in the uterus. The uterus is also called the “womb”.

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## What You Should Know About ...

# Sterilization for Men (Vasectomy)

### What is sterilization (vasectomy)?

- Sterilization is an operation to make you sterile (unable to have children).
- The operation is called vasectomy. It works 99.9% of the time.
- It is a permanent method of birth control.

### How does it work?

- In a vasectomy, the tubes (vas deferens) that carry sperm from the testicles to the penis are cut and tied.
- Sperm made in the testicles can't get into the fluid (semen) that comes out of your penis when you ejaculate ("cum").

### How is it done?

1. A vasectomy can be done in a doctor's office or in a hospital's out-patient department.
2. You will get local freezing (like the freezing in the dentist's office).
3. The doctor makes a small cut(s) in your scrotum (bag of skin that holds the testicles) to reach the vas deferens.
4. The doctor then cuts the vas deferens and ties the ends.
5. Sometimes, the doctor does not need to make a cut. The skin is pierced (not cut) so that you won't need stitches. This is called "no scalpel" vasectomy.

### Are there any risks to sterilization?

There is very little risk to sterilization if an experienced doctor does the operation.

### How long will it take me to get back to normal?

- Vasectomy is a minor procedure.
- You will need to take it easy for a couple of days.
- You may need to avoid heavy lifting or difficult exercise for a week.

### Does sterilization work right away?

- No. There will be sperm in the vas deferens that was made before you had the vasectomy.
- You will still be able to get your partner pregnant until you give several samples with no sperm present. Your doctor will tell you when and how to give these samples. Your doctor will tell you when you are not producing sperm anymore.
- You need to use condoms or another method of birth control until there is no sperm in your ejaculate ("cum")

### When can I have sex again?

- You can have sex about five days after the operation and when you feel comfortable.
- Talk to your doctor.

### **Will anything be different after the sterilization?**

- The same amount of fluid will come out of your penis as before the vasectomy. The only thing that's different is that there are no sperm in the fluid.
- Your orgasm will feel the same as before the vasectomy.
- You may enjoy sex more because you're not worried about pregnancy.

### **Does it protect me from STIs and HIV?**

- NO. Always use a latex condom or a female condom when you have sex to reduce the risk of getting an STI (sexually transmitted infection) or HIV infection.

### **Where can I get sterilization?**

- Talk to your health care provider.

### **Do I have to pay for sterilization?**

- Vasectomies done in a hospital are completely covered by the provincial health care plan.
- If your doctor does the vasectomy in the office, you'll have to pay a fee to cover the cost of the supplies he or she uses.

### **Can I have my tubes connected again (reverse sterilization) and have children in the future?**

- Sterilization is a permanent method of birth control.
- Do not have a vasectomy unless you are sure that you will not want children in the future.
- Reversing sterilization may not work. It is an expensive operation and not covered by the provincial health care plan.

### **Where can I get more information?**

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## What You Should Know About ...

See Glossary section for definitions of underlined words.

# Sterilization for Women (Tubal Ligation)

### What is sterilization?

- Sterilization is an operation to make you sterile (unable to have children).
- The operation is called tubal ligation (having fallopian tubes tied). It works 99.6% of the time
- It is a permanent method of birth control.

### How does it work?

- In a tubal ligation, the tubes which carry eggs from the ovaries to the uterus are closed.
- This prevents the sperm from meeting the egg.

### How is it done?

1. Tubal ligation is done in a hospital
2. You will get local freezing (like the freezing in the dentist's office) or general anesthesia (you will be "asleep").
3. The doctor makes a small cut in the abdomen so the fallopian tubes can be reached.
4. The doctor will close each tube with a clamp or cut and tie the tubes.
5. This is day surgery. You will be home the same day.

### Are there any risks for sterilization?

There is very little risk to sterilization if an experienced doctor does the operation.

### How long will it take me to get back to normal?

- Tubal ligation is an operation. You will have to rest for about two days.
- You will need to take it easy for about a week.
- You may need to avoid heavy lifting and difficult exercise for several weeks.

### Does sterilization work right away?

- Yes.

### When can I have sex again?

- You can have sex about one week after the operation and when you feel comfortable.
- Talk to your doctor.

### Will anything be different after the sterilization?

- Your orgasm will feel the same as before the tubal ligation.
- You may enjoy sex more because you're not worried about pregnancy.
- Your cycle will not be changed and you will still get your period.

### **Does it protect me from STIs and HIV?**

- No. Always use a latex condom or a female condom when you have sex to reduce the risk of getting an STI (sexually transmitted infection) or HIV infection.

### **Where can I get sterilization?**

- Talk to your health care provider.

### **Do I have to pay for sterilization?**

- Tubal ligation is completely covered by the provincial health care plan.

### **Can I have my tubes connected again (reverse sterilization) and have children in the future?**

- Sterilization is a permanent method of birth control.
- Do not have a tubal ligation unless you are sure that you will not want children in the future.
- Reversing sterilization may not work. It is an expensive operation and not covered by the provincial health care plan.

### **Where can I get more information?**

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

### **Glossary:**

**Birth Control** – The different ways of preventing pregnancy.

**Fallopian Tube** – Two tubes, one leading from each ovary, to the uterus. This is where an ovum (egg cell) may be fertilized by a sperm cell.

**Ovaries** – The female organs that store and release egg cells and produce the hormones estrogen and progesterone.

**Sperm** – The male reproductive cell; carried out of the penis in the semen during ejaculation.

**Uterus** – A pear-shaped, hollow organ with muscular walls. The fetus grows in the uterus. The uterus is also called the “womb”.

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## What You Should Know About ...

# Spermicides

See Glossary section for definitions of underlined words.

### What are spermicides?

- Spermicides are chemical substances that kill sperm to prevent pregnancy.
- The chemical substance is called nonoxynol-9.

### What will spermicides do?

- They will prevent pregnancy 71-82 % of the time.
- They will work better when you:
  - use spermicides with male condoms (or other barrier methods like a diaphragm or cervical barriers)
  - use them every time you have vaginal intercourse.

### How do I use a spermicide?

- You need to put the spermicide into your vagina before intercourse, read your product instructions.
- Do not have a tub bath or douche after intercourse. You need to leave the spermicide in for 6-8 hours after the last sexual intercourse so the spermicide has time to kill sperm. It's okay to shower.

### What are the different types of spermicides?

#### Foam

- It comes in a container that you shake before using (it looks like hair mousse).
- Put the foam into an applicator and insert it into your vagina close to your cervix just before vaginal intercourse.
- If you have vaginal intercourse more than once, you will need to put in more foam each time you have sex.

#### Jelly

- It comes in a squeezable tube.
- Use it with the diaphragm and cervical barriers.

#### Vaginal Contraceptive Film (VCF)

- It is a small, very thin plastic-like square sheet that contains spermicide.
- Fold the VCF and insert it by hand into your vagina. It melts inside the vagina.
- Put the VCF in about 15 minutes before vaginal intercourse.
- If you have sex more than once, put a new film in each time.

#### Suppositories

- They are small oval pellets.
- You need to use your fingers and put one suppository in your vagina 15 minutes before vaginal intercourse.
- Put another one in for repeated intercourse.

### **Do spermicides protect me against STIs and HIV?**

**NO.** Always use a latex condom or female condom when you have sex to reduce the risk of getting a sexually transmitted infection (STI), including HIV.

### **Are there any side effects in using spermicides?**

- They can cause skin irritation.
  - Do not continue using spermicides if you or your partner feel irritation; talk to your health care provider.
- Some research has found that using spermicides that contain nonoxynol-9 may increase the risk of getting HIV and sexually transmitted infections because it can cause skin irritations. The small tears in the skin and open areas of the skin can increase the chance of infection.

### **Where can I get spermicides?**

- You don't need a doctor's prescription for spermicides. You can get them from the drugstore or grocery store.
- They can be expensive. You need to talk to your health care provider if cost is a problem.

### **Where can I get more information?**

- From your health care provider, community health clinic, or public health nurse.
- From the Facts of Life On-Line: e-mail your questions to [thefactsoflife@serc.mb.ca](mailto:thefactsoflife@serc.mb.ca).

**If this method fails, and if you don't want to get pregnant, see a health care provider or pharmacist for emergency contraception as soon as you can.**

### **Glossary:**

**Cervix** – The lower part of the uterus that opens into the vagina. It is also called the “neck of the uterus”.

**Douche** – Rinsing the vagina with water, water and vinegar, or a medicated solution. Health care providers do not recommend this practice as it often causes irritation.

**Emergency Contraception** – A method used to avoid pregnancy after sex, because a birth control method failed or was not used.

**Sperm** – The male reproductive cell; carried out of the penis in the semen during ejaculation

**Vagina** – The muscular tube inside a woman's body where the menstrual blood comes out from the uterus, where a baby comes out from the uterus during childbirth, and where a penis can go in for vaginal intercourse.

Developed in collaboration with Klinik Community Health Centre and Literacy Partners of Manitoba  
Sexuality Education Resource Centre 2007

## DEMONSTRATION: USING A CONDOM PROPERLY

**Objective:** Participants will practise describing how to use a condom.

**Structure:** Large Group

**Time:** 25 minutes

**Materials:** handout: *How to Use a Condom* and *How to Make an Oral Dam*, condoms, penis model, flipchart, markers, overheads, overhead projector.

### Procedure:

Have participants read the handouts. The handouts can be completed during the demonstration or directly afterwards. Follow the demonstration guidelines below. The phrases that are in bold type indicate what participants should be drawing or describing on their handouts.

1. Latex condoms are necessary to prevent transmission of STI/HIV. Lubricated condoms should be used for anal and vaginal sex and must be put on before any genital contact. Non-lubricated condoms are generally used for oral sex, as the lubricated ones have a medicinal taste. **The expiration date should be checked.** Condoms must be stored where they won't be damaged by heat (ex: a drawer, coat pocket, wallet).
2. Condom **packages must be torn open carefully, so as not to damage the condom.** Fingernails and jewellery can also damage condoms.
3. Unroll **the condom a little (about an inch) and then hold it by pinching the receptacle tip with the fingers of one hand.** This is an easy way to hold a slippery condom. This also squeezes the air out of the tip at the same time. Air trapped at the end of a condom can cause pressure to build up and the condom can break.
4. Hold the condom onto the tip of the erect penis (still pinching the end), and with the other hand, roll the condom all the way down the shaft of the penis to the base. Either partner can do this.
5. Pull the penis out immediately after ejaculation by holding onto the base of the condom first. If the penis begins to return to its normally flaccid (limp) state, the condom may slide off and semen may leak out.
6. The condom should be removed away from one's partner, and the used condom thrown away (preferably into a garbage can lined with a plastic bag). Condoms should never be used more than once. Inform the group that while lubricated condoms are usually sufficient on their own, extra lubrication can be used to prevent excess friction and to enhance sensation. Lubrication can be put on the inside and outside of the condom. The only lubrication that is safe to use with

condoms is water-based lubricant, because oil or petroleum based products (ex: Vaseline, hand lotion, etc.) can damage latex. Water-based lubricants are often found in drugstores near the medication used for vaginal yeast infections.

7. After completing the demonstration to the group, have participants form pairs and take turns demonstrating how to properly put on a condom.
8. Once the demonstration is completed, show the *How to Make an Oral Dam* overhead to your group. Explain that the oral dam is placed over the genitals and/or anus to prevent STI transmission during oral sex. When making an oral dam, it is important to use a non-lubricated condom. Lubricated condoms have a medicinal taste, and spermicidal condoms will make the mouth go numb.

# HOW TO USE A CONDOM

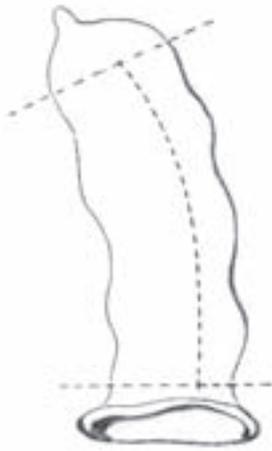
**Instructions:** Draw or describe in the boxes below, the six steps to correct condom use.

1	2
3	4
5	6

## HOW TO MAKE AN ORAL DAM

A latex dam is recommended in male-to-female and female-to-female oral-genital or oral-anal sex.

You can easily make your own dam out of a condom. Since you will be putting your mouth on one side of the condom, use a condom that isn't lubricated.



They are simple to make. Before you begin, unroll the condom, then:

1. Cut off the tip.
2. Cut off the base.
3. Now cut down one side.

You now have a square latex dam.

### For Men

For oral-genital sex between male-to-male or female-to-male, simply use a non-lubricated condom to cover the erect penis.

For oral-anal contact, use an oral dam (above).

## BIRTH CONTROL COUNSELLING GUIDELINES

**Objective:** Participants will learn how to conduct a birth control counselling session.

**Structure:** Large group presentation. Consider having a current volunteer or health practitioner as a guest presenter.

**Time:** 60 minutes

**Materials:** handout: *Birth Control Counselling Guidelines*, flipchart, markers.

### Procedure:

1. **Invite** an experienced volunteer or a health practitioner to come and present to the group on how to conduct a typical birth control counselling session. If no guest speaker is available, **make notes** for yourself to summarize the information in the *Birth Control Counselling Guidelines* into a presentation.
2. **Present** the information in the *Birth Control Counselling Guidelines* handout to the group. Invite participants to ask any questions they may have and respond to questions.
3. **Distribute** handout and ask participants to keep the guidelines for future reference. If they have any questions, tell them to see you after the session or at the next training.

**Note:** If time permits, have volunteers from the group role play parts of the birth control counselling session. Have the guest speaker demonstrate first by role playing with one of the participants. Then, participants can be invited to take over the counsellor role from the speaker.

## GUIDELINES FOR BIRTH CONTROL COUNSELLING

*(Adapted from: Women's Health Clinic, Birth Control Unplanned Pregnancy Counselling Program)*

### BIRTH CONTROL (BC)

This section looks at the BC issues to be discussed in a sexual reproductive health (SRH) counselling session, information on each birth control method and considerations for each method.

The choice of birth control can be frustrating and difficult for clients. Remember that your role is as a facilitator only. You are not responsible for making the decision. You can give information to help clients make informed choices and help themselves. The counselling session should include information, discussion and personal support.

Each counselling session and each client is different and must be treated as such. No standard procedure fits each client's situation and needs. While your counselling techniques must have structure, you won't have a single method.

The following topics should be covered in a SRH counselling/education session:

- reassure confidentiality
- story of past BC methods and experiences
- anatomy and reproduction
- each birth control method, (including the Morning After Pill), how they work:
  - where to obtain
  - advantages
  - disadvantages
  - side effects
  - effectiveness
  - effects on sexuality
  - clients' feelings about it
- relationships
- sexually transmitted infections (STIs) / HIV prevention / Safer Sex practises

- pap / pelvic examination
- plan
- follow-up
- any other concerns they wish to discuss, (ex: dating violence)

## **CONFIDENTIALITY**

At the beginning of each counselling session, counsellors should reassure clients that services are confidential. No one can call the clinic and get your personal information.

## **ANATOMY AND REPRODUCTION**

Many clients find that any method of birth control becomes more effective when they have information about anatomy and reproduction. They can relate their birth control with body function. All birth control sessions should include a discussion about anatomy and reproduction.

## **BIRTH CONTROL METHODS**

Explain the birth control methods – how they work, advantages and disadvantages, effectiveness, effects on sexuality, etc. Allow time for clients to express their concerns or ask questions about each method. Encourage clients to hold and feel each method. Never press clients into making a decision. Provide literature to take home and review. Encourage them to discuss their choices with their partners and call you if they have any questions.

If clients decide on a method, they can make an appointment to see a physician, if required, or call back for an appointment at another time.

## **RELATIONSHIPS**

Don't press client's for personal information if they are unwilling to give it. This could make them feel uncomfortable. If they do wish to discuss their relationship with you, here are a few discussion questions which often open other areas.

- How long has the relationship been going?
- How are they feeling about the relationship?
- What do they like to do together?
- How are they feeling about being sexually active?
- Was this a mutual decision discussed within the relationship?

- Have they ever had anyone do anything to them that they didn't like or want? If so, how did they handle it?
- Are they comfortable within the relationship saying "no" to intercourse? If so, is that respected or are they hassled?

## **GENERAL INFORMATION**

- Be aware that there may be other client concerns that they may or may not want to discuss (ex: abuse, sexual assault).
- When issues such as sexual assault, sexual abuse, dating violence, domestic violence arise in the counselling session, give clients the support and resource information they can use in crisis (ex: 24 hour crisis lines). Discuss a safety plan. Let clients know about ongoing counselling services available.
- If clients want to see medical staff for BC, have them see the staff to arrange an appointment or call back for an appointment.

# **BIRTH CONTROL INFORMATION SESSION**

*(Adapted from: Women's Health Clinic, Birth Control Unplanned Pregnancy Counselling Program)*

## **INTRODUCTION:**

In this section a framework of BC information typically provided in a SRH counselling session is presented. This is one suggested structure, to help volunteers organize and cover all relevant issues. The vast amount of information and the feelings of uncertainty as to how to present the information and ask the important questions can be quite overwhelming at times. This handout will reduce some of the stress we all feel when we start out as volunteers.

Everyone brings something unique and personal to a session, and we hope you feel comfortable modifying the questions to best meet your own needs. However, keep in mind that this script also serves as a way to provide some consistency as new trainees move through the sit-in and co-counselling process. New volunteers are generally able to counsel on their own, based on their use of these guidelines. Try to follow the general headings in the script so you'll provide this consistency for the clients.

## **PRIOR TO THE EDUCATION/COUNSELLING SESSION**

On a regular counselling shift, ensure you go up to the reception area and let them know you are there. Check if there are any clients waiting to be seen. If not, once a client arrives you will be informed. Once you have a client, read the file thoroughly and note the client's age, last normal menstrual period, past history of birth control, etc.

## **GREETING THE CLIENT**

Greet clients in the reception area and introduce yourself. Try to make them comfortable in the room, offer tea, water or coffee.

It is important to remember if the client brings a friend, partner, parent, social worker, etc., into the counselling room, inform them of the clinic's policy to designate some time to be with the client alone. This is to ensure that the client is making a choice that is truly his/her own and allows them to ask questions or share some concerns they may not want to discuss with others present.

If you have another counsellor sitting in with you, be sure to explain to the client that the other counsellor will be just observing and ask for the client's consent to do this.

## INTRODUCTION

Introduce the teen clinic philosophy re: **confidentiality, informed choice**. Assure clients we will support them in whatever decision they make. This will often reduce the tension in clients, especially in teens who may be afraid we will not provide birth control, or that we will contact their parents, etc.

## BEGINNING COUNSELLING

Suggestions:

- **How did you hear about the clinic?**
- **What brings you into the clinic?**
- **How do you feel about being here?** (This acknowledges how difficult talking to a stranger about birth control can be.)
- Provide **positive reinforcement for coming** to the clinic (ex: “I’m really glad that you did come.”, “I know that it can be a pretty tough/scary thing to do.”, “It takes a lot of courage to come and talk to someone.”).

## RELATIONSHIP AND/OR SEXUALITY COUNSELLING

Suggestions:

- **Does anyone else know you are here?** (This indicates how others are involved; also provides the opportunity to find out if the teen’s parents or guardians know if they are sexually active and encourages them to talk to their parents or guardians if appropriate.)
- **How are things going at home?**
- **Are you currently sexually active?** It may be necessary to clarify what you mean by this term, (ex: sexual intercourse).
- **Have you been sexually active in the past?**
- **Are you involved with someone now?**
- **How do you feel about your relationships? How are things going?**
- **What are some of the things you enjoy doing together?**
- Especially with teens, it might be important to find out the **partner’s age**. With a big age difference, you may want to explore issues of abuse or coercion, etc.
- It is a good idea to provide opportunities for them to discuss these issues throughout the session, as they become more comfortable with you.

## REPRODUCTIVE SYSTEM

- Stress the importance of having a good understanding of our reproductive systems in the successful use of birth control methods.
- Briefly discuss **anatomy, reproduction and the menstrual cycle**. It may be helpful to use the diagram of the female and male reproductive systems.
- This review is not intended to insult anyone's intelligence. However, many people at every age do not have entirely accurate information about their bodies. So a brief review for all our clients may be beneficial.
- Be sure to **ask your female clients about their own menstrual cycles** and experiences. **Ask when her last normal menstrual period was, and whether she is concerned that she might be pregnant**. If she is concerned about this, it may be a good idea to do a pregnancy test before continuing with the session.

## THE BIRTH CONTROL METHODS

- Ask what they know about birth control; if there is one they are particularly interested in; and what their experience is using birth control.
- At times, clients may want specific information on one birth control method. An assessment will need to be made as to whose best interest is being served by omitting or discussing other methods. Some considerations may include:
  - Can a person truly make an informed choice without all of the information?
  - The birth control method chosen may not be appropriate (ex: medical reasons for not using the pill).
  - It is important to discuss the correct use of a back-up method with many birth control methods.
- Encourage clients to ask questions, and try to involve them as much as possible (ex: by touching the birth control method).
- Use pictures to provide a useful support to your discussion. Some people learn better by seeing.

## THE METHODS

### Barrier Methods

- male and female condoms
- diaphragm
- vaginal sponge

### **Hormonal Methods**

- birth control pill (BCP) or Oral contraceptive pill (OCP)
- Depo-provera
- contraceptive patch
- Nuva ring
- emergency contraceptive pill (ECP)
- intra-uterine system (IUS)

### **Chemical**

- spermicide
- foam
- film

### **Other methods**

- fertility awareness
- abstinence
- sterilization
- intra-uterine device (IUD)
- withdrawal
- abortion

Review each of the above methods of BC by discussing:

- what it is
- how it works
- proper usage/storage effectiveness
- where to obtain it/cost
- pros and cons
- explore feelings (ex: “Can you see yourself using this method?”)

## **SEXUALLY TRANSMITTED INFECTIONS (STI) AND HIV/AIDS**

Suggestions:

- Try to ensure they are aware of what STIs are.
- Encourage them to ask any questions they may have about HIV.

- Ask what they already know about STIs and HIV.
- Ask if they discussed STIs/HIV with their partner.
- Ask if they know their partner's sexual history.
- Ask how their partner feels about using condoms.
- Ask if their friends ever talk about HIV.
- Stress that you can't tell if someone has a STI, and address values, morals and assumptions about STIs and HIV.

**Discuss protection from STI/HIV with each method of birth control.**

## **COERCION/SEXUAL ASSAULT**

This should be discussed as an issue for clients of all ages, but may be especially important when offering SRH counselling/education to adolescents. Reinforce that everybody has the right to say “no” to intercourse or to any form of sexual intimacy, even when it is protected. If not discussed previously, this is a good time to discuss date rape, sexual coercion, violence, emotional or sexual abuse, etc. **(ex: Have you ever been forced to do anything sexually that you didn't want to do?)**

## **UNRELIABLE BIRTH CONTROL METHODS**

### **Withdrawal**

*Occasionally*, with proper use, this method may prevent pregnancy, however, it is not recommended as a sole means of birth control. Women can get pregnant, even if there is no ejaculation within the vagina. The male discharges a pre-ejaculate fluid that can contain enough sperm to cause a pregnancy.

### **Douching**

Some women douche with water or other special solutions immediately after intercourse, in an attempt to remove semen from the vagina before it enters the uterus. DOUCHING DOES NOT prevent pregnancy or STI. Sperm swim fast, and some will reach the uterus before you've reached the bathroom. Using a douche will actually push some sperm into your uterus as it washes away others.

### **Breastfeeding**

*Occasionally*, breastfeeding on demand may prevent ovulation for some women. It should never be counted on as a form of birth control.

## **PAP TEST/PELVIC EXAM**

Explain to the client that once she is sexually active, it is important to have a pap test and pelvic exam regularly. Explain both.

## **REAFFIRM CHOICE**

Reaffirm clients' choices of birth control, ensuring that this is their choice and not their partner's, parent's, etc. (This may be the time to request time alone with your client if others are present.). Once again, provide positive reinforcement for coming to the teen clinic, and wanting to take responsibility for birth control. Encourage clients to share the information and the responsibility with their partners, if appropriate.

## INTRODUCING ISSUES ABOUT DATING VIOLENCE INTO A SRH COUNSELLING/EDUCATION SESSION

*(Adapted from Women's Health Clinic: Birth Control Unplanned Pregnancy Counselling Program)*

In our work as SRH counsellors, we often find ourselves exploring things beyond pregnancy and birth control with clients. Other important aspects in a session include relationships, sexuality and STI/HIV prevention. Especially when working with younger clients, we want to ensure we have given them an opportunity to discuss other problems and issues which may be important to them. It is our job as counsellors to make clients feel they can discuss these issues with us and that we will offer them some guidance on where they can find help. One example is dating violence and abuse in relationships. There are many places in a typical counselling session to introduce this topic.

### SRH COUNSELLING

In a SRH counselling session, we typically ask clients about their relationships. If they are in a relationship, how is it going? It is important to keep in mind that if these questions are asked close to the beginning of the session, clients may be unlikely to admit anything out of the ordinary. It may be important to return to the issue of the relationship later in the session, once greater trust has been established. Later in a session, ask questions about the partner's age and what kinds of things they enjoy doing together.

- Do they go out in groups, or only the two of them?
- Do they spend all of their free time together, or also with other friends?

Also ask if there is anything they wish to discuss in regard to their relationship.

If clients bring their partners to the counselling sessions, it is important to go over these questions after we've asked the partner to leave the room. If clients have come by themselves, you may want to discuss whether or not their partners are aware they are at the teen clinic. If they haven't told their partners, ask the reason.

In discussion about condoms, ask clients if they have ever had a sexual partner who refused to wear a condom. Explore the circumstances of the situation and ways to deal with it. If it has never come up, what would they do if it did in the future? Have they ever had sex against their will?

It is important that we be able to define situations of abuse for our clients. Some people who are in abusive relationships do not recognize it. Even if clients don't refer to an abusive situation, we can still offer help and refer them for further counselling if they wish.

When discussing abstinence as a birth control option, reinforce that everyone has the right to say "no" to intercourse or to any form of sexual intimacy. Ask clients if they have ever been forced to do anything sexually that they didn't want to.

### **WHAT TO DO IF A CLIENT IS IN A VIOLENT RELATIONSHIP**

If clients reveal they are in an abusive relationship, let them to talk about it if they want. Validate their feelings about the abuse. Let them know about crisis services such as Osborne House and Klinik's 24 Hour Crisis Line and other available supports.

## MODULE ELEVEN

# SEXUALLY TRANSMITTED INFECTIONS AND HIV/AIDS

*This module has been adapted from the Canadian Federation of Sexual Health, Beyond the Basics; A Sourcebook on Sexuality and Reproductive Health.*

### **Session Objectives:**

- Learn the various types of sexually transmitted infections (STI).
- Define and describe HIV.
- Identify attitudes and values about common behaviour or characteristics of people at risk for HIV/AIDS.
- Understand the modes of transmission of STI and HIV/AIDS.
- Identify ways to prevent the spread of STI and HIV.

### **Agenda:**

1. opening activity, icebreaker or discussion (10 minutes)
2. general STI questions and review of common STI (30 minutes)\*
3. STI quiz (20 minutes)\*
4. STI case studies (30 minutes)
5. break (10 minutes)
6. HIV attitudes and values clarification (35 minutes)
7. HIV continuum of risk (30 minutes)
8. closing activity or discussion and evaluations (15 minutes)

Total Time: three hours

\* Facilitators may want to replace the first two activities (general STI questions and STI quiz) with a guest presentation from an STI nurse specialist from the local public health office or STI clinic. A nurse could present information on common STI including transmission, symptoms, treatment and prevention.

## GENERAL STI QUESTIONS

**Objective:** Participants will identify general issues related to STIs: transmission, effect, treatment, community resources and prevention.

**Structure:** small group

**Time:** 20 minutes

**Materials:** handout: *General STD Questions*, STI fact sheets downloaded from the Sexuality Education Resource Centre at [www.serc.mb.ca](http://www.serc.mb.ca), flipchart, markers.

### Procedure:

1. Copy individual questions from the *STD Questions* handout onto the flipchart and tape sheets up at different points in the room.
2. **Divide** your group into smaller working groups (less than six). **Distribute** one handout per group. Each will work on a different question.
3. **Have** groups choose a recorder and a reporter. Give participants 5 to 10 minutes to move from station to station and answer the questions. After a few minutes at each station, have them rotate to the next question, so that each group can add their responses to each question. Continue until each group has added something to each question.
4. Bring groups back to the larger group and have the reporters from each group **share** their group's responses with everyone. The activity leader can review the responses instead of a reporter. Provide additional information as necessary (following the answer key). You can also ask groups if they have anything to add to the responses.
5. **Conclude** by pointing out that the best ways for people to protect themselves from STI is to abstain from intercourse, engage in lower risk sexual activities or, if having intercourse, use condoms every time.

## GENERAL STI QUESTIONS

1. What are the names of some STIs (sexually transmitted infections)?
2. How are STIs transmitted?
3. How do you know if you have a STI?
4. Can all STIs be treated? Where can someone go for help?
5. How can people protect themselves from getting STIs?

## GENERAL STI QUESTIONS

### What are the names of some STIs?

- Chlamydia
- Gonorrhoea
- HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome)
- Human Papilloma Virus (causes genital warts)
- Herpes (one strain of this virus causes cold sores on and around the mouth)
- Hepatitis B
- Syphilis

### How are STIs transmitted?

- through sexual contact: vaginal intercourse, anal intercourse, oral sex
- some through blood-to-blood contact (ex: needle sharing, piercing or tattooing equipment that is not properly sterilized)
- passed from a pregnant woman to her unborn baby before or during birth (HIV can also be passed from an infected mother to her baby through breast milk)

### How do you know if you have a STI?

- Get tested (the test for Chlamydia and Gonorrhoea, for example, is a simple, non-invasive urine test).
- People can have STIs without any symptoms!
- People may also have symptoms including:
  - burning during urination
  - clear, white, or yellowish discharge from the male's urethra
  - a change in the usual vaginal discharge a woman has (different colour, increased amount, unusual odour)
  - pain in testicles
  - lower abdominal pain (for women), pain during intercourse
  - sores or bumps on the genitals
  - unexpected bleeding from the vagina (not a period)

### **Can all STIs be treated? Where can someone go for help?**

- Some STIs can be cured with antibiotics (Chlamydia, Gonorrhoea, Syphilis).
- STIs caused by viruses cannot be cured, although there is often medication that can slow the virus down and improve symptoms. A vaccine has been developed against Hepatitis B.
- For help see a family physician, sexual health centre, community health centres, AIDS and sexual health information lines.

### **How can people protect themselves?**

- Choose not to have sex – the only choice that is 100 per cent effective.
- Choose low-risk sexual activities like kissing, petting, etc.
- Use condoms every time you have sex. They can be used with water-based lubricant but must be used correctly.

## STI QUIZ

**Objective:** Participants will explain the prevention, transmission, symptoms, and treatment for a variety of STIs.

**Structure:** individual

**Time:** 20 minutes

**Materials:** handout: *STI Quiz*

### Procedure:

This quiz can be done out loud in a group or written out individually.

### Answer key

1. A person can have a STI and not know it. **TRUE**
2. It is normal for women to have some vaginal discharge. **TRUE**
3. Once you have had a STI and have been cured, you can't get it again. **FALSE**
4. HIV is mainly present in semen, blood, vaginal secretions and breast milk. **TRUE**
5. Chlamydia and Gonorrhoea can cause pelvic inflammatory disease. **TRUE**
6. A pregnant woman who has a STI can pass the disease on to her baby. **TRUE**
7. Most STIs go away without treatment, if people wait long enough. **FALSE**
8. STIs that aren't cured early can cause sterility. **TRUE**
9. Birth control pills offer excellent protection from STIs. **FALSE**
10. Condoms can help prevent the spread of STIs. **TRUE**
11. If you know your partner, you can't get a STI. **FALSE**
12. Chlamydia is the most common STI. **TRUE**
13. A sexually active woman should get an annual pap test from her doctor. **TRUE**
14. What advice would you give someone who thought s/he might have a STI?  
**Go to a STI clinic or physician's office for a check-up.**

15. How can you avoid getting a STI?

- **Abstain from sexual intercourse.**
- **Engage in lower-risk sexual activities.**
- **Use condoms every time you have sexual intercourse.**
- **Get a Hepatitis B vaccination.**
- **Refuse to share needles.**

## STI QUIZ

### True or False?

1. A person can have a STI and not know it.
2. It is normal for women to have some vaginal discharge.
3. Once you have had a STI and have been cured, you can't get it again.
4. HIV is mainly present in semen, blood, vaginal secretions and breast milk.
5. Chlamydia and Gonorrhoea can cause pelvic inflammatory disease.
6. A pregnant woman who has a STI can pass the disease on to her baby.
7. Most STIs go away without treatment, if people wait long enough.
8. STIs that aren't cured early can cause sterility.
9. Birth control pills offer excellent protection from STIs.
10. Condoms can help prevent the spread of STIs.
11. If you know your partner, you can't get a STI.
12. Chlamydia is the most common STI.
13. A sexually active woman should get an annual pap test from her doctor.

**Short answer** \_\_\_\_\_

14. What advice would you give someone who thought s/he might have a STI?

**Short answer** \_\_\_\_\_

15. How can you avoid getting a STI?

**Short answer** \_\_\_\_\_

## STI CASE STUDIES

**Objective:** Participants will describe STI symptoms and consequences.

**Structure:** small group

**Time:** 25 minutes

**Materials:** handout: *STI Case Studies*, STI fact sheets (downloaded or ordered from the Sexuality Education Resource Centre website at [www.serc.mb.ca](http://www.serc.mb.ca))

### Procedure:

1. **Divide** participants into groups of four or five. Give each a copy of the *STI Case Studies* handout. Explain the group assignment:
  - Read the case studies.
  - Complete the worksheet by using the fact sheets.
2. **Discuss** group work on the case studies and correct any misconceptions (the answer key is provided on the next page).
3. **Conclude** by pointing out that many STIs are serious. While some are curable, others are not. The best thing to do is to prevent getting a STI in the first place. The only 100 per cent effective method of prevention is to abstain from intercourse. Engaging in lower-risk sexual activities decreases risk. If you're having sex, condoms should be used every time.

## STI CASE STUDIES

### Chris and Pat

1. herpes
2. There is no cure for herpes. Medication can be used to heal sores more quickly and to reduce the spread of the virus.
3. Condoms provide some protection but they do not protect all of the skin that touches during intimate contact. Pat should not have intercourse when sores are present or at the first signs of an outbreak (tingling or redness in the usual attack area). Pat may have been infected by Chris or by a previous partner.

### Laura and Shane

1. Small, cauliflower-like warts appear on and around the genitals. However, sometimes there are no symptoms at all.
2. Human Papilloma Virus (HPV) can be passed on to other sexual partners and can increase the risk of cervical cancer.
3. Shane has likely been infected. Condom use is not always helpful in preventing transmission. Condoms provide some protection but they do not protect all of the skin that touches during intimate contact. Having warts removed will decrease the virus particles on the skin. Laura should get regular pap smears.

### Greg

1. gonorrhoea or Chlamydia
2. antibiotics
3. If left untreated, Greg may transmit gonorrhoea/Chlamydia to his other sexual partners or become infertile.

### Karen

1. Antibiotics cure Chlamydia.
2. Discharge may come from genitals, burning or pain while urinating, unusual bleeding from the vagina, pain in the pelvic area. Often there are no symptoms.
3. It can cause pelvic inflammatory disease and infertility.

## STI CASE STUDIES

### A. Chris and Pat

Chris and Pat had been attracted to each other for a long time. When they finally began to date, things moved very quickly and they decided to have sex. Almost a month after having sex with Chris, Pat developed small, fluid-filled blisters on his genitals.

1. What STI might Pat have?
2. How can this STI be treated?
3. How can Chris be protected from getting this STI?
4. What other advice would you give Chris and Pat?

### B. Laura and Shane

Laura and Shane have dated throughout high school. They love and care for each other very much. One evening, Laura told Shane that she had an abnormal pap test and may have HPV.

1. What symptoms might Laura experience?
2. What are the consequences of HPV?
3. How can Shane protect himself from getting HPV?
4. What other advice might you give Laura and Shane?

### C. Greg

Greg was excited to go away to university. At university, he began to visit a local bar on weekends. One night, Greg went home with someone he had just met at the bar and they had intercourse. A few weeks later, Greg experienced pain with urination and discharge from his penis.

1. What STI might Greg have?
2. How can this STI be treated?
3. What will happen if Greg does not get treated?
4. What other advice might you give Greg?

## **D. Karen**

Karen had a crush on someone she worked with at her part-time job. They dated a couple of times and then one night they had intercourse. A few weeks later, after a full gynecological examination by her doctor, Karen found out she had chlamydia.

1. How is chlamydia treated?
2. What symptoms might Karen have?
3. What are the consequences of chlamydia if left untreated?
4. What other advice might you give Karen?

## HIV/AIDS ATTITUDES AND VALUES CLARIFICATION

**Objective:** Participants will identify attitudes and values in relation to common behaviours or characteristics of people at risk for HIV/AIDS.

**Structure:** small and large group discussion

**Time:** 35 minutes

**Materials:** handout: *Values Statements*, signs: Agree, Strongly Agree, Disagree, Strongly Disagree, flipchart, markers

### Procedure:

1. **Explain** this exercise explores the range of values and attitudes about HIV/AIDS that exist in any group. It helps improve understanding about why people hold the attitudes and values that they do.
2. **Post** the four signs around the room. **Explain** to participants that you will read three value statements and after each statement you would like them to circle the word that reflects their degree of agreement or disagreement with the statement. Participants should be spontaneous and honest in their responses. Instruct participants not to put their names on the sheets or share their responses with anyone else.
3. **Read** the following statements out loud giving participants a moment to record their answers:
  - a. **“It is hard for me to understand why people who know how HIV is spread continue to risk infection.”**
  - b. **“Anal intercourse is normal behaviour.”**
  - c. **“I would personally trust a condom to protect me in sexual intercourse with a person I know is infected with HIV.”**
4. **Collect and redistribute** all the sheets. It can be helpful to collect sheets from half the group, hold that set of papers aside, collect the second half and then reverse the sets for redistribution.
5. **Instruct** participants to move to the area where the opinion poll placard matches the response recorded by #1 on the sheet they are now holding. Tell participants that they are going to present the rationale for the opinion position they are now holding as though it were their own opinion. For the duration of this portion of the exercise each person has to act as though the opinions on the sheet are what they really believe. Suggest that no one needs to say “This is not what I really believe, but...” since everyone knows that the person speaking is not holding their own opinion sheet.

6. **Restate** the opinion and have participants talk with the other participants in that area to rationalize this view. Have them take turns very briefly expressing their rationale for the opinion to the rest of the group. **Do not** allow debate, challenge or discussion between the different areas. **Do not** express your own opinions at any time.
7. If participants are struggling to come up with responses, you may want to state one or two yourself. Avoid sarcasm, ridicule or exaggeration. Refer to some of the sample rationales below as needed:

- a. **“It is hard for me to understand why people who know how HIV is spread continue to risk infection.”**

**Agree:** Why would anyone risk contracting a very serious and possibly fatal infection? Most risky behaviours are in a person’s control, so why not avoid them?

**Disagree:** It can be really difficult to change behaviour. Sex and drug use habits are particularly difficult to change. Who am I to judge someone else’s behaviour?

- b. **Anal intercourse is normal behaviour.”**

**Agree:** Human beings have been doing it forever. Who am I to judge what two consenting adults do in the privacy of their own bedrooms? Some people find it a pleasurable and intimate experience. Who judges what is normal? It is used by some to avoid pregnancy.

**Disagree:** It’s perverted, sick, disgusting, immoral against some religious values. The rectum is an exit not an entry. It isn’t tough enough to withstand intercourse, consequently the act creates more vulnerability to infection.

- c. **“I would personally trust a condom to protect me in sexual intercourse with a person whom I know is infected with HIV.”**

**Agree:** When condoms are used properly and consistently, they offer a high level of protection against infection. I’d better feel that way; after all, it’s the message I’m always giving clients.

**Disagree:** I’m not willing to take the risk of having intercourse with an infected person no matter what.

8. When all three statements have been discussed, ask participants to return to their seats. Debrief the activity by asking:
  - a. What did you observe in doing this exercise?
  - b. How did it feel to defend an opinion that was not your own?

- c. What may happen when people's opinions are in the minority? How did it feel to be in the minority if, for example, they were the only one of the group to initially agree or disagree with a statement?
- d. What were the feelings generated by the statements, and by others' points of view?
- e. If the statements had been worded differently, would they have minimized disagreement?
- f. What is the point of doing this activity?
- g. How can we as SRH counsellors show non-judgmental behaviour?

## HIV/AIDS ATTITUDES AND VALUES CLARIFICATION

For each of the following statements, circle the answer that best indicates the extent to which you agree or disagree. **Do not** put your name on this sheet. Do not share your answers with anybody else.

1. It is hard for me to understand why people who know how HIV is spread continue to risk infection.

Strongly Agree

Agree

Disagree

Strongly Disagree

2. Anal intercourse is normal behaviour.

Strongly Agree

Agree

Disagree

Strongly Disagree

3. I would personally trust a condom to protect me in sexual intercourse with a person I know is infected with HIV.

Strongly Agree

Agree

Disagree

Strongly Disagree

## HIV/AIDS CONTINUUM OF RISK ACTIVITY

**Objective:** Participants will discuss the risk levels of various sexual activities, and problem solve how these activities can be made safer.

**Structure:** large group discussion

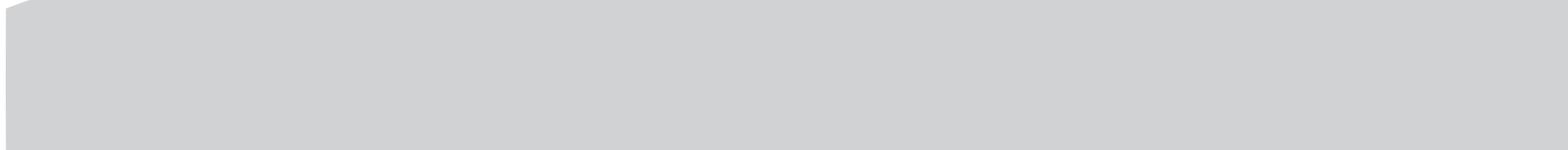
**Time:** 30 minutes

**Materials:** flipchart, cards or post-it notes with sexual activities on them, masking tape

### Procedure:

1. **Draw** a stoplight on the flipchart with the red light representing “high risk”, the yellow light representing “low risk” and the green light representing “negligible or no risk.” **Distribute** cards or post-it notes with different sexual activities written on them to participants. **Have** participants stick their notes onto the flipchart according to what the level of risk is to transmit HIV through this activity.
2. Example of sexual activities and correct risk level (**Note:** do not correct any wrong answers until after the activity is complete):

• anal sex – no condom	High risk
• anal sex – with a condom	Low risk
• vaginal sex – no condom	High risk
• vaginal sex – with a condom	Low risk
• oral sex on a man – no condom	Low risk
• oral sex on a woman – no latex barrier	Low risk
• oral sex on a man – with a condom	Negligible risk
• mutual masturbation	No risk
• kissing	No risk
• hugging	No risk
3. **Once** participants have placed their notes on the flipchart, go through each activity and have the group explain what the activity means. Discuss whether it is a high, low or no-risk activity and why. **Ask** participants to identify ways to make each activity safer.
4. **Note:** Remind the group that some STIs other than HIV, can be spread by activities that are low risk for HIV transmission. For example, while oral sex is lower risk for HIV than unprotected anal or vaginal sex, the risk for other STIs is high.



## MODULE TWELVE

# PREGNANCY OPTIONS

### Session Objectives:

- Explore the issues involved in conducting pregnancy options counselling.
- Learn about options for pregnant women; parenting, adoption and abortion.
- Review a typical pregnancy-options counselling session.
- Become comfortable doing pregnancy-options counselling with adolescents.

### Agenda:

1. opening activity, icebreaker or discussion (15 minutes)
2. presentation: pregnancy options counselling guidelines (60 minutes)
3. break (10 minutes)
4. abortion related video and discussion (90 minutes)
5. closing activity or discussion and evaluations (15 minutes)

Total Time: three hours

Note options for videos includes:

*Its Your Choice for Your Reasons (2003)* – Available from Healthy Child Manitoba Office (HCMO) or the University of Manitoba Library. Video discusses the three main options (parenting, abortion, adoption) for pregnant teens in Manitoba. Includes personal stories from teens who have been pregnant. The booklet discusses the three options and includes contact information for pregnancy agencies in Manitoba.

*Abortion: Tales from North and South (1988)* – Available from the National Film Board of Canada. It was filmed in Thailand, Japan, Ireland, Peru, Columbia, and Canada. This cross-cultural survey provides a historical overview of how church, state and the medical establishment have set policies on abortion, and illustrates the singular reality that only a small number of the world's women have access to safe, legal abortions.

*I Had an Abortion* – Contact the filmmaker at [www.speakoutfilms.com](http://www.speakoutfilms.com). This is a one-hour pro-choice video from the U.S. that presents 10 women's experiences of having an abortion over the past five decades.

Facilitators should pre-screen all videos and choose what is most suited to the participants and training objectives.

## PREGNANCY OPTIONS COUNSELLING GUIDELINES

**Objective:** Participants will learn how to do a pregnancy options counselling session.

**Structure:** large group presentation – consider a current volunteer or health practitioner as a guest presenter.

**Time:** 60 minutes

**Materials:** handout: *Pregnancy Options Counselling Guidelines*, flipchart, markers.

### Procedure:

4. **Invite** an experienced volunteer or a health practitioner to present to the group on how to conduct a typical pregnancy options counselling session. If no guest speaker is available, make notes for yourself to summarize the information in the *Pregnancy Options Counselling Guidelines* into a presentation.
5. **Present** the information in the *Pregnancy Options Counselling Guidelines* to the group. Invite participants to ask questions.
6. **Distribute** handout and ask participants to keep the guidelines for future reference. If they have any questions, tell them to see you after the session or at the next training.

**Note:** If time permits, have volunteers role play parts of the pregnancy options counselling session. Have the guest speaker demonstrate first with one of the participants. Then, participants can be invited to take over the counsellor role from the speaker.

## **GUIDELINES FOR PREGNANCY COUNSELLING/ EDUCATION SKILLS**

*(Adapted from Women's Health Clinic Unplanned Pregnancy Counselling Guidelines)*

The counsellor should be experienced in and use techniques designed to support clients and help them clarify their feelings and beliefs (values clarification).

Counsellors should know the best methods for sharing information.

Following is a list of counselling goals and specific techniques:

### **SUPPORT**

1. Develop a sense of rapport and feelings of warmth.
  - a) Use first names.
  - b) Use non-verbal communication: eye contact, nod head in agreement, posture (ex: leaning toward the woman), facial expressions (ex: smiling), tone of voice, etc.
2. Convey understanding and empathy.
  - a) Be non-judgmental.
  - b) Offer feedback on what the woman says.
  - c) Validate the woman's feelings.
  - d) Use silence; it often encourages the woman to verbalize if you make it an interested, expectant silence. This indicates you want her to express her most important needs. It also gives the client the opportunity to collect and organize her thoughts, to think through a point, or to consider introducing a topic of greater concern to her than the one being discussed.
3. Develop an atmosphere of trust and acceptance.
  - a) Accept the client's behaviour by giving her permission to express any feelings she may have, or to remain silent. Accepting does not indicate agreement, but is non-judgmental. It signifies that you are sensitive to her, and that she is a participant rather than a passive observer.
  - b) Express closeness and interest, without violating her privacy.
  - c) Stress confidentiality.
  - d) Be straightforward and honest
  - e) Demystify your role by explaining why you're asking for certain information.
  - f) Accept and respect her right to privacy if she doesn't want to talk or answer questions.

## CLARIFY VALUES

1. Help the client identify and sort out her feelings and beliefs.
2. Ask open-ended, non-directive questions: How do you feel about the pregnancy? When did you think you might be pregnant? Are you using birth control? Does anyone know?
3. Offer general leads (give encouragement to continue): General leads such as “Go on...” or “Then what?” Leave the direction of the discussion almost entirely to the client. You’ll be showing you are interested in what has been said and are interested in what is to come next. Counsellors should talk little and use non-verbal encouragement to help the client continue.
4. Clarify the relationship of events in time. Putting events in their proper chronological sequence helps both the counsellor and client to see them in perspective.
5. Make observations by saying what you see and hear. Often, the counsellor observes signs of anxiety or nervousness which they can call to the client’s attention. This can encourage their mutual understanding of the behaviour or feeling through the discussion. Counsellors can also observe their own reactions. In calling the client’s attention to herself, the counsellor is encouraging the client to notice herself and to begin to take responsibility for describing her feelings.
6. Encourage the description of perceptions by asking the client to state what she perceives.
7. Encourage the client to make comparisons. Comparing ideas or experiences or interpersonal relationships may bring out recurring themes. While comparisons are to be encouraged, it is rarely helpful for counsellors to introduce experiences from their own lives for this purpose. Too frequently, the result is a discussion focused on the views and problems of the counsellor.
8. Restate the main idea expressed. Often, putting certain statements into different words brings out related aspects of the material which may have escaped the client’s attention.
9. Reflect by directing back to the client questions, feelings and ideas. By encouraging the client to take responsibility for her own decisions and ideas, the counsellor helps her separate herself from the opinions of others and make better choices for herself.
10. Focusing is a useful technique for helping clients direct their energies at important points, rather than jumping around superficially. Counsellors should be aware that clients may not be ready to focus, and they should use this technique with caution.

11. Seek clarification so you can better understand the client's feelings. Ask specific questions. Also, the client may become clearer about her own feelings and beliefs if an outside person asks specific questions.
12. Present reality to help the client to assess her options realistically.
13. State the implied, by voicing what the client has hinted at or suggested. Attempt to translate into feelings or clearly state feelings that are expressed indirectly.
14. Organize and summarize when there is a time limit to the session.
15. Encourage clients to make a plan of action by providing her with all information that affects her choice.

### **PRESENT INFORMATION: OFFER DATA TO HELP THE CLIENT MAKE A PLAN OF ACTION ABOUT HER PREGNANCY**

To present the most relevant information, the counsellor should:

- Find out what the client already knows.
- Find out her priorities in the context of her social realities.
- Offer the information in a clear, non-technical way.
- Explore the client's understanding of the information provided in the session itself.

### **COMMON MISTAKES MADE IN COUNSELLING**

1. Taking over or being motherly is often counterproductive, since it shifts responsibility for decision-making to the counsellors, rather than leaving it with the client.
2. The counsellors should be very careful in using self-disclosure to clarify options or to present information. Relating your own experiences may be counterproductive, if they focus the discussion on yourself rather than on the client.
3. Being condescending or patronizing will often interfere with counselling and make the client feel as though she is only being accepted conditionally. Often it makes the client angry and is counterproductive to good counselling.

### **THE PREGNANCY OPTIONS COUNSELLING SESSION**

It is important to realize that as a counsellor you cannot make the decision for the client. What you can do is:

1. Provide reassurance that you are not sitting in judgment, but are there to support her in **WHATEVER** she decides.
2. Listen carefully and reflect back to her what she is thinking and how she is feeling about situations.

3. Give her any important information which sheds new light on the problem and helps her move closer to her decision. (resources for financial help, therapeutic abortion (TA) procedure, etc.).
4. Help her explore her alternatives, feelings, needs, conflicts, and concerns.
5. Reaffirm to her that it is HER decision.
6. Provide empathy.
7. Be attentive to her individual needs and support her feelings in verbal and non-verbal ways.
8. Make the necessary referrals.

### **TYPICAL PREGNANCY OPTIONS COUNSELLING/ EDUCATION SESSION**

Following are guidelines that need to be addressed in a pregnancy counselling session. The order depends on your own counselling style and the needs of your client.

- Was there a positive pregnancy test? By whom/when/where?
- Are there other symptoms of pregnancy?
- What is the date of the first day of the last normal menstrual period (LNMP)?
- How is client feeling about the pregnancy?
- Who has she told and what were the reactions?
- What is her relationship with partner and parents? (Check for abuse).
- Who does she feel will support her?
- What are her plans for the future?
- What are her resources for continuing? (financial situation/support network)
- How does she feel about adoption?
- How does she feel about abortion?
- Note the abortion **Procedure:**
  - referral process
  - anaesthetic
  - laminaria (if applicable)
  - complete physical examination
  - aftercare
  - follow-up examination

- What are her feelings around the procedure?
- What's the opportunity for follow-up counseling?
- Note birth control information:
  - Was she using any birth control?
  - How does she feel about her experiences with birth control?
  - Does she understand the need for birth control after the abortion/childbirth?
  - Review her birth control plan and encourage her to return for a more detailed birth control discussion after the abortion/childbirth.
- Ensure you discuss STI/HIV prevention and safer sex issues.
- Ask her how she sees her life after the abortion/childbirth.
- Find out what she plans to do:
  - Does she want you to make a referral?
  - Is she going to go home and think about the discussion – perhaps discuss it with significant other?
  - If the client is undecided, make arrangements to call or see her again, soon, to confirm her decision.
- Provide the client with the clinic's phone number and explain that the staff or you are available to talk if she needs support or has any questions, concerns or fears.
- Let your client know that if she is unable to contact you directly, that she can call the clinic if she has any questions or concerns.

# TYPICAL PREGNANCY OPTIONS COUNSELLING/ EDUCATION SESSION

## INTRODUCTION

In this section, a framework of a typical pregnancy decision-making counselling session is presented. It is one suggested format, designed to help SRH counsellors organize and cover all the relevant issues. The vast amount of information and the feelings of uncertainty about presenting the information and asking the important questions can be quite overwhelming at times. This will reduce some of the stress we all feel when we start out as volunteers.

Everyone brings something unique and personal to a session, and we hope you feel comfortable modifying the questions to best meet your own needs. However, keep in mind that this script also serves as a way to provide some consistency as new volunteers move through the training and co-counselling process. New volunteers are generally able to counsel on their own, based on their use of these guidelines. Try to follow the general headings in the script so you'll provide consistency for the clients.

It is important to acknowledge reality: Women can definitely get infected with STIs or HIV during intercourse. Exploring the behaviour and these issues within ourselves and with our clients is crucial. It provides us all with an opportunity to share, address and reduce fears about STIs / HIV and their impact on our sexuality and relationships.

HIV and STIs can be introduced within a pregnancy options counselling session. You should not assume your client is in too much crisis to discuss these issues. She may actually be thinking about this on her own, and you may help her clarify confidential information, which may help her choose. It can also support her in keeping herself healthy.

It is important to remember if the client brings her friend, partner, parent, social worker, etc., into the counselling room, inform her of the clinic's policy to make time to be with the client alone. This ensures the client is making a choice that is truly her own and provides her with the opportunity to ask questions or share some concerns she may not discuss with others present. This also applies to the situation most common at a teen clinic, when two or more friends who are all clients, come together for a session. It is important to see each of them separately, possibly at the end of the session, especially when one client is sexually active and another is not.

Introduce the clinic's confidentiality philosophy. We offer confidentiality within all legal requirements. Assure her we will support whatever decision she makes. This will often reduce tension, especially for teens who may be afraid we will not provide her with what she wants, or that we will contact her parents, etc. Reassure her that abortions are available in Manitoba if that is her choice and you can discuss the steps needed to obtain an abortion in the session.

### **Suggested questions:**

How did you hear about teen clinic? How are you feeling right now? (This acknowledges how difficult talking to a stranger about pregnancy options can be).

Provide her with positive reinforcement for coming to the clinic (ex: "I am really glad that you did come". "It takes a lot of courage to come and talk to someone.").

### **Discussing Circumstances of the Pregnancy**

- Reaffirm that there is a positive pregnancy test. If she hasn't had one at the clinic, get urine sample, test it and record name and result in the Pregnancy Test Results Book. Explain that the clinic must do the test for its own records.
- Find out last normal menstrual period (LNMP) and estimated gestational age (EGA) – Use wheel.
- Discuss any other pregnancy symptoms.
- How are you feeling about being pregnant?
- Who have you told about the pregnancy?
- Have you ever been pregnant before? Previous abortions? Previous births?
- Were you using any birth control? Be careful about sounding judgmental. This question can also be discussed in the context of aftercare if client's choice is abortion.
- Does the man involved know? Don't use the term boyfriend because he might not be the one involved and she may feel awkward about it. This question will be helpful in exploring the relationship and possibilities of abuse or sexual assault.
- How has he reacted?
- Before this, what was your experience with birth control? Safer sex practises? STIs/HIV?
- Have you ever discussed HIV, STIs or safer sex with the man involved or your partner?
- Have you told your parents or guardian? How have they reacted? Who will provide extra support if she needs it? Consider making a referral for additional counselling.

## Options

### Counselling:

Explain to the client the clinic's philosophy of discussing all pregnancy options to ensure she makes an informed choice. Be aware of language used: rather than saying "father of child," use "man involved;" rather than "child, baby," use "fetus, pregnancy;" rather than "keeping the baby," use "parenting;" rather than "giving up the baby," use "place for adoption."

It is important to spend some time on all of the options. Suggestions are:

- Do you know all your options and have you thought about them?
- Have you decided what might be the best decision for you?
- How did you make that decision?

### Adoption:

- How do you feel about adoption?
- What has been your experience with adoption?
- What do you know about adoption?
- Would you like to know a bit about the adoption process?
- If you try to imagine, how do you think you would feel about an adoption at the time of birth?
- Have you thought about how you would support yourself during the pregnancy (ex: financial, emotional)?
- How do you think you will feel carrying this pregnancy to term (ex; especially for teens, friends' reactions, family support, etc.)? Mention this as being a legally binding contract. How do you think the significant people in your life will respond to this decision (ex: availability of resources, especially for teens)?

For more information on adoption, refer to the section on continuing pregnancy below.

### Parenting

- How do you feel about being a parent?
- How do you think this will affect your life?
- What is your experience with babies or children?
- What kind of support and financial resources do you feel you have?

For more information on parenting, refer to the section on continuing pregnancy below.

**Abortion:**

- How do you feel about abortion?
- What do you know about having an abortion?
- Do you know anyone else who has had one?
- Would you like to know more about the procedure?

**Confirming her decision**

Clarify her feelings about the options and how she feels about her decision. Give her the opportunity to discuss any concerns, questions or issues.

**Exploring Options in More Detail**

- If the client chooses parenting, refer to *For Clients Whose Choice is Continuing*.
- If the client chooses adoption, refer to *For Clients Whose Choice is Continuing*.
- If the client chooses abortion, refer to *For Clients Whose Choice is Abortion: Referral Process*.

**For Clients whose Choice is Continuing (Parenting or Adoption)**

When making a decision to place a child for adoption, clients may struggle with the feeling that they are giving the child up. This language is extremely negative and we must always be conscious of our words. A more positive, less woman-blaming description would be to say: “The client has made a thoughtful plan to place the child for adoption.” The significant point to highlight is the fact that this woman has made a plan for what she sees as the best interest of the child and herself at that point in her life. She is not simply giving the child away. This, (as do all of the choices), requires a great deal of strength on the part of the woman. This strength should be acknowledged and validated. (Ex: “It really sounds to me as though you have put a great deal of time and thought into creating this plan.” “It takes a lot of courage and strength to make this kind of decision”).

Good health during pregnancy includes acknowledging our sexuality and promoting healthy sexual practises. A part of this could be integrating safer sexual practises as a part of prenatal care for the client. This could also increase your client’s sense of comfort and confidence in using these methods after birth. This discussion could include an overview on the use of condoms and alternatives to intercourse as methods which could greatly reduce the probability of HIV and STIs. (Ex: “Although you do not need birth control to prevent pregnancy at this point, you are not protected against STIs or HIV infection. Can you tell me how you feel about that?”)

Another important consideration is the way that, we as counsellors, feel about adoption and/or parenting. This will come out in a counselling relationship. It's essential to explore our own biases and try to keep them in perspective. For example, if you cannot comprehend how anyone could go through an entire pregnancy without keeping the child, you may never present adoption as a real option to your clients.

If adoption is her choice, or if she needs more information to make her decision, the following information should be given:

- the legalities of placing a child for adoption
- the different types of adoption
- the birth mother's rights
- the role of the Child and Family Services Agency / Manitoba Family Services and Housing / Adoption Agencies
- the post-adoption registry

If **parenting** or **adoption** is her choice, some, or all of these issues might apply:

- special considerations for minors
- legal information (ex: custody, child support)
- resources:
  - financial
  - educational
  - employment
  - housing
  - prenatal
  - postnatal
  - legal
  - emergency (food, clothing and shelter)
  - long-term emotional support (re: continuing pregnancy)
  - general counselling resources (re: relationship, parenting)

Refer to the next section on Continuing Pregnancy Resources for more information on these issues.

## **For Clients Whose Choice is Therapeutic Abortion**

Introducing the issues of HIV and STIs can be done in several places for clients whose choice is abortion:

- addressing birth control plan
- when discussing therapeutic abortion aftercare
- during post-therapeutic abortion follow-up.

Explore your client's ability to assess her level of risk.

## **Therapeutic Abortion Procedure**

A brief review of the female reproductive system may help when describing the therapeutic abortion procedure and what the woman will be experiencing. It could help ease her mind, because there are many misconceptions and horror stories about abortions. Ask her what she knows about abortions.

Tell her there is a need for complete physical and pelvic examinations and STI swabs before she has her abortion. Explaining that these tests and examinations are a standard part of the abortion process can help calm her fears.

Discuss the issues of HIV and safer sex practices within the context of how long she may have to wait until her first appointment, or the procedure itself.

Explain to her that, at present, only local anesthetics are used on women having abortions. The reasons for this are:

- less of a health risk for the woman
- quicker recovery and release from the hospital

Discuss the laminaria insertion which occurs on the day before the procedure, using the sample in the file. (Please Note: Not all abortion referral doctors use laminaria).

Depending on the number of weeks pregnant she is, you should discuss the actual procedure to be used:

- vacuum aspiration or dilation and curettage (D&C)
- manual vacuum aspiration
- dilation and evacuation
- medical abortion

Remember to also mention the Rh blood factor (if applicable) and discuss aftercare thoroughly.

## **Therapeutic Abortion Referral Process**

Explain the general process of obtaining an abortion in Manitoba, the need for a doctor's examination and the appointments required.

The client has five options when deciding what route she could take. She may choose from:

1. seeing a private physician
2. going to Women's Health Clinic Portage
3. going directly to the Pregnancy Counselling Clinic at Health Sciences Centre (HSC)
4. going out of the province
5. medical abortion (when available)

A discussion about her needs will help clarify which option would be best for her. The client's estimated gestational age will affect what choices she has. Ensure these limitations are discussed with her.

Always check out her feelings, because a lot of this information may be overwhelming. Also, encourage her to ask questions.

## **Post-Therapeutic Abortion Aftercare**

Discuss aftercare needs and how she will take care of herself immediately following her procedure. This is an appropriate time to be bringing up the topics of her plans for birth control and risk reduction for STIs and HIV. Support and affirm your client in her efforts to (re)gain control in her life (ex: "Can you tell me your plans for dealing with the risks of pregnancy and STI and HIV after your abortion? Have you thought at all about what methods you might be using?").

## **Decision-Making – For All Options:**

Reaffirm the client's choice or allow her time to think about it if she is unsure at this time. Explain, however, that although you do not want to pressure her into making a quick decision, there is the reality of the time element, if she is considering abortion – inform her of the increased risks of late abortions and the cut-off date.

## **Birth Control and Safer Sex Practises**

The pregnancy options session should be devoted to discussing the pregnancy. However, it is important that you help your client develop a plan for birth control and safer sex. Offer her an opportunity to ask questions about birth control and HIV and STI, and suggest that she may come back later for more in-depth birth control counselling, HIV information and testing, or a STI check, when more time could be devoted to the topic. Be sensitive to the fact that, at this time, most women may be overwhelmed with what they are experiencing now. They may be quite disillusioned and disappointed with birth control and safer sex. However, it is important not to assume this is how she is feeling and that she is in too much of a crisis to talk about these issues. It's most important to ensure she has effective methods and strategies to rely on when she resumes intercourse. Stress information that will help her develop a plan to keep herself healthy.

## **Contracting**

Provide her with appropriate handouts and discuss follow-up arrangements. Explain that you would like to find out how things went for her (if abortion) and how she is doing. Give her the opportunity to come back and talk about her experience and encourage her to share it with someone she can trust. Also, encourage her to look through the pamphlets and take what she finds interesting. Review her plans for birth control and any strategies for safer sex. Also review any follow-up plans that have been discussed or need to still be arranged.

## **Appointment Bookings**

- 1) ADOPTION – Tell her to contact Child and Family Services or other appropriate agencies (see next Section).
- 2) PARENTING – Tell her to contact appropriate agencies and resources (see next Section).
- 3) ABORTION – Make appropriate referrals based on her selection of one of the five options listed above.

NOTE: If the session takes place in the evening, you will not be making appointments until the following day. Explain to her that all the information will be in her chart and contract with her about when she can call to find out the appointment times. Remember to record the information in the chart as soon as the appointment is made. When making abortion appointments, remember to have your client's name, date of birth, address, phone and last normal menstrual period with you.

# GUIDELINES FOR COUNSELLING CONTINUING PREGNANCY

*(Adapted from: Women's Health Clinic Unplanned Pregnancy Counselling Program)*

## INTRODUCTION

The guidelines for a pregnancy options session apply equally to those clients who choose to continue a pregnancy. This section highlights issues specific to continuing.

All unplanned pregnancy counselling sessions begin with an exploration of the clients' physical and emotional response to the pregnancy and her support network (resources) for emotional and financial care. It should address her feeling about the three options (parenting, adopting and abortion) and her choice at this time. Issues considered when counselling a client whose choices at this time are a) undecided b) adoption or c) parenting.

## UNDECIDED

Following is a list of questions on some issues that may come up when counselling an ambivalent client:

1. Is there a lack of or false information? ("Can you tell me what you know about the abortion/adoption procedure?")
2. Is the client receiving pressure from someone? ("How do you feel about your partner's wish to have/not have a baby? Are you feeling free to choose what is best for you?")
3. Does the client have moral conflicts? ("Before you were pregnant, how did you feel about abortion/adoption?")
4. Are there further issues which the client has not disclosed? ("Can you tell me about any other concerns you have in making this choice?")
5. Does the client need to clarify issues? ("Can you tell me whether you want to have a baby/or do not want to have an abortion/or place a baby?")
6. Is the client feeling overwhelmed? ("This is a very difficult choice for any woman to make. Can we look at the circumstances that exist which could make abortion/adopting/parenting the BEST choice for you at this time?")

Provide some time for the client to think about her circumstances and her options. If the pregnancy is advanced and the client is considering abortion, you might suggest she think about what you have discussed overnight and a contact will be in touch the following day.

Summarizing helps clarify the issues for the client. One way to do this is to explore the pros and cons of each option and list them. This is something you could do together or suggest the client do herself.

Example:

Effects on self: today	Effects on self: future	Effects on significant others
Pros / Cons	Pros / Cons	Pros /Cons

**Parenting:**

**Adoption:**

**Abortion:**

Provide some basic information about the process of all three options.

Reassure the client we will provide support and referrals no matter what her choice is.

It is very important to provide follow-up care for the undecided client. In most cases, an ambivalent client will require contact before one week has passed. We may continue to follow up for up to one month, if appropriate. Encourage the client to return for further counselling.

## **ADOPTION**

Some issues of concern to a woman who is considering adoption include:

1. How do you feel about adoption?
2. What do you know about the process; your rights and responsibilities; and the adoptive parent's rights and responsibilities?
3. What plans do you have for emotional, physical and financial care during pregnancy?
4. Can you tell your friends, family, etc. of your plan? If not, will you go away? Where will you go? How will you explain your absence to friends, family, etc.?

5. If you leave home, will you qualify for assistance elsewhere?
6. How will going through the pregnancy affect your relationship with your partner, friends, family, etc.?
7. Can you accept yourself and the developing baby through the pregnancy?
8. Can you sign over your legal right and responsibility as parent for the child, to someone else?

Some topics which should be addressed:

1. Explore the pros and cons of the client's choice.
2. Provide the client with the detailed information about the adoption procedure available in the counseling room/clinic. Go through this information together if appropriate.
3. Refer your client to appropriate agencies for support during the pregnancy. One way to do this could be to explore each topic with the client (ex: financial, educational, employment, etc.).
4. It is important to use the framework of providing information as a means to continue to explore feelings.
5. Follow up with the client within two weeks and up to one month to check on her plan and circumstances. Encourage her to return to the clinic for further counselling when appropriate. This follow-up must be documented in the client's chart. The following format can be used for documenting:

DATA:

CARE:

PLAN:

ASSESSMENT:

## **PARENTING**

The following questions specifically apply to clients considering parenting:

1. Have you parented before? Do you know anyone in a similar situation who decided to parent? How did things go for you/them?
2. How do you see yourself as a parent? How is your ideal similar or different from your circumstances now?
3. Is there room in your life for a child or another child?
4. What effect will your choosing to parent have on your life today? In the future?

5. How will your choosing to parent affect your relationship with your partner, family, friends?
6. What are your goals and plans for the future? How will parenting affect them? What are the pros and cons of parenting?
7. What would you like to give to a child you would parent? How is it similar or different to what you could give this child?

The following lists topics you may want to discuss with a client who chooses to parent:

1. Care – prenatal and postnatal
  - access to health care
  - emotional support
  - financial support
  - physical supports (ex: housing, legal resources, etc.)
2. Goals:
  - Educational (if applicable)
    - present education and plans for the future
    - effects of parenting on these plans
    - alternatives and resources available
  - Employment (if applicable)
    - present employment, plans for the future
    - effects of parenting on these plans
    - alternatives and resources available
3. Follow-up: It is, as always, very important to provide follow-up care for the client. Follow up with the client from two weeks up to one month after the session, depending on the client's circumstances. It might be appropriate, with a client choosing to parent, to follow up in two to four weeks on her plan for care and support. The important point is to provide follow-up care that is appropriate to the individual woman. Always encourage the client to return for any further counselling, she might need. This follow-up must be documented in the client's chart. The following format can be used for documenting:
  - DATA:
  - CARE:
  - PLAN:
  - ASSESSMENT:

## REFERENCES

AIDS Committee of Toronto, *National HIV/AIDS Volunteer Training Kit*. Toronto, 1998. available online: <http://www.actoronto.org/website/home.nsf/cl/act.docs.0339>

Canadian Federation of Sexual Health, *Beyond the Basics: A Sourcebook on Sexual and Reproductive Health Education*. Ottawa, 2005. Available online: <http://cfsh.ca/ppfc/media/sourcebook2006contentwithform.pdf>

Immigrant Women's Association of Manitoba, *Inclusive Organizations: A Tool for Continuous Improvement in Health and Social Service Agencies*. Winnipeg, 2006.

Manitoba Harm Reduction Network, *What Does Harm Reduction Mean to Me, My Work and My Community*. Winnipeg, 2007.

Statistics Canada, *National Survey of Giving, Volunteering and Participating*. Ottawa, 2000. Available online: <http://www.statcan.ca/english/Dli/Data/Ftp/nsgvp/nsgvp2000.htm>

Volunteer Canada, *Volunteer Connections: The Benefits and Challenges of Employer-Supported Volunteerism*. Ottawa, 2001. Available online: <http://www.volunteer.ca/volunteer/pdf/ESVEnglish.pdf>

Winnipeg Regional Health Authority, *Volunteer Manager's Handbook*. Winnipeg.